112TH CONGRESS
2D SESSION

S. ______

To improve the health of minority individuals, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Mr. AKAKA (for himself and Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on ____________________

A BILL

To improve the health of minority individuals, 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.**

4 This Act may be cited as the "Health Equity and
5 Accountability Act of 2012".

6 **SEC. 2. TABLE OF CONTENTS.**

7 The table of contents of this Act is as follows:

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1 **SEC. 3. FINDINGS.**

2 The Congress finds as follows:

3 (1) The population of racial and ethnic minori-
4 ties is expected to increase over the next few dec-
5 ades, yet racial and ethnic minorities have the poor-
6 est health status and face substantial cultural, so-
7 cial, and economic barriers to obtaining quality
8 health care.

9 (2) Health disparities are a function of not only
10 access to health care, but also the social deter-

1 minants of health—including the environment, the
2 physical structure of communities, nutrition and
3 food options, educational attainment, employment,
4 race, ethnicity, sex, geography, language preference,
5 immigrant or citizenship status, sexual orientation,
6 gender identity, socioeconomic status, or disability
7 status—that directly and indirectly affect the health,
8 health care, and wellness of individuals and commu-
9 nities.
10 (3) By 2020, the Nation will face a shortage of
11 health care providers and allied health workers and
12 this shortage disproportionately affects health pro-
13 fessional shortage areas where many racial and eth-
14 nic minority populations reside.
15 (4) All efforts to reduce health disparities and
16 barriers to quality health services require better and
17 more consistent data.
18 (5) A full range of culturally and linguistically
19 appropriate health care and public health services
20 must be available and accessible in every community.
21 (6) Racial and ethnic minorities and under-
22 served populations must be included early and equi-
23 tably in health reform innovations.
24 (7) Efforts to improve minority health have
25 been limited by inadequate resources in funding,

1 staffing, stewardship and accountability. Targeted
2 investments that are focused on disparities elimi-
3 nation must be made in providing care and services
4 that are community-based, including prevention and
5 policies addressing social determinants of health.
6 (8) In 2011, the Department of Health and
7 Human Services developed the HHS Action Plan to
8 Reduce Racial and Ethnic Health Disparities and
9 the National Stakeholder Strategy for Achieving
10 Health Equity, two strategic plans that represent
11 the country's first coordinated roadmap to reducing
12 health disparities. Along with the National Preven-
13 tion Strategy and the National Health Care Quality
14 Strategy, these comprehensive plans will work to in-
15 crease the number of Americans who are healthy at
16 every stage of life.
17 (9) The Department of Health and Human
18 Services also developed other strategic planning doc-
19 uments to combat disease disparities with a high im-
20 pact on minority populations including the National
21 HIV/AIDS Strategy, and the Action Plan for the
22 Prevention, Care and Treatment of Viral Hepatitis.
23 (10) The Patient Protection and Affordable
24 Care Act, as amended by the Health Care and Edu-

cation Reconciliation Act, represents the biggest advancement for minority health in the last 40 years.

TITLE I—DATA COLLECTION AND REPORTING

SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) PURPOSE.—It is the purpose of this section to promote data collection, analysis, and reporting by race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, and socioeconomic status among federally supported health programs.

(b) AMENDMENT.—Title XXXIV of the Public Health Service Act, as amended by titles II and III of this Act, is further amended by inserting after subtitle A the following:

"Subtitle B—Strengthening Data Collection, Improving Data Analysis, and Expanding Data Reporting

"SEC. 3431. HEALTH DISPARITY DATA.

"(a) REQUIREMENTS.—

"(1) IN GENERAL.—Each health-related program operated by or that receives funding or reimbursement, in whole or in part, either directly or in-

1 directly from the Department of Health and Human
2 Services shall—
3 ‘‘(A) require the collection, by the agency
4 or program involved, of data on the race, eth-
5 nicity, sex, primary language, sexual orienta-
6 tion, disability status, gender identity, and so-
7 cioeconomic status of each applicant for and re-
8 cipient of health-related assistance under such
9 program—
10 ‘‘(i) using, at a minimum, the stand-
11 ards for data collection on race, ethnicity,
12 sex, primary language, sexual orientation,
13 disability status, gender identity, and so-
14 cioeconomic status developed under section
15 3101;
16 ‘‘(ii) collecting data for additional
17 population groups if such groups can be
18 aggregated into the minimum race and
19 ethnicity categories;
20 ‘‘(iii) additionally referring, where
21 practicable, to the standards developed by
22 the Institute of Medicine in ‘Race, Eth-
23 nicity, and Language Data: Standardiza-
24 tion for Health Care Quality Improve-
25 ment’; and

1 ''(iv) where practicable, through self-
2 reporting;
3 ''(B) with respect to the collection of the
4 data described in subparagraph (A), for appli-
5 cants and recipients who are minors, require
6 communication assistance in speech or writing,
7 and for applicants and recipients who are other-
8 wise legally incapacitated, require that—
9 ''(i) such data be collected from the
10 parent or legal guardian of such an appli-
11 cant or recipient; and
12 ''(ii) the primary language of the par-
13 ent or legal guardian of such an applicant
14 or recipient be collected;
15 ''(C) systematically analyze such data
16 using the smallest appropriate units of analysis
17 feasible to detect racial and ethnic disparities,
18 as well as disparities along the lines of primary
19 language, sex, disability status, sexual orienta-
20 tion, gender identity, and socioeconomic status
21 in health and health care, and report the results
22 of such analysis to the Secretary, the Director
23 of the Office for Civil Rights, each agency listed
24 in section 3101(c)(1), the Committee on
25 Health, Education, Labor, and Pensions and

1 the Committee on Finance of the Senate, and
2 the Committee on Energy and Commerce and
3 the Committee on Ways and Means of the
4 House of Representatives;
5 ‘‘(D) provide such data to the Secretary on
6 at least an annual basis; and
7 ‘‘(E) ensure that the provision of assist-
8 ance to an applicant or recipient of assistance
9 is not denied or otherwise adversely affected be-
10 cause of the failure of the applicant or recipient
11 to provide race, ethnicity, primary language,
12 sex, sexual orientation, disability status, gender
13 identity, and socioeconomic status data.
14 ‘‘(2) RULES OF CONSTRUCTION.—Nothing in
15 this subsection shall be construed to—
16 ‘‘(A) permit the use of information col-
17 lected under this subsection in a manner that
18 would adversely affect any individual providing
19 any such information; and
20 ‘‘(B) diminish existing or future require-
21 ments on health care providers to collect data.
22 ‘‘(b) PROTECTION OF DATA.—The Secretary shall
23 ensure (through the promulgation of regulations or other-
24 wise) that all data collected pursuant to subsection (a) are
25 protected—

1 "(1) under the same privacy protections as the
2 Secretary applies to other health data under the reg-
3 ulations promulgated under section 264(c) of the
4 Health Insurance Portability and Accountability Act
5 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
6 lating to the privacy of individually identifiable
7 health information and other protections; and
8 "(2) from all inappropriate internal use by any
9 entity that collects, stores, or receives the data, in-
10 cluding use of such data in determinations of eligi-
11 bility (or continued eligibility) in health plans, and
12 from other inappropriate uses, as defined by the
13 Secretary.
14 "(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
15 Secretary shall develop and implement a national plan to
16 ensure the collection of data in a culturally appropriate
17 and competent manner, to improve the collection, analysis,
18 and reporting of racial, ethnic, sex, primary language, sex-
19 ual orientation, disability status, gender identity, and so-
20 cioeconomic status data at the Federal, State, territorial,
21 tribal, and local levels, including data to be collected under
22 subsection (a), and to ensure that data collection activities
23 carried out under this section are in compliance with the
24 standards developed under section 3101. The Data Coun-
25 cil of the Department of Health and Human Services, in

1 consultation with the National Committee on Vital Health
2 Statistics, the Office of Minority Health, Office on Wom-
3 en's Health, and other appropriate public and private enti-
4 ties, shall make recommendations to the Secretary con-
5 cerning the development, implementation, and revision of
6 the national plan. Such plan shall include recommenda-
7 tions on how to—
8 ''(1) implement subsection (a) while minimizing
9 the cost and administrative burdens of data collec-
10 tion and reporting;
11 ''(2) expand awareness among Federal agencies,
12 States, territories, Indian tribes, health providers,
13 health plans, health insurance issuers, and the gen-
14 eral public that data collection, analysis, and report-
15 ing by race, ethnicity, primary language, sexual ori-
16 entation, disability status, gender identity, and socio-
17 economic status is legal and necessary to assure eq-
18 uity and nondiscrimination in the quality of health
19 care services;
20 ''(3) ensure that future patient record systems
21 have data code sets for racial, ethnic, primary lan-
22 guage, sexual orientation, disability status, gender
23 identity, and socioeconomic status identifiers and
24 that such identifiers can be retrieved from clinical
25 records, including records transmitted electronically;

1 "(4) improve health and health care data collec-
2 tion and analysis for more population groups if such
3 groups can be aggregated into the minimum race
4 and ethnicity categories, including exploring the fea-
5 sibility of enhancing collection efforts in States for
6 racial and ethnic groups that comprise a significant
7 proportion of the population of the State;
8 "(5) provide researchers with greater access to
9 racial, ethnic, primary language, sexual orientation,
10 disability status, gender identity, and socioeconomic
11 status data, subject to privacy and confidentiality
12 regulations; and
13 "(6) safeguard and prevent the misuse of data
14 collected under subsection (a).
15 "(d) COMPLIANCE WITH STANDARDS.—Data col-
16 lected under subsection (a) shall be obtained, maintained,
17 and presented (including for reporting purposes) in ac-
18 cordance with the 1997 Office of Management and Budget
19 Standards for Maintaining, Collecting, and Presenting
20 Federal Data on Race and Ethnicity (at a minimum).
21 "(e) TECHNICAL ASSISTANCE FOR THE COLLECTION
22 AND REPORTING OF DATA.—
23 "(1) IN GENERAL.—The Secretary may, either
24 directly or through grant or contract, provide tech-
25 nical assistance to enable a health care program or

1 an entity operating under such program to comply
2 with the requirements of this section.
3 ‘‘(2) TYPES OF ASSISTANCE.—Assistance pro-
4 vided under this subsection may include assistance
5 to—
6 ‘‘(A) enhance or upgrade computer tech-
7 nology that will facilitate racial, ethnic, primary
8 language, sexual orientation, disability status,
9 gender identity, and socioeconomic status data
10 collection and analysis;
11 ‘‘(B) improve methods for health data col-
12 lection and analysis including additional popu-
13 lation groups beyond the Office of Management
14 and Budget categories if such groups can be
15 aggregated into the minimum race and ethnicity
16 categories;
17 ‘‘(C) develop mechanisms for submitting
18 collected data subject to existing privacy and
19 confidentiality regulations; and
20 ‘‘(D) develop educational programs to in-
21 form health insurance issuers, health plans,
22 health providers, health-related agencies, and
23 the general public that data collection and re-
24 porting by race, ethnicity, primary language,
25 sexual orientation, disability status, gender

1 identity, and socioeconomic status are legal and
2 essential for eliminating health and health care
3 disparities.
4 ''(f) ANALYSIS OF HEALTH DISPARITY DATA.—The
5 Secretary, acting through the Director of the Agency for
6 Healthcare Research and Quality and in coordination with
7 the Administrator of the Centers for Medicare & Medicaid
8 Services, shall provide technical assistance to agencies of
9 the Department of Health and Human Services in meeting
10 Federal standards for health disparity data collection and
11 for analysis of racial and ethnic disparities in health and
12 health care in public programs by—
13 ''(1) identifying appropriate quality assurance
14 mechanisms to monitor for health disparities;
15 ''(2) specifying the clinical, diagnostic, or thera-
16 peutic measures which should be monitored;
17 ''(3) developing new quality measures relating
18 to racial and ethnic disparities and their overlap
19 with other disparity factors in health and health
20 care;
21 ''(4) identifying the level at which data analysis
22 should be conducted; and
23 ''(5) sharing data with external organizations
24 for research and quality improvement purposes.

1 "(g) DEFINITION.—In this section, the term 'health-
2 related program' mean a program—
3 "(1) under the Social Security Act (42 U.S.C.
4 301 et seq.) that pays for health care and services;
5 and
6 "(2) under this Act that provides Federal finan-
7 cial assistance for health care, biomedical research,
8 or health services research and or is designed to im-
9 prove the public's health.

10 **"SEC. 3432. PROVISIONS RELATING TO NATIVE AMERICANS.**

11 "(a) ESTABLISHMENT OF EPIDEMIOLOGY CEN-
12 TERS.—The Secretary shall establish an epidemiology cen-
13 ter in each service area to carry out the functions de-
14 scribed in subsection (b). Any new center established after
15 the date of the enactment of the Health Equity and Ac-
16 countability Act of 2012 may be operated under a grant
17 authorized by subsection (d), but funding under such a
18 grant shall not be divisible.
19 "(b) FUNCTIONS OF CENTERS.—In consultation with
20 and upon the request of Indian tribes, tribal organizations,
21 and urban indian organizations, each service area epidemi-
22 ology center established under this subsection shall, with
23 respect to such service area—
24 "(1) collect data relating to, and monitor
25 progress made toward meeting, each of the health

1 status objectives of the service, the Indian tribes,
2 tribal organizations, and urban indian organizations
3 in the service area;
4 ''(2) evaluate existing delivery systems, data
5 systems, and other systems that impact the improve-
6 ment of Indian health;
7 ''(3) assist Indian tribes, tribal organizations,
8 and urban indian organizations in identifying their
9 highest priority health status objectives and the
10 services needed to achieve such objectives, based on
11 epidemiological data;
12 ''(4) make recommendations for the targeting
13 of services needed by the populations served;
14 ''(5) make recommendations to improve health
15 care delivery systems for Indians and urban Indians;
16 ''(6) provide requested technical assistance to
17 Indian tribes, tribal organizations, and urban indian
18 organizations in the development of local health
19 service priorities and incidence and prevalence rates
20 of disease and other illness in the community; and
21 ''(7) provide disease surveillance and assist In-
22 dian tribes, tribal organizations, and urban Indian
23 organizations to promote public health.
24 ''(c) TECHNICAL ASSISTANCE.—The Director of the
25 Centers for Disease Control and Prevention shall provide

1 technical assistance to the centers in carrying out the re-
2 quirements of this subsection.
3 ‘‘(d) GRANTS FOR STUDIES.—
4 ‘‘(1) IN GENERAL.—The Secretary may make
5 grants to Indian tribes, tribal organizations, urban
6 indian organizations, and eligible intertribal con-
7 sortia to conduct epidemiological studies of Indian
8 communities.
9 ‘‘(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An
10 intertribal consortium is eligible to receive a grant
11 under this subsection if—
12 ‘‘(A) the intertribal consortium is incor-
13 porated for the primary purpose of improving
14 Indian health; and
15 ‘‘(B) the intertribal consortium is rep-
16 resentative of the Indian tribes or urban Indian
17 communities in which the intertribal consortium
18 is located.
19 ‘‘(3) APPLICATIONS.—An application for a
20 grant under this subsection shall be submitted in
21 such manner and at such time as the Secretary shall
22 prescribe.
23 ‘‘(4) REQUIREMENTS.—An applicant for a
24 grant under this subsection shall—

1 ‘‘(A) demonstrate the technical, adminis-
2 trative, and financial expertise necessary to
3 carry out the functions described in paragraph
4 (5);
5 ‘‘(B) consult and cooperate with providers
6 of related health and social services in order to
7 avoid duplication of existing services; and
8 ‘‘(C) demonstrate cooperation from Indian
9 tribes or urban Indian organizations in the area
10 to be served.
11 ‘‘(5) USE OF FUNDS.—A grant awarded under
12 paragraph (1) may be used—
13 ‘‘(A) to carry out the functions described
14 in subsection (b);
15 ‘‘(B) to provide information to and consult
16 with tribal leaders, urban Indian community
17 leaders, and related health staff on health care
18 and health service management issues; and
19 ‘‘(C) in collaboration with Indian tribes,
20 tribal organizations, and urban Indian commu-
21 nities, to provide the service with information
22 regarding ways to improve the health status of
23 Indians.
24 ‘‘(e) ACCESS TO INFORMATION.—An epidemiology
25 center operated by a grantee pursuant to a grant awarded

1 under subsection (d) shall be treated as a public health
2 authority for purposes of the Health Insurance Portability
3 and Accountability Act of 1996 (Public Law 104–191; 110
4 Stat. 2033), as such entities are defined in part 164.501
5 of title 45, Code of Federal Regulations (or a successor
6 regulation). The Secretary shall grant such grantees ac-
7 cess to and use of data, data sets, monitoring systems,
8 delivery systems, and other protected health information
9 in the possession of the Secretary.''.

10 **SEC. 102. ELIMINATION OF PREREQUISITE OF DIRECT AP-**
11 **PROPRIATIONS FOR DATA COLLECTION AND**
12 **ANALYSIS.**

13 Section 3101 of the Public Health Service Act (42
14 U.S.C. 300kk) is amended—
15 (1) by striking subsection (h); and
16 (2) by redesignating subsection (i) as subsection
17 (h).

18 **SEC. 103. COLLECTION OF RACE AND ETHNICITY DATA BY**
19 **THE SOCIAL SECURITY ADMINISTRATION.**

20 Part A of title XI of the Social Security Act (42
21 U.S.C. 1301 et seq.) is amended by adding at the end
22 the following:

"SEC. 1150C. COLLECTION OF RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

"(a) REQUIREMENT.—The Commissioner of Social Security, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall—

"(1) require the collection of data on the race, ethnicity, primary language, sex, and disability status of all applicants for Social Security account numbers or benefits under title II or part A of title XVIII and all individuals with respect to whom the Commissioner maintains records of wages and self-employment income in accordance with reports received by the Commissioner or the Secretary of the Treasury—

"(A) using, at a minimum, the standards for data collection on race, ethnicity, primary language, sex, and disability status developed under section 3101 of the Public Health Service Act;

"(B) where practicable, collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories; and

"(C) additionally referring, where practicable, to the standards developed by the Institute of Medicine in 'Race, Ethnicity, and Lan-

1 guage Data: Standardization for Health Care
2 Quality Improvement' (released August 31,
3 2009);
4 ''(2) with respect to the collection of the data
5 described in paragraph (1) for applicants who are
6 under 18 years of age or otherwise legally incapaci-
7 tated, require that—
8 ''(A) such data be collected from the par-
9 ent or legal guardian of such an applicant; and
10 ''(B) the primary language of the parent
11 or legal guardian of such an applicant or recipi-
12 ent be used;
13 ''(3) require that such data be uniformly ana-
14 lyzed and reported at least annually to the Commis-
15 sioner of Social Security;
16 ''(4) be responsible for storing the data re-
17 ported under paragraph (3);
18 ''(5) ensure transmission to the Centers for
19 Medicare & Medicaid Services and other Federal
20 health agencies;
21 ''(6) provide such data to the Secretary on at
22 least an annual basis; and
23 ''(7) ensure that the provision of assistance to
24 an applicant is not denied or otherwise adversely af-
25 fected because of the failure of the applicant to pro-

1 vide race, ethnicity, primary language, sex, and dis-
2 ability status data.
3 "(b) PROTECTION OF DATA.—The Commissioner of
4 Social Security shall ensure (through the promulgation of
5 regulations or otherwise) that all data collected pursuant
6 to subsection (a) are protected—
7 "(1) under the same privacy protections as the
8 Secretary applies to health data under the regula-
9 tions promulgated under section 264(c) of the
10 Health Insurance Portability and Accountability Act
11 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
12 lating to the privacy of individually identifiable
13 health information and other protections; and
14 "(2) from all inappropriate internal use by any
15 entity that collects, stores, or receives the data, in-
16 cluding use of such data in determinations of eligi-
17 bility (or continued eligibility) in health plans, and
18 from other inappropriate uses, as defined by the
19 Secretary.
20 "(c) RULE OF CONSTRUCTION.—Nothing in this sec-
21 tion shall be construed to permit the use of information
22 collected under this section in a manner that would ad-
23 versely affect any individual providing any such informa-
24 tion.

1 ‘‘(d) TECHNICAL ASSISTANCE.—The Secretary may,
2 either directly or by grant or contract, provide technical
3 assistance to enable any health entity to comply with the
4 requirements of this section.’’.

5 **SEC. 104. REVISION OF HIPAA CLAIMS STANDARDS.**

6 (a) IN GENERAL.—Not later than 1 year after the
7 date of enactment of this Act, the Secretary of Health and
8 Human Services shall revise the regulations promulgated
9 under part C of title XI of the Social Security Act (42
10 U.S.C. 1320d et seq.), relating to the collection of data
11 on race, ethnicity, and primary language in a health-re-
12 lated transaction, to require—

13 (1) the use, at a minimum, of the standards for
14 data collection on race, ethnicity, primary language,
15 disability, and sex developed under section 3101 of
16 the Public Health Service Act (42 U.S.C. 300kk);
17 and

18 (2) the designation of the racial, ethnic, pri-
19 mary language, disability, and sex code sets as re-
20 quired for claims and enrollment data.

21 (b) DISSEMINATION.—The Secretary of Health and
22 Human Services shall disseminate the new standards de-
23 veloped under subsection (a) to all health entities that are
24 subject to the regulations described in such subsection and

1 provide technical assistance with respect to the collection
2 of the data involved.
3 (c) COMPLIANCE.—The Secretary of Health and
4 Human Services shall require that health entities comply
5 with the new standards developed under subsection (a) not
6 later than 2 years after the final promulgation of such
7 standards.

8 **SEC. 105. NATIONAL CENTER FOR HEALTH STATISTICS.**

9 Section 306(n) of the Public Health Service Act (42
10 U.S.C. 242k(n)) is amended—
11 (1) in paragraph (1), by striking ''2003'' and
12 inserting ''2016'';
13 (2) in paragraph (2), in the first sentence, by
14 striking ''2003'' and inserting ''2016''; and
15 (3) in paragraph (3), by striking ''2002'' and
16 inserting ''2016''.

17 **SEC. 106. OVERSAMPLING OF ASIAN-AMERICANS, NATIVE**
18 **HAWAIIANS, OR PACIFIC ISLANDERS AND**
19 **OTHER UNDERREPRESENTED GROUPS IN**
20 **FEDERAL HEALTH SURVEYS.**

21 Part B of title III of the Public Health Service Act
22 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
23 tion 317T the following:

1 **"SEC. 317U. OVERSAMPLING OF ASIAN-AMERICANS, NATIVE**
2 **HAWAIIANS, OR PACIFIC ISLANDERS AND**
3 **OTHER UNDERREPRESENTED GROUPS IN**
4 **FEDERAL HEALTH SURVEYS.**

5 ''(a) NATIONAL STRATEGY.—

6 ''(1) IN GENERAL.—The Secretary of Health
7 and Human Services, acting through the Director of
8 the National Center for Health Statistics (referred
9 to in this section as 'NCHS') of the Centers for Dis-
10 ease Control and Prevention, and other agencies
11 within the Department of Health and Human Serv-
12 ices as the Secretary determines appropriate, shall
13 develop and implement an ongoing and sustainable
14 national strategy for oversampling Asian-Americans,
15 Native Hawaiians, or Pacific Islanders, and other
16 underrepresented populations as determined appro-
17 priate by the Secretary in Federal health surveys.

18 ''(2) CONSULTATION.—In developing and imple-
19 menting a national strategy, as described in para-
20 graph (1), not later than 180 days after the date of
21 the enactment of the this section, the Secretary—

22 ''(A) shall consult with representatives of
23 community groups, nonprofit organizations,
24 nongovernmental organizations, and govern-
25 ment agencies working with Asian-Americans,

1 Native Hawaiians, or Pacific Islanders, and
2 other underrepresented populations; and
3 ''(B) may solicit the participation of rep-
4 resentatives from other Federal departments
5 and agencies.
6 ''(b) PROGRESS REPORT.—Not later than 2 years
7 after the date of the enactment of this section, the Sec-
8 retary shall submit to the Congress a progress report,
9 which shall include the national strategy described in sub-
10 section (a)(1).''.
11 **SEC. 107. GEO-ACCESS STUDY.**
12 The Administrator of the Substance Abuse and Men-
13 tal Health Services Administration shall—
14 (1) conduct a study to—
15 (A) determine which geographic areas of
16 the United States have shortages of specialty
17 mental health providers; and
18 (B) assess the preparedness of speciality
19 mental health providers to deliver culturally and
20 linguistically appropriate, affordable, and acces-
21 sible services; and
22 (2) submit a report to the Congress on the re-
23 sults of such study.

1 **SEC. 108. RACIAL, ETHNIC, AND LINGUISTIC DATA COL-**
2 **LECTED BY THE FEDERAL GOVERNMENT.**

3 (a) COLLECTION; SUBMISSION.—Not later than 90
4 days after the date of the enactment of this Act, and Jan-
5 uary 31 of each year thereafter, each department, agency,
6 and office of the Federal Government that has collected
7 racial, ethnic, or linguistic data during the preceding cal-
8 endar year shall submit such data to the Secretary of
9 Health and Human Services.

10 (b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
11 Not later than April 30, 2012, and each April 30 there-
12 after, the Secretary of Health and Human Services, acting
13 through the Director of the National Institute on Minority
14 Health and Health Disparities and the Deputy Assistant
15 Secretary for Minority Health, shall—

16 (1) collect and analyze the racial, ethnic, and
17 linguistic data, including by stratifying such data by
18 sex, submitted under subsection (a) for the pre-
19 ceding calendar year;

20 (2) make publicly available such data and the
21 results of such analysis; and

22 (3) submit a report to the Congress on such
23 data and analysis.

1 **SEC. 109. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**
2 **NORITY-SERVING INSTITUTIONS.**
3 (a) AUTHORITY.—The Secretary of Health and
4 Human Services, acting through the National Institute on
5 Minority Health and Health Disparities and the Office of
6 Minority Health, may award grants to access and analyze
7 racial and ethnic, and where possible other health dis-
8 parity data, to monitor and report on progress to reduce
9 and eliminate disparities in health and health care. Such
10 analysis under the preceding sentence shall include strati-
11 fying such data by sex.
12 (b) ELIGIBLE ENTITY.—In this section, the term ''el-
13 igible entity'' means a historically Black college or univer-
14 sity, an Hispanic-serving institution, a tribal college or
15 university, or an Asian-American, Native American, or Pa-
16 cific Islander-serving institution with an accredited public
17 health, health policy, or health services research program.
18 **SEC. 110. STANDARDS FOR MEASURING SEXUAL ORIENTA-**
19 **TION AND GENDER IDENTITY IN COLLECTION**
20 **OF HEALTH DATA.**
21 Section 3101(a) of the Public Health Service Act (42
22 U.S.C. 300kk(a)) is amended—
23 (1) in paragraph (1)(A), by inserting ''sexual
24 orientation, gender identity,'' before ''and disability
25 status'';

1 (2) in paragraph (1)(C), by inserting "sexual
2 orientation, gender identity," before "and disability
3 status"; and
4 (3) in paragraph (2)(B), by inserting "sexual
5 orientation, gender identity," before "and disability
6 status".

7 **SEC. 111. OPTIONAL COLLECTION OF HEALTH DATA ON IM-**
8 **MIGRANTS AND INDIVIDUALS IN THEIR**
9 **HOUSEHOLDS.**

10 Section 3101(a) of the Public Health Service Act (42
11 U.S.C. 300k(a)) is amended by adding at the end the fol-
12 lowing:
13 "(4) OPTIONAL UNIFORM CATEGORIES.—Not
14 later than 12 months after the date of the enact-
15 ment of this paragraph, the Secretary shall—
16 "(A) enter into an arrangement with the
17 Institute of Medicine of the National Academies
18 (or, if the Institute of Medicine declines to
19 enter into such an arrangement, another appro-
20 priate entity) to—
21 "(i) conduct a study and develop rec-
22 ommended standards for the optional col-
23 lection of data in major health surveys and
24 research on citizens, noncitizens, and citi-
25 zens living in noncitizen households, in-

1 cluding standards protecting the confiden-
2 tiality and security of personal information
3 of respondents and research subjects, to
4 the full extent permitted by law, in order
5 to measure disparities in health coverage,
6 health care access and quality, and health
7 status among these populations;
8 ''(ii) in carrying out clause (i), ad-
9 dress how the protection of confidentiality
10 and security of personal information under
11 such clause interacts with immigration
12 laws; and
13 ''(iii) include ensuing study results
14 and recommended standards in a report to
15 the Secretary;
16 ''(B) promulgate standards based on the
17 recommendations and results of subparagraph
18 (A) for the optional collection of data in major
19 health surveys and research; and
20 ''(C) provide clear guidance that such data
21 categories are optional uniform categories and,
22 if collected, the entity and any person con-
23 ducting the survey or research shall—
24 ''(i) adhere to the standards under
25 subparagraph (B);

1 "(ii) use the information only for the
2 purposes of measuring disparities in health
3 coverage, health care access and quality,
4 and health status among these populations;
5 "(iii) comply with all applicable laws
6 and policies regarding privacy, confiden-
7 tiality and security of the personal infor-
8 mation of the respondent or research sub-
9 ject and of the family members of the re-
10 spondent or research subject; and
11 "(iv) not share that information with
12 other individuals or entities without the ex-
13 press consent of the respondent or research
14 subject.".

15 **SEC. 112. GAO STUDY ON COMPLIANCE WITH EXISTING FDA**
16 **REQUIREMENTS TO PRESENT DRUG AND DE-**
17 **VICE SAFETY AND EFFECTIVENESS DATA BY**
18 **SEX, AGE, AND RACIAL AND ETHNIC SUB-**
19 **GROUPS.**

20 (a) IN GENERAL.—The Comptroller General of the
21 United States shall conduct a study investigating the ex-
22 tent to which sponsors of clinical studies of investigational
23 drugs, biologics, and devices and sponsors of applications
24 for approval or licensure of new drugs, biologics, and de-
25 vices comply with Food and Drug Administration require-

1 ments and follow guidance for presentation of clinical
2 study safety and effectiveness data by sex, age, and racial
3 and ethnic subgroups.

4 (b) REPORT BY GAO.—

5 (1) SUBMISSION.—Not later than 18 months
6 after the date of the enactment of this Act, the
7 Comptroller General shall complete the study under
8 subsection (a) and submit to the Committee on En-
9 ergy and Commerce of the House of Representatives
10 and the Committee on Health, Education, Labor,
11 and Pensions of the Senate a report on the results
12 of such study.

13 (2) CONTENTS.—The report required by para-
14 graph (1) shall include each of the following:

15 (A) An assessment of the extent to which
16 the Food and Drug Administration assists
17 sponsors in complying with the requirements
18 and following the guidance referred to in sub-
19 section (a).

20 (B) An assessment of the effectiveness of
21 the Food and Drug Administration's enforce-
22 ment of compliance with such requirements.

23 (C) An analysis of the extent to which fe-
24 males, racial and ethnic minorities, and adults
25 of all ages are adequately represented in Food

1 and Drug Administration-approved clinical
2 studies (at all phases) so that product safety
3 and effectiveness data can be evaluated by sex,
4 age, and racial and ethnic subgroup.
5 (D) An analysis of the extent to which a
6 summary of product safety and effectiveness
7 data disaggregated by sex, age, and racial and
8 ethnic subgroup is readily available to the pub-
9 lic in a timely manner by means of the product
10 label or the Food and Drug Administration's
11 Web site.
12 (E) Recommendations for—
13 (i) modifications to the requirements
14 and guidance referred to in subsection (a);
15 or
16 (ii) oversight by the Food and Drug
17 Administration of such requirements.
18 (c) REPORT BY HHS.—Not later than 6 months
19 after the submission by the Comptroller General of the
20 report required under subsection (b), the Secretary of
21 Health and Human Services shall submit to the Com-
22 mittee on Energy and Commerce of the House of Rep-
23 resentatives and the Committee on Health, Education,
24 Labor, and Pensions of the Senate a response to that re-

1 port, including a corrective action plan as needed to re-
2 spond to the recommendations in that report.
3 (d) DEFINITIONS.—In this section:
4 (1) The term ‘‘biologic’’ has the meaning given
5 to the term ‘‘biological product’’ in section 351(i) of
6 the Public Health Service Act (42 U.S.C. 262(i)).
7 (2) The term ‘‘device’’ has the meaning given to
8 such term in section 201(h) of the Federal Food,
9 Drug, and Cosmetic Act (21 U.S.C. 321(h)).
10 (3) The term ‘‘drug’’ has the meaning given to
11 such term in section 201(g) of the Federal Food,
12 Drug, and Cosmetic Act (21 U.S.C. 321(g)).
13 **SEC. 113. IMPROVING HEALTH DATA REGARDING NATIVE**
14 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**
15 Part B of title III of the Public Health Service Act
16 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
17 tion 317U, as added, the following:
18 **‘‘SEC. 317V. NATIVE HAWAIIAN AND OTHER PACIFIC IS-**
19 **LANDER HEALTH DATA.**
20 ‘‘(a) FINDINGS.—Congress makes the following find-
21 ings:
22 ‘‘(1) Native Hawaiians and Other Pacific Is-
23 landers (referred to in this subsection as ‘NHOPI’)
24 are identified as 1 of 6 specific racial or ethnic cat-
25 egories in the United States Census. The other cat-

1 egories are African Americans, American Indians/
2 Alaska Natives, Asians, Caucasians, and Latinos/
3 Hispanics.
4 "(2) Native Hawaiians and the Pacific Jurisdic-
5 tions have a special legal relationship with the
6 United States, which requires careful consideration
7 of consultation rights and expectations that are
8 based upon formal United States policy, special trea-
9 ties with the United States, and international law.
10 "(3) The NHOPI population is unique in that
11 its peoples have homelands in the Pacific yet many
12 have moved to reside in the continental United
13 States and today are living in every state of the
14 United States. Yet, NHOPI are often 'invisible' in
15 current Federal data collection, analysis, and report-
16 ing, particularly those identifying health status.
17 "(b) DEFINITIONS.—In this section:
18 "(1) COMMUNITY GROUPS.—The term 'commu-
19 nity groups' means groups of people which are orga-
20 nized at the community level and are specific to
21 NHOPI populations such as church groups, social
22 service groups, and cultural groups.
23 "(2) DESIGNATED ORGANIZATIONS.—The term
24 'designated organizations' means organizations
25 which are constituted to represent NHOPI popu-

1 lations and which have statutory responsibilities or
2 community support for aspects of health and health
3 care.
4 "(3) GOVERNMENT REPRESENTATIVES.—The
5 term 'government representatives' mean government
6 representatives from Pacific Island Jurisdictions in-
7 cluding American Samoa, Commonwealth of the
8 Northern Mariana Islands, Federated States of Mi-
9 cronesia, Guam, Republic of Belau, and Republic of
10 the Marshall Islands.
11 "(4) NATIVE HAWAIIAN AND OTHER PACIFIC IS-
12 LANDER; NHOPI.—The terms 'Native Hawaiian and
13 Other Pacific Islander' and 'NHOPI' mean people
14 having origins in any of the original peoples of
15 American Samoa, Commonwealth of the Northern
16 Mariana Islands, Federated States of Micronesia,
17 Guam, Hawai`i, Republic of the Marshall Islands,
18 Republic of Belau, or any other Pacific Islands.
19 "(c) REPORT.—
20 "(1) IN GENERAL.—The Secretary shall submit
21 to Congress a report that describes factors that af-
22 fect NHOPI health. Such report shall describe—
23 "(A) the health disparities that affect such
24 population;

1 ''(B) an assessment of the needs of such
2 population; and
3 ''(C) an evaluation of the impact of such
4 disparities, and of efforts to address such dis-
5 parities, on the health of such population.
6 ''(2) RESOURCES; PARTNERSHIP.—In compiling
7 the report under paragraph (1), the Secretary shall
8 use data available from the National Center for
9 Health Statistics. The report shall be complied in
10 partnership with the Native Hawaiian Epidemiology
11 Center.
12 ''(d) NATIONAL STRATEGY.—
13 ''(1) IN GENERAL.—Not later than 10 months
14 after the date of enactment of the Health Equity
15 and Accountability Act of 2012, the Secretary, in
16 consultation with representatives from community
17 groups, designated organizations, government rep-
18 resentatives of NHOPI populations, and other Fed-
19 eral department representatives as determined ap-
20 propriate by the Secretary, shall develop, implement,
21 and make public an ongoing and sustainable na-
22 tional strategy for identifying and evaluating the
23 health status and health care needs of NHOPI living
24 on the continental United States, in Hawai`i, and in
25 the various Pacific Island Jurisdictions.

1 "(2) CONTENT.—The national strategy devel-
2 oped under paragraph (1) shall—
3 "(A) address gaps in quality, efficiency,
4 comparative effectiveness information, and
5 health outcomes measures and data aggregation
6 techniques; and
7 "(B) enhance the use of health care data
8 to improve quality, efficiency, transparency, and
9 outcomes.
10 "(e) IMPLEMENTATION.—The Secretary shall ask the
11 National Center for Health Statistics, in partnership with
12 the Native Hawaiian Epidemiology Center, to develop and
13 implement the national strategy developed under sub-
14 section (d). The Secretary shall require other agencies
15 within the Department of Health and Human Services to
16 assist the National Center for Health Statistics in car-
17 rying out the preceding sentence.
18 "(f) REPORT.—Not later than 2 years after the date
19 of enactment of the Health Equity and Accountability Act
20 of 2012, the Secretary shall submit to Congress a progress
21 report on the activities conducted under this section, in-
22 cluding the national strategy for identifying and evalu-
23 ating the health status and health care needs of NHOPI
24 populations.".

1 **SEC. 114. SIMPLIFIED ADMINISTRATIVE REPORTING RE-**
2 **QUIREMENT FOR NUTRITION ASSISTANCE.**

3 Section 11(a) of the Food and Nutrition Act of 2008
4 (7 U.S.C. 2020(a)) is amended by adding at the end the
5 following:

6 "(5) ADMINISTRATIVE REPORTING REQUIRE-
7 MENT RELATING TO THE INDIGENCE EXCEPTION
8 FOR ALIENS.—In satisfaction of the administrative
9 reporting requirement under section 421(e)(2) of the
10 Personal Responsibility and Work Opportunity Rec-
11 onciliation Act of 1996 (8 U.S.C. 1631(e)(2)), the
12 Secretary shall accept from the Attorney General for
13 each fiscal year an aggregate report that describes
14 the quantity of exceptions granted in that fiscal year
15 under that section.".

16 TITLE II—CULTURALLY AND LIN-
17 GUISTICALLY APPROPRIATE
18 HEALTH CARE

19 **SEC. 201. DEFINITIONS.**

20 In this title, the definitions contained in section 3400
21 of the Public Health Service Act, as added by section 202,
22 shall apply.

23 **SEC. 202. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
24 **ACT.**

25 (a) FINDINGS.—Congress finds the following:

1 (1) Effective communication is essential to
2 meaningful access to quality physical and mental
3 health care.
4 (2) Research indicates that the lack of appro-
5 priate language services creates languages barriers
6 that result in increased risk of misdiagnosis, ineffec-
7 tive treatment plans and poor health outcomes for
8 limited-English-proficient individuals and individuals
9 with communication disabilities such as hearing, vi-
10 sion or print impairments.
11 (3) The number of limited-English-speaking
12 residents in the United States who speak English
13 less than very well and, therefore, cannot effectively
14 communicate with health and social service providers
15 continues to increase significantly.
16 (4) The responsibility to fund language services
17 in the provision of health care and health care-re-
18 lated services to limited-English-proficient individ-
19 uals and individuals with communication disabilities
20 such as hearing, vision, or print impairments is a so-
21 cietal one that cannot fairly be visited solely upon
22 the health care, public health or social services com-
23 munity.
24 (5) Title VI of the Civil Rights Act of 1964
25 prohibits discrimination based on the grounds of

1 race, color or national origin by any entity receiving
2 Federal financial assistance. In order to avoid dis-
3 crimination on the grounds of national origin, all
4 programs or activities administered by the Depart-
5 ment must take adequate steps to ensure that their
6 policies and procedures do not deny or have the ef-
7 fect of denying limited-English-proficient individuals
8 with equal access to benefits and services for which
9 such persons qualify.
10 (6) Linguistic diversity in the healthcare and
11 health-care-related-services workforce is important
12 for providing all patients the environment most con-
13 ducive to positive health outcomes.
14 (7) All members of the health care and health-
15 care-related-services community should continue to
16 educate their staff and constituents about limited-
17 English proficient and disability communication
18 issues and help them identify resources to improve
19 access to quality care for limited-English-proficient
20 individuals and individuals with communication dis-
21 abilities such as hearing, vision, or print impair-
22 ments.
23 (8) Access to English as a second language and
24 sign language instructions is an important mecha-
25 nism for ensuring effective communication and elimi-

nating the language barriers that impede access to health care.

(9) Competent languages services in health care settings should be available as a matter of course.

(b) AMENDMENT.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXIV—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE

"SEC. 3400. DEFINITIONS.

"In this title:

"(1) BILINGUAL.—The term 'bilingual' with respect to an individual means a person who has sufficient degree of proficiency in two languages.

"(2) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides.

"(3) COMPETENT INTERPRETER SERVICES.— The term 'competent interpreter services' means a translanguage rendition of a spoken or signed message in which the interpreter comprehends the source language and can communicate comprehensively in the target language to convey the meaning

1 intended in the source language. The interpreter
2 knows health and health-related terminology and
3 provides accurate interpretations by choosing equiva-
4 lent expressions that convey the best matching and
5 meaning to the source language and captures, to the
6 greatest possible extent, all nuances intended in the
7 source message.

8 ''(4) COMPETENT TRANSLATION SERVICES.—
9 The term 'competent translation services' means a
10 translanguage rendition of a written document in
11 which the translator comprehends the source lan-
12 guage and can write or sign comprehensively in the
13 target language to convey the meaning intended in
14 the source language. The translator knows health
15 and health-related terminology and provides accurate
16 translations by choosing equivalent expressions that
17 convey the best matching and meaning to the source
18 language and captures, to the greatest possible ex-
19 tent, all nuances intended in the source document.

20 ''(5) CULTURAL COMPETENCE.—The term 'cul-
21 tural competence' means a set of congruent behav-
22 iors, attitudes, and policies that come together in a
23 system, agency, or among professionals that enables
24 effective work in cross-cultural situations. In the
25 preceding sentence—

1 "(A) the term 'cultural' refers to inte-
2 grated patterns of human behavior that include
3 the language, thoughts, communications, ac-
4 tions, customs, beliefs, values, and institutions
5 of racial, ethnic, religious, or social groups, in-
6 cluding lesbian, gay, bisexual, transgender and
7 intersex individuals, and individuals with phys-
8 ical and mental disabilities; and
9 "(B) the term 'competence' implies having
10 the capacity to function effectively as an indi-
11 vidual and an organization within the context of
12 the cultural beliefs, behaviors, and needs pre-
13 sented by consumers and their communities.
14 "(6) EFFECTIVE COMMUNICATION.—The term
15 'effective communication' means an exchange of in-
16 formation between the provider of health care or
17 health-care-related services and the recipient of such
18 services who is limited in English proficiency, or has
19 a communication impairment such as a hearing, vi-
20 sion, or learning impairment, that enables access,
21 understanding, and benefit from health care or
22 health-care-related services, and full participation in
23 the development of their treatment plan.
24 "(7) GRIEVANCE RESOLUTION PROCESS.—The
25 term 'grievance resolution process' means all aspects

1 of dispute resolution including filing complaints,
2 grievance and appeal procedures, and court action.
3 "(8) HEALTH CARE GROUP.—The term 'health
4 care group' means a group of physicians organized,
5 at least in part, for the purposes of providing physi-
6 cians' services under the Medicaid, SCHIP, or Medi-
7 care programs and may include a hospital and any
8 other individual or entity furnishing services covered
9 under the Medicaid, SCHIP, or Medicare programs
10 that is affiliated with the health care group.
11 "(9) HEALTH-CARE SERVICES.—The term
12 'health care services' means services that address
13 physical as well as mental health conditions in all
14 care settings.
15 "(10) HEALTH CARE-RELATED SERVICES.—The
16 term 'health-care-related services' means human or
17 social services programs or activities that provide ac-
18 cess, referrals or links to health care.
19 "(11) INDIAN TRIBE.—The term 'Indian tribe'
20 means any Indian tribe, band, nation, or other orga-
21 nized group or community, including any Alaska Na-
22 tive village or group or regional or village corpora-
23 tion as defined in or established pursuant to the
24 Alaska Native Claims Settlement Act (85 Stat. 688)
25 (43 U.S.C. 1601 et seq.), which is recognized as eli-

1 gible for the special programs and services provided
2 by the United States to Indians because of their sta-
3 tus as Indians.

4 "(12) INTEGRATED HEALTH CARE DELIVERY
5 SYSTEM.—The term 'integrated health care delivery
6 system' means an interdisciplinary system that
7 brings together providers from the primary health,
8 mental health, substance use and related disciplines
9 to improve the health outcomes of an individual.
10 Providers may include but are not limited to hos-
11 pitals, health, mental health or substance use clinics
12 and providers, home health agencies, ambulatory
13 surgery centers, skilled nursing facilities, rehabilita-
14 tion centers, and employed, independent or con-
15 tracted physicians.

16 "(13) INTERPRETING/INTERPRETATION.—The
17 terms 'interpreting' and 'interpretation' mean the
18 transmission of a spoken, written, or signed message
19 from one language or format into another, faithfully,
20 accurately, and objectively.

21 "(14) LANGUAGE ACCESS.—The term 'language
22 access' means the provision of language services to
23 an LEP individual or individual with communication
24 disabilities designed to enhance that individual's ac-

1 cess to, understanding of or benefit from health care
2 or health-care-related services.
3 ''(15) LANGUAGE OR LANGUAGE ACCESS SERV-
4 ICES.—The term 'language or language access serv-
5 ices' means provision of health care services directly
6 in a non-English language, interpretation, trans-
7 lation, signage, video recording, and English or non-
8 English alternative formats.
9 ''(16) LEP.—The term 'LEP' means limited-
10 English proficient.
11 ''(17) LEP RELATED DATA COLLECTION AC-
12 TIVITIES.—The term 'LEP related data collection
13 activities' includes identifying, collecting, storing,
14 tracking, and analyzing primary language data, and
15 information on the methods used to meet the lan-
16 guage access needs of limited-English-proficient indi-
17 viduals.
18 ''(18) MEDICARE, MEDICAID, AND SCHIP.—The
19 terms 'Medicare', 'Medicaid', and 'SCHIP' means
20 the respective programs under titles XVIII, XIX,
21 and XXI of the Social Security Act.
22 ''(19) MINORITY.—
23 ''(A) IN GENERAL.—The terms 'minority'
24 and 'minorities' refer to individuals from a mi-
25 nority group.

1 "(B) POPULATIONS.—The term 'minority',
2 with respect to populations, refers to racial and
3 ethnic minority groups.
4 "(20) MINORITY GROUP.—The term 'minority
5 group' has the meaning given the term 'racial and
6 ethnic minority group'.
7 "(21) RACIAL AND ETHNIC MINORITY GROUP.—
8 The term 'racial and ethnic minority group' means
9 American Indians and Alaska Natives, African-
10 Americans (including Caribbean Blacks, Africans
11 and other Blacks), Asian-Americans, Hispanics (in-
12 cluding Latinos), and Native Hawaiians and other
13 Pacific Islanders.
14 "(22) ON-SITE INTERPRETING/INTERPRETA-
15 TION.—The term 'on-site interpreting/interpretation'
16 means a method of interpreting or interpretation for
17 which the interpreter is in the physical presence of
18 the provider of health care or health-care-related
19 services and the recipient of such services who is
20 limited in English proficiency or has a communica-
21 tion impairment such as hearing, vision, or learning.
22 "(23) SECRETARY.—The term 'Secretary'
23 means the Secretary of Health and Human Services.
24 "(24) SIGHT TRANSLATION.—The term 'sight
25 translation' means the transmission of a written

1 message in one language into a spoken or signed
2 message in another language, or an alternative for-
3 mat in English or another language.
4 "(25) STATE.—The term 'State' means each of
5 the several States, the District of Columbia, the
6 Commonwealth of Puerto Rico, the Indian tribes,
7 the United States Virgin Islands, Guam, American
8 Samoa, and the Commonwealth of the Northern
9 Mariana Islands.
10 "(26) TELEPHONIC INTERPRETATION.—The
11 term 'telephonic interpretation' (also known as over
12 the phone interpretation or OPI) means a method of
13 interpreting/interpretation for which the interpreter
14 is not in the physical presence of the provider of
15 health care or related services and the limited-
16 English-proficient recipient of such services but is
17 connected via telephone.
18 "(27) TRANSLATION.—The term 'translation'
19 means the transmission of a written message in one
20 language into a written or signed message in an-
21 other language, and includes translation into an-
22 other language or alternative format, such as large
23 print font, Braille, audio recording, or CD.
24 "(28) VIDEO INTERPRETATION.—The term
25 'video interpretation' means a method of inter-

1 preting/interpretation for which the interpreter is
2 not in the physical presence of the provider of health
3 care or related services and the limited-English-pro-
4 ficient recipient of such services but is connected via
5 a video hook-up that includes both audio and video
6 transmission.

7 ‘‘(29) VITAL DOCUMENT.—The term ‘vital doc-
8 ument’ includes but is not limited to applications for
9 government programs that provide health care serv-
10 ices, medical or financial consent forms, financial as-
11 sistance documents, letters containing important in-
12 formation regarding patient instructions (such as
13 prescriptions, referrals to other providers, and dis-
14 charge plans) and participation in a program (such
15 as a Medicaid managed care program), notices per-
16 taining to the reduction, denial, or termination of
17 services or benefits, notices of the right to appeal
18 such actions, and notices advising limited-English-
19 proficient individuals and individuals with commu-
20 nication disabilities of the availability of free lan-
21 guage services, alternative formats, and other out-
22 reach materials.

"SEC. 3401. IMPROVING ACCESS TO SERVICES FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.

"(a) PURPOSE.—As provided in Executive Order 13166, it is the purpose of this section—

"(1) to improve Federal agency performance regarding access to federally conducted and federally assisted programs and activities for individuals who are limited in their English proficiency;

"(2) to require each Federal agency to examine the services it provides and develop and implement a system by which limited-English-proficient individuals can obtain cultural competence and meaningful access to those services consistent with, and without substantially burdening, the fundamental mission of the agency;

"(3) to require each Federal agency to ensure that recipients of Federal financial assistance provide cultural competence and meaningful access to their limited-English-proficient applicants and beneficiaries;

"(4) to ensure that recipients of Federal financial assistance take reasonable steps, consistent with the guidelines set forth in the Limited English Proficient Guidance of the Department of Justice (as issued on June 12, 2002), to ensure cultural competence and meaningful access to their programs

1 and activities by limited-English-proficient individ-
2 uals; and
3 ''(5) to ensure compliance with title VI of the
4 Civil Rights Act of 1964 and that health care pro-
5 viders and organizations do not discriminate in the
6 provision of services.
7 ''(b) FEDERALLY CONDUCTED PROGRAMS AND AC-
8 TIVITIES.—
9 ''(1) IN GENERAL.—Not later than 120 days
10 after the date of enactment of this title, each Fed-
11 eral agency that carries out health-care-related ac-
12 tivities shall prepare a plan to improve access cul-
13 tural competence to the federally conducted, health-
14 are-related programs and activities of the agency by
15 limited-English-proficient individuals. Each Federal
16 agency must ensure that such plan is fully imple-
17 mented not later than one year after the date of en-
18 actment of this Act.
19 ''(2) PLAN REQUIREMENT.—Each plan under
20 paragraph (1) shall include—
21 ''(A) the steps the agency will take to en-
22 sure that limited-English-proficient individuals
23 have access to the agency's federally conducted
24 health care and health-care-related programs
25 and activities;

1 "(B) the policies and procedures for identi-
2 fying, assessing, and meeting the language
3 needs and cultural competence needs of its lim-
4 ited-English-proficient beneficiaries served by
5 federally conducted programs and activities;

6 "(C) the steps the agency will take for its
7 federally conducted programs and activities to
8 improve cultural competence to provide a range
9 of language assistance options, notice to lim-
10 ited-English-proficient individuals of the right
11 to competent language services, periodic train-
12 ing of staff, monitoring and quality assessment
13 of the language services and, in appropriate cir-
14 cumstances, the translation of written mate-
15 rials;

16 "(D) the steps the agency will take to en-
17 sure that applications, forms, and other rel-
18 evant documents for its federally conducted pro-
19 grams and activities are competently translated
20 into the primary language of a limited-English-
21 proficient client where such materials are need-
22 ed to improve access to federally conducted and
23 federally assisted programs and activities for
24 such a limited-English-proficient individual; and

1 "(E) the resources the agency will provide
2 to improve cultural competence to assist recipi-
3 ents of Federal funds to improve access to
4 health care or health-care-related programs and
5 activities for limited-English-proficient individ-
6 uals.
7 Each agency shall send a copy of such plan to the
8 Department of Justice, which shall serve as the cen-
9 tral repository of the Agency's plans.
10 "(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVI-
11 TIES.—
12 "(1) IN GENERAL.—Not later than 120 days
13 after the date of enactment of this title, each Fed-
14 eral agency providing health-care-related Federal fi-
15 nancial assistance shall ensure that the guidance for
16 recipients of Federal financial assistance developed
17 by the agency to ensure compliance with title VI of
18 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
19 seq.) is specifically tailored to the recipients of such
20 assistance. Each agency shall send a copy of such
21 guidance to the Department of Justice which shall
22 serve as the central repository of the Agency's plans.
23 After approval by the Department of Justice, each
24 agency shall publish its guidance document in the
25 Federal Register for public comment.

1 "(2) REQUIREMENTS.—The agency-specific
2 guidance developed under paragraph (1) shall take
3 into account the types of health care services pro-
4 vided by the recipients, the individuals served by the
5 recipients, and other factors set out in such stand-
6 ards.

7 "(3) EXISTING GUIDANCES.—A Federal agency
8 that has developed a guidance for purposes of title
9 VI of the Civil Rights Act of 1964 shall examine
10 such existing guidance, as well as the programs and
11 activities to which such guidance applies, to deter-
12 mine if modification of such guidance is necessary to
13 comply with this subsection.

14 "(4) CONSULTATION.—Each Federal agency
15 shall consult with the Department of Justice in es-
16 tablishing the guidances under this subsection.

17 "(d) CONSULTATIONS.—

18 "(1) IN GENERAL.—In carrying out this sec-
19 tion, each Federal agency that carriers out health
20 care and health-care-related activities shall ensure
21 that stakeholders, such as limited-English-proficient
22 individuals and their representative organizations,
23 recipients of Federal assistance, and other appro-
24 priate individuals or entities, have an adequate op-

1 portunity to provide input with respect to the actions
2 of the agency.
3 ''(2) EVALUATION.—Each Federal agency de-
4 scribed in paragraph (1) shall evaluate the—
5 ''(A) particular needs of the limited-
6 English-proficient individuals served by the
7 agency;
8 ''(B) particular needs of the limited-
9 English-proficient individuals served by the
10 agency's recipients of Federal financial assist-
11 ance; and
12 ''(C) burdens of compliance with the agen-
13 cy guidance and this section for the agency and
14 its recipients.

15 **''SEC. 3402. NATIONAL STANDARDS FOR CULTURALLY AND**
16 **LINGUISTICALLY APPROPRIATE SERVICES IN**
17 **HEALTH CARE.**

18 ''Recipients of Federal financial assistance from the
19 Secretary shall, to the extent reasonable and practicable
20 after applying the 4-factor analysis described in title V
21 of the Guidance to Federal Financial Assistance Recipi-
22 ents Regarding Title VI Prohibition Against National Ori-
23 gin Discrimination Affecting Limited-English Proficient
24 Persons (June 12, 2002)—

1 "(1) implement strategies to recruit, retain, and
2 promote individuals at all levels of the organization
3 to maintain a diverse staff and leadership that can
4 provide culturally and linguistically appropriate
5 health care to patient populations of the service area
6 of the organization;
7 "(2) ensure that staff at all levels and across all
8 disciplines of the organization receive ongoing edu-
9 cation and training in culturally and linguistically
10 appropriate service delivery;
11 "(3) offer and provide language assistance serv-
12 ices, including trained bilingual staff and interpreter
13 services, at no cost to each patient with limited-
14 English proficiency at all points of contact, in a
15 timely manner during all hours of operation;
16 "(4) notify patients, in a culturally appropriate
17 manner, of their right to receive language assistance
18 services in their primary language;
19 "(5) ensure the competence of language assist-
20 ance provided to limited-English-proficient patients
21 by interpreters and bilingual staff, and ensure that
22 family, particularly minor children, and friends are
23 not used to provide interpretation services—
24 "(A) except in case of emergency; or

1 "(B) except on request of the patient, who
2 has been informed in his or her preferred lan-
3 guage of the availability of free interpretation
4 services;
5 "(6) make available easily understood patient-
6 related materials, if such materials exist for non-lim-
7 ited-English-proficient patients, including informa-
8 tion or notices about termination of benefits and
9 post signage in the languages of the commonly en-
10 countered groups or groups represented in the serv-
11 ice area of the organization;
12 "(7) develop and implement clear goals, poli-
13 cies, operational plans, and management account-
14 ability and oversight mechanisms to provide cul-
15 turally and linguistically appropriate services;
16 "(8) conduct initial and ongoing organizational
17 assessments of culturally and linguistically appro-
18 priate services-related activities and integrate valid
19 linguistic, competence-related measures into the in-
20 ternal audits, performance improvement programs,
21 patient satisfaction assessments, and outcomes-based
22 evaluations of the organization;
23 "(9) ensure that, consistent with the privacy
24 protections provided for under the regulations pro-
25 mulgated under section 264(c) of the Health Insur-

1 ance Portability and Accountability Act of 1996 (42
2 U.S.C. 1320d–2 note)—
3 ‘‘(A) data on the individual patient’s race,
4 ethnicity, primary language, alternative format
5 preferences, and policy modification needs are
6 collected in health records, integrated into the
7 organization’s management information sys-
8 tems, and periodically updated; and
9 ‘‘(B) if the patient is a minor or is inca-
10 pacitated, the primary language of the parent
11 or legal guardian is collected;
12 ‘‘(10) maintain a current demographic, cultural,
13 and epidemiological profile of the community as well
14 as a needs assessment to accurately plan for and im-
15 plement services that respond to the cultural and
16 linguistic characteristics of the service area of the
17 organization;
18 ‘‘(11) develop participatory, collaborative part-
19 nerships with communities and utilize a variety of
20 formal and informal mechanisms to facilitate com-
21 munity and patient involvement in designing and im-
22 plementing culturally and linguistically appropriate
23 services-related activities;
24 ‘‘(12) ensure that conflict and grievance resolu-
25 tion processes are culturally and linguistically sen-

1 sitive and capable of identifying, preventing, and re-
2 solving cross-cultural conflicts or complaints by pa-
3 tients;
4 ''(13) regularly make available to the public in-
5 formation about their progress and successful inno-
6 vations in implementing the standards under this
7 section and provide public notice in their commu-
8 nities about the availability of this information; and
9 ''(14) if requested, regularly make available to
10 the head of each Federal entity from which Federal
11 funds are received, information about their progress
12 and successful innovations in implementing the
13 standards under this section as required by the head
14 of such entity.
15 **''SEC. 3403. ROBERT T. MATSUI CENTER FOR CULTURAL**
16 **AND LINGUISTIC COMPETENCE IN HEALTH**
17 **CARE.**
18 ''(a) ESTABLISHMENT.—The Secretary, acting
19 through the Director of the Agency for Healthcare Re-
20 search and Quality, shall establish and support a center
21 to be known as the 'Robert T. Matsui Center for Cultural
22 and Linguistic Competence in Health Care' (referred to
23 in this section as the 'Center') to carry out the following
24 activities:

1 "(1) INTERPRETATION SERVICES.—The Center
2 shall provide resources via the Internet to identify
3 and link health care providers to competent inter-
4 preter and translation services.
5 "(2) TRANSLATION OF WRITTEN MATERIAL.—
6 "(A) The Center shall provide, directly or
7 through contract, vital documents from com-
8 petent translation services for providers of
9 health care and health-care-related services at
10 no cost to such providers. Materials may be
11 submitted for translation into non-English lan-
12 guages. Translation services shall be provided
13 in a timely and reasonable manner and in ac-
14 cordance with the guidelines and standards set
15 forth in subsection (c) when such standards be-
16 come available. The quality of such translation
17 services shall be monitored and reported pub-
18 licly.
19 "(B) For each form developed or revised
20 by the Secretary that will be used by LEP indi-
21 viduals in health care or health-care-related set-
22 tings, the Center shall translate the form, at a
23 minimum, into the top 15 non-English lan-
24 guages in the United States according to the
25 most recent data from the American Commu-

1 nity Survey or its replacement. The translation
2 must be completed within 45 days of the Sec-
3 retary receiving final approval of the form from
4 the Office of Management and Budget.
5 ''(3) TOLL-FREE CUSTOMER SERVICE TELE-
6 PHONE NUMBER.—The Center shall provide,
7 through a toll-free number, a customer service line
8 for LEP individuals—
9 ''(A) to obtain information about federally
10 conducted or funded health programs, including
11 Medicare, Medicaid, and SCHIP;
12 ''(B) to obtain assistance with applying for
13 or accessing these programs and understanding
14 Federal notices written in English; and
15 ''(C) to learn how to access language serv-
16 ices.
17 ''(4) HEALTH INFORMATION CLEARING-
18 HOUSE.—
19 ''(A) IN GENERAL.—The Center shall de-
20 velop and maintain an information clearing-
21 house to facilitate the provision of language
22 services by providers of health care and health-
23 care-related services to reduce medical errors,
24 improve medical outcomes, to improve cultural
25 competence, reduce health care costs caused by

1 miscommunication with individuals with lim-
2 ited-English proficiency, and reduce or elimi-
3 nate the duplication of effort to translate mate-
4 rials. The clearinghouse shall make such infor-
5 mation available on the Internet and in print.
6 Such information shall include the information
7 described in the succeeding provisions of this
8 paragraph.

9 ''(B) DOCUMENT TEMPLATES.—The Cen-
10 ter shall collect and evaluate for accuracy, de-
11 velop, and make available templates for stand-
12 ard documents that are necessary for patients
13 and consumers to access and make educated de-
14 cisions about their health care, including the
15 following:

16 ''(i) Administrative and legal docu-
17 ments, including—

18 ''(I) intake forms;

19 ''(II) Medicare, Medicaid, and
20 SCHIP forms, including eligibility in-
21 formation;

22 ''(III) forms informing patient of
23 HIPAA compliance and consent; and

1 "(IV) documents concerning in-
2 formed consent, advanced directives,
3 and waivers of rights.
4 "(ii) Clinical information, such as how
5 to take medications, how to prevent trans-
6 mission of a contagious disease, and other
7 prevention and treatment instructions.
8 "(iii) Public health, patient education,
9 and outreach materials, such as immuniza-
10 tion notices, health warnings, or screening
11 notices.
12 "(iv) Additional health or health-care-
13 related materials as determined appro-
14 priate by the Director of the Center.
15 "(C) STRUCTURE OF FORMS.—The oper-
16 ating the clearinghouse, the Center shall—
17 "(i) ensure that the documents posted
18 in English and non-English languages are
19 culturally appropriate;
20 "(ii) allow public review of the docu-
21 ments before dissemination in order to en-
22 sure that the documents are understand-
23 able and culturally appropriate for the tar-
24 get populations;

1 "(iii) allow health care providers to
2 customize the documents for their use;
3 "(iv) facilitate access to these docu-
4 ments;
5 "(v) provide technical assistance with
6 respect to the access and use of such infor-
7 mation; and
8 "(vi) carry out any other activities the
9 Secretary determines to be useful to fulfill
10 the purposes of the clearinghouse.
11 "(D) LANGUAGE ASSISTANCE PRO-
12 GRAMS.—The Center shall provide for the col-
13 lection and dissemination of information on cur-
14 rent examples of language assistance programs
15 and strategies to improve language services for
16 LEP individuals, including case studies using
17 de-identified patient information, program sum-
18 maries, and program evaluations.
19 "(E) CULTURAL AND LINGUISTIC COM-
20 PETENCE MATERIALS.—The Center shall pro-
21 vide information relating to culturally and lin-
22 guistically competent health care for minority
23 populations residing in the United States to all
24 health care providers and health-care-related

1 services at no cost. Such information shall in-
2 clude—
3 ‘‘(i) tenets of culturally and linguis-
4 tically competent care;
5 ‘‘(ii) cultural and linguistic com-
6 petence self-assessment tools;
7 ‘‘(iii) cultural and linguistic com-
8 petence training tools;
9 ‘‘(iv) strategic plans to increase cul-
10 tural and linguistic competence in different
11 types of providers of health care and
12 health-care-related services, including re-
13 gional collaborations among health care or-
14 ganizations; and
15 ‘‘(v) cultural and linguistic com-
16 petence information for educators, practi-
17 tioners, and researchers.
18 ‘‘(F) INFORMATION ABOUT PROGRESS.—
19 The Center shall regularly collect and make
20 publicly available information about the
21 progress of entities receiving grants under sec-
22 tion 3404 regarding successful innovations in
23 implementing the obligations under this sub-
24 section and provide public notice in the entities’

communities about the availability of this information;

"(b) DIRECTOR.—The Center shall be headed by a Director who shall be appointed by, and who shall report to, the Director of the Agency for Healthcare Research and Quality.

"(c) INTERPRETATION AND TRANSLATION GUIDELINES AND STANDARDS.—The Center shall convene a working group to develop and adopt interpretation and translation quality guidelines and standards for use by the Center. The guidelines and standards must be sufficient to ensure that LEP individuals have the equal opportunity to benefit from health care services to the same extent as non-LEP individuals. The guidelines and standards shall address the training, assessment, and certification of individuals to provide competent interpreter and translator services to work in health care and health-care-related settings and of bilingual staff who provide services directly in non-English languages. The working group may develop different guidelines and standards for bilingual staff, interpreters, and translators.

"(d) MEMBERSHIP.—

"(1) QUALIFICATIONS.—The Working Group shall consist of 14 members as follows:

1 "(A) Four members from organizations
2 that advocate on behalf of LEP individuals.
3 "(B) One member who represents a profes-
4 sional interpreter association (that is not the
5 National Council on Interpreting in Health
6 Care) or translator association.
7 "(C) One member from a nonprofit com-
8 munity-based organization that provides lan-
9 guage services.
10 "(D) Three members recommended by the
11 National Council on Interpreting in Health
12 Care, including one who individual who is a
13 professional interpreter.
14 "(E) Four members who are health care or
15 mental health providers or represent health care
16 provider associations, including one individual
17 who represents a health care practice of fewer
18 than 5 clinicians.
19 "(F) One member who works in or has ex-
20 tensive knowledge of issues related to health
21 care risk management.
22 "(2) GEOGRAPHIC REPRESENTATION.—The
23 membership of the Working Group shall reflect a
24 broad geographic representation including both

1 urban and rural representatives, including represent-
2 atives of the United States territories.
3 "(3) PROHIBITED APPOINTMENTS.—Members
4 of the Working Group shall not include Members of
5 Congress or other elected Federal, State, or local
6 government officials.
7 "(4) VACANCIES.—Any vacancies in the Work-
8 ing Group shall not affect the power and duties of
9 the Working Group but shall be filled in the same
10 manner as the original appointment.
11 "(5) SUBCOMMITTEES.—The Working Group
12 may establish subcommittees if doing so increases
13 the efficiency of the Working Group in completing
14 its tasks, including subcommittees to develop dif-
15 ferent guidelines and standards for interpreters,
16 translators, and bilingual staff.
17 "(6) ADVISORY PANEL TO THE WORKING
18 GROUP.—The Working Group shall consult with the
19 Advisory Panel in the development of the guidelines
20 and standards. The Advisory Panel shall include—
21 "(A) representatives from the American
22 Translators Association, Association of Lan-
23 guage Companies, the National Center for
24 State Courts, and States which have developed
25 interpreter standards such as California, Mas-

1 sachusetts, and Oregon who have experience in
2 the development or implementation of their or-
3 ganizations' interpreter and translator certifi-
4 cation programs;

5 "(B) Federal agencies including the Office
6 for Civil Rights, the Office of Minority Health,
7 the Centers for Medicare & Medicaid Services,
8 and the National Institute on Minority Health
9 and Health Disparities; and

10 "(C) other individuals or entities deter-
11 mined appropriate by the Secretary who have
12 specific expertise that will be useful to the
13 Working Group.

14 "(7) PUBLICATION.—

15 "(A) DRAFT STANDARDS.—Not later than
16 18 months after the date of enactment of this
17 title, the Working Group shall—

18 "(i) prepare and make available to the
19 public through the Internet, the Federal
20 Register, and other appropriate public
21 channels, a proposed set of interpretation
22 and translation guidelines and standards
23 for training, assessment, and certification;
24 and

1 "(ii) accept public comment on such
2 guidelines and standards for a period of
3 not less than 90 days.
4 "(B) FINAL STANDARDS.—Not later than
5 120 days after the expiration of the public com-
6 ment period described in subparagraph (A), the
7 Director of the Agency for Healthcare Research
8 and Quality shall publish, after consultation
9 with and the approval of the Working Group,
10 final guidelines and standards in the Federal
11 Register and on the Internet.
12 "(C) TESTING DEVELOPMENT.—Not later
13 than 120 days after the publication of the final
14 recommendations described in subparagraph
15 (B), the Director of the Agency for Healthcare
16 Research and Quality shall, if deemed necessary
17 by the Working Group, enter into a contract
18 with an entity experienced in the development
19 of designing certification tests in language re-
20 lated fields to develop such tests as may be nec-
21 essary to implement the guidelines and stand-
22 ards.
23 "(D) PILOT PROJECT.—
24 "(i) Not later than 120 days after
25 completion of the test development de-

1 scribed in subparagraph (C) or after publi-
2 cation of the final guidelines and stand-
3 ards, whichever is later, the Secretary shall
4 design, fund, and implement a pilot project
5 in up to 50 geographically and demo-
6 graphically diverse sites, two of which must
7 be in the United States territories, to test
8 and evaluate implementation of the rec-
9 ommendations.

10 ''(ii) The Secretary shall consult with
11 the Working Group and the Advisory
12 Panel in development of the pilot project
13 and report progress to the Working Group
14 on an ongoing basis.

15 ''(iii) The pilot project shall include
16 interpreters and translators working with
17 various provider types, including small
18 group practices, hospitals, mental health
19 and substance use clinics, and community
20 health clinics, and shall include broad geo-
21 graphic representation including both
22 urban and rural representatives.

23 ''(iv) The pilot project shall operate
24 for not less than 2 nor more than 4 years,
25 as determined by the Secretary.

1 "(v) If the Working Group determines
2 that any revisions to guidelines and stand-
3 ards are necessary as a result of the pilot
4 project, it shall revise such guidelines and
5 standards and the Director of the Agency
6 for Healthcare Research and Quality shall
7 publish the revisions in the Federal Reg-
8 ister for notice and comment. Not later
9 than 120 days after the expiration of the
10 public comment period on such revisions,
11 the Director of the Agency for Healthcare
12 Research and Quality shall publish, after
13 consultation with and the approval of the
14 Working Group, final revisions to the
15 guidelines and standards in the Federal
16 Register and on the Internet.
17 "(8) ADMINISTRATION.—
18 "(A) CHAIRPERSON.—Not later than 15
19 days after the date on which all members of the
20 Working Group have been appointed under sub-
21 section (d), the Working Group shall designate
22 its chairperson.
23 "(B) COMPENSATION.—While serving on
24 the business of the Working Group (including
25 travel time), a member of the Working Group

1 or the Advisory Panel shall be entitled to com-
2 pensation at the per diem equivalent of the rate
3 provided for level IV of the Executive Schedule
4 under section 5315 of title 5, United States
5 Code, and while so serving away from home and
6 the member's regular place of business, a mem-
7 ber may be allowed travel expenses, as author-
8 ized by the chairperson of the Working Group.
9 For purposes of pay and employment benefits,
10 rights, and privileges, all personnel of the
11 Working Group shall be treated as if they were
12 employees of the House of Representatives.
13 "(C) INFORMATION FROM FEDERAL AGEN-
14 CIES.—The Working Group may secure directly
15 from any Federal department or agency such
16 information as the Working Group considers
17 necessary to carry out this section. Upon re-
18 quest of the Working Group, the head of such
19 department or agency shall furnish such infor-
20 mation. Any information that contains individ-
21 ually identifiable information received by the
22 Working Group shall not be disseminated or
23 disclosed outside of the Working Group and
24 shall not be used except by the Working Group.

1 "(D) DETAIL.—Not more than 10 Federal
2 Government employees employed by the Depart-
3 ment of Health and Human Services may be
4 detailed to staff the Working Group under this
5 section without further reimbursement. Any de-
6 tail of an employee shall be without interruption
7 or loss of civil service status or privilege.

8 "(E) TEMPORARY AND INTERMITTENT
9 SERVICES.—The Working Group may procure
10 temporary and intermittent services under sec-
11 tion 3109(b) of title 5, United States Code, at
12 rates for individuals which do not exceed the
13 daily equivalent of the annual rate of basic pay
14 prescribed for level V of the Executive Schedule
15 under section 5316 of such title.

16 "(9) DEEMED STATUS.—

17 "(A) CERTIFICATION BY PRIVATE ORGANI-
18 ZATION.—If a private accreditation organization
19 establishes training, assessment, or certification
20 standards for interpreters or translators in
21 health care which the Secretary determines are
22 at least equivalent to the training, assessment,
23 or certification standards promulgated by the
24 Secretary as described in subsection (c), the
25 Secretary shall find that all organizations or in-

1 dividuals accredited by such organization com-
2 ply also with the standard described in sub-
3 section (c) if—
4 "(i) such organization or individual
5 authorizes the organization to release to
6 the Secretary upon the Secretary's request
7 (or such State agency as the Secretary
8 may designate) a copy of the most current
9 accreditation survey of such organization
10 or individual made by the organization, to-
11 gether with any other information directly
12 related to the survey as the Secretary may
13 require (including corrective action plans);
14 and
15 "(ii) such organization releases such a
16 copy and any such information to the Sec-
17 retary.
18 "(B) CERTIFICATION BY A STATE OR LO-
19 CALITY.—If a State or locality has or estab-
20 lishes training, assessment, or certification
21 standards for interpreters or translators in
22 health care which the Secretary determines are
23 at least equivalent to the training, assessment,
24 or certification standards promulgated by the
25 Secretary as described in subsection (c), the

1 Secretary shall find that all organizations or in-
2 dividuals accredited by such State or locality
3 comply also with the standard described in sub-
4 section (c) if—
5 ''(i) such organization or individual
6 authorizes the State or locality to release
7 to the Secretary upon his request (or such
8 State agency as the Secretary may des-
9 ignate) a copy of the most current accredi-
10 tation survey of such organization or indi-
11 vidual made by such State or locality, to-
12 gether with any other information directly
13 related to the survey as the Secretary may
14 require (including corrective action plans);
15 and
16 ''(ii) such State or locality releases
17 such a copy and any such information to
18 the Secretary.
19 ''(C) TIMELY ACTION ON APPLICATION.—
20 The Secretary shall determine, within 210 days
21 after the date the Secretary receives an applica-
22 tion by a private accrediting organization,
23 State, or locality whether the process of the pri-
24 vate accrediting organization, State, or locality
25 meets the requirements with respect to training,

1 assessment, or certification standards for inter-
2 preters or translators with respect to which
3 standards the application is made. The Sec-
4 retary may not deny an application on the basis
5 that it seeks to meet the requirements with re-
6 spect to only one, or more than one, training,
7 assessment, or certification standards for inter-
8 preters or translators.
9 ‘‘(D) DISCLOSURE OF ACCREDITATION
10 SURVEY.—The Secretary may not disclose any
11 accreditation survey made and released to him
12 by the National Council on Interpreting in
13 Health Care or any State or locality of an ac-
14 credited organization or individual, except that
15 the Secretary may disclose such a survey and
16 information related to such a survey to the ex-
17 tent such survey and information relate to an
18 enforcement action taken by the Secretary.
19 ‘‘(E) DEFICIENCIES.—If the Secretary
20 finds that an accredited organization or indi-
21 vidual has significant deficiencies (as defined in
22 regulations pertaining to the training, assess-
23 ment, or certification standards), the organiza-
24 tion or individual shall, after the date of notice
25 of such finding to the organization and for such

1 period as may be prescribed in regulations, be
2 deemed not to meet the conditions or require-
3 ments the organization or individual has been
4 treated as meeting pursuant to subparagraph
5 (A).

6 ''(e) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
7 rector shall collaborate with the Administrator of the Of-
8 fice of Minority Health, the Administrator of the Centers
9 for Medicare & Medicaid Services, and the Administrator
10 of the Health Resources and Services Administration to
11 notify health care providers and health care organizations
12 about the availability of language access services by the
13 Center.

14 ''(f) EDUCATION.—The Secretary, directly or through
15 contract, shall undertake a national education campaign
16 to inform providers, LEP individuals, health professionals,
17 graduate schools, and community health centers about—

18 ''(1) Federal and State laws and guidelines gov-
19 erning access to language services;

20 ''(2) the value of using trained interpreters and
21 the risks associated with using family members,
22 friends, minors, and untrained bilingual staff;

23 ''(3) funding sources for developing and imple-
24 menting language services; and

1 ‘‘(4) promising practices to effectively provide
2 language services.

3 **‘‘SEC. 3404. INNOVATIONS IN CULTURAL AND LINGUISTIC**
4 **COMPETENCE GRANTS.**

5 ‘‘(a) IN GENERAL.—The Secretary, acting through
6 the Director of the Agency for Healthcare Research and
7 Quality, shall award grants to eligible entities to enable
8 such entities to design, implement, and evaluate innova-
9 tive, cost-effective programs to improve cultural com-
10 petence and language access in health care for individuals
11 with limited-English proficiency. The Director of the
12 Agency for Healthcare Research and Quality shall coordi-
13 nate with, and ensure the participation of, other agencies
14 including but not limited to the Health Resources and
15 Services Administration, the Center on Minority Health
16 and Health Disparities at the National Institutes of
17 Health, and the Office of Minority Health, regarding the
18 design and evaluation of the grants program.

19 ‘‘(b) ELIGIBILITY.—To be eligible to receive a grant
20 under subsection (a) an entity shall—
21 ‘‘(1) be—
22 ‘‘(A) a city, county, Indian tribe, State,
23 territory or subdivision thereof;

1 "(B) an organization described in section
2 501(c)(3) of the Internal Revenue Code of
3 1986;
4 "(C) a community health, mental health,
5 or substance use center or clinic;
6 "(D) a solo or group physician practice;
7 "(E) an integrated health care delivery
8 system;
9 "(F) a public hospital;
10 "(G) a health care group, university, or
11 college; or
12 "(H) other entity designated by the Sec-
13 retary; and
14 "(2) prepare and submit to the Secretary an
15 application, at such time, in such manner, and ac-
16 companied by such additional information as the
17 Secretary may require.
18 "(c) USE OF FUNDS.—An entity shall use funds re-
19 ceived under a grant under this section to—
20 "(1) develop, implement, and evaluate models of
21 providing competent interpretation services through
22 on-site interpretation, telephonic interpretation, or
23 video interpretation;
24 "(2) implement strategies to recruit, retain, and
25 promote individuals at all levels of the organization

1 to maintain a diverse staff and leadership that can
2 promote and provide language services to patient
3 populations of the service area of the organization;
4 ‘‘(3) develop and maintain a needs assessment
5 that identifies the current demographic, cultural,
6 and epidemiological profile of the community to ac-
7 curately plan for and implement language services
8 needed in service area of the organization;
9 ‘‘(4) develop a strategic plan to implement lan-
10 guage services;
11 ‘‘(5) develop participatory, collaborative part-
12 nerships with communities encompassing the LEP
13 patient populations being served to gain input in de-
14 signing and implementing language services;
15 ‘‘(6) develop and implement grievance resolu-
16 tion processes that are culturally and linguistically
17 sensitive and capable of identifying, preventing, and
18 resolving complaints by LEP individuals; or
19 ‘‘(7) develop short-term medical mental health
20 interpretation training courses and incentives for bi-
21 lingual health care staff who are asked to interpret
22 in the workplace;
23 ‘‘(8) develop formal training programs, includ-
24 ing continued professional development and edu-
25 cation programs as well as supervision, for individ-

1 uals interested in becoming dedicated health care in-
2 terpreters and culturally competent providers;
3 “(9) provide staff language training instruction,
4 which shall include information on the practical limi-
5 tations of such instruction for non-native speakers;
6 “(10) develop policies that address compensa-
7 tion in salary for staff who receive training to be-
8 come either a staff interpreter or bi-lingual provider;
9 “(11) develop other language assistance services
10 as determined appropriate by the Secretary;
11 “(12) develop, implement, and evaluate models
12 of improving cultural competence; and
13 “(13) ensure that, consistent with the privacy
14 protections provided for under the regulations pro-
15 mulgated under section 264(c) of the Health Insur-
16 ance Portability and Accountability Act of 1996 (42
17 U.S.C. 1320d–2 note), and any applicable State pri-
18 vacy laws, data on the individual patient or recipi-
19 ent’s race, ethnicity, and primary language are col-
20 lected (and periodically updated) in health records
21 and integrated into the organization’s information
22 management systems or any similar system used to
23 store and retrieve data.
24 “(d) PRIORITY.—In awarding grants under this sec-
25 tion, the Secretary shall give priority to entities that pri-

1 marily engage in providing direct care and that have devel-
2 oped partnerships with community organizations or with
3 agencies with experience language access.

4 ''(e) EVALUATION.—

5 ''(1) An entity that receives a grant under this
6 section shall submit to the Secretary an evaluation
7 that describes, in the manner and to the extent re-
8 quired by the Secretary, the activities carried out
9 with funds received under the grant, and how such
10 activities improved access to health and health-care-
11 related services and the quality of health care for in-
12 dividuals with limited-English proficiency. Such eval-
13 uation shall be collected and disseminated through
14 the Robert T. Matsui Center for Cultural and Lin-
15 guistic Competence in Health Care established under
16 section 3403. The Director of the Agency for
17 Healthcare Research and Quality shall notify grant-
18 ees of the availability of technical assistance for the
19 evaluation and provide such assistance upon request.

20 ''(2) The Director of the Agency for Healthcare
21 Research and Quality shall evaluate or arrange with
22 other individuals or organizations to evaluate
23 projects funded under this section.

1 **"SEC. 3405. RESEARCH ON CULTURAL AND LANGUAGE COM-**
2 **PETENCE.**

3 "(a) IN GENERAL.—The Secretary, acting through
4 the Director of the Agency for Healthcare Research and
5 Quality, shall expand research concerning language access
6 in the provision of health care.

7 "(b) ELIGIBILITY.—The Director of the Agency for
8 Healthcare Research and Quality may conduct the re-
9 search described in subsection (a) or enter into contracts
10 with other individuals or organizations to do so.

11 "(c) USE OF FUNDS.—Research under this section
12 shall be designed to do one or more of the following:

13 "(1) To identify the barriers to mental and be-
14 havioral services that are faced by LEP individuals.

15 "(2) To identify health care providers' and
16 health administrators' attitudes, knowledge, and
17 awareness of the barriers to quality health care serv-
18 ices that are faced by LEP individuals.

19 "(3) To identify optimal approaches for deliv-
20 ering language access.

21 "(4) To identify best practices for data collec-
22 tion, including—

23 "(A) the collection by providers of health
24 care and health-care-related services of data on
25 the race, ethnicity, and primary language of re-
26 cipients of such services, taking into account ex-

1 isting research conducted by the Government or
2 private sector;
3 ''(B) the development and implementation
4 of data collection and reporting systems; and
5 ''(C) effective privacy safeguards for col-
6 lected data.
7 ''(5) To develop a minimum data collection set
8 for primary language.
9 ''(6) To evaluate the most effective ways in
10 which the Department can create or coordinate, and
11 then subsidize or otherwise fund telephonic interpre-
12 tation providers for health care providers, taking
13 into consideration, among other factors, the flexi-
14 bility necessary for such a system to accommodate
15 variations in—
16 ''(A) provider type;
17 ''(B) languages needed and their frequency
18 of use;
19 ''(C) type of encounter;
20 ''(D) time of encounter, including regular
21 business hours and after hours; and
22 ''(E) location of encounter.''.

SEC. 203. FEDERAL REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES UNDER THE MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

(a) LANGUAGE ACCESS GRANTS FOR MEDICARE PROVIDERS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary"), acting through the Centers for Medicare & Medicaid Services and in consultation with the Center for Medicare and Medicaid Innovation, shall establish demonstration program under which the Secretary shall award grants to eligible Medicare service providers to improve communication between such providers and limited-English-proficient Medicare beneficiaries, including beneficiaries who live in diverse and underserved communities.

(B) APPLICATION OF INNOVATION RULES.—The demonstration project under subparagraph (A) shall be conducted in a manner that is consistent with the applicable provisions

1 of subsections (b), (c), and (d) of section 1115A
2 of the Social Security Act.
3 (C) NUMBER OF GRANTS.—To the extent
4 practicable, the Secretary shall award not less
5 than 24 grants under this subsection.
6 (D) GRANT PERIOD.—Except as provided
7 under paragraph (2)(D), each grant awarded
8 under this subsection shall be for a 3-year pe-
9 riod.
10 (2) ELIGIBILITY REQUIREMENTS.—To be eligi-
11 ble for a grant under this subsection, an entity must
12 meet the following requirements:
13 (A) MEDICARE PROVIDER.—The entity
14 must be—
15 (i) a provider of services under part A
16 of title XVIII of the Social Security Act;
17 (ii) a provider of services under part
18 B of such title;
19 (iii) a Medicare Advantage organiza-
20 tion offering a Medicare Advantage plan
21 under part C of such title; or
22 (iv) a PDP sponsor offering a pre-
23 scription drug plan under part D of such
24 title.

1 (B) UNDERSERVED COMMUNITIES.—The
2 entity must serve a community that, with re-
3 spect to necessary language services for improv-
4 ing access and utilization of health care among
5 limited-English proficient individuals, is
6 disproportionally underserved.
7 (C) APPLICATION.—The entity must pre-
8 pare and submit to the Secretary an applica-
9 tion, at such time, in such manner, and accom-
10 panied by such additional information as the
11 Secretary may require.
12 (D) REPORTING.—In the case of a grantee
13 that received a grant under this subsection in
14 a previous year, such grantee is only eligible for
15 continued payments under a grant under this
16 subsection if the grantee met the reporting re-
17 quirements under paragraph (9) for such year.
18 If a grantee fails to meet the requirement of
19 such paragraph for the first year of a grant, the
20 Secretary may terminate the grant and solicit
21 applications from new grantees to participate in
22 the demonstration program.
23 (3) DISTRIBUTION.—To the extent feasible, the
24 Secretary shall award—

1 (A) at least 6 grants to providers of serv-
2 ices described in paragraph (2)(A)(i);
3 (B) at least 6 grants to service providers
4 described in paragraph (2)(A)(ii);
5 (C) at least 6 grants to organizations de-
6 scribed in paragraph (2)(A)(iii); and
7 (D) at least 6 grants to sponsors described
8 in paragraph (2)(A)(iv).
9 (4) CONSIDERATIONS IN AWARDING GRANTS.—
10 (A) VARIATION IN GRANTEES.—In award-
11 ing grants under this subsection, the Secretary
12 shall select grantees to ensure the following:
13 (i) The grantees provide many dif-
14 ferent types of language services.
15 (ii) The grantees serve Medicare bene-
16 ficiaries who speak different languages,
17 and who, as a population, have differing
18 needs for language services.
19 (iii) The grantees serve Medicare
20 beneficiaries in both urban and rural set-
21 tings.
22 (iv) The grantees serve Medicare
23 beneficiaries in at least two geographic re-
24 gions, as defined by the Secretary.

1 (v) The grantees serve Medicare bene-
2 ficiaries in at least two large metropolitan
3 statistical areas with racial, ethnic, and
4 economically diverse populations.
5 (B) PRIORITY FOR PARTNERSHIPS WITH
6 COMMUNITY ORGANIZATIONS AND AGENCIES.—
7 In awarding grants under this subsection, the
8 Secretary shall give priority to eligible entities
9 that have a partnership with—
10 (i) a community organization; or
11 (ii) a consortia of community organi-
12 zations, state agencies, and local agencies,
13 that has experience in providing language serv-
14 ices.
15 (5) USE OF FUNDS FOR COMPETENT LANGUAGE
16 SERVICES.—
17 (A) IN GENERAL.—Subject to subpara-
18 graph (E), a grantee may only use grant funds
19 received under this subsection to pay for the
20 provision of competent language services to
21 Medicare beneficiaries who are limited-English
22 proficient.
23 (B) COMPETENT LANGUAGE SERVICES DE-
24 FINED.—For purposes of this subsection, the
25 term ''competent language services'' means—

1 (i) interpreter and translation services
2 that—
3 (I) subject to the exceptions
4 under subparagraph (C)—
5 (aa) if the grantee operates
6 in a State that has statewide
7 health care interpreter standards,
8 meet the State standards cur-
9 rently in effect; or
10 (bb) if the grantee operates
11 in a State that does not have
12 statewide health care interpreter
13 standards, utilizes competent in-
14 terpreters who follow the Na-
15 tional Council on Interpreting in
16 Health Care's Code of Ethics and
17 Standards of Practice; and
18 (II) that, in the case of inter-
19 preter services, are provided
20 through—
21 (aa) on-site interpretation;
22 (bb) telephonic interpreta-
23 tion; or
24 (cc) video interpretation;
25 and

1 (ii) the direct provision of health care
2 or health-care-related services by a com-
3 petent bilingual health care provider.
4 (C) EXCEPTIONS.—The requirements of
5 subparagraph (B)(i)(I) do not apply—
6 (i) to a Medicare beneficiary who is
7 limited-English-proficient who has been in-
8 formed, in the beneficiary's primary lan-
9 guage, of the availability of free interpreter
10 and translation services and who, instead,
11 requests that a family member, friend, or
12 other person provide such services, if the
13 grantee documents such request in the
14 beneficiary's medical record; or
15 (ii) in the case of a medical emergency
16 where the delay directly associated with ob-
17 taining a competent interpreter or trans-
18 lation services would jeopardize the health
19 of the patient.
20 Subparagraph (C)(ii) shall not be construed to
21 exempt emergency rooms or similar entities
22 that regularly provide health care services in
23 medical emergencies to limited-English-pro-
24 ficient patients from any applicable legal or reg-
25 ulatory requirements related to providing com-

1 petent interpreter and translation services with-
2 out undue delay.
3 (D) MA ORGANIZATIONS AND PDP SPON-
4 SORS.—If a grantee is a Medicare Advantage
5 organization or a PDP sponsor, such entity
6 must provide at least 50 percent of the grant
7 funds that the entity receives under this sub-
8 section directly to the entity's network providers
9 (including physicians and pharmacies) for the
10 purpose of providing support for such providers
11 to provide competent language services to Medi-
12 care beneficiaries who are limited-English pro-
13 ficient.
14 (E) ADMINISTRATIVE AND REPORTING
15 COSTS.—A grantee may use up to 10 percent of
16 the grant funds to pay for administrative costs
17 associated with the provision of competent lan-
18 guage services and for reporting required under
19 paragraph (9).
20 (6) DETERMINATION OF AMOUNT OF GRANT
21 PAYMENTS.—
22 (A) IN GENERAL.—Payments to grantees
23 under this subsection shall be calculated based
24 on the estimated numbers of limited-English-

1 proficient Medicare beneficiaries in a grantee's
2 service area utilizing—
3 (i) data on the numbers of limited-
4 English-proficient individuals who speak
5 English less than "very well" from the
6 most recently available data from the Bu-
7 reau of the Census or other State-based
8 study the Secretary determines likely to
9 yield accurate data regarding the number
10 of such individuals in such service area; or
11 (ii) data provided by the grantee, if
12 the grantee routinely collects data on the
13 primary language of the Medicare bene-
14 ficiaries that the grantee serves and the
15 Secretary determines that the data is accu-
16 rate and shows a greater number of lim-
17 ited-English-proficient individuals than
18 would be estimated using the data under
19 clause (i).
20 (B) DISCRETION OF SECRETARY.—Subject
21 to subparagraph (C), the amount of payment
22 made to a grantee under this subsection may be
23 modified annually at the discretion of the Sec-
24 retary, based on changes in the data under sub-

1 paragraph (A) with respect to the service area
2 of a grantee for the year.
3 (C) LIMITATION ON AMOUNT.—The
4 amount of a grant made under this subsection
5 to a grantee may not exceed $500,000 for the
6 period under paragraph (1)(D).
7 (7) ASSURANCES.—Grantees under this sub-
8 section shall—
9 (A) ensure that clinical and support staff
10 receive appropriate ongoing education and
11 training in linguistically appropriate service de-
12 livery;
13 (B) ensure the linguistic competence of bi-
14 lingual providers;
15 (C) offer and provide appropriate language
16 services at no additional charge to each patient
17 with limited-English proficiency for all points of
18 contact between the patient and the grantee, in
19 a timely manner during all hours of operation;
20 (D) notify Medicare beneficiaries of their
21 right to receive language services in their pri-
22 mary language;
23 (E) post signage in the primary languages
24 commonly used by the patient population in the
25 service area of the organization; and

1 (F) ensure that—
2 (i) primary language data is collected
3 for recipients of language services and
4 such data is consistent with standards de-
5 veloped under title XXXIV of the Public
6 Health Service Act, as added by section
7 202 of this Act, to the extent such stand-
8 ards are available upon the initiation of the
9 demonstration program; and
10 (ii) consistent with the privacy protec-
11 tions provided under the regulations pro-
12 mulgated pursuant to section 264(c) of the
13 Health Insurance Portability and Account-
14 ability Act of 1996 (42 U.S.C. 1320d–2
15 note), if the recipient of language services
16 is a minor or is incapacitated, primary lan-
17 guage data is collected on the parent or
18 legal guardian of such recipient.
19 (8) NO COST SHARING.—Limited-English-pro-
20 ficient Medicare beneficiaries shall not have to pay
21 cost-sharing or co-payments for competent language
22 services provided under this demonstration program.
23 (9) REPORTING REQUIREMENTS FOR GRANT-
24 EES.—Not later than the end of each calendar year,
25 a grantee that receives funds under this subsection

1 in such year shall submit to the Secretary a report
2 that includes the following information:
3 (A) The number of Medicare beneficiaries
4 to whom competent language services are pro-
5 vided.
6 (B) The primary languages of those Medi-
7 care beneficiaries.
8 (C) The types of language services pro-
9 vided to such beneficiaries.
10 (D) Whether such language services were
11 provided by employees of the grantee or
12 through a contract with external contractors or
13 agencies).
14 (E) The types of interpretation services
15 provided to such beneficiaries, and the approxi-
16 mate length of time such service is provided to
17 such beneficiaries.
18 (F) The costs of providing competent lan-
19 guage services.
20 (G) An account of the training or accredi-
21 tation of bilingual staff, interpreters, and trans-
22 lators providing services funded by the grant
23 under this subsection.
24 (10) EVALUATION AND REPORT TO CON-
25 GRESS.—Not later than 1 year after the completion

1 of a 3-year grant under this subsection, the Sec-
2 retary shall conduct an evaluation of the demonstra-
3 tion program under this subsection and shall submit
4 to the Congress a report that includes the following:
5 (A) An analysis of the patient outcomes
6 and the costs of furnishing care to the limited-
7 English-proficient Medicare beneficiaries par-
8 ticipating in the project as compared to such
9 outcomes and costs for limited-English-pro-
10 ficient Medicare beneficiaries not participating,
11 based on the data provided under paragraph (9)
12 and any other information available to the Sec-
13 retary.
14 (B) The effect of delivering language serv-
15 ices on—
16 (i) Medicare beneficiary access to care
17 and utilization of services;
18 (ii) the efficiency and cost effective-
19 ness of health care delivery;
20 (iii) patient satisfaction;
21 (iv) health outcomes; and
22 (v) the provision of culturally appro-
23 priate services provided to such bene-
24 ficiaries.

1 (C) The extent to which bilingual staff, in-
2 terpreters, and translators providing services
3 under such demonstration were trained or ac-
4 credited and the nature of accreditation or
5 training needed by type of provider, service, or
6 other category as determined by the Secretary
7 to ensure the provision of high-quality interpre-
8 tation, translation, or other language services to
9 Medicare beneficiaries if such services are ex-
10 panded pursuant to subsection (c) of section
11 1907 of this Act.
12 (D) Recommendations, if any, regarding
13 the extension of such project to the entire Medi-
14 care program, subject the to provision of section
15 1115A(c) of the Social Security Act.
16 (b) LANGUAGE SERVICES UNDER THE MEDICARE
17 PROGRAM.—
18 (1) Subsection (aa)(1) of section 1861 of the
19 Social Security Act (42 U.S.C. 1395x) is amended—
20 (A) in subparagraph (B), by striking the
21 ''and'' at the end;
22 (B) in subparagraph (C), by inserting
23 ''and'' after the comma at the end; and
24 (C) by inserting after subparagraph (C)
25 the following:

1 "(D) language services as defined in sub-
2 section (iii),".
3 (2) Section 1833(a) of the Social Security Act
4 (42 U.S.C. 1395l(a)) is amended—
5 (A) by striking "and" at the end of para-
6 graph (8);
7 (B) by redesignating paragraph (9) as
8 paragraph (10); and
9 (C) by inserting after paragraph (8) the
10 following new paragraph:
11 "(9) in the case of language services described
12 in section 1861(iii), 100 percent of the reasonable
13 charges for such services, as determined in consulta-
14 tion with the Medicare Payment Advisory Commis-
15 sion; and".
16 (3) Section 1832(a)(2) of such Act (42 U.S.C.
17 1395k(a)(2)) is amended—
18 (A) by striking "and" at the end of sub-
19 paragraph (I);
20 (B) by striking the period at the end of
21 subparagraph (J) and inserting "; and"; and
22 (C) by adding at the end the following new
23 subparagraph:

1 "(K) language services (as defined in sec-
2 tion 1861(iii)) furnished by a interpreter or
3 translator.".
4 (4) Section 1861 of the Social Security Act (42
5 U.S.C. 1395x) is amended by adding at the end the
6 following new subsection:
7 "Language Services and Related Terms
8 "(iii)(1) LANGUAGE SERVICES DEFINED.—The term
9 'language services' has the same meaning given 'language
10 or language access services' in section 3400 of the Public
11 Health Service Act.
12 "(2) INTERPRETER SERVICES DEFINED.—For pur-
13 poses of this subsection, the term 'interpreter services' has
14 the meaning given 'competent interpreter services' under
15 section 3400(3) of the Public Health Service Act.
16 "(3) INTERPRETER DEFINED.—The term 'inter-
17 preter'—
18 "(A) means an individual—
19 "(i) who faithfully, accurately, and objec-
20 tively transmits a spoken message from one lan-
21 guage into another language; and
22 "(ii) who knows health and health-related
23 terminology in both languages; and
24 "(B) includes individuals who provide in-person,
25 telephonic, and video interpretation.

1 "(4) TRANSLATION DEFINED.—The term 'trans-
2 lation' means the transmission of a written message in one
3 language into a written message in another language that
4 retains the intended meaning of the original message.
5 "(5) LIMITED-ENGLISH-PROFICIENT AND LEP DE-
6 FINED.—The terms 'Limited-English-proficient' and
7 'LEP' have the meaning given the term 'limited english
8 proficient' under section 9101(25) of the Elementary and
9 Secondary Education Act of 1965, except that subpara-
10 graphs (A), (B), and (D) of such section shall not apply.".
11 (5) WAIVER OF BUDGET NEUTRALITY.—For
12 the 3-year period beginning on the date of enact-
13 ment of this section, the budget neutrality provision
14 of section 1848(c)(2)(B)(ii) of the Social Security
15 Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not
16 apply to language services (as such term is defined
17 in section 1861(iii) of such Act, as added by para-
18 graph (4)).
19 (c) MEDICARE PART C AND PART D.—
20 (1) MEDICARE PART C.—Section 1852 of the
21 Social Security Act (42 U.S.C. 1395ww–22) is
22 amended by adding at the end the following new
23 subsection:
24 "(m) PROVISION OF EFFECTIVE LANGUAGE SERV-
25 ICES.—

1 "(1) IN GENERAL.—Each Medicare Advantage
2 organization that offers a Medicare Advantage plan
3 under this part shall provide effective language serv-
4 ices to enrollees in such plan.
5 "(2) REPORTING REQUIREMENTS.—A Medicare
6 Advantage organization shall annually submit to the
7 Secretary a report that contains information on the
8 internal policies and procedures of Medicare Advan-
9 tage plans offered by the organization related to re-
10 cruitment and retention efforts directed to workforce
11 diversity and linguistically and culturally appropriate
12 provision of services in each of the following con-
13 texts:
14 "(A) The collection of data in a manner
15 that meets the requirements of title I of the
16 Health Equity and Accountability Act of 2012,
17 regarding the enrollee population.
18 "(B) Education of staff and contractors
19 who have routine contact with enrollees regard-
20 ing the various needs of the diverse enrollee
21 population.
22 "(C) Evaluation of the plan's language
23 services programs and services with respect to
24 the plan's enrollee population, such as through

1 analysis of complaints or satisfaction survey re-
2 sults.
3 ‘‘(D) Methods by which the plan provides
4 to the Secretary information regarding the eth-
5 nic diversity of the plan's enrollee population.
6 ‘‘(E) The periodic provision of educational
7 information to plan enrollees on the plan's lan-
8 guage services and programs.''.
9 (2) MEDICARE PART D.—Section 1860D–4 of
10 the Social Security Act (42 U.S.C. 1395w–104) is
11 amended by adding at the end the following new
12 subsection:
13 ‘‘(m) PROVISION OF EFFECTIVE LANGUAGE SERV-
14 ICES.—The provisions of section 1852(m) shall apply to
15 a PDP sponsor (and a prescription drug plan offered by
16 such sponsor) in the same manner as such provisions
17 apply to a Medicare Advantage organization (and a Medi-
18 care Advantage plan offered by such organization.''.
19 (3) EFFECTIVE DATE.—The amendments made
20 by this subsection shall apply with respect to plan
21 years beginning on or after the date of enactment of
22 this Act.
23 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID
24 AND SCHIP.—

1 (1) Section 1903(a)(2)(E) of the Social Secu-
2 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended
3 by—
4 (A) striking ''75'' and inserting ''90'';
5 (B) striking ''translation or interpretation
6 services'' and inserting ''language services'';
7 and
8 (C) striking ''children of families'' and in-
9 serting ''individuals''.
10 (2) Section 1902(a)(10)(A) of the Social Secu-
11 rity Act (42 U.S.C. 1396a(a)(10)(A)) is amended, in
12 the matter preceding clause (i), by striking ''and
13 (28)'' and inserting ''(28), and (29)''.
14 (3) Section 1905(a) of the Social Security Act
15 (42 U.S.C. 1396d(a)) is amended by—
16 (A) in paragraph (28), by striking ''and''
17 at the end;
18 (B) by redesignating paragraph (29) as
19 paragraph (30); and
20 (C) by inserting after paragraph (28) the
21 following new paragraph:
22 ''(29) language services, as such term is defined
23 in section 1861(iii), provided in a timely manner to
24 limited-English-proficient individuals who need such
25 services; and''.

1 (4) Section 1916(a)(2) of the Social Security
2 Act (42 U.S.C. 1396o(2)) is amended by—
3 (A) by striking ''or'' at the end of subpara-
4 graph (D);
5 (B) by striking ''; and'' at the end of sub-
6 paragraph (E) and inserting '', or''; and
7 (C) by adding at the end the following new
8 subparagraph:
9 ''(F) language services described in section
10 1905(a)(29); and''.
11 (5) Section 2103 of the Social Security Act (42
12 U.S.C. 1397cc) is amended—
13 (A) in subsection (a), in the matter before
14 paragraph (1), by striking '' and (7)'' and in-
15 serting ''(7), and (9)''; and
16 (B) in subsection (c), by adding at the end
17 the following new paragraph:
18 ''(9) LANGUAGE SERVICES.—The child health
19 assistance provided to a targeted low-income child
20 shall include coverage of language services, as such
21 term is defined in section 1861(iii), provided in a
22 timely manner to limited-English-proficient individ-
23 uals who need such services.''; and
24 (C) in subsection (e)(2)—

1 (i) in the heading, by striking ''PRE-
2 VENTIVE'' and inserting ''CERTAIN''; and
3 (ii) by inserting '', subsection (c)(9),''
4 after ''subsection (c)(1)(C)''.
5 (6) Section 2110(a)(27) of the Social Security
6 Act (42 U.S.C. 1397jj) is amended by striking
7 ''translation'' and inserting ''language services as
8 described in section 2103(c)(9)''.
9 (7) Pursuant to the reporting requirement de-
10 scribed in section 2107(b)(1) of the Social Security
11 Act (42 U.S.C. 1397gg(b)(1)), the Secretary of
12 Health and Human Services shall require that
13 States collect data on—
14 (A) the primary language of individuals re-
15 ceiving child health assistance under title XXI
16 of the Social Security Act; and
17 (B) in the case of such individuals who are
18 minors or incapacitated, the primary language
19 of the individual's parent or guardian.
20 (8) Section 2105 of the Social Security Act (42
21 U.S.C. 1397ee(c)) is amended—
22 (A) in subsection (a)(1), in the matter pre-
23 ceding subparagraph (A), by striking ''75'' and
24 inserting ''90''; and

1 (B) in subsection (c)(2)(A), by inserting
2 before the period '', except that expenditures
3 pursuant to clause (iv) of subparagraph (D) of
4 such paragraph shall not count towards this
5 total''.

6 (e) FUNDING LANGUAGE SERVICES FURNISHED BY
7 PROVIDERS OF HEALTH CARE AND HEALTH-CARE-RE-
8 LATED SERVICES THAT SERVE HIGH RATES OF UNIN-
9 SURED LEP INDIVIDUALS.—

10 (1) PAYMENT OF COSTS.—

11 (A) IN GENERAL.—Subject to subpara-
12 graph (B), the Secretary of Health and Human
13 Services shall make payments (on a quarterly
14 basis) directly to eligible entities to support the
15 provision of language services to limited-
16 English-proficient individuals in an amount
17 equal to an entity's eligible costs (as defined
18 under paragraph (3)) for such services for the
19 quarter.

20 (B) FUNDING.—Out of any funds in the
21 Treasury not otherwise appropriated, there are
22 appropriated to the Secretary of Health and
23 Human Services such sums as may be nec-
24 essary for each of fiscal years 2012 through
25 2016.

1 (C) RELATION TO MEDICAID DSH.—Pay-
2 ments under this subsection shall not offset or
3 reduce payments under section 1923 of the So-
4 cial Security Act, nor shall payments under
5 such section be considered when determining
6 uncompensated costs associated with the provi-
7 sion of language services.
8 (2) ELIGIBLE ENTITY.—In order to receive
9 grants under this paragraph, an entity must—
10 (A) be a Medicaid provider that is—
11 (i) a physician;
12 (ii) a hospital with a low-income utili-
13 zation rate (as defined in section
14 1923(b)(3) of the Social Security Act (42
15 U.S.C. 1396r–4(b)(3))) of greater than 25
16 percent; or
17 (iii) a federally qualified health center
18 (as defined in section 1905(l)(2)(B) of the
19 Social Security Act (42 U.S.C.
20 1396d(l)(2)(B)));
21 (B) provide language services to at least 8
22 percent of the entity's total number of patients,
23 not later than 6 months after the date of the
24 enactment of the Act; and

1 (C) prepare and submit an application to
2 the Secretary, at such time, in such manner,
3 and accompanied by such information as the
4 Secretary may require to ascertain the entity's
5 eligibility for funding under this subsection.
6 (3) ELIGIBLE COSTS DEFINED.—
7 (A) IN GENERAL.—In this subsection, the
8 term "eligible costs" means, with respect to an
9 eligible entity that provides language services to
10 LEP individuals, the product of—
11 (i) the average per person cost of lan-
12 guage services, determined according to
13 the methodology devised under subpara-
14 graph (B); and
15 (ii) the number of limited-English-pro-
16 ficient individuals who are provided lan-
17 guage services by the entity and for whom
18 no reimbursement is available for such
19 services under the amendments made by
20 subsections (a), (b), (c), or (d) or by pri-
21 vate health insurance.
22 (B) METHODOLOGY.—
23 (i) IN GENERAL.—The Secretary shall
24 establish a methodology to determine the

1 average per person cost of language serv-
2 ices.
3 (ii) DIFFERENT ENTITIES.—In estab-
4 lishing such methodology, the Secretary
5 may establish different methodologies for
6 different types of eligible entities.
7 (iii) NO INDIVIDUAL CLAIMS.—The
8 Secretary may not require eligible entities
9 to submit individual claims for language
10 services for individual patients as a re-
11 quirement for payment under this sub-
12 section.
13 (4) DATA COLLECTION INSTRUMENT.—For pur-
14 poses of this subsection, the Secretary shall create a
15 standard data collection instrument that is con-
16 sistent with any existing reporting requirements by
17 the Secretary or relevant accrediting organizations
18 regarding the number of individuals to whom lan-
19 guage access are provided.
20 (5) REPORTING REQUIREMENTS.—Entities re-
21 ceiving payment under this subsection shall provide
22 the Secretary with a quarterly report on how the en-
23 tity used such funds. Such report shall contain ag-
24 gregate (and may not contain individualized) data
25 collected using the instrument under paragraph (4)

1 and shall otherwise be in a form and manner deter-
2 mined by the Secretary.

3 (6) LANGUAGE SERVICES.—For purposes of
4 this subsection, the term ''language services'' has
5 the meaning given such term in section 1861(iii) of
6 the Social Security Act.

7 (7) GUIDELINES AND REPORT.—

8 (A) ESTABLISHMENT.—Not later than 6
9 months after the date of enactment of this Act,
10 the Secretary of Health and Human Services
11 shall establish and distribute guidelines con-
12 cerning the implementation of this subsection.

13 (B) REPORT.—Not later than 2 years after
14 the date of enactment of this Act, and every 2
15 years thereafter, the Secretary shall submit a
16 report to Congress concerning the implementa-
17 tion of this subsection.

18 (f) APPLICATION OF CIVIL RIGHTS ACT OF 1964 AND
19 OTHER LAWS.—Nothing in this section shall be construed
20 to limit otherwise existing obligations of recipients of Fed-
21 eral financial assistance under title VI of the Civil Rights
22 Act of 1964 (42 U.S.C. 2000(d) et seq.) or other laws
23 that protect the civil rights of individuals.

24 (g) EFFECTIVE DATE.—

1 (1) IN GENERAL.—Except as otherwise pro-
2 vided and subject to paragraph (2), the amendments
3 made by this section shall take effect on January 1,
4 2013.
5 (2) EXCEPTION IF STATE LEGISLATION RE-
6 QUIRED.—In the case of a State plan for medical as-
7 sistance under title XIX of the Social Security Act
8 which the Secretary of Health and Human Services
9 determines requires State legislation (other than leg-
10 islation appropriating funds) in order for the plan to
11 meet the additional requirement imposed by the
12 amendments made by this section, the State plan
13 shall not be regarded as failing to comply with the
14 requirements of such title solely on the basis of its
15 failure to meet this additional requirement before
16 the first day of the first calendar quarter beginning
17 after the close of the first regular session of the
18 State legislature that begins after the date of the en-
19 actment of this Act. For purposes of the previous
20 sentence, in the case of a State that has a 2-year
21 legislative session, each year of such session shall be
22 deemed to be a separate regular session of the State
23 legislature.

SEC. 204. INCREASING UNDERSTANDING OF AND IMPROVING HEALTH LITERACY.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and the Administrator of the Health Resources and Services Administration, in consultation with the Director of the National Institute on Minority Health and Health Disparities and the Office of Minority Health, shall award grants to eligible entities to improve health care for patient populations that have low functional health literacy.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be a hospital, health center or clinic, health plan, or other health entity (including a nonprofit minority health organization or association); and

(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) USE OF FUNDS.—

(1) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.—Grants awarded under subsection (a) through the Agency for Healthcare Research and Quality shall be used—

(A) to define and increase the understanding of health literacy;

1 (B) to investigate the correlation between
2 low health literacy and health and health care;
3 (C) to clarify which aspects of health lit-
4 eracy have an effect on health outcomes; and
5 (D) for any other activity determined ap-
6 propriate by the Director of the Agency.
7 (2) HEALTH RESOURCES AND SERVICES ADMIN-
8 ISTRATION.—Grants awarded under subsection (a)
9 through the Health Resources and Services Adminis-
10 tration shall be used to conduct demonstration
11 projects for interventions for patients with low
12 health literacy that may include—
13 (A) the development of new disease man-
14 agement programs for patients with low health
15 literacy;
16 (B) the tailoring of existing disease man-
17 agement programs addressing mental, physical,
18 oral, and behavioral health conditions for pa-
19 tients with low health literacy;
20 (C) the translation of written health mate-
21 rials for patients with low health literacy;
22 (D) the identification, implementation, and
23 testing of low health literacy screening tools;

1 (E) the conduct of educational campaigns
2 for patients and providers about low health lit-
3 eracy; and
4 (F) other activities determined appropriate
5 by the Administrator of the Health Resources
6 and Services Administration.
7 (d) DEFINITIONS.—In this section, the term ''low
8 health literacy'' means the inability of an individual to ob-
9 tain, process, and understand basic health information
10 and services needed to make appropriate health decisions.
11 **SEC. 205. ASSURANCES FOR RECEIVING FEDERAL FUNDS.**
12 (a) IN GENERAL.—Entities that receive Federal
13 funds under sections 201 or 202 (including under the
14 amendments made by such section), in order to ensure the
15 right of LEP individuals to receive access to quality health
16 care, shall—
17 (1) ensure that appropriate clinical and support
18 staff receive ongoing education and training in lin-
19 guistically appropriate service delivery;
20 (2) offer and provide appropriate language serv-
21 ices at no additional charge to each patient with lim-
22 ited-English proficiency at all points of contact, in a
23 timely manner during all hours of operation;
24 (3) notify patients of their right to receive lan-
25 guage services in their primary language; and

1 (4) utilize only competent interpreter or trans-
2 lation services which—
3 (A) until adoption of the Interpreter and
4 Translator Guidelines and Standards described
5 in section 3403(c) of the Public Health Service
6 Act, are defined in section 3400 of the Public
7 Health Service Act; and
8 (B) after adoption of the Interpreter and
9 Translator Guidelines and Standards described
10 in section 3403(c) of the Public Health Service
11 Act, meet those guidelines and standards;
12 (b) EXEMPTIONS.—The requirements of subsection
13 (a)(4) shall not apply as follows:
14 (1) When a patient (who has been informed in
15 his or her primary language of the availability of
16 free interpreter and translation services) requests
17 the use of family, friends, or other persons untrained
18 in interpretation or translation if the following con-
19 ditions are met:
20 (A) The interpreter requested by the pa-
21 tient is over the age of 18.
22 (B) The recipient informs the patient that
23 he or she has the option of having the recipient
24 provide an interpreter for him/her without
25 charge, or of using his/her own interpreter.

1 (C) The recipient informs the patient that
2 the recipient may not require an LEP person to
3 use a family member or friend as an inter-
4 preter.
5 (D) The recipient evaluates whether the
6 person the patient wishes to use as an inter-
7 preter is competent. If the recipient has reason
8 to believe that the interpreter is not competent,
9 the recipient provides the recipient's own inter-
10 preter to protect the recipient from liability if
11 the patient's interpreter is later found not com-
12 petent.
13 (E) If the recipient has reason to believe
14 that there is a conflict of interest between the
15 interpreter and patient, the recipient may not
16 use the patient's interpreter.
17 (F) The recipient has the patient sign a
18 waiver, witnessed by at least 1 individual not
19 related to the patient, that includes the infor-
20 mation stated in subparagraphs (A) through
21 (E) and is translated into the patient's lan-
22 guage.
23 (2) When a medical emergency exists and the
24 delay directly associated with obtaining competent
25 interpreter or translation services would jeopardize

1 the health of the patient but only until a competent
2 interpreter or translation service is available; how-
3 ever, nothing in this subsection shall exempt emer-
4 gency rooms or similar entities that regularly pro-
5 vide health care services in medical emergencies
6 from having in place systems to provide competent
7 interpreter and translation services without undue
8 delay.

9 **SEC. 206. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
10 **TURALLY AND LINGUISTICALLY APPRO-**
11 **PRIATE HEALTH CARE SERVICES.**

12 Not later than 1 year after the date of enactment
13 of this Act and annually thereafter, the Secretary of
14 Health and Human Services shall enter into a contract
15 with the Institute of Medicine for the preparation and
16 publication of a report that describes Federal efforts to
17 ensure that all individuals with limited-English proficiency
18 have meaningful access culturally competent to health care
19 and health-care-related services. Such report shall in-
20 clude—

21 (1) a description and evaluation of the activities
22 carried out under this Act;

23 (2) a description and analysis of best practices,
24 model programs, guidelines, and other effective

1 strategies for providing access to culturally and lin-
2 guistically appropriate health care services;
3 (3) recommendations on the development and
4 implementation of policies and practices by providers
5 of health care and health-care-related services for
6 limited-English-proficient individuals;
7 (4) a description of the effect of providing lan-
8 guage services on quality of health care and access
9 to care; and
10 (5) a description of the costs associated with or
11 savings related to the provision of language services.

12 **SEC. 207. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.**

13 (a) GRANTS AUTHORIZED.—The Secretary of Edu-
14 cation is authorized to provide grants to eligible entities
15 for the provision of English as a second language (here-
16 after referred to as ''ESL'') instruction and shall deter-
17 mine, after consultation with appropriate stakeholders, the
18 mechanism for administering and distributing such
19 grants.
20 (b) ELIGIBLE ENTITY DEFINED.—For purposes of
21 this section, the term ''eligible entity'' means a State or
22 community-based organization that employs, and serves,
23 minority populations.
24 (c) APPLICATION.—An eligible entity may apply for
25 a grant under this section by submitting such information

1 as the Secretary may require and in such form and man-
2 ner as the Secretary may require.

3 (d) USE OF GRANT.—As a condition of receiving a
4 grant under this section, an eligible entity shall—

5 (1) develop and implement a plan for assuring
6 the availability of ESL instruction that effectively
7 integrates information about the nature of the
8 United States health care system, how to access
9 care, and any special language skills that may be re-
10 quired for them to access and regularly negotiate the
11 system effectively;

12 (2) develop a plan, including, where appro-
13 priate, public-private partnerships, for making ESL
14 instruction progressively available to all individuals
15 seeking instruction; and

16 (3) maintain current ESL instruction efforts by
17 using the additional funds to supplement rather
18 than supplant any funds expended for ESL instruc-
19 tion in the State as of January 1, 2006.

20 (e) ADDITIONAL DUTIES OF THE SECRETARY.—The
21 Secretary of Education shall—

22 (1) collect and publicize annual data on how
23 much Federal, State, and local governments spend
24 on ESL instruction;

1 (2) collect data from State and local govern-
2 ments to identify the unmet needs of English lan-
3 guage learners for appropriate ESL instruction, in-
4 cluding—
5 (A) the preferred written and spoken lan-
6 guage of such English language learners;
7 (B) the extent of waiting lists including
8 how many programs maintain waiting lists and,
9 for programs that do not have waiting lists, the
10 reasons why not;
11 (C) the availability of programs to geo-
12 graphically isolated communities;
13 (D) the impact of course enrollment poli-
14 cies, including open enrollment, on the avail-
15 ability of ESL instruction;
16 (E) the number individuals in the State
17 and each participating locality;
18 (F) the effectiveness of the instruction in
19 meeting the needs of individuals receiving in-
20 struction and those needing instruction;
21 (G) as assessment of the need for pro-
22 grams that integrate job training and ESL in-
23 struction, to assist individuals to obtain better
24 jobs; and

1 (H) the availability of ESL slots by State
2 and locality;
3 (3) determine the cost and most appropriate
4 methods of making ESL instruction available to all
5 English language learners seeking instruction; and
6 (4) within 1 year of the date of enactment of
7 this Act, issue a report to Congress that assesses the
8 information collected in paragraphs (1), (2), and (3)
9 and makes recommendations on steps that should be
10 taken to progressively realize the goal of making
11 ESL instruction available to all English language
12 learners seeking instruction.
13 **SEC. 208. IMPLEMENTATION.**
14 (a) GENERAL PROVISIONS.—
15 (1) A State shall not be immune under the
16 Eleventh Amendment of the Constitution of the
17 United States from suit in Federal court for failing
18 to provide the language access funded pursuant to
19 this title.
20 (2) In a suit against a State for a violation of
21 this title, remedies (including remedies at both at
22 law and in equity) are available for such a violation
23 to the same extent as such remedies are available for
24 such a violation in the suit against any public or pri-
25 vate entity other than a State.

1 (b) RULE OF CONSTRUCTION.—Nothing in this title
2 shall be construed to limit otherwise existing obligations
3 of recipients of Federal financial assistance under title VI
4 of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et
5 seq.) or any other statute.

6 **SEC. 209. LANGUAGE ACCESS SERVICES.**

7 (a) ESSENTIAL BENEFITS.—Section 1302(b)(1) of
8 the Patient Protection and Affordable Care Act (42
9 U.S.C. 18022(b)(1)) is amended by adding at the end the
10 following:

11 ''(K) Language access services, including
12 oral interpretation and written translations.''.

13 (b) EMPLOYER-SPONSORED MINIMUM ESSENTIAL
14 COVERAGE.—Section 36B(c)(2)(C) of the Internal Rev-
15 enue Code of 1986 is amended by adding at the end the
16 following:

17 ''(v) COVERAGE MUST INCLUDE LAN-
18 GUAGE ACCESS AND SERVICES.—Except as
19 provided in clause (iii), an employee shall
20 not be treated as eligible for minimum es-
21 sential coverage if such coverage consists
22 of an eligible employer-sponsored plan (as
23 defined in section 5000A(f)(2)) and the
24 plan does not provide coverage for lan-

1 guage access services, including oral inter-
2 pretation and written translations.''.
3 (c) QUALITY REPORTING.—Section 2717(a)(1) of the
4 Public Health Service Act (42 U.S.C. 300gg–17(a)(1)) is
5 amended—
6 (1) by striking ''and'' at the end of subpara-
7 graph (C);
8 (2) by striking the period at the end of sub-
9 paragraph (D) and inserting ''; and''; and
10 (3) by adding at the end the following new sub-
11 paragraph:
12 ''(E) reduce health disparities through the
13 provision of language access services, including
14 oral interpretation and written translations.''.
15 (d) REGULATIONS REGARDING INTERNAL CLAIMS
16 AND APPEALS AND EXTERNAL REVIEW PROCESSES FOR
17 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—
18 The Secretary of the Treasury, the Secretary of Labor,
19 and the Secretary of Health and Human Services shall
20 amend the regulations in section 54.9815–2719T(e) of
21 title 26, Code of Federal Regulations, section 2590.715–
22 2719(e) of title 29, Code of Federal Regulations, and sec-
23 tion 147.136(e) of title 45, Code of Federal Regulations,
24 respectively, to require group health plans and health in-

1 surance issuers offering group or individual health insur-
2 ance coverage to which such sections apply—
3 (1) to provide oral interpretation services with-
4 out any threshold requirements;
5 (2) to provide in the English versions of all no-
6 tices a statement prominently displayed in not less
7 than 15 non–English languages clearly indicating
8 how to access the language services provided by the
9 plan or issuer; and
10 (3) with respect to written translations of no-
11 tices, to apply a threshold that 5 percent of the pop-
12 ulation or at least 500 individuals per service area
13 are literate only in the same non–English language
14 in lieu of 10 percent or more residing in a county.

15 **SEC. 210. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
16 **SERVICE.**

17 (a) IN GENERAL.—Section 5315 of title 5, United
18 States Code, is amended in the matter relating to the As-
19 sistant Secretaries of Health and Human Services by
20 striking ''(6)'' and inserting ''(7), 1 of whom shall be the
21 Assistant Secretary of the Indian Health Service''.
22 (b) CONFORMING AMENDMENTS.—
23 (1) POSITIONS AT LEVEL V.—Section 5316 of
24 title 5, United States Code, is amended by striking

1 "Director, Indian Health Service, Department of
2 Health and Human Services.".
3 (2) REFERENCES.—Any reference in a law, reg-
4 ulation, document, paper, or other record of the
5 United States to the Director of the Indian Health
6 Service shall be deemed to be a reference to the As-
7 sistant Secretary of the Indian Health Service.

8 **SEC. 211. REAUTHORIZATION OF THE NATIVE HAWAIIAN**
9 **HEALTH CARE IMPROVEMENT ACT.**

10 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
11 Section 6(h)(1) of the Native Hawaiian Health Care Im-
12 provement Act (42 U.S.C. 11705(h)(1)) is amended by
13 striking "may be necessary for fiscal years 1993 through
14 2019" and inserting "are necessary".
15 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
16 LOKAHI.—Section 7(b) of the Native Hawaiian Health
17 Care Improvement Act (42 U.S.C. 11706(b)) is amended
18 by striking "may be necessary for fiscal years 1993
19 through 2019" and inserting "are necessary".
20 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
21 Section 10(c) of the Native Hawaiian Health Care Im-
22 provement Act (42 U.S.C. 11709(c)) is amended by strik-
23 ing "may be necessary for fiscal years 1993 through
24 2019" and inserting "are necessary".

TITLE III—HEALTH WORKFORCE DIVERSITY

SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXIV of the Public Health Service Act, as added by section 202, is amended by adding at the end the following:

“Subtitle A—Diversifying the Health Care Workplace

“SEC. 3411. REPORT ON WORKFORCE DIVERSITY.

‘‘(a) IN GENERAL.—Not later than July 1, 2012, and biannually thereafter, the Secretary, acting through the director of each entity within the Department of Health and Human Services, shall prepare and 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 on health workforce diversity.

‘‘(b) REQUIREMENT.—The report under subsection (a) shall contain the following information:

‘‘(1) A description of any grant support that is provided by each entity for workforce diversity initiatives with the following information—

‘‘(A) the number of grants made;

‘‘(B) the purpose of the grants;

1 "(C) the populations served through the
2 grants;
3 "(D) the organizations and institutions re-
4 ceiving the grants; and
5 "(E) the tracking efforts that were used to
6 follow the progress of participants.
7 "(2) A description of the entity's plan to
8 achieve workforce diversity goals that includes, to
9 the extent relevant to such entity—
10 "(A) the number of underrepresented mi-
11 nority health professionals that will be needed
12 in various disciplines over the next 10 years to
13 achieve population parity;
14 "(B) the level of funding needed to fully
15 expand and adequately support health profes-
16 sions pipeline programs;
17 "(C) the impact such programs have had
18 on the admissions practices and policies of
19 health professions schools;
20 "(D) the management strategy necessary
21 to effectively administer and institutionalize
22 health profession pipeline programs; and
23 "(E) the impact that the Government Per-
24 formance and Results Act (GPRA) has had on
25 evaluating the performance of grantees and

1 whether the GPRA is the best assessment tool
2 for programs under titles VII and VIII.
3 ‘‘(3) A description of measurable objectives of
4 each entity relating to workforce diversity initiatives.
5 ‘‘(c) PUBLIC AVAILABILITY.—The report under sub-
6 section (a) shall be made available for public review and
7 comment.

8 **‘‘SEC. 3412. NATIONAL WORKING GROUP ON WORKFORCE**
9 **DIVERSITY.**

10 ‘‘(a) IN GENERAL.—The Secretary, acting through
11 the Bureau of Health Professions within the Health Re-
12 sources and Services Administration, shall award a grant
13 to an entity determined appropriate by the Secretary for
14 the establishment of a national working group on work-
15 force diversity.
16 ‘‘(b) REPRESENTATION.—In establishing the national
17 working group under subsection (a):
18 ‘‘(1) The grantee shall ensure that the group
19 has representatives of the following:
20 ‘‘(A) The Health Resources and Services
21 Administration.
22 ‘‘(B) The Department of Health and
23 Human Services Data Council.
24 ‘‘(C) The Office of Minority Health.

1 "(D) The Bureau of Labor Statistics of
2 the Department of Labor.
3 "(E) The Public Health Practice Program
4 Office—Office of Workforce Policy and Plan-
5 ning.
6 "(F) The National Institute on Minority
7 Health and Health Disparities.
8 "(G) The Agency for Healthcare Research
9 and Quality.
10 "(H) The Institute of Medicine Study
11 Committee for the 2004 workforce diversity re-
12 port.
13 "(I) The Indian Health Service.
14 "(J) Minority-serving academic institu-
15 tions.
16 "(K) Consumer organizations.
17 "(L) Health professional associations, in-
18 cluding those that represent underrepresented
19 minority populations.
20 "(M) Researchers in the area of health
21 workforce.
22 "(N) Health workforce accreditation enti-
23 ties.
24 "(O) Private foundations that have spon-
25 sored workforce diversity initiatives.

1 "(2) The grantee shall ensure that, in addition
2 to the representatives under paragraph (1), the
3 group has not less than 5 health professions stu-
4 dents representing various health profession fields
5 and levels of training.

6 "(c) ACTIVITIES.—The working group established
7 under subsection (a) shall convene at least twice each year
8 to complete the following activities:

9 "(1) Review current public and private health
10 workforce diversity initiatives.

11 "(2) Identify successful health workforce diver-
12 sity programs and practices.

13 "(3) Examine challenges relating to the devel-
14 opment and implementation of health workforce di-
15 versity initiatives.

16 "(4) Draft a national strategic work plan for
17 health workforce diversity, including recommenda-
18 tions for public and private sector initiatives.

19 "(5) Develop a framework and methods for the
20 evaluation of current and future health workforce di-
21 versity initiatives.

22 "(6) Develop recommended standards for work-
23 force diversity that could be applicable to all health
24 professions programs and programs funded under
25 this Act.

1 ‘‘(7) Develop curriculum guidelines for diversity
2 training.
3 ‘‘(8) Develop a strategy for the inclusion of
4 community members on admissions committees for
5 health profession schools.
6 ‘‘(9) Other activities determined appropriate by
7 the Secretary.
8 ‘‘(d) ANNUAL REPORT.—Not later than 1 year after
9 the establishment of the working group under subsection
10 (a), and annually thereafter, the working group shall pre-
11 pare and make available to the general public for com-
12 ment, an annual report on the activities of the working
13 group. Such report shall include the recommendations of
14 the working group for improving health workforce diver-
15 sity.

16 **‘‘SEC. 3413. TECHNICAL CLEARINGHOUSE FOR HEALTH**
17 **WORKFORCE DIVERSITY.**

18 ‘‘(a) IN GENERAL.—The Secretary, acting through
19 the Office of Minority Health, and in collaboration with
20 the Agency for Healthcare Research and Quality, the Bu-
21 reau of Health Professions within the Health Resources
22 and Services Administration, and the National Institute
23 on Minority Health and Health Disparities, shall establish
24 a technical clearinghouse on health workforce diversity

1 within the Office of Minority Health and coordinate cur-
2 rent and future clearinghouses.
3 "(b) INFORMATION AND SERVICES.—The clearing-
4 house established under subsection (a) shall offer the fol-
5 lowing information and services:
6 "(1) Information on the importance of health
7 workforce diversity.
8 "(2) Statistical information relating to under-
9 represented minority representation in health and al-
10 lied health professions and occupations.
11 "(3) Model health workforce diversity practices
12 and programs.
13 "(4) Admissions policies that promote health
14 workforce diversity and are in compliance with Fed-
15 eral and State laws.
16 "(5) Lists of scholarship, loan repayment, and
17 loan cancellation grants as well as fellowship infor-
18 mation for underserved populations for health pro-
19 fessions schools.
20 "(6) Foundation and other large organizational
21 initiatives relating to health workforce diversity.
22 "(c) CONSULTATION.—In carrying out this section,
23 the Secretary shall consult with non-Federal entities which
24 may include minority health professional associations to
25 ensure the adequacy and accuracy of information.

1 **"SEC. 3414. SUPPORT FOR INSTITUTIONS COMMITTED TO
2 WORKFORCE DIVERSITY.**

3 "(a) IN GENERAL.—The Secretary, acting through
4 the Administrator of the Health Resources and Services
5 Administration and the Centers for Disease Control and
6 Prevention, shall award grants to eligible entities that
7 demonstrate a commitment to health workforce diversity.

8 "(b) ELIGIBILITY.—To be eligible to receive a grant
9 under subsection (a), an entity shall—

10 "(1) be an educational institution or entity that
11 historically produces or trains meaningful numbers
12 of underrepresented minority health professionals,
13 including—

14 "(A) historically Black colleges and univer-
15 sities;

16 "(B) Hispanic-serving health professions
17 schools;

18 "(C) Hispanic-serving institutions;

19 "(D) tribal colleges and universities;

20 "(E) Asian-American, Native American,
21 and Pacific Islander-serving institutions;

22 "(F) institutions that have programs to re-
23 cruit and retain underrepresented minority
24 health professionals, in which a significant
25 number of the enrolled participants are under-
26 represented minorities;

1 ''(G) health professional associations,
2 which may include underrepresented minority
3 health professional associations; and
4 ''(H) institutions—
5 ''(i) located in communities with pre-
6 dominantly underrepresented minority pop-
7 ulations;
8 ''(ii) with whom partnerships have
9 been formed for the purpose of increasing
10 workforce diversity; and
11 ''(iii) in which at least 20 percent of
12 the enrolled participants are underrep-
13 resented minorities; and
14 ''(2) submit to the Secretary an application at
15 such time, in such manner, and containing such in-
16 formation as the Secretary may require.
17 ''(c) USE OF FUNDS.—Amounts received under a
18 grant under subsection (a) shall be used to expand existing
19 workforce diversity programs, implement new workforce
20 diversity programs, or evaluate existing or new workforce
21 diversity programs, including with respect to mental
22 health care professions. Such programs shall enhance di-
23 versity by considering minority status as part of an indi-
24 vidualized consideration of qualifications. Possible activi-
25 ties may include—

1 "(1) educational outreach programs relating to
2 opportunities in the health professions;
3 "(2) scholarship, fellowship, grant, loan repay-
4 ment, and loan cancellation programs;
5 "(3) postbaccalaureate programs;
6 "(4) academic enrichment programs, particu-
7 larly targeting those who would not be competitive
8 for health professions schools;
9 "(5) kindergarten through 12th grade and
10 other health pipeline programs;
11 "(6) mentoring programs;
12 "(7) internship or rotation programs involving
13 hospitals, health systems, health plans and other
14 health entities;
15 "(8) community partnership development for
16 purposes relating to workforce diversity; or
17 "(9) leadership training.
18 "(d) REPORTS.—Not later than 1 year after receiving
19 a grant under this section, and annually for the term of
20 the grant, a grantee shall submit to the Secretary a report
21 that summarizes and evaluates all activities conducted
22 under the grant.
23 "(e) DEFINITION.—In this section, the term 'Asian-
24 American, Native American, and Pacific Islander-serving
25 institutions' has the same meaning as the term 'Asian

1 American and Native American Pacific Islander-serving
2 institution' as defined in section 371(c) of the Higher
3 Education Act of 1965 (20 U.S.C. 1067q(c)).

4 **"SEC. 3415. CAREER DEVELOPMENT FOR SCIENTISTS AND**
5 **RESEARCHERS.**

6 "(a) IN GENERAL.—The Secretary, acting through
7 the Director of the National Institutes of Health, the Di-
8 rector of the Centers for Disease Control and Prevention,
9 the Commissioner of Food and Drugs, and the Director
10 of the Agency for Healthcare Research and Quality, shall
11 award grants that expand existing opportunities for sci-
12 entists and researchers and promote the inclusion of
13 underrepresented minorities in the health professions.

14 "(b) RESEARCH FUNDING.—The head of each entity
15 within the Department of Health and Human Services
16 shall establish or expand existing programs to provide re-
17 search funding to scientists and researchers in training.
18 Under such programs, the head of each such entity shall
19 give priority in allocating research funding to support
20 health research in traditionally underserved communities,
21 including underrepresented minority communities, and re-
22 search classified as community or participatory.

23 "(c) DATA COLLECTION.—The head of each entity
24 within the Department of Health and Human Services
25 shall collect data on the number (expressed as an absolute

1 number and a percentage) of underrepresented minority
2 and nonminority applicants who receive and are denied
3 agency funding at every stage of review. Such data shall
4 be reported annually to the Secretary and the appropriate
5 committees of Congress.

6 "(d) STUDENT LOAN REIMBURSEMENT.—The Sec-
7 retary shall establish a student loan reimbursement pro-
8 gram to provide student loan reimbursement assistance to
9 researchers who focus on racial and ethnic disparities in
10 health. The Secretary shall promulgate regulations to de-
11 fine the scope and procedures for the program under this
12 subsection.

13 "(e) STUDENT LOAN CANCELLATION.—The Sec-
14 retary shall establish a student loan cancellation program
15 to provide student loan cancellation assistance to research-
16 ers who focus on racial and ethnic disparities in health.
17 Students participating in the program shall make a min-
18 imum 5-year commitment to work at an accredited health
19 profession school. The Secretary shall promulgate addi-
20 tional regulations to define the scope and procedures for
21 the program under this subsection.

22 **"SEC. 3416. CAREER SUPPORT FOR NON-RESEARCH**
23 **HEALTH PROFESSIONALS.**

24 "(a) IN GENERAL.—The Secretary, acting through
25 the Director of the Centers for Disease Control and Pre-

1 vention, the Administrator of the Substance Abuse and
2 Mental Health Services Administration, the Administrator
3 of the Health Resources and Services Administration, and
4 the Administrator of the Centers for Medicare and Med-
5 icaid Services shall establish a program to award grants
6 to eligible individuals for career support in non-research-
7 related health care.
8 "(b) ELIGIBILITY.—To be eligible to receive a grant
9 under subsection (a) an individual shall—
10 "(1) be a student in a health professions school,
11 a graduate of such a school who is working in a
12 health profession, or a faculty member of such a
13 school; and
14 "(2) submit to the Secretary an application at
15 such time, in such manner, and containing such in-
16 formation as the Secretary may require.
17 "(c) USE OF FUNDS.—An individual shall use
18 amounts received under a grant under this section to—
19 "(1) support the individual's health activities or
20 projects that involve underserved communities, in-
21 cluding racial and ethnic minority communities;
22 "(2) support health-related career advancement
23 activities;
24 "(3) to pay, or as reimbursement for payments
25 of, student loans for individuals who are health pro-

fessionals and are focused on health issues affecting underserved communities, including racial and ethnic minority communities; and

"(4) to establish and promote leadership training programs to decrease health disparities and to increase cultural competence with the goal of increasing diversity in leadership positions.

"(d) DEFINITION.—In this section, the term 'career in non-research-related health care' means employment or intended employment in the field of public health, health policy, health management, health administration, medicine, nursing, pharmacy, psychology, social work, psychiatry, other mental and behavioral health, allied health, community health, social work, or other fields determined appropriate by the Secretary, other than in a position that involves research.

"SEC. 3417. RESEARCH ON THE EFFECT OF WORKFORCE DIVERSITY ON QUALITY.

"(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in collaboration with the Deputy Assistant Secretary for Minority Health and the Director of the National Institute on Minority Health and Health Disparities, shall award grants to eligible entities to expand research on the link between health workforce diversity and quality health care.

1 ‘‘(b) ELIGIBILITY.—To be eligible to receive a grant
2 under subsection (a) an entity shall—
3 ‘‘(1) be a clinical, public health, or health serv-
4 ices research entity or other entity determined ap-
5 propriate by the Director; and
6 ‘‘(2) submit to the Secretary an application at
7 such time, in such manner, and containing such in-
8 formation as the Secretary may require.
9 ‘‘(c) USE OF FUNDS.—Amounts received under a
10 grant awarded under subsection (a) shall be used to sup-
11 port research that investigates the effect of health work-
12 force diversity on—
13 ‘‘(1) language access;
14 ‘‘(2) cultural competence;
15 ‘‘(3) patient satisfaction;
16 ‘‘(4) timeliness of care;
17 ‘‘(5) safety of care;
18 ‘‘(6) effectiveness of care;
19 ‘‘(7) efficiency of care;
20 ‘‘(8) patient outcomes;
21 ‘‘(9) community engagement;
22 ‘‘(10) resource allocation;
23 ‘‘(11) organizational structure;
24 ‘‘(12) compliance of care; or

1 "(13) other topics determined appropriate by
2 the Director.
3 "(d) PRIORITY.—In awarding grants under sub-
4 section (a), the Director shall give individualized consider-
5 ation to all relevant aspects of the applicant's background.
6 Consideration of prior research experience involving the
7 health of underserved communities shall be such a factor.
8 **"SEC. 3418. HEALTH DISPARITIES EDUCATION PROGRAM.**
9 "(a) ESTABLISHMENT.—The Secretary, acting
10 through the National Institute on Minority Health and
11 Health Disparities and in collaboration with the Office of
12 Minority Health, the Office of the Surgeon General, the
13 Office for Civil Rights, the Centers for Disease Control
14 and Prevention, the Centers for Medicare & Medicaid
15 Services, the Health Resources and Services Administra-
16 tion, and other appropriate public and private entities,
17 shall establish and coordinate a health and health care dis-
18 parities education program to support, develop, and imple-
19 ment educational initiatives and outreach strategies that
20 inform health care professionals and the public about the
21 existence of and methods to reduce racial and ethnic dis-
22 parities in health and health care.
23 "(b) ACTIVITIES.—The Secretary, through the edu-
24 cation program established under subsection (a) shall,
25 through the use of public awareness and outreach cam-

1 paigns targeting the general public and the medical com-
2 munity at large—
3 ‘‘(1) disseminate scientific evidence for the ex-
4 istence and extent of racial and ethnic disparities in
5 health care, including disparities that are not other-
6 wise attributable to known factors such as access to
7 care, patient preferences, or appropriateness of
8 intervention, as described in the 2002 Institute of
9 Medicine Report entitled ‘Unequal Treatment: Con-
10 fronting Racial and Ethnic Disparities in Health
11 Care’, as well as the impact of disparities related to
12 age, disability status, socioeconomic status, sex, gen-
13 der identity, and sexual orientation on racial and
14 ethnic minorities;
15 ‘‘(2) disseminate new research findings to
16 health care providers and patients to assist them in
17 understanding, reducing, and eliminating health and
18 health care disparities;
19 ‘‘(3) disseminate information about the impact
20 of linguistic and cultural barriers on health care
21 quality and the obligation of health providers who
22 receive Federal financial assistance to ensure that
23 people with limited-English proficiency have access
24 to language access services;

1 "(4) disseminate information about the impor-
2 tance and legality of racial, ethnic, disability status,
3 socioeconomic status, sex, gender identity, and sex-
4 ual orientation, and primary language data collec-
5 tion, analysis, and reporting;

6 "(5) design and implement specific educational
7 initiatives to health care providers relating to health
8 and health care disparities; and

9 "(6) assess the impact of the programs estab-
10 lished under this section in raising awareness of
11 health and health care disparities and providing in-
12 formation on available resources.".

13 **SEC. 302. HISPANIC-SERVING HEALTH PROFESSIONS**
14 **SCHOOLS.**

15 Part B of title VII of the Public Health Service Act
16 (42 U.S.C. 293 et seq.) is amended by adding at the end
17 the following:

18 **"SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS**
19 **SCHOOLS.**

20 "(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration, shall award grants to Hispanic-serving
23 health professions schools for the purpose of carrying out
24 programs to recruit Hispanic individuals to enroll in and

1 graduate from such schools, which may include providing
2 scholarships and other financial assistance as appropriate.
3 ''(b) ELIGIBILITY.—In subsection (a), the term 'His-
4 panic-serving health professions school' means an entity
5 that—
6 ''(1) is a school or program under section
7 799B;
8 ''(2) has an enrollment of full-time equivalent
9 students that is made up of at least 9 percent His-
10 panic students;
11 ''(3) has been effective in carrying out pro-
12 grams to recruit Hispanic individuals to enroll in
13 and graduate from the school;
14 ''(4) has been effective in recruiting and retain-
15 ing Hispanic faculty members;
16 ''(5) has a significant number of graduates who
17 are providing health services to medically under-
18 served populations or to individuals in health profes-
19 sional shortage areas; and
20 ''(6) Regional Hispanic Centers of Excellence.''.
21 **SEC. 303. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
22 **DISEASE CONTROL AND PREVENTION.**
23 Section 317F(c) of the Public Health Service Act (42
24 U.S.C. 247b–7(c)) is amended—
25 (1) by striking ''and'' after ''1994,''; and

1 (2) by inserting before the period the following:
2 "$750,000 for fiscal year 2012, and such sums as
3 may be necessary for each of the fiscal years 2013
4 through 2017.".

5 **SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
6 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
7 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

8 Part B of title VII of the Public Health Service Act
9 (42 U.S.C. 293 et seq.), as amended by section 302, is
10 further amended by adding at the end the following:

11 **"SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
12 **GREE PROGRAMS.**

13 "(a) COOPERATIVE AGREEMENTS.—The Secretary,
14 acting through the Administrator of the Health Resources
15 and Services Administration, in consultation with the Di-
16 rector of the Centers for Disease Control and Prevention,
17 the Director of the Agency for Healthcare Research and
18 Quality, and the Deputy Assistant Secretary for Minority
19 Health, shall award cooperative agreements to schools of
20 public health and schools of allied health to design and
21 implement online degree programs.

22 "(b) PRIORITY.—In awarding cooperative agreements
23 under this section, the Secretary shall give priority to any
24 school of public health or school of allied health that has

an established track record of serving medically underserved communities.

"(c) REQUIREMENTS.—Awardees must design and implement an online degree program, that meet the following restrictions:

"(1) Enrolling individuals who have obtained a secondary school diploma or its recognized equivalent.

"(2) Maintaining a significant enrollment of underrepresented minority or disadvantaged students.".

SEC. 305. SENSE OF CONGRESS ON THE MISSION OF THE NATIONAL HEALTH CARE WORKFORCE COMMISSION.

It is the sense of Congress that the National Health Care Workforce Commission established by section 5101 of the Patient Protection and Affordable Care Act should, in carrying out its assigned duties under that section, give attention to the needs of racial and ethnic minorities, individuals with lower socioeconomic status, individuals with mental, developmental, and physical disabilities, lesbian, gay, bisexual and transgender populations, and individuals who are members of multiple minority or special population groups.

1 **SEC. 306. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

2 Subtitle A of title XXXIV of the Public Health Serv-
3 ice Act, as amended by section 301, is further amended
4 by inserting after section 3418 the following:

5 **"SEC. 3419. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
6 **SERVICES CORPS.**

7 "(a) IN GENERAL.—The Administrator of the Health
8 Resources and Services Administration and the Director
9 of the Centers for Disease Control and Prevention, in col-
10 laboration with the Deputy Assistant Secretary for Minor-
11 ity Health, shall award grants to eligible entities to in-
12 crease awareness among postprimary and postsecondary
13 students of career opportunities in the health professions.

14 "(b) ELIGIBILITY.—To be eligible to receive a grant
15 under subsection (a) an entity shall—

16 "(1) be a clinical, public health or health serv-
17 ices organization, community-based or nonprofit en-
18 tity, or other entity determined appropriate by the
19 Director of the Centers for Disease Control and Pre-
20 vention;

21 "(2) serve a health professional shortage area,
22 as determined by the Secretary;

23 "(3) work with students, including those from
24 racial and ethnic minority backgrounds, that have
25 expressed an interest in the health professions; and

1 "(4) submit to the Secretary an application at
2 such time, in such manner, and containing such in-
3 formation as the Secretary may require.
4 "(c) USE OF FUNDS.—Grant awards under sub-
5 section (a) shall be used to support internships that will
6 increase awareness among students of non-research-based
7 and career opportunities in the following health profes-
8 sions:
9 "(1) Medicine.
10 "(2) Nursing.
11 "(3) Public Health.
12 "(4) Pharmacy.
13 "(5) Health administration and management.
14 "(6) Health policy.
15 "(7) Psychology.
16 "(8) Dentistry.
17 "(9) International health.
18 "(10) Social work.
19 "(11) Allied health.
20 "(12) Psychiatry.
21 "(13) Hospice care.
22 "(14) Other professions deemed appropriate by
23 the Director of the Centers for Disease Control and
24 Prevention.

1 "(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Director of the Centers for Disease Con-
3 trol and Prevention shall give priority to those entities
4 that—
5 "(1) serve a high proportion of individuals from
6 disadvantaged backgrounds;
7 "(2) have experience in health disparity elimi-
8 nation programs;
9 "(3) facilitate the entry of disadvantaged indi-
10 viduals into institutions of higher education; and
11 "(4) provide counseling or other services de-
12 signed to assist disadvantaged individuals in success-
13 fully completing their education at the postsecondary
14 level.
15 "(e) STIPENDS.—The Secretary may approve sti-
16 pends under this section for individuals for any period of
17 education in student-enhancement programs (other than
18 regular courses) at health professions schools, programs,
19 or entities, except that such a stipend may not be provided
20 to an individual for more than 6 months, and such a sti-
21 pend may not exceed $20 per day (notwithstanding any
22 other provision of law regarding the amount of stipends).

1 **"SEC. 3420. LOUIS STOKES PUBLIC HEALTH SCHOLARS
2 PROGRAM.**

3 "(a) IN GENERAL.—The Director of the Centers for
4 Disease Control and Prevention, in collaboration with the
5 Deputy Assistant Secretary for Minority Health, shall
6 award scholarships to postsecondary students who seek a
7 career in public health.

8 "(b) ELIGIBILITY.—To be eligible to receive a schol-
9 arship under subsection (a) an individual shall—

10 "(1) have experience in public health research
11 or public health practice, or other health professions
12 as determined appropriate by the Director of the
13 Centers for Disease Control and Prevention;

14 "(2) reside in a health professional shortage
15 area as determined by the Secretary;

16 "(3) have expressed an interest in public health;

17 "(4) demonstrate promise for becoming a leader
18 in public health;

19 "(5) secure admission to a 4-year institution of
20 higher education;

21 "(6) comply with subsection (f); and

22 "(7) submit to the Secretary an application at
23 such time, in such manner, and containing such in-
24 formation as the Secretary may require.

1 "(c) USE OF FUNDS.—Amounts received under an
2 award under subsection (a) shall be used to support oppor-
3 tunities for students to become public health professionals.
4 "(d) PRIORITY.—In awarding grants under sub-
5 section (a), the Director shall give priority to those stu-
6 dents that—
7 "(1) are from disadvantaged backgrounds;
8 "(2) have secured admissions to a minority-
9 serving institution; and
10 "(3) have identified a health professional as a
11 mentor at their school or institution and an aca-
12 demic advisor to assist in the completion of their
13 baccalaureate degree.
14 "(e) SCHOLARSHIPS.—The Secretary may approve
15 payment of scholarships under this section for such indi-
16 viduals for any period of education in student under-
17 graduate tenure, except that such a scholarship may not
18 be provided to an individual for more than 4 years, and
19 such scholarships may not exceed $10,000 per academic
20 year (notwithstanding any other provision of law regard-
21 ing the amount of scholarship).
22 **"SEC. 3420A. PATSY MINK HEALTH AND GENDER RESEARCH**
23 **FELLOWSHIP PROGRAM.**
24 "(a) IN GENERAL.—The Director of the Centers for
25 Disease Control and Prevention, in collaboration with the

1 Deputy Assistant Secretary for Minority Health, the Ad-
2 ministrator of the Substance Abuse and Mental Health
3 Services Administration, the Director of the Indian Health
4 Service, the Director of the National Institutes of Health,
5 and the Director of the Agency for Healthcare Research
6 and Quality, shall award research fellowships to post-bac-
7 calaureate students to conduct research that will examine
8 gender and health disparities and to pursue a career in
9 the health professions.

10 ''(b) ELIGIBILITY.—To be eligible to receive a fellow-
11 ship under subsection (a) an individual shall—

12 ''(1) have experience in health research or pub-
13 lic health practice;

14 ''(2) reside in a health professional shortage
15 area as determined by the Secretary;

16 ''(3) have expressed an interest in the health
17 professions;

18 ''(4) demonstrate promise for becoming a leader
19 in the field of women's health;

20 ''(5) secure admission to a health professions
21 school or graduate program with an emphasis in
22 gender studies;

23 ''(6) comply with subsection (f); and

1 "(7) submit to the Secretary an application at
2 such time, in such manner, and containing such in-
3 formation as the Secretary may require.

4 "(c) USE OF FUNDS.—Amounts received under an
5 award under subsection (a) shall be used to support oppor-
6 tunities for students to become researchers and advance
7 the research base on the intersection between gender and
8 health.

9 "(d) PRIORITY.—In awarding grants under sub-
10 section (a), the Director of the Centers for Disease Con-
11 trol and Prevention shall give priority to those applicants
12 that—

13 "(1) are from disadvantaged backgrounds; and

14 "(2) have identified a mentor and academic ad-
15 visor who will assist in the completion of their grad-
16 uate or professional degree and have secured a re-
17 search assistant position with a researcher working
18 in the area of gender and health.

19 "(e) FELLOWSHIPS.—The Director of the Centers for
20 Disease Control and Prevention may approve fellowships
21 for individuals under this section for any period of edu-
22 cation in the student's graduate or health profession ten-
23 ure, except that such a fellowship may not be provided
24 to an individual for more than 3 years, and such a fellow-
25 ship may not exceed $18,000 per academic year (notwith-

1 standing any other provision of law regarding the amount
2 of fellowship).

3 **"SEC. 3420B. PAUL DAVID WELLSTONE INTERNATIONAL**
4 **HEALTH FELLOWSHIP PROGRAM.**

5 "(a) IN GENERAL.—The Director of the Agency for
6 Healthcare Research and Quality, in collaboration with
7 the Deputy Assistant Secretary for Minority Health, shall
8 award research fellowships to college students or recent
9 graduates to advance their understanding of international
10 health.

11 "(b) ELIGIBILITY.—To be eligible to receive a fellow-
12 ship under subsection (a) an individual shall—

13 "(1) have educational experience in the field of
14 international health;

15 "(2) reside in a health professional shortage
16 area as determined by the Secretary;

17 "(3) demonstrate promise for becoming a leader
18 in the field of international health;

19 "(4) be a college senior or recent graduate of
20 a four-year higher education institution;

21 "(5) comply with subsection (f); and

22 "(6) submit to the Secretary an application at
23 such time, in such manner, and containing such in-
24 formation as the Secretary may require.

1 "(c) USE OF FUNDS.—Amounts received under an
2 award under subsection (a) shall be used to support oppor-
3 tunities for students to become health professionals and
4 to advance their knowledge about international issues re-
5 lating to health care access and quality.

6 "(d) PRIORITY.—In awarding grants under sub-
7 section (a), the Director shall give priority to those appli-
8 cants that—

9 "(1) are from a disadvantaged background; and

10 "(2) have identified a mentor at a health pro-
11 fessions school or institution, an academic advisor to
12 assist in the completion of their graduate or profes-
13 sional degree, and an advisor from an international
14 health non-governmental organization, private volun-
15 teer organization, or other international institution
16 or program that focuses on increasing health care
17 access and quality for residents in developing coun-
18 tries.

19 "(e) FELLOWSHIPS.—The Secretary shall approve
20 fellowships for college seniors or recent graduates, except
21 that such a fellowship may not be provided to an indi-
22 vidual for more than 6 months, may not be awarded to
23 a graduate that has not been enrolled in school for more
24 than 1 year, and may not exceed $4,000 per academic year

1 (notwithstanding any other provision of law regarding the
2 amount of fellowship).

3 **"SEC. 3420C. EDWARD R. ROYBAL HEALTH CARE SCHOLAR**
4 **PROGRAM.**

5 "(a) IN GENERAL.—The Director of the Agency for
6 Healthcare Research and Quality, the Director of the Cen-
7 ters for Medicaid & Medicare, and the Administrator for
8 Health Resources and Services Administration, in collabo-
9 ration with the Deputy Assistant Secretary for Minority
10 Health, shall award grants to eligible entities to expose
11 entering graduate students to the health professions.

12 "(b) ELIGIBILITY.—To be eligible to receive a grant
13 under subsection (a) an entity shall—

14 "(1) be a clinical, public health or health serv-
15 ices organization, community-based or nonprofit en-
16 tity, or other entity determined appropriate by the
17 Director of the Agency for Healthcare Research and
18 Quality;

19 "(2) serve in a health professional shortage
20 area as determined by the Secretary;

21 "(3) work with students obtaining a degree in
22 the health professions; and

23 "(4) submit to the Secretary an application at
24 such time, in such manner, and containing such in-
25 formation as the Secretary may require.

1 "(c) USE OF FUNDS.—Amounts received under a
2 grant awarded under subsection (a) shall be used to sup-
3 port opportunities that expose students to non-research-
4 based health professions, including—
5 "(1) public health policy;
6 "(2) health care and pharmaceutical policy;
7 "(3) health care administration and manage-
8 ment;
9 "(4) health economics; and
10 "(5) other professions determined appropriate
11 by the Director of the Agency for Healthcare Re-
12 search and Quality.
13 "(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Director of the Agency for Healthcare Re-
15 search and Quality shall give priority to those entities
16 that—
17 "(1) have experience with health disparity elimi-
18 nation programs;
19 "(2) facilitate training in the fields described in
20 subsection (c); and
21 "(3) provide counseling or other services de-
22 signed to assist such individuals in successfully com-
23 pleting their education at the postsecondary level.
24 "(e) STIPENDS.—The Secretary may approve the
25 payment of stipends for individuals under this section for

1 any period of education in student-enhancement programs
2 (other than regular courses) at health professions schools
3 or entities, except that such a stipend may not be provided
4 to an individual for more than 2 months, and such a sti-
5 pend may not exceed $100 per day (notwithstanding any
6 other provision of law regarding the amount of sti-
7 pends).''.

8 **SEC. 307. ADVISORY COMMITTEE ON HEALTH PROFES-**
9 **SIONS TRAINING FOR DIVERSITY.**

10 (a) ESTABLISHMENT.—The Secretary of Health and
11 Human Services (referred to in this section as the ''Sec-
12 retary'') shall establish an advisory committee to be known
13 as the Advisory Committee on Health Professions Train-
14 ing for Diversity (in this section referred to as the ''Advi-
15 sory Committee'').

16 (b) COMPOSITION.—

17 (1) IN GENERAL.—The Secretary shall deter-
18 mine the appropriate number of individuals to serve
19 on the Advisory Committee. Such individuals shall
20 not be officers or employees of the Federal Govern-
21 ment.

22 (2) APPOINTMENT.—Not later than 60 days
23 after the date of enactment of this section, the Sec-
24 retary shall appoint the members of the Advisory
25 Committee from among individuals who are health

1 professionals. In making such appointments, the
2 Secretary shall ensure a fair balance between the
3 health professions, that at least 75 percent of the
4 members of the Advisory Committee are health pro-
5 fessionals, a broad geographic representation of
6 members and a balance between urban and rural
7 members. Members shall be appointed based on their
8 competence, interest, and knowledge of the mission
9 of the profession involved.
10 (3) MINORITY REPRESENTATION.—In appoint-
11 ing the members of the Advisory Committee under
12 paragraph (2), the Secretary shall ensure the ade-
13 quate representation of women and minorities.
14 (c) TERMS.—
15 (1) IN GENERAL.—A member of the Advisory
16 Committee shall be appointed for a term of 3 years,
17 except that of the members first appointed—
18 (A) 1⁄3 of such members shall serve for a
19 term of 1 year;
20 (B) 1⁄3 of such members shall serve for a
21 term of 2 years; and
22 (C) 1⁄3 of such members shall serve for a
23 term of 3 years.
24 (2) VACANCIES.—

1 (A) IN GENERAL.—A vacancy on the Advi-
2 sory Committee shall be filled in the manner in
3 which the original appointment was made and
4 shall be subject to any conditions which applied
5 with respect to the original appointment.
6 (B) FILLING UNEXPIRED TERM.—An indi-
7 vidual chosen to fill a vacancy shall be ap-
8 pointed for the unexpired term of the member
9 replaced.
10 (d) DUTIES.—
11 (1) IN GENERAL.—The Advisory Committee
12 shall—
13 (A) provide advice and recommendations to
14 the Secretary concerning policy and program
15 development and other matters of significance
16 concerning activities under this part; and
17 (B) not later than 2 years after the date
18 of enactment of this section, and annually
19 thereafter, prepare and submit to the Secretary,
20 and the Committee on Health, Education,
21 Labor, and Pensions of the Senate, and the
22 Committee on Energy and Commerce of the
23 House of Representatives, a report describing
24 the activities of the Committee.

1 (2) CONSULTATION WITH STUDENTS.—In car-
2 rying out duties under paragraph (1), the Advisory
3 Committee shall consult with individuals who are at-
4 tending health professions schools with which this
5 part is concerned.
6 (e) MEETINGS AND DOCUMENTS.—
7 (1) MEETINGS.—The Advisory Committee shall
8 meet not less than 2 times each year. Such meetings
9 shall be held jointly with other related entities estab-
10 lished under this title where appropriate.
11 (2) DOCUMENTS.—Not later than 14 days prior
12 to the convening of a meeting under paragraph (1),
13 the Advisory Committee shall prepare and make
14 available an agenda of the matters to be considered
15 by the Advisory Committee at such meeting. At any
16 such meeting, the Advisory Committee shall dis-
17 tribute materials with respect to the issues to be ad-
18 dressed at the meeting. Not later than 30 days after
19 the adjourning of such a meeting, the Advisory Com-
20 mittee shall prepare and make available a summary
21 of the meeting and any actions taken by the Com-
22 mittee based upon the meeting.
23 (f) COMPENSATION AND EXPENSES.—
24 (1) COMPENSATION.—Each member of the Ad-
25 visory Committee shall be compensated at a rate

1 equal to the daily equivalent of the annual rate of
2 basic pay prescribed for level IV of the Executive
3 Schedule under section 5315 of title 5, United
4 States Code, for each day (including travel time)
5 during which such member is engaged in the per-
6 formance of the duties of the Committee.
7 (2) EXPENSES.—The members of the Advisory
8 Committee shall be allowed travel expenses, includ-
9 ing per diem in lieu of subsistence, at rates author-
10 ized for employees of agencies under subchapter I of
11 chapter 57 of title 5, United States Code, while
12 away from their homes or regular places of business
13 in the performance of services for the Committee.
14 (g) FACA.—The Federal Advisory Committee Act
15 shall apply to the Advisory Committee under this section
16 only to the extent that the provisions of such Act do not
17 conflict with the requirements of this section.
18 **SEC. 308. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
19 **PROGRAM.**
20 Section 402E of the Higher Education Act of 1965
21 (20 U.S.C. 1070a–15) is amended by striking subsection
22 (g) and inserting the following:
23 ‘‘(g) COLLABORATION IN HEALTH PROFESSION DI-
24 VERSITY TRAINING PROGRAMS.—The Secretary shall co-
25 ordinate with the Secretary of Health and Human Serv-

1 ices to ensure that there is collaboration between the goals
2 of the program under this section and programs of the
3 Health Resources and Services Administration that pro-
4 mote health workforce diversity. The Secretary of Edu-
5 cation shall take such measures as may be necessary to
6 encourage participants in programs under this section to
7 consider health profession careers.''.

8 **SEC. 309. RULES FOR DETERMINATION OF FULL-TIME**
9 **EQUIVALENT RESIDENTS FOR COST REPORT-**
10 **ING PERIODS.**

11 (a) DGME DETERMINATIONS.—Section 1886(h)(4)
12 of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B))
13 is amended—
14 (1) in subparagraph (E), by striking ''Subject
15 to subparagraphs (J) and (K), such rules'' and in-
16 serting ''Subject to subparagraphs (J), (K), and (L),
17 such rules'';
18 (2) in subparagraph (J), by striking ''Such
19 rules'' and inserting ''Subject to subparagraph (L),
20 such rules'';
21 (3) in subparagraph (K), by striking ''In deter-
22 mining'' and inserting ''Subject to subparagraph
23 (L), in determining''; and
24 (4) by adding at the end the following new sub-
25 paragraph:

1 "(L) For purposes of cost-reporting peri-
2 ods beginning on or after the date of enactment
3 of the Health Equity and Accountability Act of
4 2012, in determining the hospital's number of
5 full-time equivalent residents for purposes of
6 this subparagraph, all the time spent by an in-
7 tern or resident in an approved medical resi-
8 dency training program shall be counted toward
9 the determination of full-time equivalency if the
10 hospital—
11 "(i) is recognized as a subsection (d)
12 hospital;
13 "(ii) is recognized as a subsection (d)
14 Puerto Rico hospital;
15 "(iii) is reimbursed under a reim-
16 bursement system authorized under section
17 1814(b)(3); or
18 "(iv) is a provider-based hospital out-
19 patient department.".
20 (b) IME DETERMINATIONS.—Section 1886(d)(5)(B)
21 of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—
22 (1) by redesignating clause (x), as added by
23 section 5505(b) of Public Law 111–148, as clause
24 (xi); and

(2) in clause (xi), as redesignated by paragraph (1)—

(A) in subclause (II), by striking "In determining" and inserting "Subject to subclause (IV), in determining";

(B) in subclause (III), by striking "In determining" and inserting "Subject to subclause (IV), in determining"; and

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

"(IV) The provisions of subparagraph (L) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.".

SEC. 310. DEVELOPING AND IMPLEMENTING STRATEGIES FOR LOCAL HEALTH EQUITY.

(a) GRANTS.—The Secretaries of Health and Human Services, Education, and Labor, acting jointly, shall make grants to academic institutions for the purposes of—

(1) in accordance with subsection (b), developing capacity—

(A) to build an evidence base for successful strategies for increasing local health equity; and

1 (B) to serve as national models of driving
2 local health equity;
3 (2) in accordance with subsection (c), devel-
4 oping a strategic partnership with the community in
5 which the academic institution is located; and
6 (3) collecting data on, and periodically evalu-
7 ating, the effectiveness of the institution's programs
8 funded through this section to enable the institution
9 to adapt accordingly for maximum efficiency and
10 success.
11 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
12 HEALTH EQUITY.—As a condition on receipt of a grant
13 under subsection (a), an academic institution shall agree
14 to use the grant to build an evidence base for successful
15 strategies for increasing local health equity, and to serve
16 as a national model of driving local health equity, by sup-
17 porting—
18 (1) resources to strengthen institutional metrics
19 and capacity to execute institutionwide health work-
20 force goals that can serve as models for increasing
21 health equity in communities across the country ;
22 (2) collaborations among a cohort of institu-
23 tions in implementing systemic change, partnership
24 development, and programmatic efforts supportive of

1 health equity goals across disciplines and popu-
2 lations; and
3 (3) enhanced or newly developed data systems
4 and research infrastructure capable of informing
5 current and future workforce efforts and building a
6 foundation for a broader research agenda targeting
7 urban health disparities.
8 (c) STRATEGIC PARTNERSHIPS.—As a condition on
9 receipt of a grant under subsection (a), an academic insti-
10 tution shall agree to use the grant to develop a strategic
11 partnership with the community in which the institution
12 is located for the purposes of—
13 (1) strengthening connections between the insti-
14 tution and the community—
15 (A) to improve evaluation of and address
16 the community's health and health workforce
17 needs; and
18 (B) to engage the community in health
19 workforce development;
20 (2) developing, enhancing, or accelerating inno-
21 vative undergraduate and graduate programs in the
22 biomedical sciences and health professions; and
23 (3) strengthening the ''birth to career'' pipeline
24 in the biomedical sciences and health professions, in-
25 cluding by developing partnerships between institu-

1 tions of higher education and elementary and sec-
2 ondary schools to recruit the next generation of
3 health professionals earlier in the pipeline to a
4 health care career.

5 **SEC. 311. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**
6 **IORAL HEALTH SOCIAL WORKERS.**

7 Section 455 of the Higher Education Act of 1965 (20
8 U.S.C. 1087e) is amended by adding at the end the fol-
9 lowing new subsection:

10 "(q) REPAYMENT PLAN FOR MENTAL AND BEHAV-
11 IORAL HEALTH SOCIAL WORKERS.—

12 "(1) IN GENERAL.—The Secretary shall cancel
13 the balance of interest and principal due on any eli-
14 gible Federal Direct Loan not in default for a bor-
15 rower who—

16 "(A) has made 120 monthly payments on
17 the eligible Federal Direct Loan after October
18 1, 2012, pursuant to any one or a combination
19 of the following—

20 "(i) payments under an income-based
21 repayment plan under section 493C;

22 "(ii) payments under a standard re-
23 payment plan under subsection (d)(1)(A),
24 based on a 10-year repayment period;

1 "(iii) monthly payments under a re-
2 payment plan under subsection (d)(1) or
3 (g) of not less than the monthly amount
4 calculated under subsection (d)(1)(A),
5 based on a 10-year repayment period; or
6 "(iv) payments under an income con-
7 tingent repayment plan under subsection
8 (d)(1)(D); and
9 "(B)(i) is employed as a mental health or
10 behavioral health social worker, as defined by
11 the Secretary by regulation, at the time of such
12 forgiveness; and
13 "(ii) has been employed as such a mental
14 health or behavioral health social worker during
15 the period in which the borrower makes each of
16 the 120 payments as described in subparagraph
17 (A).
18 "(2) LOAN CANCELLATION AMOUNT.—After the
19 conclusion of the employment period described in
20 paragraph (1), the Secretary shall cancel the obliga-
21 tion to repay the balance of principal and interest
22 due as of the time of such cancellation, on the eligi-
23 ble Federal Direct Loans made to the borrower
24 under this part.

"(3) DEFINITION OF ELIGIBLE FEDERAL DIRECT LOAN.—In this subsection, the term 'eligible Federal Direct Loan' means a Federal Direct Stafford Loan, Federal Direct PLUS Loan, Federal Direct Unsubsidized Stafford Loan, or a Federal Direct Consolidation Loan.".

TITLE IV—IMPROVEMENT OF HEALTH CARE SERVICES

Subtitle A—Health Empowerment Zones

SEC. 401. SHORT TITLE.

This subtitle may be cited as the "Health Empowerment Zone Act of 2012".

SEC. 402. FINDINGS.

The Congress finds the following:

(1) Numerous studies and reports, including the National Healthcare Disparities Report and Unequal Treatment, the 2002 Institute of Medicine Report, document the extensiveness to which health disparities exist across the country.

(2) These studies have found that, on average, racial and ethnic minorities are disproportionately afflicted with chronic and acute conditions—such as cancer, diabetes, and hypertension—and suffer worse health outcomes, worse health status, and

1 higher mortality rates than their White counter-
2 parts.
3 (3) Several recent studies also show that health
4 disparities are a function of not only access to health
5 care, but also the social determinants of health—in-
6 cluding the environment, the physical structure of
7 communities, nutrition and food options, educational
8 attainment, employment, race, ethnicity, geography,
9 and language preference—that directly and indi-
10 rectly affect the health, health care, and wellness of
11 individuals and communities.
12 (4) Integrally involving and fully supporting the
13 communities most affected by health inequities in
14 the assessment, planning, launch, and evaluation of
15 health disparity elimination efforts is among the
16 leading recommendations made to adequately ad-
17 dress and ultimately reduce health disparities.
18 (5) Recommendations also include supporting
19 the efforts of community stakeholders from a broad
20 cross section—including, but not limited to local
21 businesses, local departments of commerce, edu-
22 cation, labor, urban planning, and transportation,
23 and community-based and other nonprofit organiza-
24 tions—to find areas of common ground around
25 health disparity elimination and collaborate to im-

1 prove the overall health and wellness of a community
2 and its residents.

3 **SEC. 403. DESIGNATION OF HEALTH EMPOWERMENT**
4 **ZONES.**

5 (a) IN GENERAL.—At the request of an eligible com-
6 munity partnership, the Secretary may designate an eligi-
7 ble area as a health empowerment zone.

8 (b) ELIGIBILITY CRITERIA.—

9 (1) ELIGIBLE COMMUNITY PARTNERSHIP.—A
10 community partnership is eligible to submit a re-
11 quest under this section if the partnership—

12 (A) demonstrates widespread public sup-
13 port from key individuals and entities in the eli-
14 gible area, including State and local govern-
15 ments, nonprofit organizations, and community
16 and industry leaders, for designation of the eli-
17 gible area as a health empowerment zone; and

18 (B) includes representatives of—

19 (i) a broad cross section of stake-
20 holders and residents from communities in
21 the eligible area experiencing dispropor-
22 tionate disparities in health status and
23 health care; and

1 (ii) organizations, facilities, and insti-
2 tutions that have a history of working
3 within and serving such communities.
4 (2) ELIGIBLE AREA.—An area is eligible to be
5 designated as a health empowerment zone under this
6 section if one or more communities in the area expe-
7 rience disproportionate disparities in health status
8 and health care. In determining whether a commu-
9 nity experiences such disparities, the Secretary shall
10 consider the data collected by the Department of
11 Health and Human Services focusing on the fol-
12 lowing areas:
13 (A) Access to affordable high-quality
14 health services.
15 (B) Arthritis, osteoporosis, and chronic
16 back conditions.
17 (C) Cancer.
18 (D) Chronic kidney disease.
19 (E) Diabetes.
20 (F) Injury and violence prevention.
21 (G) Maternal, infant, and child health.
22 (H) Medical product safety.
23 (I) Mental health and mental disorders.
24 (J) Nutrition and overweight.
25 (K) Disability and secondary conditions.

1 (L) Educational and community-based
2 health programs.
3 (M) Environmental health.
4 (N) Family planning.
5 (O) Food safety.
6 (P) Health communication.
7 (Q) Health disease and stroke.
8 (R) HIV/AIDS.
9 (S) Immunization and infectious diseases.
10 (T) Occupational safety and health.
11 (U) Oral health.
12 (V) Physical activity and fitness.
13 (W) Public health infrastructure.
14 (X) Respiratory diseases.
15 (Y) Sexually transmitted diseases.
16 (Z) Substance abuse.
17 (AA) Tobacco use.
18 (BB) Vision and hearing.
19 (CC) The degree to which those who have
20 disabilities have access to health services, in-
21 cluding physical activity and fitness, including
22 the ability to physically access the locations
23 where such services are provided.
24 (c) PROCEDURE.—

1 (1) REQUEST.—A request under subsection (a)
2 shall—
3 (A) describe the bounds of the area to be
4 designated as a health empowerment zone and
5 the process used to select those bounds;
6 (B) demonstrate that the partnership sub-
7 mitting the request is an eligible community
8 partnership described in subsection (b)(1);
9 (C) demonstrate that the area is an eligible
10 area described in subsection (b)(2);
11 (D) include a comprehensive assessment of
12 disparities in health status and health care ex-
13 perience by one or more communities in the
14 area;
15 (E) set forth—
16 (i) a vision and a set of values for the
17 area; and
18 (ii) a comprehensive and holistic set of
19 goals to be achieved in the area through
20 designation as a health empowerment zone;
21 and
22 (F) include a strategic plan for achieving
23 the goals described in subparagraph (E)(ii).
24 (2) APPROVAL.—Not later than 60 days after
25 the receipt of a request for designation of an area

1 as a health empowerment zone under this section,
2 the Secretary shall approve or disapprove the re-
3 quest.
4 (d) MINIMUM NUMBER.—The Secretary—
5 (1) shall designate not more than 110 health
6 empowerment zones under this section; and
7 (2) shall designate at least one health empower-
8 ment zone in each of the several States, the District
9 of Columbia, and each territory or possession of the
10 United States.

11 **SEC. 404. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

12 At the request of any organization or entity seeking
13 to submit a request under section 403(a), the Secretary
14 shall provide technical assistance, and may award a grant,
15 to assist such organization or entity—
16 (1) to form an eligible community partnership
17 described in section 403(b)(1);
18 (2) to complete a health assessment, including
19 an assessment of health disparities under section
20 403(c)(1)(D); or
21 (3) to prepare and submit a request, including
22 a strategic plan, in accordance with section 403.

1 **SEC. 405. BENEFITS OF DESIGNATION.**

2 (a) PRIORITY.—In awarding any competitive grant,
3 a Federal official shall give priority to any applicant
4 that—

5 (1) meets the eligibility criteria for the grant;

6 (2) proposes to use the grant for activities in a
7 health empowerment zone; and

8 (3) demonstrates that such activities will di-
9 rectly and significantly further the goals of the stra-
10 tegic plan approved for such zone under section 403.

11 (b) GRANTS FOR INITIAL IMPLEMENTATION OF
12 STRATEGIC PLAN.—

13 (1) IN GENERAL.—Upon designating an eligible
14 area as a health empowerment zone at the request
15 of an eligible community partnership, the Secretary
16 shall, subject to the availability of appropriations,
17 make a grant to the community partnership for im-
18 plementation of the strategic plan for such zone.

19 (2) GRANT PERIOD.—A grant under paragraph
20 (1) for a health empowerment zone shall be for a pe-
21 riod of 2 years and may be renewed, except that the
22 total period of grants under paragraph (1) for such
23 zone may not exceed 10 years.

24 (3) LIMITATION.—In awarding grants under
25 this subsection, the Secretary shall not give less pri-
26 ority to an applicant or reduce the amount of a

1 grant because the Secretary rendered technical as-
2 sistance or made a grant to the same applicant
3 under section 404.

4 (4) REPORTING.—The Secretary shall require
5 each recipient of a grant under this subsection to re-
6 port to the Secretary not less than every 6 months
7 on the progress in implementing the strategic plan
8 for the health empowerment zone.

9 **SEC. 406. DEFINITION.**

10 In this subtitle, the term ''Secretary'' means the Sec-
11 retary of Health and Human Services, acting through the
12 Administrator of the Health Resources and Services Ad-
13 ministration and the Deputy Assistant Secretary for Mi-
14 nority Health, and in cooperation with the Director of the
15 Office of Community Services and the Director of the Na-
16 tional Institute for Minority Health and Health Dispari-
17 ties.

18 Subtitle B—Other Improvements of 19 Health Care Services

20 CHAPTER 1—EXPANSION OF COVERAGE

21 **SEC. 411. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
22 **ACT.**

23 Title XXXIV of the Public Health Service Act, as
24 amended by titles I, II, III, and IX of this Act, is further
25 amended by inserting after subtitle C the following:

"Subtitle D—Reconstruction and Improvement Grants for Public Health Care Facilities Serving Pacific Islanders and the Insular Areas

"SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT INITIATIVES.

"(a) IN GENERAL.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Centers for Medicare & Medicaid Services, shall award grants to eligible entities for the conduct of demonstration projects to improve the quality of and access to health care.

"(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

"(1) be a health center, hospital, health plan, health system, community clinic. or other health entity determined appropriate by the Secretary—

"(A) that, by legal mandate or explicitly adopted mission, provides patients with access to services regardless of their ability to pay;

"(B) that provides care or treatment for a substantial number of patients who are unin-

1 sured, are receiving assistance under a State
2 program under title XIX of the Social Security
3 Act, or are members of vulnerable populations,
4 as determined by the Secretary; and
5 ‘‘(C)(i) with respect to which, not less than
6 50 percent of the entity's patient population is
7 made up of racial and ethnic minorities; or
8 ‘‘(ii) that—
9 ‘‘(I) serves a disproportionate percent-
10 age of local, minority racial and ethnic pa-
11 tients, or that has a patient population, at
12 least 50 percent of which is limited-English
13 proficient; and
14 ‘‘(II) provides an assurance that
15 amounts received under the grant will be
16 used only to support quality improvement
17 activities in the racial and ethnic popu-
18 lation served; and
19 ‘‘(2) prepare and submit to the Secretary an
20 application at such time, in such manner, and con-
21 taining such information as the Secretary may re-
22 quire.
23 ‘‘(c) PRIORITY.—In awarding grants under sub-
24 section (a), the Secretary shall give priority to applicants
25 under subsection (b)(2) that—

1 "(1) demonstrate an intent to operate as part
2 of a health care partnership, network, collaborative,
3 coalition, or alliance where each member entity con-
4 tributes to the design, implementation, and evalua-
5 tion of the proposed intervention; or
6 "(2) intend to use funds to carry out system-
7 wide changes with respect to health care quality im-
8 provement, including—
9 "(A) improved systems for data collection
10 and reporting;
11 "(B) innovative collaborative or similar
12 processes;
13 "(C) group programs with behavioral or
14 self-management interventions;
15 "(D) case management services;
16 "(E) physician or patient reminder sys-
17 tems;
18 "(F) educational interventions; or
19 "(G) other activities determined appro-
20 priate by the Secretary.
21 "(d) USE OF FUNDS.—An entity shall use amounts
22 received under a grant under subsection (a) to support
23 the implementation and evaluation of health care quality
24 improvement activities or minority health and health care
25 disparity reduction activities that include—

1 ''(1) with respect to health care systems, activi-
2 ties relating to improving—
3 ''(A) patient safety;
4 ''(B) timeliness of care;
5 ''(C) effectiveness of care;
6 ''(D) efficiency of care;
7 ''(E) patient centeredness; and
8 ''(F) health information technology; and
9 ''(2) with respect to patients, activities relating
10 to—
11 ''(A) staying healthy;
12 ''(B) getting well;
13 ''(C) living with illness or disability; and
14 ''(D) coping with end-of-life issues.
15 ''(e) COMMON DATA SYSTEMS.—The Secretary shall
16 provide financial and other technical assistance to grant-
17 ees under this section for the development of common data
18 systems.
19 **''SEC. 3452. CENTERS OF EXCELLENCE.**
20 ''(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration, shall designate centers of excellence at
23 public hospitals, and other health systems serving large
24 numbers of minority patients, that—

1 “(1) meet the requirements of section
2 3451(b)(1);
3 “(2) demonstrate excellence in providing care to
4 minority populations; and
5 “(3) demonstrate excellence in reducing dispari-
6 ties in health and health care.
7 “(b) REQUIREMENTS.—A hospital or health system
8 that serves as a Center of Excellence under subsection (a)
9 shall—
10 “(1) design, implement, and evaluate programs
11 and policies relating to the delivery of care in ra-
12 cially, ethnically, and linguistically diverse popu-
13 lations;
14 “(2) provide training and technical assistance
15 to other hospitals and health systems relating to the
16 provision of quality health care to minority popu-
17 lations; and
18 “(3) develop activities for graduate or con-
19 tinuing medical education that institutionalize a
20 focus on cultural competence training for health care
21 providers.

1 **"SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**
2 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
3 **ING PACIFIC ISLANDERS AND THE INSULAR**
4 **AREAS.**
5 ''(a) IN GENERAL.—The Secretary shall provide di-
6 rect financial assistance to designated health care pro-
7 viders and community health centers in American Samoa,
8 Guam, the Commonwealth of the Northern Mariana Is-
9 lands, the United States Virgin Islands, Puerto Rico, and
10 Hawaii for the purposes of reconstructing and improving
11 health care facilities and services.
12 ''(b) ELIGIBILITY.—To be eligible to receive direct fi-
13 nancial assistance under subsection (a), an entity shall be
14 a public health facility or community health center located
15 in American Samoa, Guam, the Commonwealth of the
16 Northern Mariana Islands, the United States Virgin Is-
17 lands, Puerto Rico, or Hawaii that—
18 ''(1) is owned or operated by—
19 ''(A) the Government of American Samoa,
20 Guam, the Commonwealth of the Northern
21 Mariana Islands, the United States Virgin Is-
22 lands, Puerto Rico, or Hawaii or a unit of local
23 government; or
24 ''(B) a nonprofit organization; and
25 ''(2)(A) provides care or treatment for a sub-
26 stantial number of patients who are uninsured, re-

1 ceiving assistance under a State program under a
2 title XVIII of the Social Security Act, or a State
3 program under title XIX of such Act, or who are
4 members of a vulnerable population, as determined
5 by the Secretary; or
6 ''(B) serves a disproportionate percentage of
7 local, minority racial and ethnic patients.
8 ''(c) REPORT.—Not later than 180 days after the
9 date of enactment of this title and annually thereafter, the
10 Secretary shall submit to the Congress and the President
11 a report that includes an assessment of health resources
12 and facilities serving populations in American Samoa,
13 Guam, the Commonwealth of the Northern Mariana Is-
14 lands, the United States Virgin Islands, Puerto Rico, and
15 Hawaii. In preparing such report, the Secretary shall—
16 ''(1) consult with and obtain information on all
17 health care facilities needs from the entities de-
18 scribed in subsection (b);
19 ''(2) include all amounts of Federal assistance
20 received by each entity in the preceding fiscal year;
21 ''(3) review the total unmet needs of each juris-
22 diction for health care facilities, including needs for
23 renovation and expansion of existing facilities; and
24 ''(4) include a strategic plan for addressing the
25 needs of each jurisdiction identified in the report.''.

1 **SEC. 412. REMOVING BARRIERS TO UNSUBSIDIZED PUR-**
2 **CHASE OF PRIVATE INSURANCE IN AMER-**
3 **ICAN HEALTH BENEFIT EXCHANGES.**

4 (a) IN GENERAL.—Section 1312(f) of the Patient
5 Protection and Affordable Care Act (42 U.S.C.18032(f))
6 is amended—

7 (1) in the subsection heading, by striking the
8 semicolon and all that follows through "RESI-
9 DENTS"; and

10 (2) by striking paragraph (3).

11 (b) CONFORMING AMENDMENT.—Section 1411(a)(1)
12 of such Act (42 U.S.C. 18081(a)(1)) is amended by strik-
13 ing "1312(f)(3),".

14 **SEC. 413. STUDY ON THE UNINSURED.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall—

17 (1) conduct a study on the demographic charac-
18 teristics of the population of individuals who do not
19 have health insurance coverage; and

20 (2) predict, based on such study, the demo-
21 graphic characteristics of the population of individ-
22 uals who will not have health insurance coverage
23 after January 1, 2014.

24 (b) REPORTING REQUIREMENTS.—

25 (1) IN GENERAL.—Not later than 12 months
26 after the date of the enactment of this Act, the Sec-

retary shall submit to the Congress the results of the study under subsection (a)(1) and the prediction made under subsection (a)(2).

(2) REPORTING OF DEMOGRAPHIC CHARACTERISTICS.—The Secretary shall report the demographic characteristics under paragraphs (1) and (2) of subsection (a) on the basis of racial and ethnic group, and shall stratify the reporting on each racial and ethnic group by other demographic characteristics that can impact access to health insurance coverage, such as sexual orientation, gender identity, primary language, disability status, sex, socioeconomic status, and citizenship and immigration status, in a manner consistent with title I of this Act.

SEC. 414. MEDICAID PAYMENT PARITY FOR THE TERRITORIES.

(a) ELIMINATION OF FUNDING LIMITATIONS FOR PUERTO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM, THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—

(1) IN GENERAL.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(A) in subsection (f), in the matter before paragraph (1), by striking ‘‘subsection (g)’’ and inserting ‘‘subsections (g) and (h)’’;

1 (B) in subsection (g)(2), in the matter be-
2 fore subparagraph (A), by inserting ''and sub-
3 section (h) of this Act'' after ''paragraphs (3)
4 and (5)''; and
5 (C) by adding at the end the following new
6 subsection:
7 ''(h) SUNSET OF FUNDING LIMITATIONS FOR PUER-
8 TO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM,
9 THE COMMONWEALTH OF THE NORTHERN MARIANA IS-
10 LANDS, AND AMERICAN SAMOA.—Subsections (f) and (g)
11 shall not apply to Puerto Rico, the United States Virgin
12 Islands, Guam, the Commonwealth of the Northern Mar-
13 iana Islands, and American Samoa for any fiscal year
14 after fiscal year 2011.''.
15 (2) CONFORMING AMENDMENT.—Section
16 1903(u) of such Act (42 U.S.C. 1396c(u)) is amend-
17 ed by striking paragraph (4).
18 (3) EFFECTIVE DATE.—The amendments made
19 by this subsection shall apply beginning with fiscal
20 year 2012.
21 (b) PARITY IN FMAP.—
22 (1) IN GENERAL.—The first sentence of section
23 1905(b) of such Act (42 U.S.C. 1396d(b)) is amend-
24 ed by inserting after ''shall be 50 per centum'' the
25 following: ''(except that, beginning with fiscal year

1 2014, the Federal medical assistance percentage for
2 Puerto Rico, the United States Virgin Islands,
3 Guam, the Commonwealth of the Northern Mariana
4 Islands, and American Samoa shall be the Federal
5 medical assistance percentage determined by the
6 Secretary in consultation (for the United States Vir-
7 gin Islands, Guam, the Commonwealth of the North-
8 ern Mariana Islands, and American Samoa) with the
9 Secretary of the Interior)''.
10 (2) 2-FISCAL-YEAR TRANSITION.—Notwith-
11 standing any other provision of law, during fiscal
12 years 2012 and 2013, the Federal medical assist-
13 ance percentage established under section 1905(b) of
14 the Social Security Act (42 U.S.C. 1396d(b)) for
15 Puerto Rico, the United States Virgin Islands,
16 Guam, the Commonwealth of the Northern Mariana
17 Islands, and American Samoa shall be the highest
18 such Federal medical assistance percentage applica-
19 ble to any of the 50 States or the District of Colum-
20 bia for the fiscal year involved, taking into account
21 the application of subsections (a) and (b)(1) of 5001
22 of division B of the American Recovery and Rein-
23 vestment Act of 2009 (Public Law 111–5) to such
24 States and District of Columbia for calendar quar-

1 ters during such fiscal years for which such sub-
2 sections apply respectively.
3 (3) PER CAPITA INCOME DATA.—
4 (A) REPORT TO CONGRESS.—Not later
5 than October 1, 2012, the Secretary of Health
6 and Human Services shall submit to Congress
7 a report that describes the per capita income
8 data used to promulgate the Federal medical
9 assistance percentage in the territories and how
10 such data differ from the per capita income
11 data used to promulgate Federal medical assist-
12 ance percentages for the 50 States and the Dis-
13 trict of Columbia. The report should include
14 recommendations on how the Federal medical
15 assistance percentages can be calculated for the
16 territories to ensure parity with the 50 States
17 and the District of Columbia.
18 (B) APPLICATION.—Section 1101(a)(8)(B)
19 of the Social Security Act (42 U.S.C.
20 1308(a)(8)(B)) is amended—
21 (i) by striking ''(other than Puerto
22 Rico, the United States Virgin Islands, and
23 Guam)'' and inserting ''(including Puerto
24 Rico, the United States Virgin Islands,
25 Guam, the Commonwealth of the Northern

1 Mariana Islands, and American Samoa)'';
2 and
3 (ii) by inserting ''(or, if such satisfac-
4 tory data are not available in the case of
5 the Virgin Islands, Guam, the Northern
6 Mariana Islands, or American Samoa, sat-
7 isfactory data available from the Depart-
8 ment of the Interior for the same period,
9 or if such satisfactory data are not avail-
10 able in the case of Puerto Rico, satisfac-
11 tory data available from the government of
12 the Commonwealth of Puerto Rico for the
13 same period)'' after ''Department of Com-
14 merce''.
15 (4) RELATION TO AMERICAN RECOVERY AND
16 REINVESTMENT ACT OF 2009.—For any period and
17 territory in which the provisions of this subsection
18 apply to a territory, the provisions of section
19 5001(b)(2) of division B of the American Recovery
20 and Reinvestment Act of 2009 (Public Law 111–5)
21 shall not apply (except as otherwise specifically pro-
22 vided in paragraph (2)).

1 **SEC. 415. MEDICAID ELIGIBILITY FOR CITIZENS OF FREELY**
2 **ASSOCIATED STATES.**
3 (a) IN GENERAL.—Section 402(b)(2) of the Personal
4 Responsibility and Work Opportunity Reconciliation Act
5 of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at
6 the end the following:
7 "(G) MEDICAID EXCEPTION FOR CITIZENS
8 OF FREELY ASSOCIATED STATES.—With respect
9 to eligibility for benefits for the program de-
10 fined in paragraph (3)(C) (relating to Med-
11 icaid), paragraph (1) shall not apply to any in-
12 dividual who lawfully resides in the United
13 States (including territories and possessions of
14 the United States) in accordance with—
15 "(i) section 141 of the Compact of
16 Free Association between the Government
17 of the United States and the Government
18 of the Federated States of Micronesia, ap-
19 proved by Congress in the Compact of
20 Free Association Amendments Act of
21 2003;
22 "(ii) section 141 of the Compact of
23 Free Association between the Government
24 of the United States and the Government
25 of the Republic of the Marshall Islands,
26 approved by Congress in the Compact of

Free Association Amendments Act of 2003; or

"(iii) section 141 of the Compact of Free Association between the Government of the United States and the Government of Palau, approved by Congress in Public Law 99–658 (100 Stat. 3672).".

(b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—Section 403(d) of such Act (8 U.S.C. 1613(d)) is amended—

(1) in paragraph (1), by striking "or" at the end;

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

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

"(3) an individual described in section 402(b)(2)(G), but only with respect to the designated Federal program defined in section 402(b)(3)(C).".

(c) DEFINITION OF QUALIFIED ALIEN.—Section 431(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(b)) is amended—

1 (1) in paragraph (6), by striking ''or'' at the
2 end;
3 (2) in paragraph (7), by striking the period at
4 the end and inserting ''; or''; and
5 (3) by adding at the end the following:
6 ''(8) an individual who lawfully resides in the
7 United States (including territories and possessions
8 of the United States) in accordance with a Compact
9 of Free Association referred to in section
10 402(b)(2)(G).''.
11 (d) CONFORMING AMENDMENTS.—Section 1108 of
12 the Social Security Act (42 U.S.C. 1308) is amended—
13 (1) in subsection (f), in the matter preceding
14 paragraph (1), by striking ''subsection (g)'' and in-
15 serting ''subsections (g) and (h)''; and
16 (2) by adding at the end the following:
17 ''(h) The limitations of subsections (f) and (g) shall
18 not apply with respect to medical assistance provided to
19 an individual described in section 431(b)(8) of the Per-
20 sonal Responsibility and Work Opportunity Reconciliation
21 Act of 1996.''.
22 (e) EFFECTIVE DATE.—The amendments made by
23 this section take effect on the date of enactment of this
24 Act and apply to benefits for items and services furnished
25 on or after that date.

1 **SEC. 416. EXTENSION OF MEDICARE SECONDARY PAYER.**

2 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
3 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
4 ed—

5 (1) in the last sentence, by inserting ", and be-
6 fore January 1, 2013" after "prior to such date)";
7 and

8 (2) by adding at the end the following new sen-
9 tence: "Effective for items and services furnished on
10 or after January 1, 2013 (with respect to periods
11 beginning on or after the date that is 42 months
12 prior to such date), clauses (i) and (ii) shall be ap-
13 plied by substituting '42-month' for '12-month' each
14 place it appears in the first sentence.".

15 (b) EFFECTIVE DATE.—The amendments made by
16 this subsection shall take effect on the date of enactment
17 of this Act. For purposes of determining an individual's
18 status under section 1862(b)(1)(C) of the Social Security
19 Act (42 U.S.C. 1395y(b)(1)(C)), as amended by para-
20 graph (1), an individual who is within the coordinating
21 period as of the date of enactment of this Act shall have
22 that period extended to the full 42 months described in
23 the last sentence of such section, as added by the amend-
24 ment made by paragraph (1)(B).

1 **SEC. 417. BORDER HEALTH GRANTS.**

2 (a) ELIGIBLE ENTITY DEFINED.—In this section,
3 the term ''eligible entity'' means a State, public institution
4 of higher education, local government, tribal government,
5 nonprofit health organization, community health center, or
6 community clinic receiving assistance under section 330
7 of the Public Health Service Act (42 U.S.C. 254b), that
8 is located in the border area.

9 (b) AUTHORIZATION.—The Secretary of Health and
10 Human Services (in this section referred to as the ''Sec-
11 retary''), acting through the United States members of the
12 United States-Mexico Border Health Commission, shall
13 award grants to eligible entities to address priorities and
14 recommendations to improve the health of border area
15 residents that are established by—

16 (1) the United States members of the United
17 States-Mexico Border Health Commission;

18 (2) the State border health offices; and

19 (3) the Secretary.

20 (c) APPLICATION.—An eligible entity that desires a
21 grant under subsection (b) shall submit an application to
22 the Secretary at such time, in such manner, and con-
23 taining such information as the Secretary may require.

24 (d) USE OF FUNDS.—An eligible entity that receives
25 a grant under subsection (b) shall use the grant funds
26 for—

1 (1) programs relating to—
2 (A) maternal and child health;
3 (B) primary care and preventative health;
4 (C) public health and public health infra-
5 structure;
6 (D) health education and promotion;
7 (E) oral health;
8 (F) mental and behavioral health;
9 (G) substance abuse;
10 (H) health conditions that have a high
11 prevalence in the border area;
12 (I) medical and health services research;
13 (J) workforce training and development;
14 (K) community health workers or
15 promotoras;
16 (L) health care infrastructure problems in
17 the border area (including planning and con-
18 struction grants);
19 (M) health disparities in the border area;
20 (N) environmental health; and
21 (O) outreach and enrollment services with
22 respect to Federal programs (including pro-
23 grams authorized under titles XIX and XXI of
24 the Social Security Act (42 U.S.C. 1396 and
25 1397aa)); and

1 (2) other programs determined appropriate by
2 the Secretary.

3 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
4 vided to an eligible entity awarded a grant under sub-
5 section (b) shall be used to supplement and not supplant
6 other funds available to the eligible entity to carry out the
7 activities described in subsection (d).

8 (f) PRIMARY CARE DEFINITION.—In this Act, the
9 term ''primary care'' includes obstetrical and gynecological
10 care and psychiatric and mental health care.

11 **SEC. 418. REMOVING MEDICARE BARRIERS TO HEALTH**
12 **CARE.**

13 (a) PART A.—Section 1818(a)(3) of the Social Secu-
14 rity Act (42 U.S.C. 1395i–2(a)(3)) is amended by striking
15 ''(B) an alien'' and all that follows through the comma
16 and inserting ''(B) an individual who is lawfully present
17 in the United States,''.

18 (b) PART B.—Section 1836(2) of the Social Security
19 Act (42 U.S.C. 1395o(2)) is amended by striking ''(B) an
20 alien'' and all that follows through the comma and insert-
21 ing ''(B) an individual who is lawfully present in the
22 United States,''.

1 **SEC. 419. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
2 **PROVIDED BY URBAN INDIAN HEALTH CEN-**
3 **TERS.**

4 (a) IN GENERAL.—Section 1905(b) of the Social Se-
5 curity Act (42 U.S.C. 1396(b)), as amended by section
6 414(b)(1), is amended by striking ''or by an Indian tribe
7 or tribal organization (as defined in section 4 of the Indian
8 Health Care Improvement Act)'' and inserting '', by an
9 Indian tribe or tribal organization (as defined in section
10 4 of the Indian Health Care Improvement Act), or are
11 received through a program operated by an urban Indian
12 organization through a grant or contract under section
13 502 of the Indian Health Care Improvement Act''.

14 (b) EFFECTIVE DATE.—The amendment made by
15 this section shall apply to medical assistance provided on
16 or after the date of enactment of this Act.

17 **SEC. 420. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
18 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
19 **A FEDERALLY QUALIFIED HEALTH CENTER**
20 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
21 **TEM UNDER THE MEDICAID PROGRAM.**

22 (a) IN GENERAL.—The third sentence of section
23 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),
24 as amended by section 419, is amended by inserting '';
25 and, with respect to medical assistance provided to a Na-
26 tive Hawaiian (as defined in section 12(2) of the Native

1 Hawaiian Health Care Improvement Act) through a feder-
2 ally qualified health center or a Native Hawaiian health
3 care system (as defined in section 12(6) of such Act),
4 whether directly, by referral, or under contract or other
5 arrangement between such federally qualified health cen-
6 ter or Native Hawaiian health care system and another
7 health care provider'' before the period.

8 (b) EFFECTIVE DATE.—The amendment made by
9 this section shall apply to medical assistance provided on
10 or after the date of enactment of this Act.

11 CHAPTER 2—EXPANSION OF ACCESS

12 SEC. 421. GRANTS FOR RACIAL AND ETHNIC APPROACHES 13 TO COMMUNITY HEALTH.

14 (a) PURPOSE.—It is the purpose of this section to
15 provide for the awarding of grants to assist communities
16 in mobilizing and organizing resources in support of effec-
17 tive and sustainable programs that will reduce or eliminate
18 disparities in health and health care experienced by racial
19 and ethnic minority individuals.

20 (b) AUTHORITY TO AWARD GRANTS.—The Sec-
21 retary, acting through the Centers for Disease Control and
22 Prevention, shall award grants to eligible entities to assist
23 in designing, implementing, and evaluating culturally and
24 linguistically appropriate, science-based, and community-

1 driven sustainable strategies to eliminate racial and ethnic
2 health and health care disparities.
3 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
4 grant under this section, an entity shall—
5 (1) represent a coalition—
6 (A) whose principal purpose is to develop
7 and implement interventions to reduce or elimi-
8 nate a health or health care disparity in a tar-
9 geted racial or ethnic minority group in the
10 community served by the coalition; and
11 (B) that includes—
12 (i) members selected from among—
13 (I) public health departments;
14 (II) community-based organiza-
15 tions;
16 (III) university and research or-
17 ganizations;
18 (IV) American Indian tribal or-
19 ganizations, national American Indian
20 organizations, Indian Health Service,
21 or organizations serving Alaska Na-
22 tives; and
23 (V) interested public or private
24 health care providers or organizations

1 as deemed appropriate by the Sec-
2 retary; and
3 (ii) at least 1 member from a commu-
4 nity-based organization that represents the
5 targeted racial or ethnic minority group;
6 and
7 (2) submit to the Secretary an application at
8 such time, in such manner, and containing such in-
9 formation as the Secretary may require, which shall
10 include—
11 (A) a description of the targeted racial or
12 ethnic populations in the community to be
13 served under the grant;
14 (B) a description of at least 1 health dis-
15 parity that exists in the racial or ethnic tar-
16 geted populations, including health issues such
17 as infant mortality, breast and cervical cancer
18 screening and management, cardiovascular dis-
19 ease, diabetes, child and adult immunization
20 levels, or other health priority areas as des-
21 ignated by the Secretary; and
22 (C) a demonstration of a proven record of
23 accomplishment of the coalition members in
24 serving and working with the targeted commu-
25 nity.

1 (d) SUSTAINABILITY.—The Secretary shall give pri-
2 ority to an eligible entity under this section if the entity
3 agrees that, with respect to the costs to be incurred by
4 the entity in carrying out the activities for which the grant
5 was awarded, the entity (and each of the participating
6 partners in the coalition represented by the entity) will
7 maintain its expenditures of non-Federal funds for such
8 activities at a level that is not less than the level of such
9 expenditures during the fiscal year immediately preceding
10 the first fiscal year for which the grant is awarded.
11 (e) NONDUPLICATION.—Funds provided through this
12 grant program should supplement, not supplant, existing
13 Federal funding, and the funds should not be used to du-
14 plicate the activities of the other health disparity grant
15 programs in this Act.
16 (f) TECHNICAL ASSISTANCE.—The Secretary may,
17 either directly or by grant or contract, provide any entity
18 that receives a grant under this section with technical and
19 other nonfinancial assistance necessary to meet the re-
20 quirements of this section.
21 (g) DISSEMINATION.—The Secretary shall encourage
22 and enable grantees to share best practices, evaluation re-
23 sults, and reports with communities not affiliated with
24 grantees using the Internet, conferences, and other perti-
25 nent information regarding the projects funded by this

1 section, including the outreach efforts of the Office of Mi-
2 nority Health and Health Disparity Elimination and the
3 Centers for Disease Control and Prevention.

4 (h) ADMINISTRATIVE BURDENS.—The Secretary
5 shall make every effort to minimize duplicative or unneces-
6 sary administrative burdens on grantees.

7 **SEC. 422. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

8 (a) ELIMINATION OF ISOLATION TEST FOR COST-
9 BASED AMBULANCE REIMBURSEMENT.—

10 (1) IN GENERAL.—Section 1834(l)(8) of the
11 Social Security Act (42 U.S.C. 1395m(l)(8)) is
12 amended—

13 (A) in subparagraph (B)—

14 (i) by striking ''owned and''; and

15 (ii) by inserting ''(including when
16 such services are provided by the entity
17 under an arrangement with the hospital)''
18 after ''hospital''; and

19 (B) by striking the comma at the end of
20 subparagraph (B) and all that follows and in-
21 serting a period.

22 (2) EFFECTIVE DATE.—The amendments made
23 by this subsection shall apply to services furnished
24 on or after January 1, 2013.

1 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
2 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
3 REQUIREMENT.—
4 (1) IN GENERAL.—Section 1820(c)(2) of the
5 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
6 amended—
7 (A) in subparagraph (B)(iii), by striking
8 ''provides not more than'' and inserting ''sub-
9 ject to subparagraph (F), provides not more
10 than''; and
11 (B) by adding at the end the following new
12 subparagraph:
13 ''(F) ALTERNATIVE TO 25 INPATIENT BED
14 LIMIT REQUIREMENT.—
15 ''(i) IN GENERAL.—A State may elect
16 to treat a facility, with respect to the des-
17 ignation of the facility for a cost reporting
18 period, as satisfying the requirement of
19 subparagraph (B)(iii) relating to a max-
20 imum number of acute care inpatient beds
21 if the facility elects, in accordance with a
22 method specified by the Secretary and be-
23 fore the beginning of the cost reporting pe-
24 riod, to meet the requirement under clause
25 (ii).

1 "(ii) ALTERNATE REQUIREMENT.—
2 The requirement under this clause, with
3 respect to a facility and a cost reporting
4 period, is that the total number of inpa-
5 tient bed days described in subparagraph
6 (B)(iii) during such period will not exceed
7 7,300. For purposes of this subparagraph,
8 an individual who is an inpatient in a bed
9 in the facility for a single day shall be
10 counted as one inpatient bed day.
11 "(iii) WITHDRAWAL OF ELECTION.—
12 The option described in clause (i) shall not
13 apply to a facility for a cost reporting pe-
14 riod if the facility (for any two consecutive
15 cost-reporting periods during the previous
16 5 cost-reporting periods) was treated under
17 such option and had a total number of in-
18 patient bed days for each of such two cost-
19 reporting periods that exceeded the num-
20 ber specified in such clause.".
21 (2) EFFECTIVE DATE.—The amendments made
22 by paragraph (1) shall apply to cost-reporting peri-
23 ods beginning on or after the date of the enactment
24 of this Act.

1 **SEC. 423. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
2 **PITAL (RCH) PROGRAM.**

3 (a) IN GENERAL.—Section 1861 of the Social Secu-
4 rity Act (42 U.S.C. 1395x), as amended by section
5 203(b)(1)(A), is amended by adding at the end of the fol-
6 lowing new subsection:

7 ''Rural Community Hospital; Rural Community Hospital
8 Services

9 ''(jjj)(1) The term 'rural community hospital' means
10 a hospital (as defined in subsection (e)) that—
11 ''(A) is located in a rural area (as defined in
12 section 1886(d)(2)(D)) or treated as being so lo-
13 cated pursuant to section 1886(d)(8)(E);
14 ''(B) subject to paragraph (2), has less than 51
15 acute care inpatient beds, as reported in its most re-
16 cent cost report;
17 ''(C) makes available 24-hour emergency care
18 services;
19 ''(D) subject to paragraph (3), has a provider
20 agreement in effect with the Secretary and is open
21 to the public as of January 1, 2010; and
22 ''(E) applies to the Secretary for such designa-
23 tion.
24 ''(2) For purposes of paragraph (1)(B), beds in a
25 psychiatric or rehabilitation unit of the hospital which is
26 a distinct part of the hospital shall not be counted.

1 "(3) Paragraph (1)(D) shall not be construed to pro-
2 hibit any of the following from qualifying as a rural com-
3 munity hospital:
4 "(A) A replacement facility (as defined by the
5 Secretary in regulations in effect on January 1,
6 2012) with the same service area (as defined by the
7 Secretary in regulations in effect on such date).
8 "(B) A facility obtaining a new provider num-
9 ber pursuant to a change of ownership.
10 "(C) A facility which has a binding written
11 agreement with an outside, unrelated party for the
12 construction, reconstruction, lease, rental, or financ-
13 ing of a building as of January 1, 2012.
14 "(4) Nothing in this subsection shall be construed as
15 prohibiting a critical access hospital from qualifying as a
16 rural community hospital if the critical access hospital
17 meets the conditions otherwise applicable to hospitals
18 under subsection (e) and section 1866.
19 "(5) Nothing in this subsection shall be construed as
20 prohibiting a rural community hospital participating in
21 the demonstration program under section 410A of the
22 Medicare Prescription Drug, Improvement, and Mod-
23 ernization Act of 2003 (Public Law 108–173; 117 Stat.
24 2313) from qualifying as a rural community hospital if
25 the rural community hospital meets the conditions other-

1 wise applicable to hospitals under subsection (e) and sec-
2 tion 1866.''.

3 (b) PAYMENT.—

4 (1) INPATIENT HOSPITAL SERVICES.—Section
5 1814 of the Social Security Act (42 U.S.C. 1395f)
6 is amended by adding at the end the following new
7 subsection:

8 ''Payment for Inpatient Services Furnished in Rural
9 Community Hospitals

10 ''(m) The amount of payment under this part for in-
11 patient hospital services furnished in a rural community
12 hospital, other than such services furnished in a psy-
13 chiatric or rehabilitation unit of the hospital which is a
14 distinct part, is, at the election of the hospital in the appli-
15 cation referred to in section 1861(jjj)(1)(E)—

16 ''(1) 101 percent of the reasonable costs of pro-
17 viding such services, without regard to the amount
18 of the customary or other charge, or

19 ''(2) the amount of payment provided for under
20 the prospective payment system for inpatient hos-
21 pital services under section 1886(d).''.

22 (2) OUTPATIENT SERVICES.—Section 1834 of
23 such Act (42 U.S.C. 1395m) is amended by adding
24 at the end the following new subsection:

1 "(p) PAYMENT FOR OUTPATIENT SERVICES FUR-
2 NISHED IN RURAL COMMUNITY HOSPITALS.—The
3 amount of payment under this part for outpatient services
4 furnished in a rural community hospital is, at the election
5 of the hospital in the application referred to in section
6 1861(jjj)(1)(E)—
7 "(1) 101 percent of the reasonable costs of pro-
8 viding such services, without regard to the amount
9 of the customary or other charge and any limitation
10 under section 1861(v)(1)(U), or
11 "(2) the amount of payment provided for under
12 the prospective payment system for covered OPD
13 services under section 1833(t).".
14 (3) EXEMPTION FROM REDUCTION IN REIM-
15 BURSEMENT FOR BAD DEBT.—Section 1861(v)(1) of
16 such Act (42 U.S.C. 1395x(v)(1)) is amended—
17 (A) in subparagraph (T), in the matter
18 preceding clause (i), by inserting "(other than
19 for a rural community hospital)" after "In de-
20 termining such reasonable costs for hospitals";
21 and
22 (B) in subparagraph (W)(ii), as added by
23 section 3201(c) of the Middle Class Tax Relief
24 and Job Creation Act of 2012 (Public Law

1 112–96), by inserting "(other than a rural com-
2 munity hospital)" after "(V)".
3 (c) BENEFICIARY COPAYMENT FOR OUTPATIENT
4 SERVICES.—Section 1834(p) of such Act (as added by
5 subsection (b)(2)) is amended—
6 (1) by redesignating paragraphs (1) and (2) as
7 subparagraphs (A) and (B), respectively;
8 (2) by inserting "(1)" after "(p)"; and
9 (3) by adding at the end the following:
10 "(2) The amounts of beneficiary cost sharing for out-
11 patient services furnished in a rural community hospital
12 under this part shall be as follows:
13 "(A) For items and services that would have
14 been paid under section 1833(t) if provided by a
15 hospital, the amount of copayment determined under
16 paragraph (8) of such section.
17 "(B) For items and services that would have
18 been paid under section 1833(h) if furnished by a
19 provider or supplier, no copayment shall apply.
20 "(C) For all other items and services, the
21 amount of copayment that would apply to the item
22 or service under the methodology that would be used
23 to determine payment for such item or service if pro-
24 vided by a physician, provider, or supplier, as the
25 case may be.".

1 (d) CONFORMING AMENDMENTS.—
2 (1) PART A PAYMENT.—Section 1814(b) of
3 such Act (42 U.S.C. 1395f(b)) is amended in the
4 matter preceding paragraph (1) by inserting "other
5 than inpatient hospital services furnished by a rural
6 community hospital," after "critical access hospital
7 services,".
8 (2) PART B PAYMENT.—Section 1833(a) of
9 such Act (42 U.S.C. 1395l(a)), as amended by sec-
10 tion 203(b)(2), is amended—
11 (A) in paragraph (2), in the matter before
12 subparagraph (A), by striking "and (I)" and in-
13 serting "(I), and (K)";
14 (B) by striking "and" at the end of para-
15 graph (9);
16 (C) by striking the period at the end of
17 paragraph (10) and inserting "; and"; and
18 (D) by adding at the end the following:
19 "(11) in the case of outpatient services fur-
20 nished by a rural community hospital, the amounts
21 described in section 1834(p).".
22 (3) TECHNICAL AMENDMENTS.—
23 (A) CONSULTATION WITH STATE AGEN-
24 CIES.—Section 1863 of such Act (42 U.S.C.

1 1395z) is amended by striking "and (dd)(2)"
2 and inserting "(dd)(2), (mm)(1), and (jjj)(1)".
3 (B) PROVIDER AGREEMENTS.—Section
4 1866(a)(2)(A) of such Act (42 U.S.C.
5 1395cc(a)(2)(A)) is amended by inserting "sec-
6 tion 1834(p)(2)," after "section 1833(b),".
7 (e) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to items and services furnished on
9 or after October 1, 2012.

10 **SEC. 424. MEDICARE REMOTE MONITORING PILOT**
11 **PROJECTS.**

12 (a) PILOT PROJECTS.—
13 (1) IN GENERAL.—Not later than 9 months
14 after the date of enactment of this Act, the Sec-
15 retary of Health and Human Services (in this sec-
16 tion referred to as the "Secretary") shall conduct
17 pilot projects under title XVIII of the Social Secu-
18 rity Act for the purpose of providing incentives to
19 home health agencies to utilize home monitoring and
20 communications technologies that—
21 (A) enhance health outcomes for Medicare
22 beneficiaries; and
23 (B) reduce expenditures under such title.
24 (2) SITE REQUIREMENTS.—

1 (A) URBAN AND RURAL.—The Secretary
2 shall conduct the pilot projects under this sec-
3 tion in both urban and rural areas.
4 (B) SITE IN A SMALL STATE.—The Sec-
5 retary shall conduct at least 3 of the pilot
6 projects in a State with a population of less
7 than 1,000,000.
8 (3) DEFINITION OF HOME HEALTH AGENCY.—
9 In this section, the term ''home health agency'' has
10 the meaning given that term in section 1861(o) of
11 the Social Security Act (42 U.S.C. 1395x(o)).
12 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
13 OF PROJECTS.—The Secretary shall specify the criteria
14 for identifying those Medicare beneficiaries who shall be
15 considered within the scope of the pilot projects under this
16 section for purposes of the application of subsection (c)
17 and for the assessment of the effectiveness of the home
18 health agency in achieving the objectives of this section.
19 Such criteria may provide for the inclusion in the projects
20 of Medicare beneficiaries who begin receiving home health
21 services under title XVIII of the Social Security Act after
22 the date of the implementation of the projects.
23 (c) INCENTIVES.—
24 (1) PERFORMANCE TARGETS.—The Secretary
25 shall establish for each home health agency partici-

1 pating in a pilot project under this section a per-
2 formance target using one of the following meth-
3 odologies, as determined appropriate by the Sec-
4 retary:
5 (A) ADJUSTED HISTORICAL PERFORMANCE
6 TARGET.—The Secretary shall establish for the
7 agency—
8 (i) a base expenditure amount equal
9 to the average total payments made to the
10 agency under parts A and B of title XVIII
11 of the Social Security Act for Medicare
12 beneficiaries determined to be within the
13 scope of the pilot project in a base period
14 determined by the Secretary; and
15 (ii) an annual per capita expenditure
16 target for such beneficiaries, reflecting the
17 base expenditure amount adjusted for risk
18 and adjusted growth rates.
19 (B) COMPARATIVE PERFORMANCE TAR-
20 GET.—The Secretary shall establish for the
21 agency a comparative performance target equal
22 to the average total payments under such parts
23 A and B during the pilot project for comparable
24 individuals in the same geographic area that

1 are not determined to be within the scope of the
2 pilot project.
3 (2) INCENTIVE.—Subject to paragraph (3), the
4 Secretary shall pay to each participating home care
5 agency an incentive payment for each year under the
6 pilot project equal to a portion of the Medicare sav-
7 ings realized for such year relative to the perform-
8 ance target under paragraph (1).
9 (3) LIMITATION ON EXPENDITURES.—The Sec-
10 retary shall limit incentive payments under this sec-
11 tion in order to ensure that the aggregate expendi-
12 tures under title XVIII of the Social Security Act
13 (including incentive payments under this subsection)
14 do not exceed the amount that the Secretary esti-
15 mates would have been expended if the pilot projects
16 under this section had not been implemented.
17 (d) WAIVER AUTHORITY.—The Secretary may waive
18 such provisions of titles XI and XVIII of the Social Secu-
19 rity Act as the Secretary determines to be appropriate for
20 the conduct of the pilot projects under this section.
21 (e) REPORT TO CONGRESS.—Not later than 5 years
22 after the date that the first pilot project under this section
23 is implemented, the Secretary shall submit to Congress a
24 report on the pilot projects. Such report shall contain a
25 detailed description of issues related to the expansion of

1 the projects under subsection (f) and recommendations for
2 such legislation and administrative actions as the Sec-
3 retary considers appropriate.

4 (f) EXPANSION.—If the Secretary determines that
5 any of the pilot projects under this section enhance health
6 outcomes for Medicare beneficiaries and reduce expendi-
7 tures under title XVIII of the Social Security Act, the Sec-
8 retary may initiate comparable projects in additional
9 areas.

10 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
11 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
12 tive payment under this section—

13 (1) shall be in addition to the payments that a
14 home health agency would otherwise receive under
15 title XVIII of the Social Security Act for the provi-
16 sion of home health services; and

17 (2) shall have no effect on the amount of such
18 payments.

19 **SEC. 425. RURAL HEALTH QUALITY ADVISORY COMMISSION**
20 **AND DEMONSTRATION PROJECTS.**

21 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
22 SION.—

23 (1) ESTABLISHMENT.—Not later than 6
24 months after the date of the enactment of this sec-
25 tion, the Secretary of Health and Human Services

1 (in this section referred to as the ''Secretary'') shall
2 establish a commission to be known as the Rural
3 Health Quality Advisory Commission (in this section
4 referred to as the ''Commission'').
5 (2) DUTIES OF COMMISSION.—
6 (A) NATIONAL PLAN.—The Commission
7 shall develop, coordinate, and facilitate imple-
8 mentation of a national plan for rural health
9 quality improvement. The national plan shall—
10 (i) identify objectives for rural health
11 quality improvement;
12 (ii) identify strategies to eliminate
13 known gaps in rural health system capacity
14 and improve rural health quality; and
15 (iii) provide for Federal programs to
16 identify opportunities for strengthening
17 and aligning policies and programs to im-
18 prove rural health quality.
19 (B) DEMONSTRATION PROJECTS.—The
20 Commission shall design demonstration projects
21 to test alternative models for rural health qual-
22 ity improvement, including with respect to both
23 personal and population health.

1 (C) MONITORING.—The Commission shall
2 monitor progress toward the objectives identi-
3 fied pursuant to paragraph (1)(A).
4 (3) MEMBERSHIP.—
5 (A) NUMBER.—The Commission shall be
6 composed of 11 members appointed by the Sec-
7 retary.
8 (B) SELECTION.—The Secretary shall se-
9 lect the members of the Commission from
10 among individuals with significant rural health
11 care and health care quality expertise, including
12 expertise in clinical health care, health care
13 quality research, population or public health, or
14 purchaser organizations.
15 (4) CONTRACTING AUTHORITY.—Subject to the
16 availability of funds, the Commission may enter into
17 contracts and make other arrangements, as may be
18 necessary to carry out the duties described in para-
19 graph (2).
20 (5) STAFF.—Upon the request of the Commis-
21 sion, the Secretary may detail, on a reimbursable
22 basis, any of the personnel of the Office of Rural
23 Health Policy of the Health Resources and Services
24 Administration, the Agency for Health care Quality
25 and Research, or the Centers for Medicare & Med-

1 icaid Services to the Commission to assist in car-
2 rying out this subsection.
3 (6) REPORTS TO CONGRESS.—Not later than 1
4 year after the establishment of the Commission, and
5 annually thereafter, the Commission shall submit a
6 report to the Congress on rural health quality. Each
7 such report shall include the following:
8 (A) An inventory of relevant programs and
9 recommendations for improved coordination and
10 integration of policy and programs.
11 (B) An assessment of achievement of the
12 objectives identified in the national plan devel-
13 oped under paragraph (2) and recommenda-
14 tions for realizing such objectives.
15 (C) Recommendations on Federal legisla-
16 tion, regulations, or administrative policies to
17 enhance rural health quality and outcomes.
18 (b) RURAL HEALTH QUALITY DEMONSTRATION
19 PROJECTS.—
20 (1) IN GENERAL.—Not later than 270 days
21 after the date of the enactment of this section, the
22 Secretary, in consultation with the Rural Health
23 Quality Advisory Commission, the Office of Rural
24 Health Policy of the Health Resources and Services
25 Administration, the Agency for Healthcare Research

1 and Quality, and the Centers for Medicare & Med-
2 icaid Services, shall make grants to eligible entities
3 for 5 demonstration projects to implement and
4 evaluate methods for improving the quality of health
5 care in rural communities. Each such demonstration
6 project shall include—
7 (A) alternative community models that—
8 (i) will achieve greater integration of
9 personal and population health services;
10 and
11 (ii) address safety, effectiveness,
12 patient- or community-centeredness, timeli-
13 ness, efficiency, and equity (the 6 aims
14 identified by the Institute of Medicine of
15 the National Academies in its report enti-
16 tled "Crossing the Quality Chasm: A New
17 Health System for the 21st Century" re-
18 leased on March 1, 2001);
19 (B) innovative approaches to the financing
20 and delivery of health services to achieve rural
21 health quality goals; and
22 (C) development of quality improvement
23 support structures to assist rural health sys-
24 tems and professionals (such as workforce sup-
25 port structures, quality monitoring and report-

1 ing, clinical care protocols, and information
2 technology applications).
3 (2) ELIGIBLE ENTITIES.—In this subsection,
4 the term ''eligible entity'' means a consortium
5 that—
6 (A) shall include—
7 (i) at least one health care provider or
8 health care delivery system located in a
9 rural area; and
10 (ii) at least one organization rep-
11 resenting multiple community stakeholders;
12 and
13 (B) may include other partners such as
14 rural research centers.
15 (3) CONSULTATION.—In developing the pro-
16 gram for awarding grants under this subsection, the
17 Secretary shall consult with the Administrator of the
18 Agency for Healthcare Research and Quality, rural
19 health care providers, rural health care researchers,
20 and private and nonprofit groups (including national
21 associations) which are undertaking similar efforts.
22 (4) EXPEDITED WAIVERS.—The Secretary shall
23 expedite the processing of any waiver that—

1 (A) is authorized under title XVIII or XIX
2 of the Social Security Act (42 U.S.C. 1395 et
3 seq.); and
4 (B) is necessary to carry out a demonstra-
5 tion project under this subsection.
6 (5) DEMONSTRATION PROJECT SITES.—The
7 Secretary shall ensure that the 5 demonstration
8 projects funded under this subsection are conducted
9 at a variety of sites representing the diversity of
10 rural communities in the Nation.
11 (6) DURATION.—Each demonstration project
12 under this subsection shall be for a period of 4
13 years.
14 (7) INDEPENDENT EVALUATION.—The Sec-
15 retary shall enter into an arrangement with an enti-
16 ty that has experience working directly with rural
17 health systems for the conduct of an independent
18 evaluation of the program carried out under this
19 subsection.
20 (8) REPORT.—Not later than 1 year after the
21 conclusion of all of the demonstration projects fund-
22 ed under this subsection, the Secretary shall submit
23 a report to the Congress on the results of such
24 projects. The report shall include—

1 (A) an evaluation of patient access to care,
2 patient outcomes, and an analysis of the cost
3 effectiveness of each such project; and
4 (B) recommendations on Federal legisla-
5 tion, regulations, or administrative policies to
6 enhance rural health quality and outcomes.

7 **SEC. 426. RURAL HEALTH CARE SERVICES.**

8 Section 330A of the Public Health Service Act (42
9 U.S.C. 254c) is amended to read as follows:

10 **''SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
11 **RURAL HEALTH NETWORK DEVELOPMENT,**
12 **DELTA RURAL DISPARITIES AND HEALTH**
13 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
14 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
15 **MENT GRANT PROGRAMS.**

16 ''(a) PURPOSE.—The purpose of this section is to
17 provide for grants—
18 ''(1) under subsection (b), to promote rural
19 health care services outreach;
20 ''(2) under subsection (c), to provide for the
21 planning and implementation of integrated health
22 care networks in rural areas;
23 ''(3) under subsection (d), to assist rural com-
24 munities in the Delta Region to reduce health dis-

1 parities and to promote and enhance health system
2 development; and
3 ''(4) under subsection (e), to provide for the
4 planning and implementation of small rural health
5 care provider quality improvement activities.
6 ''(b) RURAL HEALTH CARE SERVICES OUTREACH
7 GRANTS.—
8 ''(1) GRANTS.—The Director of the Office of
9 Rural Health Policy of the Health Resources and
10 Services Administration may award grants to eligible
11 entities to promote rural health care services out-
12 reach by expanding the delivery of health care serv-
13 ices to include new and enhanced services in rural
14 areas. The Director may award the grants for peri-
15 ods of not more than 3 years.
16 ''(2) ELIGIBILITY.—To be eligible to receive a
17 grant under this subsection for a project, an enti-
18 ty—
19 ''(A) shall be a rural public or rural non-
20 profit private entity, a facility that qualifies as
21 a rural health clinic under title XVIII of the
22 Social Security Act, a public or nonprofit entity
23 existing exclusively to provide services to mi-
24 grant and seasonal farm workers in rural areas,
25 or a tribal government whose grant-funded ac-

1 tivities will be conducted within federally recog-
2 nized tribal areas;
3 ‘‘(B) shall represent a consortium com-
4 posed of members—
5 ‘‘(i) that include 3 or more independ-
6 ently owned health care entities; and
7 ‘‘(ii) that may be nonprofit or for-
8 profit entities; and
9 ‘‘(C) shall not previously have received a
10 grant under this subsection for the same or a
11 similar project, unless the entity is proposing to
12 expand the scope of the project or the area that
13 will be served through the project.
14 ‘‘(3) APPLICATIONS.—To be eligible to receive a
15 grant under this subsection, an eligible entity shall
16 prepare and submit to the Director an application at
17 such time, in such manner, and containing such in-
18 formation as the Director may require, including—
19 ‘‘(A) a description of the project that the
20 eligible entity will carry out using the funds
21 provided under the grant;
22 ‘‘(B) a description of the manner in which
23 the project funded under the grant will meet
24 the health care needs of rural populations in
25 the local community or region to be served;

1 "(C) a plan for quantifying how health
2 care needs will be met through identification of
3 the target population and benchmarks of service
4 delivery or health status, such as—
5 "(i) quantifiable measurements of
6 health status improvement for projects fo-
7 cusing on health promotion; or
8 "(ii) benchmarks of increased access
9 to primary care (which includes obstetrical
10 and gynecological care and psychiatric and
11 mental health care), including tracking fac-
12 tors such as the number and type of pri-
13 mary care visits, identification of a medical
14 home, or other general measures of such
15 access;
16 "(D) a description of how the local com-
17 munity or region to be served will be involved
18 in the development and ongoing operations of
19 the project;
20 "(E) a plan for sustaining the project after
21 Federal support for the project has ended;
22 "(F) a description of how the project will
23 be evaluated;

1 "(G) the administrative capacity to submit
2 annual performance data electronically as speci-
3 fied by the Director; and
4 "(H) other such information as the Direc-
5 tor determines to be appropriate.
6 "(c) RURAL HEALTH NETWORK DEVELOPMENT
7 GRANTS.—
8 "(1) GRANTS.—
9 "(A) IN GENERAL.—The Director may
10 award rural health network development grants
11 to eligible entities to promote, through planning
12 and implementation, the development of inte-
13 grated health care networks that have combined
14 the functions of the entities participating in the
15 networks in order to—
16 "(i) achieve efficiencies and economies
17 of scale;
18 "(ii) expand access to, coordinate, and
19 improve the quality of the health care de-
20 livery system through development of orga-
21 nizational efficiencies;
22 "(iii) implement health information
23 technology to achieve efficiencies, reduce
24 medical errors, and improve quality;

1 "(iv) coordinate care and manage
2 chronic illness; and
3 "(v) strengthen the rural health care
4 system as a whole in such a manner as to
5 show a quantifiable return on investment
6 to the participants in the network.
7 "(B) GRANT PERIODS.—The Director may
8 award such a rural health network development
9 grant—
10 "(i) for a period of 3 years for imple-
11 mentation activities; or
12 "(ii) for a period of 1 year for plan-
13 ning activities to assist in the initial devel-
14 opment of an integrated health care net-
15 work, if the proposed participants in the
16 network do not have a history of collabo-
17 rative efforts and a 3-year grant would be
18 inappropriate.
19 "(2) ELIGIBILITY.—To be eligible to receive a
20 grant under this subsection, an entity—
21 "(A) shall be a rural public or rural non-
22 profit private entity, a facility that qualifies as
23 a rural health clinic under title XVIII of the
24 Social Security Act, a public or nonprofit entity
25 existing exclusively to provide services to mi-

1 grant and seasonal farm workers in rural areas,
2 or a tribal government whose grant-funded ac-
3 tivities will be conducted within federally recog-
4 nized tribal areas;
5 ''(B) shall represent a network composed
6 of participants—
7 ''(i) that include 3 or more independ-
8 ently owned health care entities; and
9 ''(ii) that may be nonprofit or for-
10 profit entities; and
11 ''(C) shall not previously have received a
12 grant under this subsection (other than a 1-
13 year grant for planning activities) for the same
14 or a similar project.
15 ''(3) APPLICATIONS.—To be eligible to receive a
16 grant under this subsection, an eligible entity, in
17 consultation with the appropriate State office of
18 rural health or another appropriate State entity,
19 shall prepare and submit to the Director an applica-
20 tion at such time, in such manner, and containing
21 such information as the Director may require, in-
22 cluding—
23 ''(A) a description of the project that the
24 eligible entity will carry out using the funds
25 provided under the grant;

1 "(B) an explanation of the reasons why
2 Federal assistance is required to carry out the
3 project;
4 "(C) a description of—
5 "(i) the history of collaborative activi-
6 ties carried out by the participants in the
7 network;
8 "(ii) the degree to which the partici-
9 pants are ready to integrate their func-
10 tions; and
11 "(iii) how the local community or re-
12 gion to be served will benefit from and be
13 involved in the activities carried out by the
14 network;
15 "(D) a description of how the local com-
16 munity or region to be served will experience in-
17 creased access to quality health care services
18 across the continuum of care as a result of the
19 integration activities carried out by the net-
20 work, including a description of—
21 "(i) return on investment for the com-
22 munity and the network members; and
23 "(ii) other quantifiable performance
24 measures that show the benefit of the net-
25 work activities;

1 "(E) a plan for sustaining the project after
2 Federal support for the project has ended;
3 "(F) a description of how the project will
4 be evaluated;
5 "(G) the administrative capacity to submit
6 annual performance data electronically as speci-
7 fied by the Director; and
8 "(H) other such information as the Direc-
9 tor determines to be appropriate.
10 "(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
11 TEMS DEVELOPMENT GRANTS.—
12 "(1) GRANTS.—The Director may award grants
13 to eligible entities to support reduction of health dis-
14 parities, improve access to health care, and enhance
15 rural health system development in the Delta Re-
16 gion.
17 "(2) ELIGIBILITY.—To be eligible to receive a
18 grant under this subsection, an entity shall be a
19 rural public or rural nonprofit private entity, a facil-
20 ity that qualifies as a rural health clinic under title
21 XVIII of the Social Security Act, a public or non-
22 profit entity existing exclusively to provide services
23 to migrant and seasonal farm workers in rural
24 areas, or a tribal government whose grant-funded

1 activities will be conducted within federally recog-
2 nized tribal areas.
3 ''(3) APPLICATIONS.—To be eligible to receive a
4 grant under this subsection, an eligible entity shall
5 prepare and submit to the Director an application at
6 such time, in such manner, and containing such in-
7 formation as the Director may require, including—
8 ''(A) a description of the project that the
9 eligible entity will carry out using the funds
10 provided under the grant;
11 ''(B) an explanation of the reasons why
12 Federal assistance is required to carry out the
13 project;
14 ''(C) a description of the manner in which
15 the project funded under the grant will meet
16 the health care needs of the Delta Region;
17 ''(D) a description of how the local com-
18 munity or region to be served will experience in-
19 creased access to quality health care services as
20 a result of the activities carried out by the enti-
21 ty;
22 ''(E) a description of how health dispari-
23 ties will be reduced or the health system will be
24 improved;

1 "(F) a plan for sustaining the project after
2 Federal support for the project has ended;
3 "(G) a description of how the project will
4 be evaluated including process and outcome
5 measures related to the quality of care provided
6 or how the health care system improves its per-
7 formance;
8 "(H) a description of how the grantee will
9 develop an advisory group made up of rep-
10 resentatives of the communities to be served to
11 provide guidance to the grantee to best meet
12 community need; and
13 "(I) other such information as the Director
14 determines to be appropriate.
15 "(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
16 ITY IMPROVEMENT GRANTS.—
17 "(1) GRANTS.—The Director may award grants
18 to provide for the planning and implementation of
19 small rural health care provider quality improvement
20 activities. The Director may award the grants for
21 periods of 1 to 3 years.
22 "(2) ELIGIBILITY.—To be eligible for a grant
23 under this subsection, an entity—
24 "(A) shall be—

1 "(i) a rural public or rural nonprofit
2 private health care provider or provider of
3 health care services, such as a rural health
4 clinic; or
5 "(ii) another rural provider or net-
6 work of small rural providers identified by
7 the Director as a key source of local care;
8 and
9 "(B) shall not previously have received a
10 grant under this subsection for the same or a
11 similar project.
12 "(3) PREFERENCE.—In awarding grants under
13 this subsection, the Director shall give preference to
14 facilities that qualify as rural health clinics under
15 title XVIII of the Social Security Act.
16 "(4) APPLICATIONS.—To be eligible to receive a
17 grant under this subsection, an eligible entity shall
18 prepare and submit to the Director an application at
19 such time, in such manner, and containing such in-
20 formation as the Director may require, including—
21 "(A) a description of the project that the
22 eligible entity will carry out using the funds
23 provided under the grant;

1 "(B) an explanation of the reasons why
2 Federal assistance is required to carry out the
3 project;
4 "(C) a description of the manner in which
5 the project funded under the grant will assure
6 continuous quality improvement in the provision
7 of services by the entity;
8 "(D) a description of how the local com-
9 munity or region to be served will experience in-
10 creased access to quality health care services as
11 a result of the activities carried out by the enti-
12 ty;
13 "(E) a plan for sustaining the project after
14 Federal support for the project has ended;
15 "(F) a description of how the project will
16 be evaluated including process and outcome
17 measures related to the quality of care pro-
18 vided; and
19 "(G) other such information as the Direc-
20 tor determines to be appropriate.
21 "(f) GENERAL REQUIREMENTS.—
22 "(1) PROHIBITED USES OF FUNDS.—An entity
23 that receives a grant under this section may not use
24 funds provided through the grant—
25 "(A) to build or acquire real property; or

1 ''(B) for construction.
2 ''(2) COORDINATION WITH OTHER AGENCIES.—
3 The Director shall coordinate activities carried out
4 under grant programs described in this section, to
5 the extent practicable, with Federal and State agen-
6 cies and nonprofit organizations that are operating
7 similar grant programs, to maximize the effect of
8 public dollars in funding meritorious proposals.
9 ''(g) REPORT.—Not later than September 30, 2014,
10 the Secretary shall prepare and submit to the appropriate
11 committees of Congress a report on the progress and ac-
12 complishments of the grant programs described in sub-
13 sections (b), (c), (d), and (e).
14 ''(h) DEFINITIONS.—In this section:
15 ''(1) The term 'Delta Region' has the meaning
16 given to the term 'region' in section 382A of the
17 Consolidated Farm and Rural Development Act (7
18 U.S.C. 2009aa).
19 ''(2) The term 'Director' means the Director of
20 the Office of Rural Health Policy of the Health Re-
21 sources and Services Administration.''.

1 **SEC. 427. COMMUNITY HEALTH CENTER COLLABORATIVE**
2 **ACCESS EXPANSION.**

3 Section 330 of the Public Health Service Act (42
4 U.S.C. 254b) is amended by adding at the end the fol-
5 lowing:

6 "(t) MISCELLANEOUS PROVISIONS.—
7 "(1) RULE OF CONSTRUCTION WITH RESPECT
8 TO RURAL HEALTH CLINICS.—
9 "(A) IN GENERAL.—Nothing in this sec-
10 tion shall be construed to prevent a community
11 health center from contracting with a federally
12 certified rural health clinic (as defined by sec-
13 tion 1861(aa)(2) of the Social Security Act) for
14 the delivery of primary health care services that
15 are available at the rural health clinic to indi-
16 viduals who would otherwise be eligible for free
17 or reduced cost care if that individual were able
18 to obtain that care at the community health
19 center. Such services may be limited in scope to
20 those primary health care services available in
21 that rural health clinic.
22 "(B) ASSURANCES.—In order for a rural
23 health clinic to receive funds under this section
24 through a contract with a community health
25 center under paragraph (1), such rural health
26 clinic shall establish policies to ensure—

1 "(i) nondiscrimination based upon the
2 ability of a patient to pay; and
3 "(ii) the establishment of a sliding fee
4 scale for low-income patients.".

5 **SEC. 428. FACILITATING THE PROVISION OF TELEHEALTH**
6 **SERVICES ACROSS STATE LINES.**

7 (a) IN GENERAL.—For purposes of expediting the
8 provision of telehealth services, for which payment is made
9 under the Medicare program, across State lines, the Sec-
10 retary of Health and Human Services shall, in consulta-
11 tion with representatives of States, physicians, health care
12 practitioners, and patient advocates, encourage and facili-
13 tate the adoption of provisions allowing for multistate
14 practitioner practice across State lines.

15 (b) DEFINITIONS.—In subsection (a):

16 (1) TELEHEALTH SERVICE.—The term "tele-
17 health service" has the meaning given that term in
18 subparagraph (F) of section 1834(m)(4) of the So-
19 cial Security Act (42 U.S.C. 1395m(m)(4)).

20 (2) PHYSICIAN, PRACTITIONER.—The terms
21 "physician" and "practitioner" have the meaning
22 given those terms in subparagraphs (D) and (E), re-
23 spectively, of such section.

24 (3) MEDICARE PROGRAM.—The term "Medicare
25 program" means the program of health insurance

1 administered by the Secretary of Health and Human
2 Services under title XVIII of the Social Security Act
3 (42 U.S.C. 1395 et seq.).

4 **SEC. 429. SCORING OF PREVENTIVE HEALTH SAVINGS.**

5 Section 202 of the Congressional Budget and Im-
6 poundment Control Act of 1974 (2 U.S.C. 602) is amend-
7 ed by adding at the end the following new subsection:

8 ‘‘(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

9 ‘‘(1) DETERMINATION BY THE DIRECTOR.—
10 Upon a request by the chairman or ranking minority
11 member of the Committee on the Budget of the Sen-
12 ate, or by the chairman or ranking minority member
13 of the Committee on the Budget of the House of
14 Representatives, the Director shall determine if a
15 proposed measure would result in reductions in
16 budget outlays in budgetary outyears through the
17 use of preventive health and preventive health serv-
18 ices.

19 ‘‘(2) PROJECTIONS.—If the Director determines
20 that a measure would result in substantial reduc-
21 tions in budget outlays as described in paragraph
22 (1), the Director—

23 ‘‘(A) shall include, in any projection pre-
24 pared by the Director, a description and esti-
25 mate of the reductions in budget outlays in the

1 budgetary outyears and a description of the
2 basis for such conclusions; and
3 ''(B) may prepare a budget projection that
4 includes some or all of the budgetary outyears,
5 notwithstanding the time periods for projections
6 described in subsection (e) and sections 308,
7 402, and 424.
8 ''(3) DEFINITIONS.—As used in this sub-
9 section—
10 ''(A) the term 'preventive health' means an
11 action that focuses on the health of the public,
12 individuals, and defined populations in order to
13 protect, promote, and maintain health, wellness,
14 and functional ability, and prevent disease, dis-
15 ability, and premature death that is dem-
16 onstrated by credible and publicly available epi-
17 demiological projection models, incorporating
18 clinical trials or observational studies in hu-
19 mans, to avoid future health care costs; and
20 ''(B) the term 'budgetary outyears' means
21 the 2 consecutive 10-year periods beginning
22 with the first fiscal year that is 10 years after
23 the budget year provided for in the most re-
24 cently agreed to concurrent resolution on the
25 budget.''.

1 **SEC. 430. SENSE OF CONGRESS.**

2 It is the sense of the Congress that—

3 (1) the maintenance of effort (MOE) provisions
4 added to sections 1902 and 2105(d) of the Social
5 Security Act by sections 2001(b) and 2101(b) of the
6 Patient Protection and Affordable Care Act were
7 written to maintain the eligibility standards for the
8 Medicaid program and Children's Health Insurance
9 Program until the American Health Benefit Ex-
10 changes in the States are fully operational;

11 (2) it is imperative that the MOE provisions are
12 enforced to the strict standard intended by the Con-
13 gress;

14 (3) waiving the MOE provisions should not be
15 permitted, except in the case of a request for a waiv-
16 er that meets the explicit nonapplication require-
17 ments;

18 (4) the MOE provisions ensure the continued
19 success of the Medicaid program and CHIP and
20 were written deliberately to specifically protect vul-
21 nerable and disabled individuals, children, and senior
22 citizens, many of whom are also members of commu-
23 nities of color; and

24 (5) the MOE provisions must be strictly en-
25 forced and proposals to weaken the MOE provisions
26 must not be considered in this time of recession.

1 **SEC. 431. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
2 **TION EVIDENCING CITIZENSHIP OR NATION-**
3 **ALITY UNDER THE MEDICAID PROGRAM.**

4 (a) REPEAL.—Subsections (i)(22) and (x) of section
5 1903 of the Social Security Act (42 U.S.C. 1396b), as
6 added by section 6036 of the Deficit Reduction Act of
7 2005, are each repealed.

8 (b) CONFORMING AMENDMENTS.—

9 (1) Section 1902(a)(46)(B) of the Social Secu-
10 rity Act (42 U.S.C. 1396a(a)(46)(B)) is amended by
11 striking ''requirements of'' and all that follows
12 through ''subsection (ee);'' and inserting ''require-
13 ments of subsection (ee);''.

14 (2) Subsection (c) of section 6036 of the Deficit
15 Reduction Act of 2005 is repealed.

16 (c) EFFECTIVE DATE.—The repeals and amend-
17 ments made by this section shall take effect as if included
18 in the enactment of the Deficit Reduction Act of 2005.

19 **SEC. 432. OFFICE OF MINORITY HEALTH IN VETERANS**
20 **HEALTH ADMINISTRATION OF DEPARTMENT**
21 **OF VETERANS AFFAIRS.**

22 (a) ESTABLISHMENT AND FUNCTIONS.—Subchapter
23 I of chapter 73 of title 38, United States Code, is amended
24 by adding at the end the following new section:

1 **“§ 7309. Office of Minority Health**

2 “(a) ESTABLISHMENT.—There is established in the
3 Department within the Office of the Under Secretary for
4 Health an office to be known as the ‘Office of Minority
5 Health’ (in this section referred to as the ‘Office’).

6 “(b) HEAD.—The Director of the Office of Minority
7 Health shall be the head of the Office. The Director of
8 the Office of Minority Health shall be appointed by the
9 Under Secretary of Health from among individuals quali-
10 fied to perform the duties of the position.

11 “(c) FUNCTIONS.—The functions of the Office are as
12 follows:

13 “(1) To establish short-range and long-range
14 goals and objectives and coordinate all other activi-
15 ties within the Veterans Health Administration that
16 relate to disease prevention, health promotion, health
17 care services delivery, and health care research con-
18 cerning veterans who are members of a racial or eth-
19 nic minority group.

20 “(2) To support research, demonstrations, and
21 evaluations to test new and innovative models for
22 the discharge of activities described in paragraph
23 (1).

24 “(3) To increase knowledge and understanding
25 of health risk factors for veterans who are members
26 of a racial or ethnic minority group.

1 "(4) To develop mechanisms that support bet-
2 ter health care information dissemination, education,
3 prevention, and services delivery to veterans from
4 disadvantaged backgrounds, including veterans who
5 are members of a racial or ethnic minority group.

6 "(5) To enter into contracts or agreements with
7 appropriate public and nonprofit private entities to
8 develop and carry out programs to provide bilingual
9 or interpretive services to assist veterans who are
10 members of a racial or ethnic minority group and
11 who lack proficiency in speaking the English lan-
12 guage in accessing and receiving health care services
13 through the Veterans Health Administration.

14 "(6) To carry out programs to improve access
15 to health care services through the Veterans Health
16 Administration for veterans with limited proficiency
17 in speaking the English language, including the de-
18 velopment and evaluation of demonstration and pilot
19 projects for that purpose.

20 "(7) To advise the Under Secretary of Health
21 on matters relating to the development, implementa-
22 tion, and evaluation of health professions education
23 in decreasing disparities in health care outcomes be-
24 tween veterans who are members of a racial or eth-
25 nic minority group and other veterans, including cul-

1 tural competency as a method of eliminating such
2 health disparities.
3 "(8) To perform such other functions and du-
4 ties as the Secretary or the Under Secretary for
5 Health considers appropriate.
6 "(d) DEFINITIONS.—In this section:
7 "(1) The term 'racial or ethnic minority group'
8 means the following:
9 "(A) American Indians (including Alaska
10 Natives, Eskimos, and Aleuts).
11 "(B) Asian Americans.
12 "(C) Native Hawaiians and other Pacific
13 Islanders.
14 "(D) Blacks.
15 "(E) Hispanics.
16 "(2) The term 'Hispanic' means individuals
17 whose origin is Mexican, Puerto Rican, Cuban, Cen-
18 tral or South American, or any other Spanish-speak-
19 ing country.".
20 **SEC. 433. ACCESS FOR NATIVE AMERICANS UNDER PPACA.**
21 (a) IN GENERAL.—Title I of the Patient Protection
22 and Affordable Care Act is amended—
23 (1) in section 1311(c)(6)(D), by striking "(as
24 defined in section 4 of the Indian Health Care Im-
25 provement Act)" and inserting "(as defined in sec-

1 tion 447.50(b)(1) of title 42 of the Code of Federal
2 Regulations, as in effect on July 1, 2010)''; and
3 (2) in section 1402(d)(1), by striking ''(as de-
4 fined in section 4(d) of the Indian Self-Determina-
5 tion and Education Assistance Act (25 U.S.C.
6 450b(d)))'' and inserting (f) ''(as defined in section
7 447.50(b)(1) of title 42 of the Code of Federal Reg-
8 ulations, as in effect on July 1, 2010)''.
9 (b) INDIVIDUAL MANDATE.—In section 5000A(e)(3)
10 of the Internal Revenue Code of 1986, by striking ''(as
11 defined in section 45A(c)(6))'' and inserting ''(as defined
12 in section 447.50(b)(1) of title 42 of the Code of Federal
13 Regulations, as in effect on July 1, 2010)''.
14 **SEC. 434. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
15 **ACCESS FOR LOW-INCOME PATIENTS.**
16 (a) IN GENERAL.—Not later than January 1, 2016,
17 the Comptroller General of the United States shall—
18 (1) evaluate and examine the continued need
19 for payments to disproportionate share hospitals
20 under section 1886(d)(5)(F) of the Social Security
21 Act (42 U.S.C. 1395ww(d)(5)(F)) and section 1923
22 of such Act (42 U.S.C. 1396r-4) to ensure timely ac-
23 cess to health care services for low-income patients
24 after the expansion of coverage under the Medicaid
25 program pursuant to the Patient Protection and Af-

1 fordable Care Act (Public Law 111-148) in 2014, as
2 well as how such funding should be allocated among
3 such hospitals; and
4 (2) provide recommendations—
5 (A) to the Secretary of Health and Human
6 Services for purposes of assisting in develop-
7 ment of the methodology for reduction of pay-
8 ments to disproportionate share hospitals, as
9 required pursuant to sections 2551 and 3133 of
10 the Patient Protection and Affordable Care Act;
11 and
12 (B) to Congress for any legislative changes
13 to the payment levels provided for dispropor-
14 tionate share hospitals that are needed to en-
15 sure access to health services for low-income pa-
16 tients, as based on the number of individuals
17 without health insurance, the amount of uncom-
18 pensated care provided by such hospitals, and
19 the impact of reduced payments levels on low-
20 income communities.
21 (b) ADDITIONAL CONSIDERATIONS.—For purposes of
22 the study and recommendations described in subsection
23 (a), the Comptroller General shall take into account—

1 (1) the impact of the expansion of coverage
2 under the Medicaid program pursuant to the Patient
3 Protection and Affordable Care Act on—
4 (A) the number of individuals in the
5 United States who are without health insur-
6 ance, as well as the distribution of such individ-
7 uals in relation to areas primarily served by dis-
8 proportionate share hospitals; and
9 (B) the low-income utilization rate of such
10 hospitals and their resulting fiscal sustain-
11 ability;
12 (2) the role played by disproportionate share
13 hospitals in providing critical access to emergency,
14 inpatient, and outpatient health services, as well as
15 their location in relation to medically underserved
16 areas;
17 (3) the appropriate level and distribution of
18 payments to disproportionate share hospitals in
19 order to—
20 (A) sufficiently account for the level of un-
21 compensated care provided by such hospitals to
22 low-income patients; and
23 (B) provide timely access to health services
24 for individuals in medically underserved areas;

1 (4) the extent to which disproportionate share
2 hospitals satisfy the requirements established for
3 charitable hospital organizations under section
4 501(r) of the Internal Revenue Code of 1986 in re-
5 gard to community health needs assessments, finan-
6 cial assistance policy requirements, limitations on
7 charges, and billing and collection requirements; and
8 (5) any reports submitted by the Secretary of
9 the Treasury, in consultation with the Secretary of
10 Health and Human Services, to Congressional com-
11 mittees in regard to the costs incurred by charitable
12 hospital organizations for charity care, bad debt,
13 and non-reimbursed expenses for services provided
14 to individuals under the Medicare and Medicaid pro-
15 grams, as well as any community benefit activities
16 provided by such organizations.

17 TITLE V—IMPROVING HEALTH 18 OUTCOMES FOR WOMEN, 19 CHILDREN, AND FAMILIES

20 SEC. 501. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV- 21 IORS IN WOMEN AND CHILDREN.

22 Part P of title III of the Public Health Service Act
23 (42 U.S.C. 280g et seq.) is amended by adding at the end
24 the following:

1 **"SEC. 399V–6. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
2 **HAVIORS IN WOMEN AND CHILDREN.**

3 "(a) GRANTS AUTHORIZED.—The Secretary, in col-
4 laboration with the Administrator of the Health Resources
5 and Services Administration and other Federal officials
6 determined appropriate by the Secretary, is authorized to
7 award grants to eligible entities to promote positive health
8 behaviors for women and children in target populations,
9 especially racial and ethnic minority women and children
10 in medically underserved communities and in underserved
11 rural communities.

12 "(b) USE OF FUNDS.—Grants awarded pursuant to
13 subsection (a) may be used to support the activities of
14 community health workers, including those activities—

15 "(1) to educate and provide outreach regarding
16 enrollment in health insurance including the State
17 Children's Health Insurance Program under title
18 XXI of the Social Security Act, Medicare under title
19 XVIII of such Act, and Medicaid under title XIX of
20 such Act;

21 "(2) to educate, guide, and provide outreach in
22 a community setting regarding health problems prev-
23 alent among women and children and especially
24 among racial and ethnic minority women and chil-
25 dren;

1 ‘‘(3) to educate, guide, and provide experiential
2 learning opportunities that target behavioral risk
3 factors including—
4 ‘‘(A) poor nutrition;
5 ‘‘(B) physical inactivity;
6 ‘‘(C) being overweight or obese;
7 ‘‘(D) tobacco use;
8 ‘‘(E) alcohol and substance use;
9 ‘‘(F) injury and violence;
10 ‘‘(G) risky sexual behavior;
11 ‘‘(H) mental health problems;
12 ‘‘(I) musculoskeletal health;
13 ‘‘(J) dental and oral health problems; and
14 ‘‘(K) understanding informed consent;
15 ‘‘(4) to educate and guide regarding effective
16 strategies to promote positive health behaviors with-
17 in the family;
18 ‘‘(5) to promote community wellness and aware-
19 ness; and
20 ‘‘(6) to educate and refer target populations to
21 appropriate health care agencies and community-
22 based programs and organizations in order to in-
23 crease access to quality health care services, includ-
24 ing preventive health services.
25 ‘‘(c) APPLICATION.—

1 "(1) IN GENERAL.—Each eligible entity that
2 desires to receive a grant under subsection (a) shall
3 submit an application to the Secretary, at such time,
4 in such manner, and accompanied by such additional
5 information as the Secretary may require.
6 "(2) CONTENTS.—Each application submitted
7 pursuant to paragraph (1) shall—
8 "(A) describe the activities for which as-
9 sistance under this section is sought;
10 "(B) contain an assurance that with re-
11 spect to each community health worker pro-
12 gram receiving funds under the grant awarded,
13 such program provides training and supervision
14 to community health workers to enable such
15 workers to provide authorized program services;
16 "(C) contain an assurance that the appli-
17 cant will evaluate the effectiveness of commu-
18 nity health worker programs receiving funds
19 under the grant;
20 "(D) contain an assurance that each com-
21 munity health worker program receiving funds
22 under the grant will provide services in the cul-
23 tural context most appropriate for the individ-
24 uals served by the program;

1 "(E) contain a plan to document and dis-
2 seminate project description and results to
3 other States and organizations as identified by
4 the Secretary; and
5 "(F) describe plans to enhance the capac-
6 ity of individuals to utilize health services and
7 health-related social services under Federal,
8 State, and local programs by—
9 "(i) assisting individuals in estab-
10 lishing eligibility under the programs and
11 in receiving the services or other benefits
12 of the programs; and
13 "(ii) providing other services as the
14 Secretary determines to be appropriate,
15 that may include transportation and trans-
16 lation services.
17 "(d) PRIORITY.—In awarding grants under sub-
18 section (a), the Secretary shall give priority to those appli-
19 cants—
20 "(1) who propose to target geographic areas—
21 "(A) with a high percentage of residents
22 who are eligible for health insurance but are
23 uninsured or underinsured; and
24 "(B) with a high percentage of families for
25 whom English is not their primary language;

1 "(2) with experience in providing health or
2 health-related social services to individuals who are
3 underserved with respect to such services; and
4 "(3) with documented community activity and
5 experience with community health workers.
6 "(e) COLLABORATION WITH ACADEMIC INSTITU-
7 TIONS.—The Secretary shall encourage community health
8 worker programs receiving funds under this section to col-
9 laborate with academic institutions, including minority-
10 serving institutions. Nothing in this section shall be con-
11 strued to require such collaboration.
12 "(f) QUALITY ASSURANCE AND COST EFFECTIVE-
13 NESS.—The Secretary shall establish guidelines for assur-
14 ing the quality of the training and supervision of commu-
15 nity health workers under the programs funded under this
16 section and for assuring the cost effectiveness of such pro-
17 grams.
18 "(g) MONITORING.—The Secretary shall monitor
19 community health worker programs identified in approved
20 applications and shall determine whether such programs
21 are in compliance with the guidelines established under
22 subsection (f).
23 "(h) TECHNICAL ASSISTANCE.—The Secretary may
24 provide technical assistance to community health worker
25 programs identified in approved applications with respect

1 to planning, developing, and operating programs under the
2 grant.
3 ‘‘(i) REPORT TO CONGRESS.—
4 ‘‘(1) IN GENERAL.—Not later than 4 years
5 after the date on which the Secretary first awards
6 grants under subsection (a), the Secretary shall sub-
7 mit to Congress a report regarding the grant
8 project.
9 ‘‘(2) CONTENTS.—The report required under
10 paragraph (1) shall include the following:
11 ‘‘(A) A description of the programs for
12 which grant funds were used.
13 ‘‘(B) The number of individuals served.
14 ‘‘(C) An evaluation of—
15 ‘‘(i) the effectiveness of these pro-
16 grams;
17 ‘‘(ii) the cost of these programs; and
18 ‘‘(iii) the impact of the project on the
19 health outcomes of the community resi-
20 dents.
21 ‘‘(D) Recommendations for sustaining the
22 community health worker programs developed
23 or assisted under this section.

1 "(E) Recommendations regarding training
2 to enhance career opportunities for community
3 health workers.
4 "(j) DEFINITIONS.—In this section:
5 "(1) COMMUNITY HEALTH WORKER.—The term
6 'community health worker' means an individual who
7 promotes health or nutrition within the community
8 in which the individual resides, including by—
9 "(A) serving as a liaison between commu-
10 nities and health care agencies;
11 "(B) providing guidance and social assist-
12 ance to community residents;
13 "(C) enhancing community residents' abil-
14 ity to effectively communicate with health care
15 providers;
16 "(D) providing culturally and linguistically
17 appropriate health or nutrition education;
18 "(E) advocating for individual and commu-
19 nity health, including dental, oral, mental, and
20 environmental health, or nutrition needs; and
21 "(F) providing referral and followup serv-
22 ices.
23 "(2) COMMUNITY SETTING.—The term 'commu-
24 nity setting' means a home or a community organi-
25 zation that serves a population.

1 "(3) ELIGIBLE ENTITY.—The term 'eligible en-
2 tity' means—
3 "(A) a unit of State, territorial, local, or
4 tribal government (including a federally recog-
5 nized tribe or Alaska Native village); or
6 "(B) a community-based organization.
7 "(4) MEDICALLY UNDERSERVED COMMUNITY.—
8 The term 'medically underserved community' means
9 a community—
10 "(A) that has a substantial number of in-
11 dividuals who are members of a medically un-
12 derserved population, as defined by section
13 330(b)(3); and
14 "(B) a significant portion of which is a
15 health professional shortage area as designated
16 under section 332.
17 "(5) SUPPORT.—The term 'support' means the
18 provision of training, supervision, and materials
19 needed to effectively deliver the services described in
20 subsection (b), reimbursement for services, and
21 other benefits.
22 "(6) TARGET POPULATION.—The term 'target
23 population' means women of reproductive age, re-
24 gardless of their current childbearing status and
25 children under 21 years of age.".

1 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
2 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
3 **NANT WOMEN, AND LAWFULLY PRESENT IN-**
4 **DIVIDUALS.**
5 (a) MEDICAID.—Paragraph (4) of section 1903(v) of
6 the Social Security Act (42 U.S.C. 1396b(v)) is amended
7 to read as follows:
8 ''(4)(A) Notwithstanding sections 401(a),
9 402(b), 403, and 421 of the Personal Responsibility
10 and Work Opportunity Reconciliation Act of 1996,
11 payment shall be made under this section for care
12 and services that are furnished to aliens, including
13 those described in paragraph (1), if they otherwise
14 meet the eligibility requirements for medical assist-
15 ance under the State plan approved under this sub-
16 chapter (other than the requirement of the receipt of
17 aid or assistance under title IV, supplemental secu-
18 rity income benefits under title XVI, or a State sup-
19 plementary payment), and are—
20 ''(i) lawfully present in the United
21 States;
22 ''(ii) children under 21 years of age,
23 including any optional targeted low-income
24 child (as such term is defined in section
25 1905(u)(2)(B)); or

1 "(iii) pregnant women during preg-
2 nancy and during the 60-day period begin-
3 ning on the last day of the pregnancy.
4 "(B) No debt shall accrue under an affidavit of
5 support against any sponsor of such an alien on the
6 basis of provision of assistance to such alien under
7 this paragraph and the cost of such assistance shall
8 not be considered as an unreimbursed cost.".
9 (b) SCHIP.—Section 2107(e)(1) of the Social Secu-
10 rity Act (42 U.S.C. 1397gg(e)(1)) is amended by amend-
11 ing subparagraph (J) to read as follows:
12 "(J) Paragraph (4) of section 1903(v) (re-
13 lating to individuals who, but for sections
14 401(a), 403, and 421 of the Personal Responsi-
15 bility and Work Opportunity Reconciliation Act
16 of 1996, would be eligible for medical assistance
17 under title XXI).".
18 (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-
19 withstanding sections 401(a), 402(a), and 403(a) of the
20 Personal Responsibility and Work Opportunity Reconcili-
21 ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))
22 and section 6(f) of the Food and Nutrition Act of 2008
23 (7 U.S.C. 2015(f)), persons who are lawfully present in
24 the United States shall be not be ineligible for benefits
25 under the supplemental nutrition assistance program on

1 the basis of their immigration status or date of entry into
2 the United States.

3 (d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—
4 Section of the 421(d)(3) of the Personal Responsibility
5 and Work Opportunity Reconciliation Act of 1996 (8
6 U.S.C. 1631(d)(3)) is amended by striking ''to the extent
7 that a qualified alien is eligible under section
8 402(a)(2)(J)'' and inserting, ''to the extent that a child
9 is a member of a household under the supplemental nutri-
10 tion assistance program''.

11 (e) ENSURING PROPER SCREENING.—Section
12 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7
13 U.S.C. 2020(e)(2)(B)) is amended—

14 (1) by redesignating clauses (vi) and (vii) as
15 clauses (vii) and (viii); and

16 (2) by inserting after clause (v) the following:

17 ''(vi) shall provide a method for imple-
18 menting section 421 of the Personal Re-
19 sponsibility and Work Opportunity Rec-
20 onciliation Act of 1996 (8 U.S.C. 1631)
21 that does not require any unnecessary in-
22 formation from persons who may be ex-
23 empt from that provision;''.

1 **SEC. 503. REPEAL OF DENIAL OF BENEFITS.**

2 Section 115 of the Personal Responsibility and Work
3 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
4 is amended—
5 (1) in subsection (a) by striking paragraph (2);
6 (2) in subsection (b) by striking paragraph (2);
7 and
8 (3) in subsection (e) by striking paragraph (2).

9 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
10 **AND AWARENESS.**

11 (a) IN GENERAL.—The Secretary shall establish and
12 implement a birth defects prevention and public awareness
13 program, consisting of the activities described in sub-
14 sections (c) and (d).
15 (b) DEFINITIONS.—In this section:
16 (1) The term ''pregnancy and breastfeeding in-
17 formation services'' includes only—
18 (A) information services to provide accu-
19 rate, evidence-based, clinical information re-
20 garding maternal exposures during pregnancy
21 that may be associated with birth defects or
22 other health risks, such as exposures to medica-
23 tions, chemicals, infections, foodborne patho-
24 gens, illnesses, nutrition, or lifestyle factors;
25 (B) information services to provide accu-
26 rate, evidence-based, clinical information re-

1 garding maternal exposures during breast-
2 feeding that may be associated with health risks
3 to a breast-fed infant, such as exposures to
4 medications, chemicals, infections, foodborne
5 pathogens, illnesses, nutrition, or lifestyle fac-
6 tors;
7 (C) the provision of accurate, evidence-
8 based information weighing risks of exposures
9 during breastfeeding against the benefits of
10 breastfeeding; and
11 (D) the provision of information described
12 in subparagraph (A), (B), or (C) through coun-
13 selors, Web sites, fact sheets, telephonic or elec-
14 tronic communication, community outreach ef-
15 forts, or other appropriate means.
16 (2) The term ''Secretary'' means the Secretary
17 of Health and Human Services, acting through the
18 Director of the Centers for Disease Control and Pre-
19 vention.
20 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
21 subsection (a), the Secretary shall conduct or support a
22 nationwide media campaign to increase awareness among
23 health care providers and at-risk populations about preg-
24 nancy and breastfeeding information services.

1 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
2 INFORMATION SERVICES.—
3 (1) IN GENERAL.—In carrying out subsection
4 (a), the Secretary shall award grants to State or re-
5 gional agencies or organizations for any of the fol-
6 lowing:
7 (A) INFORMATION SERVICES.—The provi-
8 sion of, or campaigns to increase awareness
9 about, pregnancy and breastfeeding information
10 services.
11 (B) SURVEILLANCE AND RESEARCH.—The
12 conduct or support of—
13 (i) surveillance of or research on—
14 (I) maternal exposures and ma-
15 ternal health conditions that may in-
16 fluence the risk of birth defects, pre-
17 maturity, or other adverse pregnancy
18 outcomes; and
19 (II) maternal exposures that may
20 influence health risks to a breastfed
21 infant; or
22 (ii) networking to facilitate surveil-
23 lance or research described in this sub-
24 paragraph.

1 (2) PREFERENCE FOR CERTAIN STATES.—The
2 Secretary, in making any grant under this sub-
3 section, shall give preference to States, otherwise
4 equally qualified, that have or had a pregnancy and
5 breastfeeding information service in place on or after
6 January 1, 2006.
7 (3) MATCHING FUNDS.—The Secretary may
8 only award a grant under this subsection to a State
9 or regional agency or organization that agrees, with
10 respect to the costs to be incurred in carrying out
11 the grant activities, to make available (directly or
12 through donations from public or private entities)
13 non-Federal funds toward such costs in an amount
14 equal to not less than 25 percent of the amount of
15 the grant.
16 (4) COORDINATION.—The Secretary shall en-
17 sure that activities funded through a grant under
18 this subsection are coordinated, to the maximum ex-
19 tent practicable, with other birth defects prevention
20 and environmental health activities of the Federal
21 Government, including with respect to pediatric envi-
22 ronmental health specialty units and children's envi-
23 ronmental health centers.
24 (e) EVALUATION.—In furtherance of the program
25 under subsection (a), the Secretary shall provide for an

1 evaluation of pregnancy and breastfeeding information
2 services to identify efficient and effective models of—
3 (1) providing information;
4 (2) raising awareness and increasing knowledge
5 about birth defects prevention measures;
6 (3) modifying risk behaviors; or
7 (4) other outcome measures as determined ap-
8 propriate by the Secretary.

9 **SEC. 505. UNIFORM STATE MATERNAL MORTALITY REVIEW**
10 **COMMITTEES ON PREGNANCY-RELATED**
11 **DEATHS.**

12 (a) CONDITION OF RECEIPT OF PAYMENTS FROM
13 ALLOTMENT UNDER MATERNAL AND CHILD HEALTH
14 SERVICE BLOCK GRANT.—Title V of the Social Security
15 Act (42 U.S.C. 701 et seq.) is amended by adding at the
16 end the following new section:

17 **“SEC. 514. UNIFORM STATE MATERNAL MORTALITY RE-**
18 **VIEW COMMITTEES ON PREGNANCY-RE-**
19 **LATED DEATHS.**

20 ‘‘(a) GRANTS.—
21 ‘‘(1) IN GENERAL.—Notwithstanding any other
22 provision of this title, for each of fiscal years 2012
23 through 2018, in addition to payments from allot-
24 ments for States under section 502 for such year,
25 the Secretary shall, subject to paragraph (3) and in

1 accordance with the criteria established under para-
2 graph (2), award grants to States to—
3 ‘‘(A) carry out the activities described in
4 subsection (b)(1);
5 ‘‘(B) establish a State maternal mortality
6 review committee, in accordance with subsection
7 (b)(2), to carry out the activities described in
8 subsection (b)(2)(A), and to establish the proc-
9 esses described in subsection (b)(1);
10 ‘‘(C) ensure the State department of
11 health carries out the applicable activities de-
12 scribed in subsection (b)(3), with respect to
13 pregnancy-related deaths occurring within the
14 State during such fiscal year;
15 ‘‘(D) implement and use the comprehensive
16 case abstraction form developed under sub-
17 section (c), in accordance with such subsection;
18 and
19 ‘‘(E) provide for public disclosure of infor-
20 mation, in accordance with subsection (e).
21 ‘‘(2) CRITERIA.—The Secretary shall establish
22 criteria for determining eligibility for and the
23 amount of a grant awarded to a State under para-
24 graph (1). Such criteria shall provide that in the
25 case of a State that receives such a grant for a fiscal

1 year and is determined by the Secretary to have not
2 used such grant in accordance with this section,
3 such State shall not be eligible for such a grant for
4 any subsequent fiscal year.
5 "(b) PREGNANCY-RELATED DEATH REVIEW.—
6 "(1) REVIEW OF PREGNANCY-RELATED DEATH
7 AND PREGNANCY-ASSOCIATED DEATH CASES.—For
8 purposes of subsection (a), with respect to a State
9 that receives a grant under subsection (a), the fol-
10 lowing shall apply:
11 "(A) MANDATORY REPORTING OF PREG-
12 NANCY-RELATED DEATHS.—
13 "(i) IN GENERAL.—The State shall,
14 through the State maternal mortality re-
15 view committee, develop a process, sepa-
16 rate from any reporting process established
17 by the State department of health prior to
18 the date of the enactment of this section,
19 that provides for mandatory and confiden-
20 tial case reporting by individuals and enti-
21 ties described in clause (ii) of pregnancy-
22 related deaths to the State department of
23 health.
24 "(ii) INDIVIDUALS AND ENTITIES DE-
25 SCRIBED.—Individuals and entities de-

1 scribed in this clause include each of the
2 following:
3 ''(I) Health care providers.
4 ''(II) Medical examiners.
5 ''(III) Medical coroners.
6 ''(IV) Hospitals.
7 ''(V) Free-standing birth centers.
8 ''(VI) Other health care facilities.
9 ''(VII) Any other individuals re-
10 sponsible for completing death certifi-
11 cates.
12 ''(VIII) Any other appropriate in-
13 dividuals or entities specified by the
14 Secretary.
15 ''(B) VOLUNTARY REPORTING OF PREG-
16 NANCY-RELATED AND PREGNANCY-ASSOCIATED
17 DEATHS.—
18 ''(i) The State shall, through the
19 State maternal mortality review committee,
20 develop a process for and encourage, sepa-
21 rate from any reporting process established
22 by the State department of health prior to
23 the date of the enactment of this section,
24 voluntary and confidential case reporting
25 by individuals described in clause (ii) of

1 pregnancy-associated deaths to the State
2 department of health.
3 "(ii) The State shall, through the
4 State maternal mortality review committee,
5 develop a process for voluntary and con-
6 fidential reporting by family members of
7 the deceased and by other individuals on
8 possible pregnancy-related and pregnancy-
9 associated deaths to the State department
10 of health. Such process shall include—
11 "(I) making publicly available on
12 the Internet Web site of the State de-
13 partment of health a telephone num-
14 ber, Internet Web link, and email ad-
15 dress for such reporting; and
16 "(II) publicizing to local profes-
17 sional organizations, community orga-
18 nizations, and social services agencies
19 the availability of the telephone num-
20 ber, Internet Web link, and email ad-
21 dress made available under subclause
22 (I).
23 "(C) DEVELOPMENT OF CASE-FINDING.—
24 The State, through the vital statistics unit of
25 the State, shall annually identify pregnancy-re-

1 lated and pregnancy-associated deaths occur-
2 ring in such State during the year involved
3 by—
4 "(i) matching all death records, with
5 respect to such year, for women of child-
6 bearing age to live birth certificates and in-
7 fant death certificates to identify deaths of
8 women that occurred during pregnancy
9 and within one year after the end of a
10 pregnancy;
11 "(ii) identifying deaths reported dur-
12 ing such year as having an underlying or
13 contributing cause of death related to
14 pregnancy, regardless of the time that has
15 passed between the end of the pregnancy
16 and the death;
17 "(iii) collecting data from medical ex-
18 aminer and coroner reports; and
19 "(iv) any other methods the States
20 may devise to identify maternal deaths,
21 such as through review of a random sam-
22 ple of reported deaths of women of child-
23 bearing age to ascertain cases of preg-
24 nancy-related and pregnancy-associated

1 deaths that are not discernable from a re-
2 view of death certificates alone.
3 When feasible and for purposes of effectively
4 collecting and obtaining data on pregnancy-re-
5 lated and pregnancy-associated deaths, the
6 State shall adopt the most recent standardized
7 birth and death certificates, as issued by the
8 National Center for Vital Health Statistics, in-
9 cluding the recommended checkbox section for
10 pregnancy on the death certificates.
11 ‘‘(D) CASE INVESTIGATION AND DEVELOP-
12 MENT OF CASE SUMMARIES.—Following receipt
13 of reports by the State department of health
14 pursuant to subparagraph (A) or (B) and col-
15 lection by the vital statistics unit of the State
16 of possible cases of pregnancy-related and preg-
17 nancy-associated deaths pursuant to subpara-
18 graph (C), the State, through the State mater-
19 nal mortality review committee established
20 under subsection (a), shall investigate each
21 case, utilizing the case abstraction form de-
22 scribed in subsection (c), and prepare de-identi-
23 fied case summaries, which shall be reviewed by
24 the committee and included in applicable re-
25 ports. For purposes of subsection (a), under the

1 processes established under subparagraphs (A),
2 (B), and (C), a State department of health or
3 vital statistics unit of a State shall provide to
4 the State maternal mortality review committee
5 access to information collected pursuant to such
6 subparagraphs as necessary to carry out this
7 subparagraph. Data and information collected
8 for the case summary and review are for pur-
9 poses of public health activities, in accordance
10 with HIPAA privacy and security law (as de-
11 fined in section 3009(a)(2) of the Public Health
12 Service Act). Such case investigations shall in-
13 clude data and information obtained through—
14 "(i) medical examiner and autopsy re-
15 ports of the woman involved;
16 "(ii) medical records of the woman,
17 including such records related to health
18 care prior to pregnancy, prenatal and post-
19 natal care, labor and delivery care, emer-
20 gency room care, hospital discharge
21 records, and any care delivered up until
22 the time of death of the woman for pur-
23 poses of public health activities, in accord-
24 ance with HIPAA privacy and security law

1 (as defined in section 3009(a)(2) of the
2 Public Health Service Act);
3 "(iii) oral and written interviews of in-
4 dividuals directly involved in the maternal
5 care of the woman during and immediately
6 following the pregnancy of the woman, in-
7 cluding health care, mental health, and so-
8 cial service providers, as applicable;
9 "(iv) optional oral or written inter-
10 views of the family of the woman;
11 "(v) socioeconomic and other relevant
12 background information about the woman;
13 "(vi) information collected in subpara-
14 graph (C)(i); and
15 "(vii) other information on the cause
16 of death of the woman, such as social serv-
17 ices and child welfare reports.
18 "(2) STATE MATERNAL MORTALITY REVIEW
19 COMMITTEES.—
20 "(A) DUTIES.—
21 "(i) REQUIRED COMMITTEE ACTIVI-
22 TIES.—For purposes of subsection (a), a
23 maternal mortality review committee estab-
24 lished by a State pursuant to a grant
25 under such subsection shall carry out the

1 following pregnancy-related death and
2 pregnancy-associated death review activi-
3 ties and shall include all information rel-
4 evant to the death involved on the case ab-
5 straction form developed under subsection
6 (d):
7 ‘‘(I) With respect to a case of
8 pregnancy-related or pregnancy-asso-
9 ciated death of a woman, review the
10 case summaries prepared under sub-
11 paragraphs (A), (B), (C), and (D) of
12 paragraph (1).
13 ‘‘(II) Review aggregate statistical
14 reports developed by the vital statis-
15 tics unit of the State under paragraph
16 (1)(C) regarding pregnancy-related
17 and pregnancy-associated deaths to
18 identify trends, patterns, and dispari-
19 ties in adverse outcomes and address
20 medical, non-medical, and system-re-
21 lated factors that may have contrib-
22 uted to such pregnancy-related and
23 pregnancy-associated deaths and dis-
24 parities.

1 "(III) Develop recommendations,
2 based on the review of the case sum-
3 maries under paragraph (1)(D) and
4 aggregate statistical reports under
5 subclause (II), to improve maternal
6 care, social and health services, and
7 public health policy and institutions,
8 including with respect to improving
9 access to maternal care, improving the
10 availability of social services, and
11 eliminating disparities in maternal
12 care and outcomes.
13 "(ii) OPTIONAL COMMITTEE ACTIVI-
14 TIES.—For purposes of subsection (a), a
15 maternal mortality review committee estab-
16 lished by a State under such subsection
17 may present findings and recommendations
18 regarding a specific case or set of cir-
19 cumstances directly to a health care facil-
20 ity or its local or State professional organi-
21 zation for the purpose of instituting policy
22 changes, educational activities, or other-
23 wise improving the quality of care provided
24 by the facilities.

1 "(B) COMPOSITION OF MATERNAL MOR-
2 TALITY REVIEW COMMITTEES.—
3 "(i) IN GENERAL.—Each State mater-
4 nal mortality review committee established
5 pursuant to a grant under subsection (a)
6 shall be multi-disciplinary, consisting of
7 health care and social service providers,
8 public health officials, other persons with
9 professional expertise on maternal health
10 and mortality, and patient and community
11 advocates who represent those communities
12 within such State that are the most af-
13 fected by maternal mortality. Membership
14 on such a committee of a State shall be re-
15 viewed annually by the State department
16 of health to ensure that membership rep-
17 resentation requirements are being fulfilled
18 in accordance with this paragraph.
19 "(ii) REQUIRED MEMBERSHIP.—Each
20 such review committee shall include—
21 "(I) representatives from medical
22 specialities providing care to pregnant
23 and postpartum patients, including
24 obstetricians (including generalists

1 and maternal fetal medicine special-
2 ists), and family practice physicians;
3 "(II) certified nurse midwives,
4 certified midwives, and advanced prac-
5 tice nurses;
6 "(III) hospital-based nurses;
7 "(IV) representatives of the State
8 department of health maternal and
9 child health department;
10 "(V) social service providers or
11 social workers;
12 "(VI) the chief medical exam-
13 iners or designees;
14 "(VII) facility representatives,
15 such as from hospitals or free-stand-
16 ing birth centers; and
17 "(VIII) community or patient ad-
18 vocates who represent those commu-
19 nities within the State that are the
20 most affected by maternal mortality.
21 "(iii) ADDITIONAL MEMBERS.—Each
22 such review committee may also include
23 representatives from other relevant aca-
24 demic, health, social service, or policy pro-
25 fessions, or community organizations, on

1 an ongoing basis, or as needed, as deter-
2 mined beneficial by the review committee,
3 including—
4 ‘‘(I) anesthesiologists;
5 ‘‘(II) emergency physicians;
6 ‘‘(III) pathologists;
7 ‘‘(IV) epidemiologists or biostat-
8 isticians;
9 ‘‘(V) intensivists;
10 ‘‘(VI) vital statistics officers;
11 ‘‘(VII) nutritionists;
12 ‘‘(VIII) mental health profes-
13 sionals;
14 ‘‘(IX) substance abuse treatment
15 specialists;
16 ‘‘(X) representatives of relevant
17 advocacy groups;
18 ‘‘(XI) academics;
19 ‘‘(XII) representatives of bene-
20 ficiaries of the State plan under the
21 Medicaid program under title XIX;
22 ‘‘(XIII) paramedics;
23 ‘‘(XIV) lawyers;
24 ‘‘(XV) risk management special-
25 ists;

1 "(XVI) representatives of the de-
2 partments of health or public health
3 of major cities in the State involved;
4 and
5 "(XVII) policy makers.
6 "(iv) DIVERSE COMMUNITY MEMBER-
7 SHIP.—The composition of such a com-
8 mittee, with respect to a State, shall in-
9 clude—
10 "(I) representatives from diverse
11 communities, particularly those com-
12 munities within such State most se-
13 verely affected by pregnancy-related
14 deaths or pregnancy-associated deaths
15 and by a lack of access to relevant
16 maternal care services, from commu-
17 nity maternal child health organiza-
18 tions, and from minority advocacy
19 groups;
20 "(II) members, including health
21 care providers, from different geo-
22 graphic regions in the State, including
23 any rural, urban, and tribal areas;
24 and

1 "(III) health care and social serv-
2 ice providers who work in commu-
3 nities that are diverse with regard to
4 race, ethnicity, immigration status,
5 Indigenous status, and English pro-
6 ficiency.
7 "(v) MATERNAL MORTALITY REVIEW
8 STAFF.—Staff of each such review com-
9 mittee shall include—
10 "(I) vital health statisticians, ma-
11 ternal child health statisticians, or
12 epidemiologists;
13 "(II) a coordinator of the State
14 maternal mortality review committee,
15 to be designated by the State; and
16 "(III) administrative staff.
17 "(C) OPTION FOR STATES TO FORM RE-
18 GIONAL MATERNAL MORTALITY REVIEWS.—
19 States with a low rate of occurrence of preg-
20 nancy-associated or pregnancy-related deaths
21 may choose to partner with one or more neigh-
22 boring States to fulfill the activities described in
23 paragraph (1)(C). In such a case, with respect
24 to States in such a partnership, any require-
25 ment under this section relating to the report-

1 ing of information related to such activities
2 shall be deemed to be fulfilled by each such
3 State if a single such report is submitted for
4 the partnership.
5 "(3) STATE DEPARTMENT OF HEALTH ACTIVI-
6 TIES.—For purposes of subsection (a), a State de-
7 partment of health of a State receiving a grant
8 under such subsection shall—
9 "(A) in consultation with the maternal
10 mortality review committee of the State and in
11 conjunction with relevant professional organiza-
12 tions, develop a plan for ongoing health care
13 provider education, based on the findings and
14 recommendations of the committee, in order to
15 improve the quality of maternal care; and
16 "(B) take steps to widely disseminate the
17 findings and recommendations of the State ma-
18 ternal mortality review committees of the State
19 and to implement the recommendations of such
20 committee.
21 "(c) CASE ABSTRACTION FORM.—
22 "(1) DEVELOPMENT.—The Director of the Cen-
23 ters for Disease Control and Prevention shall de-
24 velop a uniform, comprehensive case abstraction
25 form and make such form available to States for

1 State maternal mortality review committees for use
2 by such committees in order to—
3 “(A) ensure that the cases and information
4 collected and reviewed by such committees can
5 be pooled for review by the Department of
6 Health and Human Services and its agencies;
7 and
8 “(B) preserve the uniformity of the infor-
9 mation and its use for Federal public health
10 purposes.
11 “(2) PERMISSIBLE STATE MODIFICATION.—
12 Each State may modify the form developed under
13 paragraph (1) for implementation and use by such
14 State or by the State maternal mortality review com-
15 mittee of such State by including on such form addi-
16 tional information to be collected, but may not alter
17 the standard questions on such form, in order to en-
18 sure that the information can be collected and re-
19 viewed centrally at the Federal level.
20 “(d) TREATMENT AS PUBLIC HEALTH AUTHORITY
21 FOR PURPOSES OF HIPAA.—For purposes of applying
22 HIPAA privacy and security law (as defined in section
23 3009(a)(2) of the Public Health Service Act), a State ma-
24 ternal mortality review committee of a State established
25 pursuant to this section to carry out activities described

1 in subsection (b)(2)(A) shall be deemed to be a public
2 health authority described in section 164.501 (and ref-
3 erenced in section 164.512(b)(1)(i)) of title 45, Code of
4 Federal Regulations (or any successor regulation), car-
5 rying out public health activities and purposes described
6 in such section 164.512(b)(1)(i) (or any such successor
7 regulation).

8 ''(e) PUBLIC DISCLOSURE OF INFORMATION.—

9 ''(1) IN GENERAL.—For fiscal year 2012 or a
10 subsequent fiscal year, each State receiving a grant
11 under this section for such year shall, subject to
12 paragraph (3), provide for the public disclosure, and
13 submission to the information clearinghouse estab-
14 lished under paragraph (2), of the information in-
15 cluded in the report of the State under section
16 506(a)(2)(F) for such year (relating to the findings
17 for such year of the State maternal mortality review
18 committee established by the State under this sec-
19 tion).

20 ''(2) INFORMATION CLEARINGHOUSE.—The
21 Secretary of Health and Human Services shall es-
22 tablish an information clearinghouse, that shall be
23 administered by the Director of the Centers for Dis-
24 ease Control and Prevention, that will maintain find-
25 ings and recommendations submitted pursuant to

1 paragraph (1) and provide such findings and rec-
2 ommendations for public review and research pur-
3 poses by State health departments, maternal mor-
4 tality review committees, and health providers and
5 institutions.
6 ‘‘(3) CONFIDENTIALITY OF INFORMATION.—In
7 no case shall any individually identifiable health in-
8 formation be provided to the public, or submitted to
9 the information clearinghouse, under paragraph (1).
10 ‘‘(f) CONFIDENTIALITY OF REVIEW COMMITTEE
11 PROCEEDINGS.—
12 ‘‘(1) IN GENERAL.—All proceedings and activi-
13 ties of a State maternal mortality review committee
14 under this section, opinions of members of such a
15 committee formed as a result of such proceedings
16 and activities, and records obtained, created, or
17 maintained pursuant to this section, including
18 records of interviews, written reports, and state-
19 ments procured by the Department of Health and
20 Human Services or by any other person, agency, or
21 organization acting jointly with the Department, in
22 connection with morbidity and mortality reviews
23 under this section, shall be confidential, and not sub-
24 ject to discovery, subpoena, or introduction into evi-
25 dence in any civil, criminal, legislative, or other pro-

1 ceeding. Such records shall not be open to public in-
2 spection.
3 "(2) TESTIMONY OF MEMBERS OF COM-
4 MITTEE.—
5 "(A) IN GENERAL.—Members of a State
6 maternal mortality review committee under this
7 section may not be questioned in any civil,
8 criminal, legislative, or other proceeding regard-
9 ing information presented in, or opinions
10 formed as a result of, a meeting or communica-
11 tion of the committee.
12 "(B) CLARIFICATION.—Nothing in this
13 subsection shall be construed to prevent a mem-
14 ber of such a committee from testifying regard-
15 ing information that was obtained independent
16 of such member's participation on the com-
17 mittee, or that is public information.
18 "(3) AVAILABILITY OF INFORMATION FOR RE-
19 SEARCH PURPOSES.—Nothing in this subsection
20 shall prohibit the publishing by such a committee or
21 the Department of Health and Human Services of
22 statistical compilations and research reports that—
23 "(A) are based on confidential information,
24 relating to morbidity and mortality review; and

1 "(B) do not contain identifying informa-
2 tion or any other information that could be
3 used to ultimately identify the individuals con-
4 cerned.
5 "(g) DEFINITIONS.—For purposes of this section:
6 "(1) The term 'pregnancy-associated death'
7 means the death of a woman while pregnant or dur-
8 ing the one-year period following the date of the end
9 of pregnancy, irrespective of the cause of such death.
10 "(2) The term 'pregnancy-related death' means
11 the death of a woman while pregnant or during the
12 one-year period following the date of the end of
13 pregnancy, irrespective of the duration or site of the
14 pregnancy, from any cause related to or aggravated
15 by the pregnancy or its management, but not from
16 any accidental or incidental cause.
17 "(3) The term 'woman of childbearing age'
18 means a woman who is at least 10 years of age and
19 not more than 54 years of age.".
20 (b) INCLUSION OF FINDINGS OF REVIEW COMMIT-
21 TEES IN REQUIRED REPORTS.—
22 (1) STATE TRIENNIAL REPORTS.—Paragraph
23 (2) of section 506(a) of such Act (42 U.S.C. 706(a))
24 is amended by inserting after subparagraph (E) the
25 following new subparagraph:

1 "(F) In the case of a State receiving a
2 grant under section 514, beginning for the first
3 fiscal year beginning after 3 years after the
4 date of establishment of the State maternal
5 mortality review committee established by the
6 State pursuant to such grant and once every 3
7 years thereafter, information containing the
8 findings and recommendations of such com-
9 mittee and information on the implementation
10 of such recommendations during the period in-
11 volved.".
12 (2) ANNUAL REPORTS TO CONGRESS.—Para-
13 graph (3) of such section is amended—
14 (A) in subparagraph (D), at the end, by
15 striking "and";
16 (B) in subparagraph (E), at the end, by
17 striking the period and inserting "; and"; and
18 (C) by adding at the end the following new
19 subparagraph:
20 "(F) For fiscal year 2012 and each subse-
21 quent fiscal year, taking into account the find-
22 ings, recommendations, and implementation in-
23 formation submitted by States pursuant to
24 paragraph (2)(F), on the status of pregnancy-
25 related deaths and pregnancy-associated deaths

1 in the United States and including rec-
2 ommendations on methods to prevent such
3 deaths in the United States.''.

4 **SEC. 506. ELIMINATING DISPARITIES IN MATERNITY**
5 **HEALTH OUTCOMES.**

6 Part B of title III of the Public Health Service Act
7 is amended by inserting after section 317V, as added, the
8 following new section:

9 **''SEC. 317W. ELIMINATING DISPARITIES IN MATERNITY**
10 **HEALTH OUTCOMES.**

11 ''(a) IN GENERAL.—The Secretary shall, in consulta-
12 tion with relevant national stakeholder organizations, such
13 as national medical specialty organizations, national ma-
14 ternal child health organizations, and national health dis-
15 parity organizations, carry out the following activities to
16 eliminate disparities in maternal health outcomes:

17 ''(1) Conduct research into the determinants
18 and the distribution of disparities in maternal care,
19 health risks, and health outcomes, and improve the
20 capacity of the performance measurement infrastruc-
21 ture to measure such disparities.

22 ''(2) Expand access to services that have been
23 demonstrated to improve the quality and outcomes
24 of maternity care for vulnerable populations.

1 "(3) Establish a demonstration project to com-
2 pare the effectiveness of interventions to reduce dis-
3 parities in maternity services and outcomes, and im-
4 plement and assess effective interventions.

5 "(b) SCOPE AND SELECTION OF STATES FOR DEM-
6 ONSTRATION PROJECT.—The demonstration project
7 under subsection (a)(3) shall be conducted in no more
8 than 8 States, which shall be selected by the Secretary
9 based on—

10 "(1) applications submitted by States, which
11 specify which regions and populations the State in-
12 volved will serve under the demonstration project;

13 "(2) criteria designed by the Secretary to en-
14 sure that, as a whole, the demonstration project is,
15 to the greatest extent possible, representative of the
16 demographic and geographic composition of commu-
17 nities most affected by disparities;

18 "(3) criteria designed by the Secretary to en-
19 sure that a variety of type of models are tested
20 through the demonstration project and that such
21 models include interventions that have an existing
22 evidence base for effectiveness; and

23 "(4) criteria designed by the Secretary to as-
24 sure that the demonstration projects and models will
25 be carried out in consultation with local and regional

1 provider organizations, such as community health
2 centers, hospital systems, and medical societies rep-
3 resenting providers of maternity services.
4 ''(c) DURATION OF DEMONSTRATION PROJECT.—
5 The demonstration project under subsection (a)(3) shall
6 begin on January 1, 2012, and end on December 31,
7 2016.
8 ''(d) GRANTS FOR EVALUATION AND MONITORING.—
9 The Secretary may make grants to States and health care
10 providers participating in the demonstration project under
11 subsection (a)(3) for the purpose of collecting data nec-
12 essary for the evaluation and monitoring of such project.
13 ''(e) REPORTS.—
14 ''(1) STATE REPORTS.—Each State that par-
15 ticipates in the demonstration project under sub-
16 section (a)(3) shall report to the Secretary, in a
17 time, form, and manner specified by the Secretary,
18 the data necessary to—
19 ''(A) monitor the—
20 ''(i) outcomes of the project;
21 ''(ii) costs of the project; and
22 ''(iii) quality of maternity care pro-
23 vided under the project; and
24 ''(B) evaluate the rationale for the selec-
25 tion of the items and services included in any

1 bundled payment made by the State under the
2 project.
3 "(2) FINAL REPORT.—Not later than December
4 31, 2017, the Secretary shall submit to Congress a
5 report on the results of the demonstration project
6 under subsection (a)(3).".

7 **SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN**
8 **UNEXPECTED INFANT DEATH AND SUDDEN**
9 **UNEXPLAINED DEATH IN CHILDHOOD.**

10 (a) ESTABLISHMENT.—The Secretary of Health and
11 Human Services acting through the Administrator of the
12 Health Resources and Services Administration and in con-
13 sultation with the Director of the Centers for Disease Con-
14 trol and Prevention and the Director of the National Insti-
15 tutes of Health (in this section referred to as the "Sec-
16 retary") shall establish and implement a culturally com-
17 petent public health awareness and education campaign
18 to provide information that is focused on decreasing the
19 risk factors for sudden unexpected infant death and sud-
20 den unexplained death in childhood, including educating
21 individuals about safe sleep environments, sleep positions,
22 and reducing exposure to smoking during pregnancy and
23 after birth.
24 (b) TARGETED POPULATIONS.—The campaign under
25 subsection (a) shall be designed to reduce health dispari-

1 ties through the targeting of populations with high rates
2 of sudden unexpected infant death and sudden unex-
3 plained death in childhood.

4 (c) CONSULTATION.—In establishing and imple-
5 menting the campaign under subsection (a), the Secretary
6 shall consult with national organizations representing
7 health care providers, including nurses and physicians,
8 parents, child care providers, children's advocacy and safe-
9 ty organizations, maternal and child health programs and
10 women's, infants, and children nutrition professionals, and
11 other individuals and groups determined necessary by the
12 Secretary for such establishment and implementation.

13 (d) GRANTS.—

14 (1) IN GENERAL.—In carrying out the cam-
15 paign under subsection (a), the Secretary shall
16 award grants to national organizations, State and
17 local health departments, and community-based or-
18 ganizations for the conduct of education and out-
19 reach programs for nurses, parents, child care pro-
20 viders, public health agencies, and community orga-
21 nizations.

22 (2) APPLICATION.—To be eligible to receive a
23 grant under paragraph (1), an entity shall submit to
24 the Secretary an application at such time, in such

1 manner, and containing such information as the Sec-
2 retary may require.

3 **SEC. 508. REDUCING TEENAGE PREGNANCIES.**

4 Title III of the Public Health Service Act (42 U.S.C.
5 241 et seq.) is amended by adding at the end the following
6 new part:

7 **"PART W—YOUTH PREGNANCY PREVENTION**
8 **PROGRAMS**

9 **"SEC. 399OO. PURPOSE.**

10 "It is the purpose of this part to develop and carry
11 out research and demonstration projects on new and exist-
12 ing program interventions to provide youth in racial or
13 ethnic minority or immigrant communities the information
14 and skills needed to reduce teenage pregnancies, build
15 healthy relationships, and improve overall health and well-
16 being.

17 **"SEC. 399OO–1. DEMONSTRATION GRANTS TO REDUCE**
18 **TEENAGE PREGNANCIES.**

19 "(a) IN GENERAL.—The Secretary shall award com-
20 petitive grants to eligible entities for establishing or ex-
21 panding programs to provide youth in racial or ethnic mi-
22 nority or immigrant communities the information and
23 skills needed to avoid teenage pregnancy and develop
24 healthy relationships.

1 "(b) PRIORITY.—In awarding grants under this sec-
2 tion, the Secretary shall give priority to applicants—
3 "(1) proposing to carry out projects in racial or
4 ethnic minority or immigrant communities;
5 "(2) that have a demonstrated history of effec-
6 tively working with such targeted communities; or
7 "(3) that have a demonstrated history of engag-
8 ing in a meaningful and significant partnership with
9 such targeted communities.
10 "(c) PROGRAM SETTINGS.—Programs funded
11 through a grant under subsection (a) shall be provided—
12 "(1) through classroom-based settings, such as
13 school health education, humanities, language arts,
14 or family and consumer science education; after-
15 school programs; community-based programs; work-
16 force development programs; and health care set-
17 tings; or
18 "(2) in collaboration with systems that serve
19 large numbers of at-risk youth such as juvenile jus-
20 tice or foster care systems.
21 "(d) PROJECT REQUIREMENTS.—As a condition of
22 receipt of a grant under this section, an entity shall agree
23 that, with respect to information and skills provided
24 through the grant—
25 "(1) such information and skills will be—

1 "(A) age-appropriate;
2 "(B) evidence-based or evidence-informed;
3 "(C) provided in accordance with section
4 399OO–5(b); and
5 "(D) culturally sensitive and relevant to
6 the target populations; and
7 "(2) any information provided about contracep-
8 tives shall include the health benefits and side ef-
9 fects of all contraceptives and barrier methods.
10 "(e) EVALUATION.—Of the total amount made avail-
11 able to carry out this section for a fiscal year, the Sec-
12 retary, acting through the Director of the Centers for Dis-
13 ease Control and Prevention and other agencies as appro-
14 priate, shall allot up to 10 percent of such amount to carry
15 out a rigorous, independent evaluation to determine the
16 extent and the effectiveness of activities funded through
17 this section during such fiscal year in changing attitudes
18 and behavior of teenagers with respect to healthy relation-
19 ships and childbearing.
20 "(f) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGA-
21 NIZATIONS.—Of the total amount made available to carry
22 out this section for a fiscal year, the Secretary shall re-
23 serve 5 percent of such amount to award grants under
24 this section to Indian tribes and tribal organizations in
25 such manner, and subject to such requirements, as the

1 Secretary, in consultation with Indian tribes and tribal or-
2 ganizations, determines appropriate.
3 ''(g) ELIGIBLE ENTITY DEFINED.—
4 ''(1) IN GENERAL.—In this section, the term
5 'eligible entity' means a State, local, or tribal agen-
6 cy; a school or postsecondary institution; an after-
7 school program; a nonprofit organization; or a com-
8 munity or faith-based organization.
9 ''(2) PREVENTING EXCLUSION OF SMALLER
10 COMMUNITY-BASED ORGANIZATIONS.—In carrying
11 out this section, the Secretary shall ensure that the
12 amounts and requirements of grants provided under
13 this section do not preclude receipt of such grants
14 by community-based organizations with a dem-
15 onstrated history of effectively working with adoles-
16 cents in racial or ethnic minority or immigrant com-
17 munities or engaged in meaningful and significant
18 partnership with such communities.
19 **''SEC. 399OO–2. MULTIMEDIA CAMPAIGNS TO REDUCE**
20 **TEENAGE PREGNANCIES.**
21 ''(a) IN GENERAL.—The Secretary shall award com-
22 petitive grants to public and private entities to carry out
23 multimedia campaigns to provide public education and in-
24 crease public awareness regarding teenage pregnancy and

1 related social and emotional issues, such as violence pre-
2 vention.
3 ''(b) PRIORITY.—In awarding grants under this sec-
4 tion, the Secretary shall give priority to applicants pro-
5 posing to carry out campaigns developed for racial or eth-
6 nic minority or immigrant communities.
7 ''(c) INFORMATION TO BE PROVIDED.—As a condi-
8 tion of receipt of a grant under this section, an entity shall
9 agree to use the grant to carry out multimedia campaigns
10 described in subsection (a) that—
11 ''(1) at a minimum, shall provide information
12 on—
13 ''(A) the prevention of teenage pregnancy;
14 and
15 ''(B) healthy relationship development; and
16 ''(2) may provide information on the prevention
17 of dating violence.
18 **''SEC. 399OO–3. RESEARCH ON REDUCING TEENAGE PREG-**
19 **NANCIES AND TEENAGE DATING VIOLENCE**
20 **AND IMPROVING HEALTHY RELATIONSHIPS.**
21 ''(a) IN GENERAL.—The Secretary, acting through
22 the Director of the Centers for Disease Control and Pre-
23 vention, shall make grants to public and private entities
24 to conduct, support, or coordinate research on teenage
25 pregnancy, dating violence, and healthy relationships

1 among racial or ethnic minority or immigrant communities
2 that—
3 "(1) improves data collection on—
4 "(A) sexual and reproductive health, in-
5 cluding teenage pregnancies and births, among
6 all minority communities and subpopulations in
7 which such data are not collected, including
8 American Indian and Alaska Native youth;
9 "(B) sexual behavior, reproductive and sex-
10 ual coercion, and teenage contraceptive use pat-
11 terns at the State level, as appropriate; and
12 "(C) teenage pregnancies among youth in
13 and aging out of foster care or juvenile justice
14 systems and the underlying factors that lead to
15 teenage pregnancy among youth in foster care
16 or juvenile justice systems;
17 "(2) investigates—
18 "(A) the variance in the rates of teenage
19 pregnancy by—
20 "(i) racial and ethnic group (such as
21 Hispanic, Asian-American, African-Amer-
22 ican, Pacific Islander, American Indian,
23 and Alaska Native); and

1 "(ii) socioeconomic status, including
2 as based on the income of the family and
3 education attainment;
4 "(B) factors affecting the risk for youth of
5 teenage pregnancy or dating abuse, including
6 the physical and social environment, level of ac-
7 culturation, access to health care, aspirations
8 for the future, and history of physical or sexual
9 violence or abuse;
10 "(C) the role that violence and abuse play
11 in teenage sex, pregnancy, and childbearing;
12 "(D) strategies to address the dispropor-
13 tionate rates of teenage pregnancies and dating
14 violence in racial or ethnic minority or immi-
15 grant communities;
16 "(E) how effective interventions can be
17 replicated or adapted in other settings to serve
18 racial or ethnic minority or immigrant commu-
19 nities; and
20 "(F) the effectiveness of media campaigns
21 in addressing healthy relationship development,
22 dating violence prevention, and teenage preg-
23 nancy; and
24 "(3) tests research-based strategies for address-
25 ing high rates of unintended teenage pregnancy

through programs that emphasize healthy relationships and violence prevention.

"(b) PRIORITY.—In carrying out this section, the Secretary shall give priority to research that incorporates—

"(1) interdisciplinary approaches;

"(2) a strong emphasis on community-based participatory research; or

"(3) translational research.

"SEC. 399OO–4. HHS ADOLESCENT HEALTH WORK GROUP.

"(a) PURPOSE.—Not later than 30 days after the date of the enactment of this part, the Secretary shall direct the interagency adolescent health workgroup within the Office of Adolescent Health of the Department of Health and Human Services to—

"(1) include in the work of the group strategies for teenage dating violence prevention and healthy teenage relationships with a particular focus among racial or ethnic minority or immigrant communities; and

"(2) with respect to including such strategies, consult, to the greatest extent possible, with the Federal Interagency Workgroup on Teen Dating Violence formed under the leadership of the National Institute of Justice of the Department of Justice.

1 “(b) REPORT REQUIREMENT.—The Secretary,
2 through the Office of Adolescent Health, shall periodically
3 submit to Congress a report that—
4 “(1) includes a review of the evidence-based
5 programs on preventing teenage pregnancy, which
6 are carried out and identified by the Office; and
7 “(2) identifies the programs of the Department
8 of Health and Human Services that include teenage
9 dating violence prevention and the promotion of
10 healthy teenage relationships as part of a strategy to
11 prevent teenage pregnancy.

12 **“SEC. 399OO–5. GENERAL GRANT PROVISIONS.**

13 “(a) APPLICATIONS.—To seek a grant under this
14 part, an entity shall submit an application to the Secretary
15 in such form, in such manner, and containing such agree-
16 ments, assurances, and information as the Secretary may
17 require.
18 “(b) ADDITIONAL REQUIREMENTS.—A grant may be
19 made under this part only if the applicant involved agrees
20 that information, activities, and services provided under
21 the grant—
22 “(1) will be evidence-based or evidence in-
23 formed;
24 “(2) will be factually and medically accurate
25 and complete; and

1 "(3) if directed to a particular population
2 group, will be provided in an appropriate language
3 and cultural context.
4 "(c) TRAINING AND TECHNICAL ASSISTANCE.—
5 "(1) IN GENERAL.—Of the total amount made
6 available to carry out this part for a fiscal year, the
7 Secretary shall use 10 percent to provide, directly or
8 through a competitive grant process, training and
9 technical assistance to the grant recipients under
10 this part, including by disseminating research and
11 information regarding effective and promising prac-
12 tices, providing consultation and resources on a
13 broad array of teenage and unintended pregnancy
14 and violence prevention strategies, and developing
15 resources and materials.
16 "(2) COLLABORATION.—In carrying out this
17 subsection, the Secretary shall collaborate with enti-
18 ties that have expertise in the prevention of teenage
19 pregnancy, healthy relationship development, minor-
20 ity health and health disparities, and violence pre-
21 vention.
22 **"SEC. 399OO–6. DEFINITIONS.**
23 "In this part:
24 "(1) MEDICALLY ACCURATE AND COMPLETE.—
25 The term 'medically accurate and complete' means,

1 with respect to information, activities, or services,
2 verified or supported by the weight of research con-
3 ducted in compliance with accepted scientific meth-
4 ods and—
5 ‘‘(A) published in peer-reviewed journals,
6 where applicable; or
7 ‘‘(B) comprising information that leading
8 professional organizations and agencies with
9 relevant expertise in the field recognize as accu-
10 rate, objective, and complete.
11 ‘‘(2) RACIAL OR ETHNIC MINORITY OR IMMI-
12 GRANT COMMUNITIES.—The term ‘racial or ethnic
13 minority or immigrant communities’ means commu-
14 nities with a substantial number of residents who
15 are members of racial or ethnic minority groups or
16 who are immigrants.
17 ‘‘(3) REPRODUCTIVE AND SEXUAL COERCION.—
18 The term ‘reproductive and sexual coercion’—
19 ‘‘(A) means, with respect to a person, coer-
20 cive behavior that interferes with the ability of
21 such person to control the reproductive deci-
22 sionmaking of such person, such as inten-
23 tionally exposing such person to sexually trans-
24 mitted infections; in the case such person is a
25 female, attempting to impregnate such person

1 against her will; intentionally interfering with
2 the person's birth control; or threatening or act-
3 ing violent if the person does not comply with
4 the perpetrator's wishes regarding contracep-
5 tion or the decision whether to terminate or
6 continue a pregnancy; and
7 ''(B) includes a range of behaviors that a
8 partner may use related to sexual decision-
9 making to pressure or coerce a person to have
10 sex without using physical force, such as re-
11 peatedly pressuring a partner to have sex when
12 he or she does not want to; threatening to end
13 a relationship if a person does not have sex;
14 and threatening retaliation if notified of a posi-
15 tive sexually transmitted disease test result.
16 ''(4) YOUTH.—The term 'youth' means individ-
17 uals who are 11 to 19 years of age.
18 **''SEC. 399OO–7. REPORTS.**
19 ''(a) REPORT ON USE OF FUNDS.—Not later than
20 1 year after the date of the enactment of this part, the
21 Secretary shall submit to Congress a report on the use
22 of funds provided pursuant to this part.
23 ''(b) REPORT ON IMPACT OF PROGRAMS.—Not later
24 than March 1, 2016, the Secretary shall submit to Con-

1 gress a report on the impact that the programs under this
2 part had on reducing teenage pregnancies.''.

3 **SEC. 509. GESTATIONAL DIABETES.**

4 Part B of title III of the Public Health Service Act
5 (42 U.S.C. 243 et seq.) is amended by adding after section
6 317H the following:

7 **''SEC. 317H–1. GESTATIONAL DIABETES.**

8 ''(a) UNDERSTANDING AND MONITORING GESTA-
9 TIONAL DIABETES.—

10 ''(1) IN GENERAL.—The Secretary, acting
11 through the Director of the Centers for Disease
12 Control and Prevention, in consultation with the Di-
13 abetes Mellitus Interagency Coordinating Committee
14 established under section 429 and representatives of
15 appropriate national health organizations, shall de-
16 velop a multisite gestational diabetes research
17 project within the diabetes program of the Centers
18 for Disease Control and Prevention to expand and
19 enhance surveillance data and public health research
20 on gestational diabetes.

21 ''(2) AREAS TO BE ADDRESSED.—The research
22 project developed under paragraph (1) shall ad-
23 dress—

24 ''(A) procedures to establish accurate and
25 efficient systems for the collection of gestational

1 diabetes data within each State and common-
2 wealth, territory, or possession of the United
3 States;
4 ‘‘(B) the progress of collaborative activities
5 with the National Vital Statistics System, the
6 National Center for Health Statistics, and
7 State health departments with respect to the
8 standard birth certificate, in order to improve
9 surveillance of gestational diabetes;
10 ‘‘(C) postpartum methods of tracking
11 women with gestational diabetes after delivery
12 as well as targeted interventions proven to
13 lower the incidence of type 2 diabetes in that
14 population;
15 ‘‘(D) variations in the distribution of diag-
16 nosed and undiagnosed gestational diabetes,
17 and of impaired fasting glucose tolerance and
18 impaired fasting glucose, within and among
19 groups of women; and
20 ‘‘(E) factors and culturally sensitive inter-
21 ventions that influence risks and reduce the in-
22 cidence of gestational diabetes and related com-
23 plications during childbirth, including cultural,
24 behavioral, racial, ethnic, geographic, demo-
25 graphic, socioeconomic, and genetic factors.

1 "(3) REPORT.—Not later than 2 years after the
2 date of the enactment of this section, and annually
3 thereafter, the Secretary shall generate a report on
4 the findings and recommendations of the research
5 project including prevalence of gestational diabetes
6 in the multisite area and disseminate the report to
7 the appropriate Federal and non-Federal agencies.
8 "(b) EXPANSION OF GESTATIONAL DIABETES RE-
9 SEARCH.—The Secretary shall expand and intensify public
10 health research regarding gestational diabetes. Such re-
11 search may include—
12 "(1) developing and testing novel approaches
13 for improving postpartum diabetes testing or screen-
14 ing and for preventing type 2 diabetes in women
15 with a history of gestational diabetes; and
16 "(2) conducting public health research to fur-
17 ther understanding of the epidemiologic,
18 socioenvironmental, behavioral, translation, and bio-
19 medical factors and health systems that influence
20 the risk of gestational diabetes and the development
21 of type 2 diabetes in women with a history of gesta-
22 tional diabetes.
23 "(c) DEMONSTRATION GRANTS TO LOWER THE
24 RATE OF GESTATIONAL DIABETES.—

1 "(1) IN GENERAL.—The Secretary, acting
2 through the Director of the Centers for Disease
3 Control and Prevention, shall award grants, on a
4 competitive basis, to eligible entities for demonstra-
5 tion projects that implement evidence-based inter-
6 ventions to reduce the incidence of gestational diabe-
7 tes, the recurrence of gestational diabetes in subse-
8 quent pregnancies, and the development of type 2 di-
9 abetes in women with a history of gestational diabe-
10 tes.
11 "(2) PRIORITY.—In making grants under this
12 subsection, the Secretary shall give priority to
13 projects focusing on—
14 "(A) helping women who have 1 or more
15 risk factors for developing gestational diabetes;
16 "(B) working with women with a history of
17 gestational diabetes during a previous preg-
18 nancy;
19 "(C) providing postpartum care for women
20 with gestational diabetes;
21 "(D) tracking cases where women with a
22 history of gestational diabetes developed type 2
23 diabetes;

1 "(E) educating mothers with a history of
2 gestational diabetes about the increased risk of
3 their child developing diabetes;
4 "(F) working to prevent gestational diabe-
5 tes and prevent or delay the development of
6 type 2 diabetes in women with a history of ges-
7 tational diabetes; and
8 "(G) achieving outcomes designed to assess
9 the efficacy and cost-effectiveness of interven-
10 tions that can inform decisions on long-term
11 sustainability, including third-party reimburse-
12 ment.
13 "(3) APPLICATION.—An eligible entity desiring
14 to receive a grant under this subsection shall submit
15 to the Secretary—
16 "(A) an application at such time, in such
17 manner, and containing such information as the
18 Secretary may require; and
19 "(B) a plan to—
20 "(i) lower the rate of gestational dia-
21 betes during pregnancy; or
22 "(ii) develop methods of tracking
23 women with a history of gestational diabe-
24 tes and develop effective interventions to
25 lower the incidence of the recurrence of

1 gestational diabetes in subsequent preg-
2 nancies and the development of type 2 dia-
3 betes.
4 ‘‘(4) USES OF FUNDS.—An eligible entity re-
5 ceiving a grant under this subsection shall use the
6 grant funds to carry out demonstration projects de-
7 scribed in paragraph (1), including—
8 ‘‘(A) expanding community-based health
9 promotion education, activities, and incentives
10 focused on the prevention of gestational diabe-
11 tes and development of type 2 diabetes in
12 women with a history of gestational diabetes;
13 ‘‘(B) aiding State- and tribal-based diabe-
14 tes prevention and control programs to collect,
15 analyze, disseminate, and report surveillance
16 data on women with, and at risk for, gesta-
17 tional diabetes, the recurrence of gestational di-
18 abetes in subsequent pregnancies, and, for
19 women with a history of gestational diabetes,
20 the development of type 2 diabetes; and
21 ‘‘(C) training and encouraging health care
22 providers—
23 ‘‘(i) to promote risk assessment, high-
24 quality care, and self-management for ges-
25 tational diabetes and the recurrence of ges-

1 tational diabetes in subsequent preg-
2 nancies; and
3 “(ii) to prevent the development of
4 type 2 diabetes in women with a history of
5 gestational diabetes, and its complications
6 in the practice settings of the health care
7 providers.
8 “(5) REPORT.—Not later than 4 years after the
9 date of the enactment of this section, the Secretary
10 shall prepare and submit to the Congress a report
11 concerning the results of the demonstration projects
12 conducted through the grants awarded under this
13 subsection.
14 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
15 this subsection, the term ‘eligible entity’ means a
16 nonprofit organization (such as a nonprofit academic
17 center or community health center) or a State, trib-
18 al, or local health agency.
19 “(d) POSTPARTUM FOLLOW-UP REGARDING GESTA-
20 TIONAL DIABETES.—The Secretary, acting through the
21 Director of the Centers for Disease Control and Preven-
22 tion, shall work with the State- and tribal-based diabetes
23 prevention and control programs assisted by the Centers
24 to encourage postpartum follow-up after gestational diabe-
25 tes, as medically appropriate, for the purpose of reducing

1 the incidence of gestational diabetes, the recurrence of
2 gestational diabetes in subsequent pregnancies, the devel-
3 opment of type 2 diabetes in women with a history of ges-
4 tational diabetes, and related complications.''.

5 **SEC. 510. EMERGENCY CONTRACEPTION EDUCATION AND**
6 **INFORMATION PROGRAMS.**

7 (a) EMERGENCY CONTRACEPTION PUBLIC EDU-
8 CATION PROGRAM.—

9 (1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall develop and dissemi-
12 nate to the public information on emergency contra-
13 ception.

14 (2) DISSEMINATION.—The Secretary may dis-
15 seminate information under paragraph (1) directly
16 or through arrangements with nonprofit organiza-
17 tions, consumer groups, institutions of higher edu-
18 cation, clinics, the media, and Federal, State, and
19 local agencies.

20 (3) INFORMATION.—The information dissemi-
21 nated under paragraph (1) shall include, at a min-
22 imum, a description of emergency contraception and
23 an explanation of the use, safety, efficacy, and avail-
24 ability of such contraception.

1 (b) EMERGENCY CONTRACEPTION INFORMATION
2 PROGRAM FOR HEALTH CARE PROVIDERS.—
3 (1) IN GENERAL.—The Secretary, acting
4 through the Administrator of the Health Resources
5 and Services Administration and in consultation
6 with major medical and public health organizations,
7 shall develop and disseminate to health care pro-
8 viders information on emergency contraception.
9 (2) INFORMATION.—The information dissemi-
10 nated under paragraph (1) shall include, at a min-
11 imum—
12 (A) information describing the use, safety,
13 efficacy, and availability of emergency contra-
14 ception;
15 (B) a recommendation regarding the use of
16 such contraception in appropriate cases; and
17 (C) information explaining how to obtain
18 copies of the information developed under sub-
19 section (a) for distribution to the patients of
20 the providers.
21 (c) DEFINITIONS.—In this section:
22 (1) EMERGENCY CONTRACEPTION.—The term
23 ''emergency contraception'' means a drug or device
24 (as the terms are defined in section 201 of the Fed-

eral Food, Drug, and Cosmetic Act (21 U.S.C. 321)) or a drug regimen that—

(A) is used postcoitally;

(B) prevents pregnancy primarily by preventing or delaying ovulation, and does not terminate an established pregnancy; and

(C) is approved by the Food and Drug Administration.

(2) HEALTH CARE PROVIDER.—The term "health care provider" means an individual who is licensed or certified under State law to provide health care services and who is operating within the scope of such license. Such term shall include a pharmacist.

(3) INSTITUTION OF HIGHER EDUCATION.—The term "institution of higher education" has the same meaning given such term in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

SEC. 511. SUPPORTING HEALTHY ADOLESCENT DEVELOPMENT.

(a) IN GENERAL.—The Secretary may award a grant to each eligible State to conduct programs of sex education described in subsection (b), including education on both

1 abstinence and contraception for the prevention of teenage
2 pregnancy and sexually transmitted diseases, including
3 HIV/AIDS.
4 (b) REQUIREMENTS FOR SEX EDUCATION PRO-
5 GRAMS.—A program of sex education described in this
6 subsection is a program that—
7 (1) is age appropriate and medically accurate;
8 (2) stresses the value of abstinence while not ig-
9 noring those young people who have been or are sex-
10 ually active;
11 (3) provides information about the health bene-
12 fits and side effects of contraceptive and barrier
13 methods used—
14 (A) as a means to prevent pregnancy; and
15 (B) to reduce the risk of contracting sexu-
16 ally transmitted disease, including HIV/AIDS;
17 (4) encourages family communication between
18 parent and child about sexuality;
19 (5) cultivates a respectful dialogue about sexu-
20 ality, including sexual orientation and gender iden-
21 tity, and embraces the principles of nondiscrimina-
22 tion based on sexual orientation and gender identity;
23 (6) counters the perpetuation of narrow gender
24 roles, including the sexualization of female children,
25 adolescents, and adults;

1 (7) teaches young people the skills to make re-
2 sponsible decisions about sexuality, including how to
3 avoid unwanted verbal, physical, and sexual ad-
4 vances and how to avoid making verbal, physical,
5 and sexual advances that are not wanted by the
6 other party;
7 (8) develops healthy relationships, including the
8 prevention of dating and sexual violence;
9 (9) teaches young people how alcohol and drug
10 use can affect responsible decisionmaking; and
11 (10) does not teach or promote religion.
12 (c) ADDITIONAL ACTIVITIES.—In carrying out a pro-
13 gram of sex education, a State may expend grant funds
14 awarded under subsection (a) to carry out educational and
15 motivational activities that help young people—
16 (1) gain knowledge about the physical, emo-
17 tional, biological, and hormonal changes of adoles-
18 cence and subsequent stages of human maturation;
19 (2) develop the knowledge and skills necessary
20 to ensure and protect their sexual and reproductive
21 health from unintended pregnancy and sexually
22 transmitted disease, including HIV/AIDS, through-
23 out their lifespan;

1 (3) gain knowledge about the specific involve-
2 ment and responsibility of each individual in sexual
3 decisionmaking;
4 (4) develop healthy attitudes and values about
5 adolescent growth and development, body image,
6 gender roles, racial and ethnic diversity, sexual ori-
7 entation and gender identity, and other subjects;
8 (5) develop and practice healthy life skills in-
9 cluding goal-setting, decisionmaking, negotiation,
10 communication, and stress management; and
11 (6) promote self-esteem and positive inter-
12 personal skills focusing on relationship dynamics, in-
13 cluding friendships, dating, romantic involvement,
14 marriage, and family interactions.
15 (d) MATCHING FUNDS.—The Secretary may not
16 make payments to a State under this section in an amount
17 exceeding Federal medical assistance percentage for such
18 State (as such term is defined in section 1905(b) of the
19 Social Security Act (42 U.S.C. 1396d(b))) of the costs of
20 the programs conducted by the State under this section.
21 (e) EVALUATION OF PROGRAMS.—
22 (1) IN GENERAL.—For the purpose of evalu-
23 ating the effectiveness of programs of sex education
24 carried out with a grant under this section, evalua-

1 tions shall be carried out in accordance with para-
2 graphs (2) and (3).
3 (2) NATIONAL EVALUATION.—
4 (A) METHOD.—The Secretary shall pro-
5 vide for a national evaluation of a representa-
6 tive sample of programs of sex education car-
7 ried out with grants under this section to deter-
8 mine—
9 (i) the effectiveness of such programs
10 in helping to delay the initiation of sexual
11 intercourse and other high-risk behaviors;
12 (ii) the effectiveness of such programs
13 in preventing adolescent pregnancy;
14 (iii) the effectiveness of such pro-
15 grams in preventing sexually transmitted
16 disease, including HIV/AIDS;
17 (iv) the effectiveness of such programs
18 in increasing contraceptive knowledge and
19 contraceptive behaviors when sexual inter-
20 course occurs; and
21 (v) a list of best practices based upon
22 essential programmatic components of
23 evaluated programs that have led to suc-
24 cess described in clauses (i) through (iv).

1 (B) GRANT CONDITION.—A condition for
2 the receipt of a grant to a State under this sec-
3 tion is that the State cooperate with the evalua-
4 tion under subparagraph (A).
5 (C) REPORT.—The Secretary shall submit
6 to the Congress—
7 (i) not later than the end of each fis-
8 cal year during the 5-year period beginning
9 with fiscal year 2012, an interim report on
10 the national evaluation under subpara-
11 graph (A); and
12 (ii) not later than March 31, 2017, a
13 final report providing the results of such
14 national evaluation.
15 (3) INDIVIDUAL STATE EVALUATIONS.—A con-
16 dition for the receipt of a grant under this section
17 is that the State evaluate of the programs of sex
18 education funded through such grant in accordance
19 with the following requirements:
20 (A) The evaluation will be conducted by an
21 external, independent entity.
22 (B) The purposes of the evaluation will be
23 the determination of—

1 (i) the effectiveness of such programs
2 in helping to delay the initiation of sexual
3 intercourse and other high-risk behaviors;
4 (ii) the effectiveness of such programs
5 in preventing adolescent pregnancy;
6 (iii) the effectiveness of such pro-
7 grams in preventing sexually transmitted
8 disease, including HIV/AIDS; and
9 (iv) the effectiveness of such programs
10 in increasing contraceptive and barrier
11 method knowledge and contraceptive be-
12 haviors when sexual intercourse occurs.
13 (f) LIMITATIONS ON USE OF FUNDS.—
14 (1) LIMITATIONS ON SECRETARY.—Of the
15 amounts appropriated for a fiscal year for purposes
16 of this section, the Secretary may not use more
17 than—
18 (A) 7 percent of such amounts for admin-
19 istrative expenses related to carrying out this
20 section for that fiscal year; and
21 (B) 10 percent of such amounts for the
22 national evaluation under subsection (e)(2).
23 (2) LIMITATIONS TO STATES.—Of amounts pro-
24 vided to an eligible State under this subsection, the
25 State may not use more than 10 percent of the

1 grant to conduct any evaluation under subsection
2 (e)(3).
3 (g) NONDISCRIMINATION REQUIRED.—Programs
4 funded under this section shall not discriminate on the
5 basis of sex, race, ethnicity, national origin, disability, reli-
6 gion, marital status, familial status, sexual orientation, or
7 gender identity. Nothing in this section shall be construed
8 to invalidate or limit rights, remedies, procedures, or legal
9 standards available to victims of discrimination under any
10 other Federal law or any law of a State or a political sub-
11 division of a State, including title VI of the Civil Rights
12 Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the
13 Education Amendments of 1972 (20 U.S.C. 1681 et seq.),
14 section 504 of the Rehabilitation Act of 1973 (29 U.S.C.
15 794), and the Americans with Disabilities Act of 1990 (42
16 U.S.C. 12101 et seq.).
17 (h) DEFINITIONS.—For purposes of this section:
18 (1) The term ''age appropriate'' means, with re-
19 spect to topics, messages, and teaching methods,
20 those suitable to particular ages or age groups of
21 children, adolescents, and adults, based on devel-
22 oping cognitive, emotional, and behavioral capacity
23 typical for the age or age group.
24 (2) The term ''eligible State'' means a State
25 that submits to the Secretary an application for a

1 grant under this section that is in such form, is
2 made in such manner, and contains such agree-
3 ments, assurances, and information as the Secretary
4 determines to be necessary to carry out this section.
5 (3) The term ''HIV/AIDS'' means the human
6 immunodeficiency virus, and includes acquired im-
7 mune deficiency syndrome.
8 (4) The term ''medically accurate'', with respect
9 to information, means information that is supported
10 by research, recognized as accurate and objective by
11 leading medical, psychological, psychiatric, and pub-
12 lic health organizations and agencies, and, published
13 in journals that are peer reviewed.
14 (5) The term ''State'' means the 50 States, the
15 District of Columbia, the Commonwealth of Puerto
16 Rico, the Commonwealth of the Northern Mariana
17 Islands, American Samoa, Guam, the United States
18 Virgin Islands, and any other territory or possession
19 of the United States.

20 TITLE VI—MENTAL HEALTH

21 SEC. 601. COMMUNITY MENTAL HEALTH AND ADDICTION 22 SAFETY NET EQUITY ACT.

23 (a) FEDERALLY QUALIFIED BEHAVIORAL HEALTH
24 CENTERS.—Section 1913 of the Public Health Service Act
25 (42 U.S.C. 300x–3) is amended—

1 (1) in subsection (a)(2)(A), by striking ''com-
2 munity mental health services'' and inserting ''be-
3 havioral health services (of the type offered by feder-
4 ally qualified behavioral health centers consistent
5 with subsection (c)(3))'';
6 (2) in subsection (b)—
7 (A) by striking paragraph (1) and insert-
8 ing the following:
9 ''(1) services under the plan will be provided
10 only through appropriate, qualified community pro-
11 grams (which may include federally qualified behav-
12 ioral health centers, child mental health programs,
13 psychosocial rehabilitation programs, mental health
14 peer-support programs, and mental health primary
15 consumer-directed programs); and''; and
16 (B) in paragraph (2), by striking ''commu-
17 nity mental health centers'' and inserting ''fed-
18 erally qualified behavioral health centers''; and
19 (3) by striking subsection (c) and inserting the
20 following:
21 ''(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAV-
22 IORAL HEALTH CENTERS.—
23 ''(1) IN GENERAL.—The Administrator shall
24 certify, and recertify at least every 5 years, federally

1 qualified behavioral health centers as meeting the
2 criteria specified in this subsection.
3 ‘‘(2) REGULATIONS.—Not later than 18 months
4 after the date of the enactment of this section, the
5 Administrator shall issue final regulations for certi-
6 fying nonprofit or local government centers as cen-
7 ters under paragraph (1).
8 ‘‘(3) CRITERIA.—The criteria referred to in
9 subsection (b)(2) are that the center performs each
10 of the following:
11 ‘‘(A) Provide services in locations that en-
12 sure services will be promptly available, be
13 physically accessible, provide reasonable policy
14 modifications, and be provided in a manner
15 which preserves human dignity and assures con-
16 tinuity of care.
17 ‘‘(B) Provide services in a mode of service
18 delivery appropriate for the target population.
19 ‘‘(C) Provide individuals with a choice of
20 service options where there is more than one ef-
21 ficacious treatment.
22 ‘‘(D) Employ a core staff of clinical staff
23 that is multidisciplinary and culturally and lin-
24 guistically competent.

1 "(E) Provide services, within the limits of
2 the capacities of the center, to any individual
3 residing or employed in the service area of the
4 center, regardless of the ability of the individual
5 to pay.

6 "(F) Provide, directly or through contract,
7 to the extent covered for adults in the State
8 Medicaid plan under title XIX of the Social Se-
9 curity Act and for children in accordance with
10 section 1905(r) of such Act regarding early and
11 periodic screening, diagnosis, and treatment,
12 each of the following services:

13 "(i) Screening, assessment, and diag-
14 nosis, including risk assessment.

15 "(ii) Person-centered treatment plan-
16 ning or similar processes, including risk as-
17 sessment and crisis planning.

18 "(iii) Outpatient clinic mental health
19 services, including screening, assessment,
20 diagnosis, psychotherapy, substance abuse
21 counseling, medication management, and
22 integrated treatment for mental illness and
23 substance abuse which shall be evidence-
24 based (including cognitive behavioral ther-

1 apy and other such therapies which are
2 evidence-based).
3 ''(iv) Outpatient clinic primary care
4 services (which includes obstetrical and
5 gynecological care and psychiatric and
6 mental health care), including screening
7 and monitoring of key health indicators
8 and health risk (including screening for di-
9 abetes, hypertension, and cardiovascular
10 disease and monitoring of weight, height,
11 body mass index (BMI), blood pressure,
12 blood glucose or HbA1C, and lipid profile).
13 ''(v) Crisis mental health services, in-
14 cluding 24-hour mobile crisis teams, emer-
15 gency crisis intervention services, and cri-
16 sis stabilization.
17 ''(vi) Targeted case management
18 (services to assist individuals gaining ac-
19 cess to needed medical, social, educational,
20 and other home- and community-based
21 services and applying for income security
22 and other benefits to which they may be
23 entitled).
24 ''(vii) Psychiatric rehabilitation serv-
25 ices including skills training, assertive com-

1 munity treatment, family psychoeducation,
2 disability self-management, supported em-
3 ployment, supported housing services,
4 therapeutic foster care services, and such
5 other evidence-based practices as the Sec-
6 retary may require.
7 "(viii) Peer support and counselor
8 services and family supports.
9 "(G) Maintain linkages, and where possible
10 enter into formal contracts with the following:
11 "(i) Inpatient psychiatric facilities and
12 substance abuse detoxification and residen-
13 tial programs.
14 "(ii) Adult and youth peer support
15 and counselor services.
16 "(iii) Family support services for fam-
17 ilies of children with serious mental dis-
18 orders.
19 "(iv) Other home- and community-
20 based or regional services, supports, and
21 providers, including schools, child welfare
22 agencies, juvenile and criminal justice
23 agencies and facilities, housing agencies
24 and programs, employers, and other social
25 services.

1 "(v) Onsite or offsite access to pri-
2 mary care services (which includes obstet-
3 rical and gynecological care and psychiatric
4 and mental health care).
5 "(vi) Enabling services, including out-
6 reach, transportation, and translation.
7 "(vii) Health and wellness services, in-
8 cluding services for tobacco cessation.".
9 (b) MEDICAID COVERAGE AND PAYMENT FOR FED-
10 ERALLY QUALIFIED BEHAVIORAL HEALTH CENTER
11 SERVICES.—
12 (1) PAYMENT FOR SERVICES PROVIDED BY
13 FEDERALLY QUALIFIED BEHAVIORAL HEALTH CEN-
14 TERS.—Section 1902(bb) of the Social Security Act
15 (42 U.S.C. 1396a(bb)) is amended—
16 (A) in the heading, by striking "AND
17 RURAL HEALTH CLINICS" and inserting ",
18 FEDERALLY QUALIFIED BEHAVIORAL HEALTH
19 CENTERS, AND RURAL HEALTH CLINICS";
20 (B) in paragraph (1), by inserting "(and
21 beginning with fiscal year 2012 with respect to
22 services furnished on or after January 1, 2012,
23 and each succeeding fiscal year, for services de-
24 scribed in section 1905(a)(2)(D) furnished by a

1 federally qualified behavioral health center)''
2 after ''by a rural health clinic'';
3 (C) in paragraph (2)—
4 (i) by striking the heading and insert-
5 ing ''INITIAL FISCAL YEAR'';
6 (ii) by inserting ''(or, in the case of
7 services described in section 1905(a)(2)(D)
8 furnished by a federally qualified behav-
9 ioral health center, for services furnished
10 on and after January 1, 2012, during fis-
11 cal year 2012)'' after ''January 1, 2001,
12 during fiscal year 2001'';
13 (iii) by inserting ''(or, in the case of
14 services described in section 1905(a)(2)(D)
15 furnished by a federally qualified behav-
16 ioral health center, during fiscal years
17 2010 and 2011)'' after ''1999 and 2000'';
18 and
19 (iv) by inserting ''(or, in the case of
20 services described in section 1905(a)(2)(D)
21 furnished by a federally qualified behav-
22 ioral health center, during fiscal year
23 2012)'' before the period;
24 (D) in paragraph (3)—

1 (i) in the heading, by striking "FIS-
2 CAL YEAR 2002 AND SUCCEEDING" and in-
3 serting "SUCCEEDING"; and
4 (ii) by inserting "(or, in the case of
5 services described in section 1905(a)(2)(D)
6 furnished by a federally qualified behav-
7 ioral health center, for services furnished
8 during fiscal year 2013 or a succeeding fis-
9 cal year)" after "2002 or a succeeding fis-
10 cal year";
11 (E) in paragraph (4)—
12 (i) by inserting "(or as a federally
13 qualified behavioral health center after fis-
14 cal year 2011)" after "or rural health clin-
15 ic after fiscal year 2000";
16 (ii) by striking "furnished by the cen-
17 ter or" and inserting "furnished by the
18 federally qualified health center, services
19 described in section 1905(a)(2)(D) fur-
20 nished by the federally qualified behavioral
21 health center, or";
22 (iii) in the second sentence, by strik-
23 ing "or rural health clinic" and inserting
24 ", federally qualified behavioral health cen-
25 ter, or rural health clinic";

1 (F) in paragraph (5), in each of subpara-
2 graphs (A) and (B), by striking "or rural
3 health clinic" and inserting ", federally quali-
4 fied behavioral health center, or rural health
5 clinic"; and
6 (G) in paragraph (6), by striking "or to a
7 rural health clinic" and inserting ", to a feder-
8 ally qualified behavioral health center for serv-
9 ices described in section 1905(a)(2)(D), or to a
10 rural health clinic".
11 (2) INCLUSION OF FEDERALLY QUALIFIED BE-
12 HAVIORAL HEALTH CENTER SERVICES IN THE TERM
13 MEDICAL ASSISTANCE.—Section 1905(a)(2) of the
14 Social Security Act (42 U.S.C. 1396d(a)(2)) is
15 amended—
16 (A) by striking "and" before "(C)"; and
17 (B) by inserting before the semicolon at
18 the end the following: ", and (D) federally
19 qualified behavioral health center services (as
20 defined in subsection (l)(4))".
21 (3) DEFINITION OF FEDERALLY QUALIFIED BE-
22 HAVIORAL HEALTH CENTER SERVICES.—Section
23 1905(l) of the Social Security Act (42 U.S.C.
24 1396d(l)) is amended by adding at the end the fol-
25 lowing paragraph:

1 ‘‘(4)(A) The term ‘federally qualified behavioral
2 health center services’ means services furnished to
3 an individual at a federally qualified behavioral
4 health center (as defined by subparagraph (B)).
5 ‘‘(B) The term ‘federally qualified behavioral
6 health center’ means an entity that is certified under
7 section 1913(c) of the Public Health Service Act as
8 meeting the criteria described in paragraph (3) of
9 such section.’’.
10 (c) MENTAL HEALTH AND ADDICTION SAFETY NET
11 STUDIES.—
12 (1) PAPERWORK REDUCTION STUDY.—
13 (A) IN GENERAL.—Not later than 12
14 months after the date of the enactment of this
15 Act, the Institute of Medicine shall submit to
16 the appropriate committees of Congress a re-
17 port that evaluates the combined paperwork
18 burden of federally qualified behavioral health
19 centers certified section 1913(c) of the Public
20 Health Service Act, as inserted by subsection
21 (a).
22 (B) SCOPE.—In preparing the report
23 under subparagraph (A), the Institute of Medi-
24 cine shall examine licensing, certification, serv-
25 ice definitions, claims payment, billing codes,

1 and financial auditing requirements utilized by
2 the Office of Management and Budget, the
3 Centers for Medicare & Medicaid Services, the
4 Health Resources and Services Administration,
5 the Substance Abuse and Mental Health Serv-
6 ices Administration, the Office of the Inspector
7 General, State Medicaid agencies, State depart-
8 ments of health, State departments of edu-
9 cation, and State and local juvenile justice and
10 social services agencies to—
11 (i) establish an estimate of the com-
12 bined nationwide cost of complying with
13 the requirements described in this subpara-
14 graph, in terms of both administrative
15 funding and staff time;
16 (ii) establish an estimate of the per
17 capita cost to each federally qualified be-
18 havioral health center certified under sec-
19 tion 1913(c) of the Public Health Service
20 Act to comply with the requirements de-
21 scribed in this subparagraph, in terms of
22 both administrative funding and staff time;
23 and
24 (iii) make administrative and statu-
25 tory recommendations to Congress, which

1 may include a uniform methodology, to re-
2 duce the paperwork burden experienced by
3 such federally qualified behavioral health
4 centers.
5 (2) WAGE STUDY.—
6 (A) IN GENERAL.—Not later than 12
7 months after the date of the enactment of this
8 Act, the Institute of Medicine shall conduct a
9 nationwide analysis, and submit a report to the
10 appropriate committees of Congress, concerning
11 the compensation structure of professional and
12 paraprofessional personnel employed by feder-
13 ally qualified behavioral health centers certified
14 under section 1913(c) of the Public Health
15 Service Act, as inserted by subsection (a), as
16 compared with the compensation structure of
17 comparable health safety net providers and rel-
18 evant private sector health care employers.
19 (B) SCOPE.—In preparing the report
20 under subparagraph (A), the Institute of Medi-
21 cine shall examine compensation disparities, if
22 such disparities are determined to exist, by type
23 of personnel, type of provider or private sector
24 employer, and by geographic region.

1 **SEC. 602. MINORITY FELLOWSHIP PROGRAM.**

2 Title V of the Public Health Service Act is amended
3 by inserting after section 506B of such Act (42 U.S.C.
4 290aa–5b) the following:

5 **"SEC. 506C. MINORITY FELLOWSHIP PROGRAM.**

6 "(a) FELLOWSHIPS.—The Administrator shall main-
7 tain a program, to be known as the Minority Fellowship
8 Program, under which the Administrator awards grants
9 or contracts to national associations or other appropriate
10 entities for the financial support of graduate students,
11 postdoctoral fellows, and residents in the professions of
12 psychology, psychiatry, social work, psychiatric advance-
13 practice nursing, and marriage and family therapy to stu-
14 dents who demonstrate a commitment to clinical or re-
15 search careers focused on racial and ethnic minority popu-
16 lations.

17 "(b) TERM OF FINANCIAL SUPPORT.—Financial sup-
18 port provided to an individual pursuant to subsection (a)
19 shall be for a term of not more than 12 months and may
20 be renewed thereafter.".

21 **SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION**
22 **PROGRAM.**

23 Part D of title V of the Public Health Service Act
24 (42 U.S.C. 290dd et seq.) is amended by adding at the
25 end the following:

1 **"SEC. 544. INTERPROFESSIONAL HEALTH CARE TEAMS FOR
2 PROVISION OF BEHAVIORAL HEALTH CARE
3 IN PRIMARY CARE SETTINGS.**

4 "(a) GRANTS.—The Secretary, acting through the
5 Director of the Office of Minority Health of the Adminis-
6 tration, shall award grants to eligible entities for the pur-
7 pose of providing technical assistance and training regard-
8 ing the effective development and implementation of inte-
9 grated interprofessional health care teams that provide be-
10 havioral health care.

11 "(b) ELIGIBLE ENTITIES.—To be eligible to receive
12 a grant under this section, an entity shall be a federally
13 qualified health center (as defined in section 1861(aa) of
14 the Social Security Act) serving a high proportion of indi-
15 viduals from racial and ethnic minority groups (as defined
16 in section 1707(g)).".

17 **SEC. 604. ADDRESSING RACIAL AND ETHNIC MINORITY
18 MENTAL HEALTH DISPARITIES RESEARCH
19 GAPS.**

20 Not later than 6 months after the date of the enact-
21 ment of this Act, the Director of the National Institute
22 on Minority Health and Health Disparities shall enter into
23 an arrangement with the Institute of Medicine (or, if the
24 Institute declines to enter into such an arrangement, an-
25 other appropriate entity)—

1 (1) to conduct a study with respect to mental
2 and behavioral health disparities in racial and ethnic
3 minority groups (as defined in section 1707(g) of
4 the Public Health Service Act (42 U.S.C. 300u–
5 6(g)); and
6 (2) to submit to the Congress a report on the
7 results of such study, including—
8 (A) a compilation of information on the dy-
9 namics of mental disorders in such racial and
10 ethnic minority groups;
11 (B) an identification of gaps in knowledge
12 and research needs; and
13 (C) recommendations for an interprofes-
14 sional research agenda at the National Insti-
15 tutes of Health aimed at reducing and ulti-
16 mately eliminating mental and behavioral health
17 disparities in such racial and ethnic minority
18 groups.

19 TITLE VII—ADDRESSING HIGH 20 IMPACT MINORITY DISEASES

21 Subtitle A—Cancer

22 SEC. 701. LUNG CANCER MORTALITY REDUCTION.

23 (a) SHORT TITLE.—This section may be cited as the
24 "Lung Cancer Mortality Reduction Act of 2012".

1 (b) FINDINGS.—Congress makes the following find-
2 ings:
3 (1) Lung cancer is the leading cause of cancer
4 death for both men and women, accounting for 28
5 percent of all cancer deaths.
6 (2) Lung cancer kills more people annually
7 than breast cancer, prostate cancer, colon cancer,
8 liver cancer, melanoma, and kidney cancer combined.
9 (3) Since the National Cancer Act of 1971
10 (Public Law 92–218; 85 Stat. 778), coordinated and
11 comprehensive research has raised the 5-year sur-
12 vival rates for breast cancer to 88 percent, for pros-
13 tate cancer to 99 percent, and for colon cancer to
14 64 percent.
15 (4) However, the 5-year survival rate for lung
16 cancer is still only 15 percent and a similar coordi-
17 nated and comprehensive research effort is required
18 to achieve increases in lung cancer survivability
19 rates.
20 (5) Sixty percent of lung cancer cases are now
21 diagnosed nonsmokers or former smokers.
22 (6) Two-thirds of nonsmokers diagnosed with
23 lung cancer are women.
24 (7) Certain minority populations, such as Afri-
25 can-American males, have disproportionately high

1 rates of lung cancer incidence and mortality, not-
2 withstanding their similar smoking rate.
3 (8) Members of the baby boomer generation are
4 entering their sixties, the most common age at which
5 people develop lung cancer.
6 (9) Tobacco addiction and exposure to other
7 lung cancer carcinogens such as Agent Orange and
8 other herbicides and battlefield emissions are serious
9 problems among military personnel and war vet-
10 erans.
11 (10) Significant and rapid improvements in
12 lung cancer mortality can be expected through great-
13 er use and access to lung cancer screening tests for
14 at-risk individuals.
15 (11) Additional strategies are necessary to fur-
16 ther enhance the existing tests and therapies avail-
17 able to diagnose and treat lung cancer in the future.
18 (12) The August 2001 Report of the Lung
19 Cancer Progress Review Group of the National Can-
20 cer Institute stated that funding for lung cancer re-
21 search was ''far below the levels characterized for
22 other common malignancies and far out of propor-
23 tion to its massive health impact''.
24 (13) The Report of the Lung Cancer Progress
25 Review Group identified as its ''highest priority'' the

1 creation of integrated, multidisciplinary, multi-insti-
2 tutional research consortia organized around the
3 problem of lung cancer rather than around specific
4 research disciplines.
5 (14) The United States must enhance its re-
6 sponse to the issues raised in the Report of the
7 Lung Cancer Progress Review Group, and this can
8 be accomplished through the establishment of a co-
9 ordinated effort designed to reduce the lung cancer
10 mortality rate by 50 percent by 2015 and targeted
11 funding to support this coordinated effort.
12 (c) SENSE OF CONGRESS CONCERNING INVESTMENT
13 IN LUNG CANCER RESEARCH.—It is the sense of the Con-
14 gress that—
15 (1) lung cancer mortality reduction should be
16 made a national public health priority; and
17 (2) a comprehensive mortality reduction pro-
18 gram coordinated by the Secretary of Health and
19 Human Services is justified and necessary to ade-
20 quately address and reduce lung cancer mortality.
21 (d) LUNG CANCER MORTALITY REDUCTION PRO-
22 GRAM.—
23 (1) IN GENERAL.—Subpart 1 of part C of title
24 IV of the Public Health Service Act (42 U.S.C. 285

1 et seq.) is amended by adding at the end the fol-
2 lowing:

3 **"SEC. 417G. LUNG CANCER MORTALITY REDUCTION PRO-**
4 **GRAM.**

5 "(a) IN GENERAL.—Not later than 6 months after
6 the date of the enactment of this section, the Secretary,
7 in consultation with the Secretary of Defense, the Sec-
8 retary of Veterans Affairs, the Director of the National
9 Institutes of Health, the Director of the Centers for Dis-
10 ease Control and Prevention, the Commissioner of Food
11 and Drugs, the Administrator of the Centers for Medicare
12 & Medicaid Services, the Director of the National Institute
13 on Minority Health and Health Disparities, and other
14 members of the Lung Cancer Advisory Board established
15 under section 546 of the Lung Cancer Mortality Reduc-
16 tion Act of 2012, shall implement a comprehensive pro-
17 gram, to be known as the Lung Cancer Mortality Reduc-
18 tion Program, to achieve a reduction of at least 25 percent
19 in the mortality rate of lung cancer by 2017.

20 "(b) REQUIREMENTS.—The Program shall include at
21 least the following:

22 "(1) With respect to the National Institutes of
23 Health—

24 "(A) a strategic review and prioritization
25 by the National Cancer Institute of research

1 grants to achieve the goal of the Lung Cancer
2 Mortality Reduction Program in reducing lung
3 cancer mortality;
4 ''(B) the provision of funds to enable the
5 Airway Biology and Disease Branch of the Na-
6 tional Heart, Lung, and Blood Institute to ex-
7 pand its research programs to include pre-
8 dispositions to lung cancer, the interrelationship
9 between lung cancer and other pulmonary and
10 cardiac disease, and the diagnosis and treat-
11 ment of these interrelationships;
12 ''(C) the provision of funds to enable the
13 National Institute of Biomedical Imaging and
14 Bioengineering to expedite the development of
15 computer assisted diagnostic, surgical, treat-
16 ment, and drug-testing innovations to reduce
17 lung cancer mortality, such as through expan-
18 sion of the Institute's Quantum Grant Program
19 and Image-Guided Interventions programs; and
20 ''(D) the provision of funds to enable the
21 National Institute of Environmental Health
22 Sciences to implement research programs rel-
23 ative to the lung cancer incidence.
24 ''(2) With respect to the Food and Drug Ad-
25 ministration—

1 "(A) activities under section 529 of the
2 Federal Food, Drug, and Cosmetic Act; and
3 "(B) activities under section 561 of the
4 Federal Food, Drug, and Cosmetic Act to ex-
5 pand access to investigational drugs and devices
6 for the diagnosis, monitoring, or treatment of
7 lung cancer.
8 "(3) With respect to the Centers for Disease
9 Control and Prevention, the establishment of an
10 early disease research and management program
11 under section 1511.
12 "(4) With respect to the Agency for Healthcare
13 Research and Quality, the conduct of a biannual re-
14 view of lung cancer screening, diagnostic, and treat-
15 ment protocols, including consideration of how lung
16 cancer screening and treatment affect men and
17 women differently, and the issuance of updated
18 guidelines.
19 "(5) The cooperation and coordination of all
20 minority and health disparity programs within the
21 Department of Health and Human Services to en-
22 sure that all aspects of the Lung Cancer Mortality
23 Reduction Program under this section adequately
24 address the burden of lung cancer on minority and
25 rural populations.

1 "(6) The cooperation and coordination of all to-
2 bacco control and cessation programs within agen-
3 cies of the Department of Health and Human Serv-
4 ices to achieve the goals of the Lung Cancer Mor-
5 tality Reduction Program under this section with
6 particular emphasis on the coordination of drug and
7 other cessation treatments with early detection pro-
8 tocols.".

9 (2) FEDERAL FOOD, DRUG, AND COSMETIC
10 ACT.—Subchapter B of chapter V of the Federal
11 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
12 seq.) is amended by adding at the end the following:

13 "DRUGS RELATING TO LUNG CANCER

14 "SEC. 529. (a) IN GENERAL.—The provisions of this
15 subchapter shall apply to a drug described in subsection
16 (b) to the same extent and in the same manner as such
17 provisions apply to a drug for a rare disease or condition.

18 "(b) QUALIFIED DRUGS.—A drug described in this
19 subsection is—

20 "(1) a chemoprevention drug for precancerous
21 conditions of the lung;

22 "(2) a drug for targeted therapeutic treat-
23 ments, including any vaccine, for lung cancer; and

24 "(3) a drug to curtail or prevent nicotine addic-
25 tion.

1 "(c) BOARD.—The Board established under the Lung
2 Cancer Mortality Reduction Act of 2012 shall monitor the
3 program implemented under this section.".
4 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
5 tion 561(e) of the Federal Food, Drug, and Cos-
6 metic Act (21 U.S.C. 360bbb(e)) is amended by in-
7 serting before the period the following: "and shall
8 include expanding access to drugs under section
9 529, with substantial consideration being given to
10 whether the totality of information available to the
11 Secretary regarding the safety and effectiveness of
12 an investigational drug, as compared to the risk of
13 morbidity and death from the disease, indicates that
14 a patient may obtain more benefit than risk if treat-
15 ed with the drug".
16 (4) CDC.—Title XV of the Public Health Serv-
17 ice Act (42 U.S.C. 300k et seq.) is amended by add-
18 ing at the end the following:
19 **"SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
20 **PROGRAM.**
21 "The Secretary shall establish and implement an
22 early disease research and management program targeted
23 at the high incidence and mortality rates of lung cancer
24 among minority and low-income populations.".

1 (e) DEPARTMENT OF DEFENSE AND THE DEPART-
2 MENT OF VETERANS AFFAIRS.—The Secretary of Defense
3 and the Secretary of Veterans Affairs shall coordinate
4 with the Secretary of Health and Human Services—
5 (1) in the development of the Lung Cancer
6 Mortality Reduction Program under section 417H;
7 (2) in the implementation within the Depart-
8 ment of Defense and the Department of Veterans
9 Affairs of an early detection and disease manage-
10 ment research program for military personnel and
11 veterans whose smoking history and exposure to car-
12 cinogens during active duty service has increased
13 their risk for lung cancer; and
14 (3) in the implementation of coordinated care
15 programs for military personnel and veterans diag-
16 nosed with lung cancer.
17 (f) LUNG CANCER ADVISORY BOARD.—
18 (1) IN GENERAL.—The Secretary of Health and
19 Human Services shall convene a Lung Cancer Advi-
20 sory Board (referred to in this section as the
21 ''Board'')—
22 (A) to monitor the programs established
23 under this section (and the amendments made
24 by this section); and

1 (B) to provide annual reports to the Con-
2 gress concerning benchmarks, expenditures,
3 lung cancer statistics, and the public health im-
4 pact of such programs.
5 (2) COMPOSITION.—The Board shall be com-
6 posed of—
7 (A) the Secretary of Health and Human
8 Services;
9 (B) the Secretary of Defense;
10 (C) the Secretary of Veterans Affairs; and
11 (D) two representatives each from the
12 fields of clinical medicine focused on lung can-
13 cer, lung cancer research, imaging, drug devel-
14 opment, and lung cancer advocacy, to be ap-
15 pointed by the Secretary of Health and Human
16 Services.

17 **SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUT-**
18 **REACH, SCREENING, TESTING, ACCESS, AND**
19 **TREATMENT EFFECTIVENESS.**

20 (a) SHORT TITLE.—This section may be cited as the
21 "Prostate Research, Outreach, Screening, Testing, Access,
22 and Treatment Effectiveness Act of 2012" or the "PROS-
23 TATE Act".
24 (b) FINDINGS.—Congress makes the following find-
25 ings:

1 (1) Prostate cancer is the second leading cause
2 of cancer death among men.
3 (2) In 2010, more than 217,730 new patients
4 were diagnosed with prostate cancer and more than
5 32,000 men died from this disease.
6 (3) Roughly 2,000,000 Americans are living
7 with a diagnosis of prostate cancer and its con-
8 sequences.
9 (4) While prostate cancer generally affects older
10 individuals, younger men are also at risk for the dis-
11 ease, and when prostate cancer appears in early
12 middle age it frequently takes on a more aggressive
13 form.
14 (5) There are significant racial and ethnic dis-
15 parities that demand attention, namely African-
16 Americans have prostate cancer mortality rates that
17 are more than double those in the White population.
18 (6) Underserved rural populations have higher
19 rates of mortality compared to their urban counter-
20 parts, and innovative and cost-efficient methods to
21 improve rural access to high quality care should take
22 advantage of advances in telehealth to diagnose and
23 treat prostate cancer when appropriate.

1 (7) Certain veterans populations may have
2 nearly twice the incidence of prostate cancer as the
3 general population of the United States.
4 (8) Urologists may constitute the specialists
5 who diagnose and treat the vast majority of prostate
6 cancer patients.
7 (9) Although much basic and translational re-
8 search has been completed and much is currently
9 known, there are still many unanswered questions.
10 For example, it is not fully understood how much of
11 known disparities are attributable to disease eti-
12 ology, access to care, or education and awareness in
13 the community.
14 (10) Causes of prostate cancer are not known.
15 There is not good information regarding how to dif-
16 ferentiate accurately, early on, between aggressive
17 and indolent forms of the disease. As a result, there
18 is significant overtreatment in prostate cancer.
19 There are no treatments that can durably arrest
20 growth or cure prostate cancer once it has metasta-
21 sized.
22 (11) A significant proportion (roughly 23 to 54
23 percent) of cases may be clinically indolent and
24 ''overdiagnosed'', resulting in significant overtreat-
25 ment. More accurate tests will allow men and their

1 families to face less physical, psychological, financial,
2 and emotional trauma and billions of dollars could
3 be saved in private and public health care systems
4 in an area that has been identified by the Medicare
5 program as one of eight high-volume, high-cost areas
6 in the Resource Utilization Report program author-
7 ized by Congress under the Medicare Improvements
8 for Patients and Providers Act of 2008.
9 (12) Prostate cancer research and health care
10 programs across Federal agencies should be coordi-
11 nated to improve accountability and actively encour-
12 age the translation of research into practice, to iden-
13 tify and implement best practices, in order to foster
14 an integrated and consistent focus on effective pre-
15 vention, diagnosis, and treatment of this disease.
16 (c) PROSTATE CANCER COORDINATION AND EDU-
17 CATION.—
18 (1) INTERAGENCY PROSTATE CANCER COORDI-
19 NATION AND EDUCATION TASK FORCE.—Not later
20 than 180 days after the date of the enactment of
21 this section, the Secretary of Veterans Affairs, in co-
22 operation with the Secretary of Defense and the Sec-
23 retary of Health and Human Services, shall estab-
24 lish an Interagency Prostate Cancer Coordination

1 and Education Task Force (in this section referred
2 to as the "Prostate Cancer Task Force").
3 (2) DUTIES.—The Prostate Cancer Task Force
4 shall—
5 (A) develop a summary of advances in
6 prostate cancer research supported or con-
7 ducted by Federal agencies relevant to the diag-
8 nosis, prevention, and treatment of prostate
9 cancer, including psychosocial impairments re-
10 lated to prostate cancer treatment, and compile
11 a list of best practices that warrant broader
12 adoption in health care programs;
13 (B) consider establishing, and advocating
14 for, a guidance to enable physicians to allow
15 screening of men who are over age 74, on a
16 case-by-case basis, taking into account quality
17 of life and family history of prostate cancer;
18 (C) share and coordinate information on
19 Federal research and health care program ac-
20 tivities, including activities related to—
21 (i) determining how to improve re-
22 search and health care programs, including
23 psychosocial impairments related to pros-
24 tate cancer treatment;

1 (ii) identifying any gaps in the overall
2 research inventory and in health care pro-
3 grams;
4 (iii) identifying opportunities to pro-
5 mote translation of research into practice;
6 and
7 (iv) maximizing the effects of Federal
8 efforts by identifying opportunities for col-
9 laboration and leveraging of resources in
10 research and health care programs that
11 serve those susceptible to or diagnosed
12 with prostate cancer;
13 (D) develop a comprehensive interagency
14 strategy and advise relevant Federal agencies in
15 the solicitation of proposals for collaborative,
16 multidisciplinary research and health care pro-
17 grams, including proposals to evaluate factors
18 that may be related to the etiology of prostate
19 cancer, that would—
20 (i) result in innovative approaches to
21 study emerging scientific opportunities or
22 eliminate knowledge gaps in research to
23 improve the prostate cancer research port-
24 folio of the Federal Government;

1 (ii) outline key research questions,
2 methodologies, and knowledge gaps; and
3 (iii) ensure consistent action, as out-
4 lined by section 402(b) of the Public
5 Health Service Act;
6 (E) develop a coordinated message related
7 to screening and treatment for prostate cancer
8 to be reflected in educational and beneficiary
9 materials for Federal health programs as such
10 documents are updated; and
11 (F) not later than 2 years after the date
12 of the establishment of the Prostate Cancer
13 Task Force, submit to the Expert Advisory
14 Panel to be reviewed and returned within 30
15 days, and then within 90 days submitted to
16 Congress recommendations—
17 (i) regarding any appropriate changes
18 to research and health care programs, in-
19 cluding recommendations to improve the
20 research portfolio of the Department of
21 Veterans Affairs, Department of Defense,
22 National Institutes of Health, and other
23 Federal agencies to ensure that scientif-
24 ically based strategic planning is imple-

1 mented in support of research and health
2 care program priorities;
3 (ii) designed to ensure that the re-
4 search and health care programs and ac-
5 tivities of the Department of Veterans Af-
6 fairs, the Department of Defense, the De-
7 partment of Health and Human Services,
8 and other Federal agencies are free of un-
9 necessary duplication;
10 (iii) regarding public participation in
11 decisions relating to prostate cancer re-
12 search and health care programs to in-
13 crease the involvement of patient advo-
14 cates, community organizations, and med-
15 ical associations representing a broad geo-
16 graphical area;
17 (iv) on how to best disseminate infor-
18 mation on prostate cancer research and
19 progress achieved by health care programs;
20 (v) about how to expand partnerships
21 between public entities, including Federal
22 agencies, and private entities to encourage
23 collaborative, cross-cutting research and
24 health care delivery;

1 (vi) assessing any cost savings and ef-
2 ficiencies realized through the efforts iden-
3 tified and supported in this section and
4 recommending expansion of those efforts
5 that have proved most promising while also
6 ensuring against any conflicts in directives
7 from other congressional or statutory man-
8 dates or enabling statutes;
9 (vii) identifying key priority action
10 items from among the recommendations;
11 and
12 (viii) with respect to the level of fund-
13 ing needed by each agency to implement
14 the recommendations contained in the re-
15 port.
16 (3) MEMBERS OF THE PROSTATE CANCER TASK
17 FORCE.—The Prostate Cancer Task Force described
18 in subsection (a) shall be composed of representa-
19 tives from such Federal agencies, as each Secretary
20 determines necessary, to coordinate a uniform mes-
21 sage relating to prostate cancer screening and treat-
22 ment where appropriate, including representatives of
23 the following:
24 (A) The Department of Veterans Affairs,
25 including representatives of each relevant pro-

1 gram areas of the Department of Veterans Af-
2 fairs.
3 (B) The Prostate Cancer Research Pro-
4 gram of the Congressionally Directed Medical
5 Research Program of the Department of De-
6 fense.
7 (C) The Department of Health and
8 Human Services, including at a minimum rep-
9 resentatives of the following:
10 (i) The National Institutes of Health.
11 (ii) National research institutes and
12 centers, including the National Cancer In-
13 stitute, the National Institute of Allergy
14 and Infectious Diseases, and the Office of
15 Minority Health.
16 (iii) The Centers for Medicare & Med-
17 icaid Services.
18 (iv) The Food and Drug Administra-
19 tion.
20 (v) The Centers for Disease Control
21 and Prevention.
22 (vi) The Agency for Healthcare Re-
23 search and Quality.
24 (vii) The Health Resources and Serv-
25 ices Administration.

1 (4) APPOINTING EXPERT ADVISORY PANELS.—
2 The Prostate Cancer Task Force shall appoint ex-
3 pert advisory panels, as determined appropriate, to
4 provide input and concurrence from individuals and
5 organizations from the medical, prostate cancer pa-
6 tient and advocate, research, and delivery commu-
7 nities with expertise in prostate cancer diagnosis,
8 treatment, and research, including practicing urolo-
9 gists, primary care providers, and others and indi-
10 viduals with expertise in education and outreach to
11 underserved populations affected by prostate cancer.
12 (5) MEETINGS.—The Prostate Cancer Task
13 Force shall convene not less than twice a year, or
14 more frequently as the Secretary determines to be
15 appropriate.
16 (6) SUBMISSION OF RECOMMENDATIONS TO
17 CONGRESS.—The Secretary of Veterans Affairs shall
18 submit to Congress any recommendations submitted
19 to the Secretary under paragraph (2)(E).
20 (7) FEDERAL ADVISORY COMMITTEE ACT.—
21 (A) IN GENERAL.—Except as provided in
22 subparagraph (B), the Federal Advisory Com-
23 mittee Act (5 U.S.C. App.) shall apply to the
24 Prostate Cancer Task Force.

1 (B) EXCEPTION.—Section 14(a)(2)(B) of
2 such Act (relating to the termination of advi-
3 sory committees) shall not apply to the Prostate
4 Cancer Task Force.
5 (8) SUNSET DATE.—The Prostate Cancer Task
6 Force shall terminate at the end of fiscal year 2016.
7 (d) PROSTATE CANCER RESEARCH.—
8 (1) RESEARCH COORDINATION.—The Secretary
9 of Veterans Affairs, in coordination with the Secre-
10 taries of Defense and of Health and Human Serv-
11 ices, shall establish and carry out a program to co-
12 ordinate and intensify prostate cancer research as
13 needed. Specifically, such research program shall—
14 (A) develop advances in diagnostic and
15 prognostic methods and tests, including bio-
16 markers and an improved prostate cancer
17 screening blood test, including improvements or
18 alternatives to the prostate specific antigen test
19 and additional tests to distinguish indolent from
20 aggressive disease;
21 (B) better understand the etiology of the
22 disease (including an analysis of lifestyle factors
23 proven to be involved in higher rates of prostate
24 cancer, such as obesity and diet, and in dif-
25 ferent ethnic, racial, and socioeconomic groups,

1 such as the African-American, Latino, and
2 American Indian populations and men with a
3 family history of prostate cancer) to improve
4 prevention efforts;
5 (C) expand basic research into prostate
6 cancer, including studies of fundamental molec-
7 ular and cellular mechanisms;
8 (D) identify and provide clinical testing of
9 novel agents for the prevention and treatment
10 of prostate cancer;
11 (E) establish clinical registries for prostate
12 cancer;
13 (F) use the National Institute of Bio-
14 medical Imaging and Bioengineering and the
15 National Cancer Institute for assessment of ap-
16 propriate imaging modalities; and
17 (G) address such other matters relating to
18 prostate cancer research as may be identified by
19 the Federal agencies participating in the pro-
20 gram under this section.
21 (2) PROSTATE CANCER ADVISORY BOARD.—
22 There is established in the Office of the Chief Sci-
23 entist of the Food and Drug Administration a Pros-
24 tate Cancer Scientific Advisory Board. Such board
25 shall be responsible for accelerating real-time shar-

1 ing of the latest research data and accelerating
2 movement of new medicines to patients.
3 (3) UNDERSERVED MINORITY GRANT PRO-
4 GRAM.—In carrying out such program, the Secretary
5 shall—
6 (A) award grants to eligible entities to
7 carry out components of the research outlined
8 in paragraph (1);
9 (B) integrate and build upon existing
10 knowledge gained from comparative effective-
11 ness research; and
12 (C) recognize and address—
13 (i) the racial and ethnic disparities in
14 the incidence and mortality rates of pros-
15 tate cancer and men with a family history
16 of prostate cancer;
17 (ii) any barriers in access to care and
18 participation in clinical trials that are spe-
19 cific to racial, ethnic, and other under-
20 served minorities and men with a family
21 history of prostate cancer;
22 (iii) needed outreach and educational
23 efforts to raise awareness in these commu-
24 nities; and

1 (iv) appropriate access and utilization
2 of imaging modalities.
3 (e) TELEHEALTH AND RURAL ACCESS PILOT
4 PROJECT.—
5 (1) IN GENERAL.—The Secretary of Veterans
6 Affairs, the Secretary of Defense, and the Secretary
7 of Health and Human Services (in this section re-
8 ferred to as the ''Secretaries'') shall establish 4-year
9 telehealth pilot projects for the purpose of analyzing
10 the clinical outcomes and cost effectiveness associ-
11 ated with telehealth services in a variety of geo-
12 graphic areas that contain high proportions of medi-
13 cally underserved populations, including African-
14 Americans, Latinos, American Indians, and those in
15 rural areas. Such projects shall promote efficient use
16 of specialist care through better coordination of pri-
17 mary care and physician extender teams in under-
18 served areas and more effectively employ tumor
19 boards to better counsel patients.
20 (2) ELIGIBLE ENTITIES.—
21 (A) IN GENERAL.—The Secretaries shall
22 select eligible entities to participate in the pilot
23 projects under this section.
24 (B) PRIORITY.—In selecting eligible enti-
25 ties to participate in the pilot projects under

1 this section, the Secretaries shall give priority
2 to such entities located in medically under-
3 served areas, particularly those that include Af-
4 rican-Americans, Latinos, and facilities of the
5 Indian Health Service, and those in rural areas.
6 (3) EVALUATION.—The Secretaries shall,
7 through the pilot projects, evaluate—
8 (A) the effective and economic delivery of
9 care in diagnosing and treating prostate cancer
10 with the use of telehealth services in medically
11 underserved and tribal areas including collabo-
12 rative uses of health professionals and integra-
13 tion of the range of telehealth and other tech-
14 nologies;
15 (B) the effectiveness of improving the ca-
16 pacity of nonmedical providers and nonspecial-
17 ized medical providers to provide health services
18 for prostate cancer in medically underserved
19 and tribal areas, including the exploration of in-
20 novative medical home models with collabora-
21 tion between urologists, other relevant medical
22 specialists, including oncologists, radiologists,
23 and primary care teams and coordination of
24 care through the efficient use of primary care
25 teams and physician extenders; and

1 (C) the effectiveness of using telehealth
2 services to provide prostate cancer treatment in
3 medically underserved areas, including the use
4 of tumor boards to facilitate better patient
5 counseling.
6 (4) REPORT.—Not later than 12 months after
7 the completion of the pilot projects under this sub-
8 section, the Secretaries shall submit to Congress a
9 report describing the outcomes of such pilot projects,
10 including any cost savings and efficiencies realized,
11 and providing recommendations, if any, for expand-
12 ing the use of telehealth services.
13 (f) EDUCATION AND AWARENESS.—
14 (1) IN GENERAL.—The Secretary of Veterans
15 Affairs shall develop a national education campaign
16 for prostate cancer. Such campaign shall involve the
17 use of written educational materials and public serv-
18 ice announcements consistent with the findings of
19 the Prostate Cancer Task Force under subsection
20 (c), that are intended to encourage men to seek
21 prostate cancer screening when appropriate.
22 (2) RACIAL DISPARITIES AND THE POPULATION
23 OF MEN WITH A FAMILY HISTORY OF PROSTATE
24 CANCER.—In developing the national campaign
25 under paragraph (1), the Secretary shall ensure that

1 such educational materials and public service an-
2 nouncements are more readily available in commu-
3 nities experiencing racial disparities in the incidence
4 and mortality rates of prostate cancer and by men
5 of any race classification with a family history of
6 prostate cancer.

7 (3) GRANTS.—In carrying out the national
8 campaign under this section, the Secretary shall
9 award grants to nonprofit private entities to enable
10 such entities to test alternative outreach and edu-
11 cation strategies.

12 **SEC. 703. IMPROVED MEDICAID COVERAGE FOR CERTAIN**
13 **BREAST AND CERVICAL CANCER PATIENTS**
14 **IN THE TERRITORIES.**

15 (a) ELIMINATION OF FUNDING LIMITATIONS.—

16 (1) IN GENERAL.—Section 1108(g)(4) of the
17 Social Security Act (42 U.S.C. 1308(g)(4)) is
18 amended by adding at the end the following: ''With
19 respect to fiscal years beginning with fiscal year
20 2012, payment for medical assistance for individuals
21 who are eligible for such assistance only on the basis
22 of section 1902(a)(10)(A)(ii)(XVIII) shall not be
23 taken into account in applying subsection (f) (as in-
24 creased in accordance with paragraphs (1), (2), and

1 (3) of this subsection) to such commonwealth or ter-
2 ritory for such fiscal year.''.
3 (2) TECHNICAL AMENDMENT.—Section
4 1108(g)(4) of such Act is further amended by strik-
5 ing ''(3), and (4)'' and inserting ''and (3)''.
6 (b) APPLICATION OF ENHANCED FMAP FOR HIGH-
7 EST STATE.—Section 1905(b) of such Act (42 U.S.C.
8 1396d(b)) is amended by adding at the end the following:
9 ''Notwithstanding the first sentence of this subsection,
10 with respect to medical assistance described in clause (4)
11 of such sentence that is furnished in Puerto Rico, the
12 United States Virgin Islands, Guam, the Commonwealth
13 of the Northern Mariana Islands, or American Samoa in
14 a fiscal year, the Federal medical assistance percentage
15 is equal to the highest such percentage applied under such
16 clause for such fiscal year for any of the 50 States or the
17 District of Columbia that provides such medical assistance
18 for any portion of such fiscal year.''
19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to payment for medical assistance
21 for items and services furnished on or after October 1,
22 2011.

1 **SEC. 704. CANCER PREVENTION AND TREATMENT DEM-**
2 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
3 **NORITIES.**
4 (a) DEMONSTRATION.—
5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services (in this section referred to as the
7 ''Secretary'') shall conduct demonstration projects
8 (in this section referred to as ''demonstration
9 projects'') for the purpose of developing models and
10 evaluating methods that—
11 (A) improve the quality of items and serv-
12 ices provided to target individuals in order to
13 facilitate reduced disparities in early detection
14 and treatment of cancer;
15 (B) improve clinical outcomes, satisfaction,
16 quality of life, and appropriate use of Medicare-
17 covered services and referral patterns among
18 those target individuals with cancer;
19 (C) eliminate disparities in the rate of pre-
20 ventive cancer screening measures, such as Pap
21 smears, prostate cancer screenings, and CT
22 scans for lung cancer among target individuals;
23 (D) promote collaboration with community-
24 based organizations to ensure cultural com-
25 petency of health care professionals and lin-

1 guistic access for persons with limited-English
2 proficiency; and
3 (E) encourage the incorporation of commu-
4 nity health workers to increase the efficiency
5 and appropriateness of cancer screening pro-
6 grams.
7 (2) COMMUNITY HEALTH WORKER DEFINED.—
8 In this section, the term ''community health worker''
9 includes a community health advocate, a lay health
10 worker, a community health representative, a peer
11 health promoter, a community health outreach work-
12 ers, and promotores de salud, who promotes health
13 or nutrition within the community in which the indi-
14 vidual resides.
15 (3) TARGET INDIVIDUAL DEFINED.—In this
16 section, the term ''target individual'' means an indi-
17 vidual of a racial and ethnic minority group, as de-
18 fined in section 1707(g)(1) of the Public Health
19 Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-
20 tled to benefits under part A, and enrolled under
21 part B, of title XVIII of the Social Security Act.
22 (b) PROGRAM DESIGN.—
23 (1) INITIAL DESIGN.—Not later than 1 year
24 after the date of the enactment of this Act, the Sec-
25 retary shall evaluate best practices in the private

1 sector, community programs, and academic research
2 of methods that reduce disparities among individuals
3 of racial and ethnic minority groups in the preven-
4 tion and treatment of cancer and shall design the
5 demonstration projects based on such evaluation.
6 (2) NUMBER AND PROJECT AREAS.—Not later
7 than 2 years after the date of the enactment of this
8 Act, the Secretary shall implement at least nine
9 demonstration projects, including the following:
10 (A) Two projects for each of the four fol-
11 lowing major racial and ethnic minority groups:
12 (i) American Indians and Alaska Na-
13 tives, Eskimos and Aleuts.
14 (ii) Asian-Americans.
15 (iii) Blacks/African-Americans.
16 (iv) Hispanic/Latinos.
17 (v) Native Hawaiians and other Pa-
18 cific Islanders.
19 The two projects must target different ethnic
20 subpopulations.
21 (B) One project within the Pacific Islands
22 or United States insular areas.
23 (C) At least one project each in a rural
24 area and inner-city area.

1 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
2 TION OF DEMONSTRATION PROJECT RESULTS.—If
3 the initial report under subsection (c) contains an
4 evaluation that demonstration projects—
5 (A) reduce expenditures under the Medi-
6 care program under title XVIII of the Social
7 Security Act; or
8 (B) do not increase expenditures under the
9 Medicare program and reduce racial and ethnic
10 health disparities in the quality of health care
11 services provided to target individuals and in-
12 crease satisfaction of beneficiaries and health
13 care providers;
14 the Secretary shall continue the existing demonstra-
15 tion projects and may expand the number of dem-
16 onstration projects.
17 (c) REPORT TO CONGRESS.—
18 (1) IN GENERAL.—Not later than 2 years after
19 the date the Secretary implements the initial dem-
20 onstration projects, and biannually thereafter, the
21 Secretary shall submit to Congress a report regard-
22 ing the demonstration projects.
23 (2) CONTENTS OF REPORT.—Each report under
24 paragraph (1) shall include the following:

1 (A) A description of the demonstration
2 projects.
3 (B) An evaluation of—
4 (i) the cost effectiveness of the dem-
5 onstration projects;
6 (ii) the quality of the health care serv-
7 ices provided to target individuals under
8 the demonstration projects; and
9 (iii) beneficiary and health care pro-
10 vider satisfaction under the demonstration
11 projects.
12 (C) Any other information regarding the
13 demonstration projects that the Secretary de-
14 termines to be appropriate.
15 (d) WAIVER AUTHORITY.—The Secretary shall waive
16 compliance with the requirements of title XVIII of the So-
17 cial Security Act to such extent and for such period as
18 the Secretary determines is necessary to conduct dem-
19 onstration projects.
20 **SEC. 705. REDUCING CANCER TREATMENT DISPARITIES**
21 **WITHIN MEDICARE.**
22 (a) DEVELOPMENT OF MEASURES OF DISPARITIES
23 IN QUALITY OF CANCER CARE.—
24 (1) DEVELOPMENT OF MEASURES.—

1 (A) IN GENERAL.—The Secretary of
2 Health and Human Services (in this section re-
3 ferred to as the ''Secretary'') shall enter into an
4 agreement with an entity that specializes in de-
5 veloping quality measures for cancer care under
6 which the entity shall—
7 (i) develop a uniform set of measures
8 to evaluate disparities in the quality of
9 cancer care; and
10 (ii) annually update such set of meas-
11 ures.
12 (B) MEASURES TO BE INCLUDED.—Such
13 set of measures shall include, with respect to
14 the treatment of cancer, measures of patient
15 outcomes, the process for delivering medical
16 care related to such treatment, patient coun-
17 seling and engagement in decisionmaking, pa-
18 tient experience of care, resource use, and prac-
19 tice capabilities, such as care coordination.
20 (2) ENDORSEMENT OF MEASURES.—Any meas-
21 ure included in the set of measures developed pursu-
22 ant to this subsection must have been endorsed by
23 the entity with a contract under section 1890(a) of
24 the Social Security Act (42 U.S.C. 1395aaa(a)).
25 (b) ESTABLISHMENT OF REPORTING PROCESS.—

1 (1) IN GENERAL.—The Secretary shall establish
2 a reporting process that provides for a method for
3 health care providers specified under paragraph (2)
4 to submit to the Secretary and make public data on
5 the performance of such providers during each re-
6 porting period through use of the measures devel-
7 oped pursuant to subsection (a). Such data shall be
8 submitted in a form and manner and at a time spec-
9 ified by the Secretary.
10 (2) SPECIFICATION OF PROVIDERS TO REPORT
11 ON MEASURES.—The Secretary shall specify the
12 classes of Medicare providers of services and sup-
13 pliers, including hospitals, cancer centers, physi-
14 cians, primary care providers, and specialty pro-
15 viders, that will be required under such process to
16 publicly report on the measures developed pursuant
17 to subsection (a).
18 (3) ASSESSMENT OF CHANGES.—Within this re-
19 porting process, the Secretary shall also establish a
20 format that assesses changes in both the absolute
21 and relative disparities over time. These measures
22 shall be presented in an easily comprehensible for-
23 mat, such as those presented in the final publica-
24 tions relating to Healthy People 2010 or the Na-
25 tional Healthcare Disparities Report.

(4) INITIAL IMPLEMENTATION.—The Secretary shall implement the reporting process under this subsection for reporting periods beginning not later than 6 months after the date that measures are first developed pursuant to subsection (a).

Subtitle B—Viral Hepatitis and Liver Cancer Control and Prevention

SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL AND PREVENTION.

(a) SHORT TITLE.—This subtitle may be cited as the ''Viral Hepatitis and Liver Cancer Control and Prevention Act of 2012''.

(b) FINDINGS.—Congress finds the following:

(1) Approximately 5,300,000 Americans are chronically infected with the hepatitis B virus (referred to in this section as ''HBV''), the hepatitis C virus (referred to in this section as ''HCV''), or both.

(2) In the United States, chronic HBV and HCV are the most common cause of liver cancer, one of the most lethal and fastest growing cancers in this country. It is the most common cause of chronic liver disease, liver cirrhosis, and the most common indication for liver transplantation. It is

1 also a leading cause of death in Americans living
2 with HIV/AIDS, many of whom are coinfected with
3 chronic HBV, chronic HCV, or both. At least 15,000
4 deaths per year in the United States can be attrib-
5 uted to chronic HBV and HCV.

6 (3) According to the Centers for Disease Con-
7 trol and Prevention (referred to in this section as
8 the ''CDC''), approximately 2 percent of the popu-
9 lation of the United States is living with chronic
10 HBV, chronic HCV, or both. The CDC has recog-
11 nized HCV as the Nation's most common chronic
12 bloodborne virus infection and HBV as the deadliest
13 vaccine-preventable disease.

14 (4) HBV is easily transmitted and is 100 times
15 more infectious than HIV. According to the CDC,
16 HBV is transmitted through percutaneous (i.e.,
17 puncture through the skin) or mucosal contact with
18 infectious blood or body fluids. HCV is transmitted
19 by percutaneous exposures to infectious blood.

20 (5) The CDC conservatively estimates that in
21 2008 approximately 18,000 Americans were newly
22 infected with HCV and more than 38,000 Americans
23 were newly infected with HBV.

24 (6) There were 6 outbreaks reported to CDC
25 for investigation in 2008 related to health care ac-

1 quired infection of HBV and HCV, potentially ex-
2 posing more than 52,000 Americans to the viruses,
3 in 2009–2010 there were 15 outbreaks in which
4 more than 30,000 people were potentially exposed.
5 (7) Chronic HBV and chronic HCV usually do
6 not cause symptoms early in the course of the dis-
7 ease, but after many years of a clinically ''silent''
8 phase, more than 50 percent of infected individuals
9 will develop cirrhosis, end-stage liver disease, or liver
10 cancer. Since most of those with chronic HBV and
11 HCV are unaware of their infection, they do not
12 know to take precautions to prevent the spread of
13 their infection and can unknowingly exacerbate their
14 own disease progression.
15 (8) HBV and HCV disproportionately affect
16 certain populations in the United States. Although
17 representing only 5 percent of the population, Asian-
18 Americans and Pacific Islanders account for over
19 half of the 1,400,000 domestic chronic HBV cases.
20 Baby boomers (those born between 1946 and 1964)
21 account for more than half of domestic chronic hepa-
22 titis C cases. In addition, African-Americans,
23 Latinos, and American Indian/Alaskan Natives are
24 among the groups which have disproportionately

1 high rates of HBV and/or HCV infections in the
2 United States.
3 (9) For both chronic HBV and chronic HCV,
4 behavioral changes can slow disease progression if
5 diagnosis is made early. Early diagnosis, which is
6 determined through simple blood tests, can reduce
7 the risk of transmission and disease progression
8 through education and vaccination of household
9 members and other susceptible persons at risk.
10 (10) For those chronically infected with HBV
11 or HCV, regular monitoring can lead to the early de-
12 tection of liver cancer at a stage where cure is still
13 possible. Liver cancer is the third deadliest cancer in
14 the United States however, liver cancer has received
15 little funding for research, prevention, or treatment.
16 (11) Treatment for chronic HCV can eradicate
17 the disease in approximately 75 percent of those cur-
18 rently treated. The treatment of chronic HBV can
19 effectively suppress viral replication in the over-
20 whelming majority (>80%) of those treated thereby
21 reducing the risk of transmission and progression to
22 liver scarring or liver cancer even though a complete
23 cure is much less common than for HCV.
24 (12) To combat the HBV and HCV epidemics
25 in the United States, in May 2011, the Department

1 of Health and Human Services released Combating
2 the Silent Epidemic of Viral Hepatitis: Action Plan
3 for the Prevention, Care & Treatment of Viral Hepa-
4 titis (hereafter referred to as the HHS Action Plan).
5 The Institute of Medicine (IOM) of the National
6 Academies 2010 reported on the Federal response to
7 HBV and HCV titled: Hepatitis and Liver Cancer:
8 A National Strategy for Prevention and Control of
9 Hepatitis B and C. These recommendations and
10 guidelines provide a framework for HBV and HCV
11 prevention, education, control, research, and medical
12 management programs.
13 (13) The annual health care costs attributable
14 to HBV and HCV in the United States are signifi-
15 cant. For HBV, it is estimated to be approximately
16 $1,000,000,000 to 2,000,000,000 ($1,000 to $2,000
17 per infected person). More than $1,000,000,000 is
18 spent each year for HBV-related hospitalizations.
19 The indirect costs of chronic HBV infection are
20 harder to measure, but include reduced physical and
21 emotional quality of life, reduced economic produc-
22 tivity, long-term disability, and premature death.
23 For HCV, medical costs for patients are expected to
24 increase from $30,000,000,000 in 2009 to over
25 $85,000,000,000 in 2024. Avoiding these costs by

1 screening and diagnosing individuals earlier—and
2 connecting them to appropriate treatment and care
3 will save lives and critical health care dollars. Cur-
4 rently, without a comprehensive screening, testing
5 and diagnosis program, most patients are diagnosed
6 too late when they need a liver transplant costing at
7 least $314,000 for uncomplicated cases or when they
8 have liver cancer or end stage liver disease which
9 costs $30,980 to $110,576 per hospital admission.
10 As health care costs continue to grow, it is critical
11 that the Federal Government invests in effective
12 mechanisms to avoid documented cost drivers.
13 (14) According to the IOM report in 2010,
14 chronic HBV and HCV infections cause substantial
15 morbidity and mortality despite being preventable
16 and treatable. Deficiencies in the implementation of
17 established guidelines for the prevention, diagnosis,
18 and medical management of chronic HBV and HCV
19 infections perpetuate personal and economic bur-
20 dens. Existing grants are not sufficient for the scale
21 of the health burden presented by HBV and HCV.
22 (15) Screening and testing for HBV and HCV
23 is aligned with the Healthy People 2020 goal; In-
24 crease immunization rates and reduce preventable
25 infectious diseases. Awareness of disease and access

to prevention and treatment remain essential components for reducing infectious disease transmission.

(16) Federal support is necessary to increase knowledge and awareness of HBV and HCV and to assist State and local prevention and control efforts in reducing the morbidity and mortality of these epidemics.

(c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended—

(1) by striking section 317N (42 U.S.C. 247b–15); and

(2) by adding at the end the following:

"PART X—BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN

"SEC. 399NN. BIENNIAL UPDATE OF THE PLAN.

"(a) IN GENERAL.—The Secretary shall conduct a biennial assessment of the Secretary's plan for the prevention, control, and medical management of, and education and research relating to, hepatitis B and hepatitis C, for the purposes of—

1 "(1) incorporating into such plan new knowl-
2 edge or observations relating to hepatitis B and hep-
3 atitis C (such as knowledge and observations that
4 may be derived from clinical, laboratory, and epide-
5 miological research and disease detection, preven-
6 tion, and surveillance outcomes);
7 "(2) addressing gaps in the coverage or effec-
8 tiveness of the plan; and
9 "(3) evaluating and, if appropriate, updating
10 recommendations, guidelines, or educational mate-
11 rials of the Centers for Disease Control and Preven-
12 tion or the National Institutes of Health for health
13 care providers or the public on viral hepatitis in
14 order to be consistent with the plan.
15 "(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
16 Not later than October 1 of the first even-numbered year
17 beginning after the date of the enactment of this part,
18 and October 1 of each even-numbered year thereafter, the
19 Secretary shall publish in the Federal Register a notice
20 of the results of the assessments conducted under para-
21 graph (1). Such notice shall include—
22 "(1) a description of any revisions to the plan
23 referred to in subsection (a) as a result of the as-
24 sessment;

1 "(2) an explanation of the basis for any such
2 revisions, including the ways in which such revisions
3 can reasonably be expected to further promote the
4 original goals and objectives of the plan; and
5 "(3) in the case of a determination by the Sec-
6 retary that the plan does not need revision, an expla-
7 nation of the basis for such determination.

8 **"SEC. 399NN–1. ELEMENTS OF PROGRAM.**

9 "(a) EDUCATION AND AWARENESS PROGRAMS.—The
10 Secretary, acting through the Director of the Centers for
11 Disease Control and Prevention, the Administrator of the
12 Health Resources and Services Administration, and the
13 Administrator of the Substance Abuse and Mental Health
14 Services Administration, and in accordance with the plan
15 referred to in section 399NN(a), shall implement pro-
16 grams to increase awareness and enhance knowledge and
17 understanding of hepatitis B and hepatitis C. Such pro-
18 grams shall include—
19 "(1) the conduct of culturally and language ap-
20 propriate health education in primary and secondary
21 schools, college campuses, public awareness cam-
22 paigns, and community outreach activities (especially
23 to the ethnic communities with high rates of chronic
24 hepatitis B and chronic hepatitis C and other high-
25 risk groups) to promote public awareness and knowl-

1 edge about the value of hepatitis A and hepatitis B
2 immunization, risk factors, the transmission and
3 prevention of hepatitis B and hepatitis C, the value
4 of screening for the early detection of hepatitis B
5 and hepatitis C, and options available for the treat-
6 ment of chronic hepatitis B and chronic hepatitis C;
7 ‘‘(2) the promotion of immunization programs
8 that increase awareness and access to hepatitis A
9 and hepatitis B vaccines for susceptible adults and
10 children;
11 ‘‘(3) the training of health care professionals
12 regarding the importance of vaccinating individuals
13 infected with hepatitis C and individuals who are at
14 risk for hepatitis C infection against hepatitis A and
15 hepatitis B;
16 ‘‘(4) the training of health care professionals
17 regarding the importance of vaccinating individuals
18 chronically infected with hepatitis B and individuals
19 who are at risk for chronic hepatitis B infection
20 against the hepatitis A virus;
21 ‘‘(5) the training of health care professionals
22 and health educators to make them aware of the
23 high rates of chronic hepatitis B and chronic hepa-
24 titis C in certain adult ethnic populations, and the
25 importance of prevention, detection, and medical

1 management of hepatitis B and hepatitis C and of
2 liver cancer screening;

3 "(6) the development and distribution of health
4 education curricula (including information relating
5 to the special needs of individuals infected with hep-
6 atitis B and hepatitis C, such as the importance of
7 prevention and early intervention, regular moni-
8 toring, the recognition of psychosocial needs, appro-
9 priate treatment, and liver cancer screening) for in-
10 dividuals providing hepatitis B and hepatitis C coun-
11 seling; and

12 "(7) support for the implementation curricula
13 described in paragraph (6) by State and local public
14 health agencies.

15 "(b) IMMUNIZATION, PREVENTION, AND CONTROL
16 PROGRAMS.—

17 "(1) IN GENERAL.—The Secretary, acting
18 through the Director of the Centers for Disease
19 Control and Prevention, shall support the integra-
20 tion of activities described in paragraph (2) into ex-
21 isting clinical and public health programs at State,
22 local, territorial, and tribal levels (including commu-
23 nity health clinics, programs for the prevention and
24 treatment of HIV/AIDS, sexually transmitted dis-

1 eases, and substance abuse, and programs for indi-
2 viduals in correctional settings).
3 "(2) ACTIVITIES.—
4 "(A) VOLUNTARY TESTING PROGRAMS.—
5 "(i) IN GENERAL.—The Secretary
6 shall establish a mechanism by which to
7 support and promote the development of
8 State, local, territorial, and tribal vol-
9 untary hepatitis B and hepatitis C testing
10 programs to screen the high-prevalence
11 populations to aid in the early identifica-
12 tion of chronically infected individuals.
13 "(ii) CONFIDENTIALITY OF THE TEST
14 RESULTS.—The Secretary shall prohibit
15 the use of the results of a hepatitis B or
16 hepatitis C test conducted by a testing pro-
17 gram developed or supported under this
18 subparagraph for any of the following:
19 "(I) Issues relating to health in-
20 surance.
21 "(II) To screen or determine
22 suitability for employment.
23 "(III) To discharge a person
24 from employment.

1 "(B) COUNSELING REGARDING VIRAL HEPATITIS.—The Secretary shall support State, local, territorial, and tribal programs in a wide variety of settings, including those providing primary and specialty health care services in nonprofit private and public sectors, to—

"(i) provide individuals with ongoing risk factors for hepatitis B and hepatitis C infection with client-centered education and counseling which concentrates on—

"(I) promoting testing of individuals that have been exposed to their blood, family members, and their sexual partners; and

"(II) changing behaviors that place individuals at risk for infection;

"(ii) provide individuals chronically infected with hepatitis B or hepatitis C with education, health information, and counseling to reduce their risk of—

"(I) dying from end-stage liver disease and liver cancer; and

"(II) transmitting viral hepatitis to others; and

1 "(iii) provide women chronically in-
2 fected with hepatitis B or hepatitis C who
3 are pregnant or of childbearing age with
4 culturally and language appropriate health
5 information, such as how to prevent hepa-
6 titis B perinatal infection, and to alleviate
7 fears associated with pregnancy or raising
8 a family.
9 "(C) IMMUNIZATION.—The Secretary shall
10 support State, local, territorial, and tribal ef-
11 forts to expand the current vaccination pro-
12 grams to protect every child in the country and
13 all susceptible adults, particularly those infected
14 with hepatitis C and high-prevalence ethnic
15 populations and other high-risk groups, from
16 the risks of acute and chronic hepatitis B infec-
17 tion by—
18 "(i) ensuring continued funding for
19 hepatitis B vaccination for all children 19
20 years of age or younger through the Vac-
21 cines for Children Program;
22 "(ii) ensuring that the recommenda-
23 tions of the Advisory Committee on Immu-
24 nization Practices are followed regarding

1 the birth dose of hepatitis B vaccinations
2 for newborns;
3 ''(iii) requiring proof of hepatitis B
4 vaccination for entry into public or private
5 daycare, preschool, elementary school, sec-
6 ondary school, and institutions of higher
7 education;
8 ''(iv) expanding the availability of
9 hepatitis B vaccination for all susceptible
10 adults to protect them from becoming
11 acutely or chronically infected, including
12 ethnic and other populations with high
13 prevalence rates of chronic hepatitis B in-
14 fection;
15 ''(v) expanding the availability of hep-
16 atitis B vaccination for all susceptible
17 adults, particularly those in their reproduc-
18 tive age (women and men less than 45
19 years of age), to protect them from the
20 risk of hepatitis B infection;
21 ''(vi) ensuring the vaccination of indi-
22 viduals infected, or at risk for infection,
23 with hepatitis C against hepatitis A, hepa-
24 titis B, and other infectious diseases, as

1 appropriate, for which such individuals
2 may be at increased risk; and
3 "(vii) ensuring the vaccination of indi-
4 viduals infected, or at risk for infection,
5 with hepatitis B against hepatitis A virus
6 and other infectious diseases, as appro-
7 priate, for which such individuals may be
8 at increased risk.
9 "(D) MEDICAL REFERRAL.—The Secretary
10 shall support State, local, territorial, and tribal
11 programs that support—
12 "(i) referral of persons chronically in-
13 fected with hepatitis B or hepatitis C—
14 "(I) for medical evaluation to de-
15 termine the appropriateness for
16 antiviral treatment to reduce the risk
17 of progression to cirrhosis and liver
18 cancer; and
19 "(II) for ongoing medical man-
20 agement including regular monitoring
21 of liver function and screening for
22 liver cancer; and
23 "(ii) referral of persons infected with
24 acute or chronic hepatitis B infection or
25 acute or chronic hepatitis C infection for

1 drug and alcohol abuse treatment where
2 appropriate.
3 "(3) INCREASED SUPPORT FOR ADULT VIRAL
4 HEPATITIS COORDINATORS.—The Secretary, acting
5 through the Director of the Centers for Disease
6 Control and Prevention, shall provide increased sup-
7 port to Adult Viral Hepatitis Coordinators in State,
8 local, territorial, and tribal health departments in
9 order to enhance the additional management, net-
10 working, and technical expertise needed to ensure
11 successful integration of hepatitis B and hepatitis C
12 prevention and control activities into existing public
13 health programs.
14 "(c) EPIDEMIOLOGICAL SURVEILLANCE.—
15 "(1) IN GENERAL.—The Secretary, acting
16 through the Director of the Centers for Disease
17 Control and Prevention, shall support the establish-
18 ment and maintenance of a national chronic and
19 acute hepatitis B and hepatitis C surveillance pro-
20 gram, in order to identify—
21 "(A) trends in the incidence of acute and
22 chronic hepatitis B and acute and chronic hepa-
23 titis C;
24 "(B) trends in the prevalence of acute and
25 chronic hepatitis B and acute and chronic hepa-

1 titis C infection among groups that may be dis-
2 proportionately affected; and
3 ''(C) trends in liver cancer and end-stage
4 liver disease incidence and deaths, caused by
5 chronic hepatitis B and chronic hepatitis C in
6 the high-risk ethnic populations.
7 ''(2) SEROPREVALENCE AND LIVER CANCER
8 STUDIES.—The Secretary, acting through the Direc-
9 tor of the Centers for Disease Control and Preven-
10 tion, shall prepare a report outlining the population-
11 based seroprevalence studies currently underway, fu-
12 ture planned studies, the criteria involved in deter-
13 mining which seroprevalence studies to conduct,
14 defer, or suspend, and the scope of those studies, the
15 economic and clinical impact of hepatitis B and hep-
16 atitis C, and the impact of chronic hepatitis B and
17 chronic hepatitis C infections on the quality of life.
18 Not later than one year after the date of the enact-
19 ment of this part, the Secretary shall submit the re-
20 port to the Committee on Energy and Commerce of
21 the House of Representatives and the Committee on
22 Health, Education, Labor, and Pensions of the Sen-
23 ate.
24 ''(3) CONFIDENTIALITY.—The Secretary shall
25 not disclose any individually identifiable information

1 identified under paragraph (1) or derived through
2 studies under paragraph (2).
3 ''(d) RESEARCH.—The Secretary, acting through the
4 Director of the Centers for Disease Control and Preven-
5 tion, the Director of the National Cancer Institute, and
6 the Director of the National Institutes of Health, shall—
7 ''(1) conduct epidemiologic and community-
8 based research to develop, implement, and evaluate
9 best practices for hepatitis B and hepatitis C pre-
10 vention especially in the ethnic populations with high
11 rates of chronic hepatitis B and chronic hepatitis C
12 and other high-risk groups;
13 ''(2) conduct research on hepatitis B and hepa-
14 titis C natural history, pathophysiology, improved
15 treatments and prevention (such as the hepatitis C
16 vaccine), and noninvasive tests that help to predict
17 the risk of progression to liver cirrhosis and liver
18 cancer;
19 ''(3) conduct research that will lead to better
20 noninvasive or blood tests to screen for liver cancer,
21 and more effective treatments of liver cancer caused
22 by chronic hepatitis B and chronic hepatitis C; and
23 ''(4) conduct research comparing the effective-
24 ness of screening, diagnostic, management, and
25 treatment approaches for chronic hepatitis B, chron-

1 ic hepatitis C, and liver cancer in the affected com-
2 munities.
3 ‘‘(e) UNDERSERVED AND DISPROPORTIONATELY AF-
4 FECTED POPULATIONS.—In carrying out this section, the
5 Secretary shall provide expanded support for individuals
6 with limited access to health education, testing, and health
7 care services and groups that may be disproportionately
8 affected by hepatitis B and hepatitis C.
9 ‘‘(f) EVALUATION OF PROGRAM.—The Secretary
10 shall develop benchmarks for evaluating the effectiveness
11 of the programs and activities conducted under this sec-
12 tion and make determinations as to whether such bench-
13 marks have been achieved.
14 **‘‘SEC. 399NN–2. GRANTS.**
15 ‘‘(a) IN GENERAL.—The Secretary may award grants
16 to, or enter into contracts or cooperative agreements with,
17 States, political subdivisions of States, territories, Indian
18 tribes, or nonprofit entities that have special expertise re-
19 lating to hepatitis B, hepatitis C, or both, to carry out
20 activities under this part.
21 ‘‘(b) APPLICATION.—To be eligible for a grant, con-
22 tract, or cooperative agreement under subsection (a), an
23 entity shall prepare and submit to the Secretary an appli-
24 cation at such time, in such manner, and containing such
25 information as the Secretary may require.’’.

1 (d) ENHANCING SAMHSA'S ROLE IN HEPATITIS AC-
2 TIVITIES.—Paragraph (6) of section 501(d) of the Public
3 Health Service Act (42 U.S.C. 290aa(d)) is amended by
4 striking ''HIV or tuberculosis'' and inserting ''HIV, tuber-
5 culosis, or hepatitis''.

6 Subtitle C—Acquired Bone Marrow 7 Failure Diseases

8 **SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

9 (a) SHORT TITLE.—This subtitle may be cited as the
10 ''Bone Marrow Failure Disease Research and Treatment
11 Act of 2012''.

12 (b) FINDINGS.—The Congress finds the following:

13 (1) Between 20,000 and 30,000 Americans are
14 diagnosed each year with myelodysplastic syndromes,
15 aplastic anemia, paroxysmal nocturnal hemo-
16 globinuria, and other acquired bone marrow failure
17 diseases.

18 (2) Acquired bone marrow failure diseases have
19 a debilitating and often fatal impact on those diag-
20 nosed with these diseases.

21 (3) While some treatments for acquired bone
22 marrow failure diseases can prolong and improve the
23 quality of patients' lives, there is no single cure for
24 these diseases.

1 (4) The prevalence of acquired bone marrow
2 failure diseases in the United States will continue to
3 grow as the general public ages.
4 (5) Evidence exists suggesting that acquired
5 bone marrow failure diseases occur more often in
6 minority populations, particularly in Asian-American
7 and Hispanic/Latino populations.
8 (6) The National Heart, Lung, and Blood Insti-
9 tute and the National Cancer Institute have con-
10 ducted important research into the causes of and
11 treatments for acquired bone marrow failure dis-
12 eases.
13 (7) The National Marrow Donor Program Reg-
14 istry has made significant contributions to the fight
15 against bone marrow failure diseases by connecting
16 millions of potential marrow donors with individuals
17 and families suffering from these conditions.
18 (8) Despite these advances, a more comprehen-
19 sive Federal strategic effort among numerous Fed-
20 eral agencies is needed to discover a cure for ac-
21 quired bone marrow failure disorders.
22 (9) Greater Federal surveillance of acquired
23 bone marrow failure diseases is needed to gain a bet-
24 ter understanding of the causes of acquired bone
25 marrow failure diseases.

1 (10) The Federal Government should increase
2 its research support for and engage with public and
3 private organizations in developing a comprehensive
4 approach to combat and cure acquired bone marrow
5 failure diseases.
6 (c) NATIONAL ACQUIRED BONE MARROW FAILURE
7 DISEASE REGISTRY.—Part B of the Public Health Service
8 Act (42 U.S.C. 311 et seq.) is amended by inserting after
9 section 317W, as added, the following:

10 **"SEC. 317X. NATIONAL ACQUIRED BONE MARROW FAILURE**
11 **DISEASE REGISTRY.**

12 "(a) ESTABLISHMENT OF REGISTRY.—
13 "(1) IN GENERAL.—Not later than 6 months
14 after the date of the enactment of this section, the
15 Secretary, acting through the Director of the Cen-
16 ters for Disease Control and Prevention, shall—
17 "(A) develop a system to collect data on
18 acquired bone marrow failure diseases; and
19 "(B) establish and maintain a national and
20 publicly available registry, to be known as the
21 National Acquired Bone Marrow Failure Dis-
22 ease Registry, in accordance with paragraph
23 (3).
24 "(2) RECOMMENDATIONS OF ADVISORY COM-
25 MITTEE.—In carrying out this subsection, the Sec-

1 retary shall take into consideration the recommenda-
2 tions of the Advisory Committee on Acquired Bone
3 Marrow Failure Diseases established under sub-
4 section (b).
5 ''(3) PURPOSES OF REGISTRY.—The National
6 Acquired Bone Marrow Failure Disease Registry—
7 ''(A) shall identify the incidence and preva-
8 lence of acquired bone marrow failure diseases
9 in the United States;
10 ''(B) shall be used to collect and store data
11 on acquired bone marrow failure diseases, in-
12 cluding data concerning—
13 ''(i) the age, race or ethnicity, general
14 geographic location, sex, and family history
15 of individuals who are diagnosed with ac-
16 quired bone marrow failure diseases, and
17 any other characteristics of such individ-
18 uals determined appropriate by the Sec-
19 retary;
20 ''(ii) the genetic and environmental
21 factors that may be associated with devel-
22 oping acquired bone marrow failure dis-
23 eases;

1 "(iii) treatment approaches for deal-
2 ing with acquired bone marrow failure dis-
3 eases;
4 "(iv) outcomes for individuals treated
5 for acquired bone marrow failure diseases,
6 including outcomes for recipients of stem
7 cell therapeutic products as contained in
8 the database established pursuant to sec-
9 tion 379A; and
10 "(v) any other factors pertaining to
11 acquired bone marrow failure diseases de-
12 termined appropriate by the Secretary; and
13 "(C) shall be made available—
14 "(i) to the general public; and
15 "(ii) to researchers to facilitate fur-
16 ther research into the causes of, and treat-
17 ments for, acquired bone marrow failure
18 diseases in accordance with standard prac-
19 tices of the Centers for Disease Control
20 and Preventions.
21 "(b) ADVISORY COMMITTEE.—
22 "(1) ESTABLISHMENT.—Not later than 6
23 months after the date of the enactment of this sec-
24 tion, the Secretary, acting through the Director of
25 the Centers for Disease Control and Prevention,

1 shall establish an advisory committee, to be known
2 as the Advisory Committee on Acquired Bone Mar-
3 row Failure Diseases.
4 ‘‘(2) MEMBERS.—The members of the Advisory
5 Committee on Acquired Bone Marrow Failure Dis-
6 eases shall be appointed by the Secretary, acting
7 through the Director of the Centers for Disease
8 Control and Prevention, and shall include at least
9 one representative from each of the following:
10 ‘‘(A) A national patient advocacy organiza-
11 tion with experience advocating on behalf of pa-
12 tients suffering from acquired bone marrow
13 failure diseases.
14 ‘‘(B) The National Institutes of Health, in-
15 cluding at least one representative from each
16 of—
17 ‘‘(i) the National Cancer Institute;
18 ‘‘(ii) the National Heart, Lung, and
19 Blood Institute; and
20 ‘‘(iii) the Office of Rare Diseases.
21 ‘‘(C) The Centers for Disease Control and
22 Prevention.
23 ‘‘(D) Clinicians with experience in—
24 ‘‘(i) diagnosing or treating acquired
25 bone marrow failure diseases; and

1 "(ii) medical data registries.
2 "(E) Epidemiologists who have experience
3 with data registries.
4 "(F) Publicly or privately funded research-
5 ers who have experience researching acquired
6 bone marrow failure diseases.
7 "(G) The entity operating the C.W. Bill
8 Young Cell Transplantation Program estab-
9 lished pursuant to section 379 and the entity
10 operating the C.W. Bill Young Cell Transplan-
11 tation Program Outcomes Database.
12 "(3) RESPONSIBILITIES.—The Advisory Com-
13 mittee on Acquired Bone Marrow Failure Diseases
14 shall provide recommendations to the Secretary on
15 the establishment and maintenance of the National
16 Acquired Bone Marrow Failure Disease Registry, in-
17 cluding recommendations on the collection, mainte-
18 nance, and dissemination of data.
19 "(4) PUBLIC AVAILABILITY.—The Secretary
20 shall make the recommendations of the Advisory
21 Committee on Acquired Bone Marrow Failure Dis-
22 ease publicly available.
23 "(c) GRANTS.—The Secretary, acting through the
24 Director of the Centers for Disease Control and Preven-
25 tion, may award grants to, and enter into contracts and

1 cooperative agreements with, public or private nonprofit
2 entities for the management of, as well as the collection,
3 analysis, and reporting of data to be included in, the Na-
4 tional Acquired Bone Marrow Failure Disease Registry.
5 "(d) DEFINITION.—In this section, the term 'ac-
6 quired bone marrow failure disease' means—
7 "(1) myelodysplastic syndromes (MDS);
8 "(2) aplastic anemia;
9 "(3) paroxysmal nocturnal hemoglobinuria
10 (PNH);
11 "(4) pure red cell aplasia;
12 "(5) acute myeloid leukemia that has pro-
13 gressed from myelodysplastic syndromes; or
14 "(6) large granular lymphocytic leukemia.".
15 (d) PILOT STUDIES THROUGH THE AGENCY FOR
16 TOXIC SUBSTANCES AND DISEASE REGISTRY.—
17 (1) PILOT STUDIES.—The Secretary of Health
18 and Human Services, acting through the Adminis-
19 trator of the Agency for Toxic Substances and Dis-
20 ease Registry, shall conduct pilot studies to deter-
21 mine which environmental factors, including expo-
22 sure to toxins, may cause acquired bone marrow fail-
23 ure diseases.
24 (2) COLLABORATION WITH THE RADIATION IN-
25 JURY TREATMENT NETWORK.—In carrying out the

1 directives of this section, the Secretary may collabo-
2 rate with the Radiation Injury Treatment Network
3 of the C.W. Bill Young Cell Transplantation Pro-
4 gram established pursuant to section 379 of the
5 Public Health Service Act (42 U.S.C. 274j) to—
6 (A) augment data for the pilot studies au-
7 thorized by this section;
8 (B) access technical assistance that may be
9 provided by the Radiation Injury Treatment
10 Network; or
11 (C) perform joint research projects.
12 (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
13 BONE MARROW FAILURE DISEASES.—Title XVII of the
14 Public Health Service Act (42 U.S.C. 300u et seq.) is
15 amended by inserting after section 1707A the following:
16 "MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE
17 MARROW FAILURE DISEASES
18 "SEC. 1707B. (a) INFORMATION AND REFERRAL
19 SERVICES.—
20 "(1) IN GENERAL.—Not later than 6 months
21 after the date of the enactment of this section, the
22 Secretary, acting through the Deputy Assistant Sec-
23 retary for Minority Health, shall establish and co-
24 ordinate outreach and informational programs tar-
25 geted to minority populations affected by acquired
26 bone marrow failure diseases.

1 "(2) PROGRAM REQUIREMENTS.—Minority-fo-
2 cused outreach and informational programs author-
3 ized by this section—
4 "(A) shall make information about treat-
5 ment options and clinical trials for acquired
6 bone marrow failure diseases publicly available,
7 and
8 "(B) shall provide referral services for
9 treatment options and clinical trials,
10 at the national minority health resource center sup-
11 ported under section 1707(b)(8) (including by means
12 of the center's Web site, through appropriate loca-
13 tions such as the center's knowledge center, and
14 through appropriate programs such as the center's
15 resource persons network) and through minority
16 health consultants located at each Department of
17 Health and Human Services regional office.
18 "(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
19 ISLANDER OUTREACH.—
20 "(1) IN GENERAL.—The Secretary, acting
21 through the Deputy Assistant Secretary for Minority
22 Health, shall undertake a coordinated outreach ef-
23 fort to connect Hispanic, Asian-American, and Pa-
24 cific Islander communities with comprehensive serv-

1 ices focused on treatment of, and information about,
2 acquired bone marrow failure diseases.
3 "(2) COLLABORATION.—In carrying out this
4 subsection, the Secretary may collaborate with public
5 health agencies, nonprofit organizations, community
6 groups, and online entities to disseminate informa-
7 tion about treatment options and clinical trials for
8 acquired bone marrow failure diseases.
9 "(c) GRANTS AND COOPERATIVE AGREEMENTS.—
10 "(1) IN GENERAL.—Not later than 6 months
11 after the date of the enactment of this section, the
12 Secretary, acting through the Deputy Assistant Sec-
13 retary for Minority Health, shall award grants to, or
14 enter into cooperative agreements with, entities to
15 perform research on acquired bone marrow failure
16 diseases.
17 "(2) REQUIREMENT.—Grants and cooperative
18 agreements authorized by this subsection shall be
19 awarded or entered into on a competitive, peer-re-
20 viewed basis.
21 "(3) SCOPE OF RESEARCH.—Research funded
22 under this section shall examine factors affecting the
23 incidence of acquired bone marrow failure diseases
24 in minority populations.

1 "(d) DEFINITION.—In this section, the term 'ac-
2 quired bone marrow failure disease' has the meaning given
3 to such term in section 317X(d).".
4 (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-
5 QUIRED BONE MARROW FAILURE DISEASES.—The Sec-
6 retary of Health and Human Services, acting through the
7 Director of the Agency for Healthcare Research and Qual-
8 ity, shall award grants to entities to improve diagnostic
9 practices and quality of care with respect to patients with
10 acquired bone marrow failure diseases.
11 (g) DEFINITION.—In this section, the term "acquired
12 bone marrow failure disease" means—
13 (1) myelodysplastic syndromes (MDS);
14 (2) aplastic anemia;
15 (3) paroxysmal nocturnal hemoglobinuria
16 (PNH);
17 (4) pure red cell aplasia;
18 (5) acute myeloid leukemia that progressed
19 from myelodysplastic syndromes; or
20 (6) large granular lymphocytic leukemia.

Subtitle D—Cardiovascular Disease, Chronic Disease, and Other Disease Issues

SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MINORITY PATIENTS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall convene a series of meetings to develop guidelines for disease screening for minority patient populations which have a higher than average risk for many chronic diseases and cancers.

(b) PARTICIPANTS.—In convening meetings under subsection (a), the Secretary shall ensure that meeting participants include representatives of—

(1) professional societies and associations;

(2) minority health organizations;

(3) health care researchers and providers, including those with expertise in minority health;

(4) Federal health agencies, including the Office of Minority Health, the National Institute on Minority Health and Health Disparities, and the National Institutes of Health; and

(5) other experts determined appropriate by the Secretary.

1 (c) DISEASES.—Screening guidelines for minority
2 populations shall be developed as appropriate under sub-
3 section (a) for—
4 (1) hypertension;
5 (2) hypercholesterolemia;
6 (3) diabetes;
7 (4) cardiovascular disease;
8 (5) cancers, including breast, prostate, colon,
9 cervical, and lung cancer;
10 (6) asthma;
11 (7) diabetes;
12 (8) kidney diseases;
13 (9) eye diseases and disorders, including glau-
14 coma;
15 (10) HIV/AIDS and sexually transmitted dis-
16 eases;
17 (11) uterine fibroids;
18 (12) autoimmune disease;
19 (13) mental health conditions;
20 (14) dental health conditions and oral diseases;
21 (15) environmental and related health illnesses
22 and conditions;
23 (16) Sickle cell disease;
24 (17) violence and injury prevention and control;
25 (18) genetic and related conditions;

1 (19) heart disease and stroke;

2 (20) tuberculosis;

3 (21) chronic obstructive pulmonary disease; and

4 (22) other diseases determined appropriate by
5 the Secretary.

6 (d) DISSEMINATION.—Not later than 24 months
7 after the date of enactment of this title, the Secretary
8 shall publish and disseminate to health care provider orga-
9 nizations the guidelines developed under subsection (a).

10 **SEC. 732. COVERAGE OF THE SHINGLES VACCINE UNDER**
11 **THE MEDICARE PROGRAM.**

12 (a) IN GENERAL.—Section 1861 of the Social Secu-
13 rity Act (42 U.S.C. 1395x) is amended—

14 (1) in subsection (s)(10)(A), by inserting '',
15 shingles vaccine and its administration,'' before
16 ''and, subject to''; and

17 (2) in subsection (ww)(2)(A), by inserting
18 ''shingles,'' after ''Pneumococcal,''.

19 (b) EFFECTIVE DATE.—The amendments made by
20 subsection (a) shall apply to shingles vaccine furnished on
21 or after January 1 of the first calendar year beginning
22 more than 60 days after the date of the enactment of this
23 Act.

1 **SEC. 733. CDC WISEWOMAN SCREENING PROGRAM.**

2 Section 1509 of the Public Health Service Act (42
3 U.S.C. 300n–4a) is amended—
4 (1) in subsection (a)—
5 (A) by striking the heading and inserting
6 ''IN GENERAL.—''; and
7 (B) in the matter preceding paragraph (1),
8 by striking ''may make grants'' and all that fol-
9 lows through ''purpose'' and inserting the fol-
10 lowing: ''may make grants to such States for
11 the purpose''; and
12 (2) in subsection (d)(1), by striking ''there are
13 authorized'' and all that follows through the period
14 and inserting ''there are authorized to be appro-
15 priated $23,000,000 for fiscal year 2012,
16 $25,300,000 for fiscal year 2013, $27,800,000 for
17 fiscal year 2014, $30,800,000 for fiscal year 2015,
18 and $34,000,000 for fiscal year 2016.''.

19 **SEC. 734. REPORT ON CARDIOVASCULAR CARE FOR WOMEN**
20 **AND MINORITIES.**

21 Part P of title III of the Public Health Service Act
22 (42 U.S.C. 280g et seq.) is amended by adding at the end
23 the following:

1 **"SEC. 399V–7. REPORT ON CARDIOVASCULAR CARE FOR**
2 **WOMEN AND MINORITIES.**

3 "Not later than September 30, 2014, and annually
4 thereafter, the Secretary shall prepare and submit to the
5 Congress a report on the quality of and access to care
6 for women and minorities with heart disease, stroke, and
7 other cardiovascular diseases. The report shall contain rec-
8 ommendations for eliminating disparities in, and improv-
9 ing the treatment of, heart disease, stroke, and other car-
10 diovascular diseases in women, racial and ethnic minori-
11 ties, those for whom English is not their primary lan-
12 guage, and individuals with disabilities.".

13 **SEC. 735. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
14 **SATION SERVICES IN MEDICAID.**

15 (a) REQUIRING COVERAGE OF COUNSELING AND
16 PHARMACOTHERAPY FOR CESSATION OF TOBACCO
17 USE.—Section 1905 of the Social Security Act (42 U.S.C.
18 1396d) is amended—

19 (1) in subsection (a)(4), by striking "by preg-
20 nant women"; and

21 (2) in subsection (bb)—

22 (A) by striking "by pregnant women" each
23 place it appears;

24 (B) in paragraph (1), in the matter before
25 subparagraph (A), by inserting "by individuals"
26 before "who use tobacco"; and

1 (C) in paragraph (2)(A), by striking ''with
2 respect to pregnant women''.
3 (b) EXCEPTION FROM OPTIONAL RESTRICTION
4 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
5 Section 1927(d)(2)(F) of the Social Security Act (42
6 U.S.C. 1396r–8(d)(2)(F)) is amended by striking ''in the
7 case of pregnant women''.
8 (c) REMOVAL OF COST SHARING FOR COUNSELING
9 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
10 USE.—
11 (1) GENERAL COST SHARING LIMITATIONS.—
12 Section 1916 of the Social Security Act (42 U.S.C.
13 1396o) is amended—
14 (A) in subsections (a)(2)(B) and (b)(2)(B),
15 by striking '', and counseling and
16 pharmacotherapy for cessation of tobacco use
17 by pregnant women (as defined in section
18 1905(bb)) and covered outpatient drugs (as de-
19 fined in subsection (k)(2) of section 1927 and
20 including nonprescription drugs described in
21 subsection (d)(2) of such section) that are pre-
22 scribed for purposes of promoting, and when
23 used to promote, tobacco cessation by pregnant
24 women in accordance with the Guideline re-

1 ferred to in section 1905(bb)(2)(A)'' each place
2 it appears; and
3 (B) in each of subsections (a)(2)(D) and
4 (b)(2)(D) by inserting ''and counseling and
5 pharmacotherapy for cessation of tobacco use
6 (as defined in section 1905(bb)) and covered
7 outpatient drugs (as defined in subsection
8 (k)(2) of section 1927 and including non-
9 prescription drugs described in subsection
10 (d)(2) of such section) that are prescribed for
11 purposes of promoting, and when used to pro-
12 mote, tobacco cessation in accordance with the
13 Guideline referred to in section
14 1905(bb)(2)(A),'' after ''section
15 1905(a)(4)(C),''.
16 (2) APPLICATION TO ALTERNATIVE COST-SHAR-
17 ING.—Section 1916A(b)(3)(B) of such Act (42
18 U.S.C. 1396o–1(b)(3)(B)) is amended—
19 (A) in clause (iii), by striking '', and coun-
20 seling and pharmacotherapy for cessation of to-
21 bacco use by pregnant women (as defined in
22 section 1905(bb))''; and
23 (B) by adding at the end the following:
24 ''(xi) Counseling and
25 pharmacotherapy for cessation of tobacco

1 use (as defined in section 1905(bb)) and
2 covered outpatient drugs (as defined in
3 subsection (k)(2) of section 1927 and in-
4 cluding nonprescription drugs described in
5 subsection (d)(2) of such section) that are
6 prescribed for purposes of promoting, and
7 when used to promote, tobacco cessation in
8 accordance with the Guideline referred to
9 in section 1905(bb)(2)(A).''.

10 (d) EFFECTIVE DATE.—The amendments made by
11 this section shall take effect on October 1, 2012.

12 **SEC. 736. CLINICAL RESEARCH FUNDING FOR ORAL**
13 **HEALTH.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services shall expand and intensify the conduct
16 and support of the research activities of the National In-
17 stitutes of Health and the National Institute of Dental
18 and Craniofacial Research to improve the oral health of
19 the population through the prevention and management
20 of oral diseases and conditions.

21 (b) INCLUDED RESEARCH ACTIVITIES.—Research
22 activities under subsection (a) shall include—

23 (1) comparative effectiveness research and clin-
24 ical disease management research addressing early
25 childhood caries and oral cancer; and

(2) awarding of grants and contracts to support the training and development of health services researchers, comparative effectiveness researchers, and clinical researchers whose research improves the oral health of the population.

SEC. 737. PARTICIPATION BY MEDICAID BENEFICIARIES IN APPROVED CLINICAL TRIALS.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1943 the following new section:

"PARTICIPATION IN AN APPROVED CLINICAL TRIAL

"SEC. 1944. (a) COVERAGE OF ROUTINE PATIENT COSTS ASSOCIATED WITH APPROVED CLINICAL TRIALS.—

"(1) INCLUSION.—Subject to paragraph (2), routine patient costs shall include all items and services consistent with the medical assistance provided under the State plan that would otherwise be provided to the individual under such State plan if such individual was not enrolled in the approved clinical trial, including any items or services related to the prevention, detection, and treatment of any medical complications that arise as a result of participation in the approved clinical trial.

"(2) EXCLUSION.—For purposes of paragraph (1), routine patient costs does not include—

1 "(A) the investigational item, device, or
2 service itself;
3 "(B) items and services that are provided
4 solely to satisfy data collection and analysis
5 needs and that are not used in the direct clin-
6 ical management of the patient; or
7 "(C) a service that is clearly inconsistent
8 with widely accepted and established standards
9 of care for a particular diagnosis.
10 "(3) INFORMATION CONCERNING CLINICAL
11 TRIALS.—
12 "(A) IN GENERAL.—Subject to subpara-
13 graph (B), the Secretary, in consultation with
14 relevant stakeholders, shall develop a single
15 standardized electronic form for use by the indi-
16 vidual or the referring health care provider to
17 submit to the State agency administering the
18 State plan in order to verify that the clinical
19 trial meets the conditions established for an ap-
20 proved clinical trial (as defined in subsection
21 (c)).
22 "(B) EXCLUDED INFORMATION.—For pur-
23 poses of subparagraph (A) or any such request
24 by the State agency for information regarding

1 a clinical trial, an individual or referring health
2 care provider shall not be required to submit—
3 ''(i) the clinical protocol document for
4 the clinical trial; or
5 ''(ii) subject to subparagraph (C), any
6 additional information other than such in-
7 formation as is required pursuant to the
8 form described in subparagraph (A).
9 ''(C) OPTIONAL INFORMATION.—For pur-
10 poses of subparagraphs (A) and (B)(ii), the
11 form may include a requirement that the refer-
12 ring health care provider attest that the indi-
13 vidual is eligible to participate in the clinical
14 trial pursuant to the trial protocol and that
15 their participation in such trial would be appro-
16 priate.
17 ''(D) REVIEW OF INFORMATION.—
18 ''(i) IN GENERAL.—A State plan
19 under this title shall establish a process for
20 timely review by the State agency of the
21 form and information submitted pursuant
22 to subparagraph (A) and, not later than
23 48 hours after receipt of such form, con-
24 firmation that the information provided in
25 such form satisfies the requirements estab-

1 lished under such subparagraph, with such
2 process to include establishment and oper-
3 ation of a 24-hour toll-free telephone num-
4 ber and e-mail address to provide for expe-
5 dited communication.
6 ''(ii) FAILURE TO RESPOND.—If an
7 individual or the referring health care pro-
8 vider does not receive a response or re-
9 quest for additional information from the
10 State agency following the 48-hour period
11 described in clause (i), the information
12 provided in the form may be presumed to
13 satisfy the requirements established under
14 this paragraph.
15 ''(b) ENCOURAGEMENT OF PARTICIPATION IN AP-
16 PROVED CLINICAL TRIALS.—
17 ''(1) REASONABLY ACCESSIBLE PROVIDER.—
18 For purposes of participation in an approved clinical
19 trial by an individual eligible for medical assistance
20 under this title, the State agency administering the
21 State plan shall make reasonable efforts to ensure
22 that the individual is provided with access to a pro-
23 vider who is—
24 ''(A) participating in the approved clinical
25 trial;

1 "(B) located not more than 25 miles from
2 the residence of the individual (or, if no such
3 provider is available, as close as possible to the
4 residence of the individual); and
5 "(C) a participating provider under the
6 State plan or has been deemed to be a partici-
7 pating provider under the State plan for pur-
8 poses of providing medical assistance to the in-
9 dividual during their participation in the ap-
10 proved clinical trial.
11 "(2) INFORMATIONAL MATERIALS.—The State
12 agency administering the plan approved under this
13 title shall develop informational materials and pro-
14 grams to encourage participating providers to make
15 appropriate referrals to physicians and other appro-
16 priate health care professionals who can provide in-
17 dividuals with access to approved clinical trials.
18 "(c) DEFINITION OF APPROVED CLINICAL TRIAL.—
19 The term 'approved clinical trial' has the same meaning
20 as provided under section 2709(d) of the Public Health
21 Service Act.".
22 (b) CONFORMING AMENDMENTS.—Section 1902(a)
23 of such Act (42 U.S.C. 1396a(a)) is amended—
24 (1) in paragraph (82)(C), by striking "and" at
25 the end;

1 (2) in paragraph (83), by striking the period at
2 the end and inserting ''; and''; and
3 (3) by inserting after paragraph (83) the fol-
4 lowing:
5 ''(84) provide that participation in an approved
6 clinical trial and coverage of routine patient costs
7 associated with such trial for an individual eligible
8 for medical assistance under this title is conducted
9 in accordance with the requirements under section
10 1944.''.
11 (c) EFFECTIVE DATE.—
12 (1) IN GENERAL.—Except as provided in para-
13 graph (2), the amendments made by this section
14 shall apply to calendar quarters beginning on or
15 after October 1, 2012.
16 (2) DELAY PERMITTED FOR STATE PLAN
17 AMENDMENT.—In the case of a State plan for med-
18 ical assistance under title XIX of the Social Security
19 Act which the Secretary of Health and Human Serv-
20 ices determines requires State legislation (other than
21 legislation appropriating funds) in order for the plan
22 to meet the additional requirements imposed by the
23 amendments made by this section, the State plan
24 shall not be regarded as failing to comply with the
25 requirements of such title solely on the basis of its

1 failure to meet these additional requirements before
2 the first day of the first calendar quarter beginning
3 after the close of the first regular session of the
4 State legislature that begins after the date of enact-
5 ment of this Act. For purposes of the previous sen-
6 tence, in the case of a State that has a 2-year legis-
7 lative session, each year of such session shall be
8 deemed to be a separate regular session of the State
9 legislature.

10 Subtitle E—HIV/AIDS

11 SEC. 741. FINDINGS.

12 The Congress finds the following:
13 (1) Over one million people are estimated to be
14 living with HIV in the United States according to
15 the Centers for Disease Control and Prevention.
16 (2) Annually there are over 17,000 deaths in
17 people with an HIV diagnoses in 40 States and 5
18 dependent areas of the United States.
19 (3) The Centers for Disease Control and Pre-
20 vention estimates that in 2009 there were approxi-
21 mately 48,100 people newly infected with HIV.
22 Though this number seems to be staying relatively
23 stable, the number of new infections is rapidly in-
24 creasing among certain populations especially among
25 young African-American men who have sex with men

1 who had an overall 48 percent increase in new infec-
2 tions from 2006 to 2009.
3 (4) HIV disproportionately affects certain popu-
4 lations in the United States. Though African-Ameri-
5 cans represent less than 13 percent of the popu-
6 lation, African-Americans account for almost half
7 (46 percent) of all people living with HIV in the
8 United States. Men who have sex with men (MSM)
9 make up approximately 2 percent of the population,
10 but account for over half (53 percent) of individuals
11 living with HIV and are the only risk group in which
12 HIV infections continue to increase.
13 (5) Disparities exist among Latinos; they make
14 up 15 percent of US population and 17 percent of
15 new infections (2006).
16 (6) Though American Indians/Alaska Natives
17 represent less than 1 percent of the total number of
18 HIV/AIDS cases, American Indians and Alaska Na-
19 tives rank third in rates of HIV/AIDS diagnosis,
20 after African-Americans and Latinos.
21 (7) While Asian-Americans, Native Hawaiians,
22 and Pacific Islanders HIV/AIDS cases account for
23 approximately 1 percent of cases nationally, Asian
24 Americans and Pacific Islanders were the only ra-
25 cial/ethnic groups with a statistically significant in-

1 crease in new HIV diagnoses between 2001 and
2 2008.
3 (8) The limited data available on transgender
4 individuals point to a disproportionate burden of
5 HIV infection.
6 (9) Stigma and discrimination contribute to
7 these disparities.
8 (10) For HIV, early detection and treatment
9 can have huge effects. New research suggests that
10 treatment of individuals not only slows disease pro-
11 gression, but can also greatly reduce the risk of
12 transmission to other individuals.
13 (11) To combat the HIV epidemic in the United
14 States, the National HIV/AIDS Strategy (NHAS)
15 from the White House Office of National AIDS Pol-
16 icy provides a framework of increasing access to
17 care, reducing new infections, and eliminating HIV-
18 related health disparities. The vision of NHAS is
19 ''The United States will become a place where new
20 HIV infections are rare and when they do occur,
21 every person, regardless of age, gender, race/eth-
22 nicity, sexual orientation, gender identity, or socio-
23 economic circumstance, will have unfettered access
24 to high quality, life extending care, free from stigma
25 and discrimination.''.

1 (12) Although the cost of education, treatment
2 and care, and research are not inconsequential, they
3 are substantially less than the annual health care
4 cost attributable to HIV in the United States. The
5 lifetime cost of HIV care and treatment in 2004 was
6 estimated to be $405,000 to $648,000 dollars annu-
7 ally. Preventing 40,000 new infections in the United
8 States each year would save $12.8 billion annually.

9 **SEC. 742. ADDRESSING HIV/AIDS IN COMMUNITIES OF**
10 **COLOR.**

11 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
12 of the Congress that national observance days highlighting
13 the impact of HIV/AIDS on communities of color include
14 the following:
15 (1) National Black HIV/AIDS Awareness Day.
16 (2) National Latino AIDS Awareness Day.
17 (3) National Asian and Pacific Islander HIV/
18 AIDS Awareness Day.
19 (4) National Native HIV/AIDS Awareness Day.
20 (5) Caribbean American HIV/AIDS Awareness
21 Day.
22 (b) CALL TO ACTION.—It is the sense of the Con-
23 gress that the President should call on members of com-
24 munities of color—

1 (1) to become involved at the local community
2 level in HIV/AIDS testing, policy, and advocacy;
3 (2) to become aware, engaged, and empowered
4 on the HIV/AIDS epidemic within their commu-
5 nities; and
6 (3) to urge members of their communities to re-
7 duce risk factors, practice safe sex and other preven-
8 tive measures, be tested for HIV/AIDS, and seek
9 care when appropriate.

10 **SEC. 743. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MI-**
11 **NORITY COMMUNITIES.**

12 (a) EXPANDED FUNDING.—The Secretary, in col-
13 laboration with the Deputy Assistant Secretary for Minor-
14 ity Health, the Director of the Centers for Disease Control
15 and Prevention, the Administrator of the Health Re-
16 sources and Services Administration, and the Adminis-
17 trator of the Substance Abuse and Mental Health Services
18 Administration, shall provide funds and carry out activi-
19 ties to expand the Minority HIV/AIDS Initiative.
20 (b) USE OF FUNDS.—The additional funds made
21 available under this section may be used, through the Mi-
22 nority AIDS Initiative, to support the following activities:
23 (1) Providing technical assistance and infra-
24 structure support to reduce HIV/AIDS in minority
25 populations.

1 (2) Increasing minority populations' access to
2 HIV/AIDS prevention and care services.
3 (3) Building strong community programs and
4 partnerships to address HIV prevention and the
5 health care needs of specific racial and ethnic minor-
6 ity populations.
7 (c) PRIORITY INTERVENTIONS.—Within the racial
8 and ethnic minority populations referred to in subsection
9 (b), priority in conducting intervention services shall be
10 given to—
11 (1) women;
12 (2) youth;
13 (3) men who have sex with men;
14 (4) persons who engage in intravenous drug
15 abuse;
16 (5) homeless individuals; and
17 (6) individuals incarcerated or in the penal sys-
18 tem.

19 **SEC. 744. REPEALING INEFFECTIVE AND INCOMPLETE AB-**
20 **STINENCE-ONLY EDUCATION PROGRAM.**

21 (a) IN GENERAL.—Title V of the Social Security Act
22 (42 U.S.C. 701 et seq.) is amended by striking section
23 510.
24 (b) RESCISSION.—Amounts appropriated for each of
25 fiscal years 2010 and 2011 under section 510(d) of the

1 Social Security Act (42 U.S.C. 710(d)) (as in effect on
2 the day before the date of enactment of this Act) that are
3 unobligated as of the date of enactment of this Act are
4 rescinded.

5 (c) REPROGRAM OF ELIMINATED ABSTINENCE-ONLY
6 FUNDS FOR THE PERSONAL RESPONSIBILITY EDUCATION
7 PROGRAM (PREP).—Section 513(f) of the Social Security
8 Act (42 U.S.C. 713(f)) is amended by striking ''for each
9 of fiscal years 2010 through 2014'' and inserting ''for fis-
10 cal year 2010, $75,000,000 increased by an amount equal
11 to the unobligated portion of funds appropriated for each
12 of fiscal years 2010 and 2011 under section 510(d) that
13 are rescinded under subsection (b), and $125,000,000 for
14 each of fiscal years 2012 through 2014''.

15 **SEC. 745. DENTAL EDUCATION LOAN REPAYMENT PRO-**
16 **GRAM.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services may enter into an agreement with any
19 dentist under which—

20 (1) the dentist agrees to serve as a dentist for
21 a period of not less than 2 years at a facility with
22 a critical shortage of dentists (as determined by the
23 Secretary) in an area with a high incidence of HIV/
24 AIDS; and

1 (2) the Secretary agrees to make payments in
2 accordance with subsection (b) on the dental edu-
3 cation loans of the dentist.
4 (b) MANNER OF PAYMENTS.—The payments de-
5 scribed in subsection (a) shall be made by the Secretary
6 as follows:
7 (1) Upon completion by the dentist for whom
8 the payments are to be made of the first year of the
9 service specified in the agreement entered into with
10 the Secretary under subsection (a), the Secretary
11 shall pay 30 percent of the principal of and the in-
12 terest on the dental education loans of the dentist.
13 (2) Upon completion by the dentist of the sec-
14 ond year of such service, the Secretary shall pay an-
15 other 30 percent of the principal of and the interest
16 on such loans.
17 (3) Upon completion by that individual of a
18 third year of such service, the Secretary shall pay
19 another 25 percent of the principal of and the inter-
20 est on such loans.
21 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
22 provisions of subpart III of part D of title III of the Public
23 Health Service Act (42 U.S.C. 254l et seq.) shall, except
24 as inconsistent with this section, apply to the program car-
25 ried out under this section in the same manner and to

1 the same extent as such provisions apply to the National
2 Health Service Corps Loan Repayment Program.
3 (d) REPORTS.—Not later than 18 months after the
4 date of the enactment of this Act, and annually thereafter,
5 the Secretary shall prepare and submit to the Congress
6 a report describing the program carried out under this sec-
7 tion, including statements regarding the following:
8 (1) The number of dentists enrolled in the pro-
9 gram.
10 (2) The number and amount of loan repay-
11 ments.
12 (3) The placement location of loan repayment
13 recipients at facilities described in subsection (a)(1).
14 (4) The default rate and actions required.
15 (5) The amount of outstanding default funds.
16 (6) To the extent that it can be determined, the
17 reason for the default.
18 (7) The demographics of individuals partici-
19 pating in the program.
20 (8) An evaluation of the overall costs and bene-
21 fits of the program.
22 (e) DEFINITIONS.—In this section:
23 (1) The term ''dental education loan''—
24 (A) means a loan that is incurred for the
25 cost of attendance (including tuition, other rea-

1 sonable educational expenses, and reasonable
2 living costs) at a school of dentistry; and
3 (B) includes only the portion of the loan
4 that is outstanding on the date the dentist in-
5 volved begins the service specified in the agree-
6 ment under subsection (a).
7 (2) The term ''dentist'' means a graduate of a
8 school of dentistry who has completed postgraduate
9 training in general or pediatric dentistry.
10 (3) The term ''HIV/AIDS'' means human im-
11 munodeficiency virus and acquired immune defi-
12 ciency syndrome.
13 (4) The term ''school of dentistry'' has the
14 meaning given to that term in section 799B of the
15 Public Health Service Act (42 U.S.C. 295p).
16 (5) The term ''Secretary'' means the Secretary
17 of Health and Human Services.

18 **SEC. 746. REPORT ON THE IMPLEMENTATION OF THE NA-**
19 **TIONAL HIV/AIDS STRATEGY.**

20 (a) REPORT REQUIRED.—Not later than 6 months
21 after the date of the enactment of this Act, the President,
22 in consultation with the heads of all relevant agencies in-
23 cluding the Department of Education, the Department of
24 Health and Human Services, the Department of Housing
25 and Urban Development, the Department of Justice, the

1 Department of Labor, the Department of Veterans Af-
2 fairs, and the Social Security Administration, shall trans-
3 mit to the Congress and make publicly available a report
4 on the status of the implementation of the National HIV/
5 AIDS Strategy.

6 (b) CONTENTS.—The report required by subsection
7 (a) shall include a description, analysis, and evaluation
8 of—

9 (1) key steps taken by the Federal Government
10 towards the achievement of the goals of the National
11 HIV/AIDS Strategy, including the goals of—

12 (A) reducing the number of people who be-
13 come infected with HIV;

14 (B) increasing access to care and opti-
15 mizing health outcomes for people living with
16 HIV; and

17 (C) reducing HIV-related health dispari-
18 ties;

19 (2) the extent to which the National HIV/AIDS
20 Strategy has improved coordination of efforts to
21 maximize the effective delivery of HIV/AIDS preven-
22 tion, care, and treatment services at the community
23 level, including coordination—

24 (A) within and among Federal agencies
25 and departments;

1 (B) between the Federal Government and
2 State and local governments and health depart-
3 ments;
4 (C) between the Federal Government and
5 nonprofit foundations and civil society organiza-
6 tions, including community- and faith-based or-
7 ganizations focused on addressing the issue of
8 HIV/AIDS; and
9 (D) between the Federal Government and
10 private businesses;
11 (3) efforts by the Federal Government to edu-
12 cate, involve, and establish and strengthen partner-
13 ships with civil society organizations, including
14 community- and faith-based organizations, in order
15 to implement the National HIV/AIDS Strategy and
16 achieve its goals;
17 (4) how Federal resources are being deployed to
18 implement the Strategy, including—
19 (A) the amount of funding used to date, by
20 each Federal agency and department, to imple-
21 ment the National HIV/AIDS Strategy;
22 (B) a brief summary for each Federal
23 agency and department of the number and
24 function of all Federal employees assisting in
25 implementing the Strategy; and

1 (C) an estimate of the amount of funding
2 necessary to implement the National HIV/AIDS
3 Strategy, by each Federal agency and depart-
4 ment, for the next fiscal year; and
5 (5) what additional steps, if any, are necessary
6 to fully implement the National HIV/AIDS Strategy,
7 including—
8 (A) whether any existing statutory laws,
9 policies, or regulations are impeding the imple-
10 mentation of the National HIV/AIDS Strategy,
11 at the Federal, State, or local level, and wheth-
12 er any changes to such laws, policies, or regula-
13 tions are necessary or recommended; and
14 (B) whether any Federal agencies or de-
15 partments require additional statutory authority
16 to effectively carry out their duties as part of
17 the National HIV/AIDS Strategy.
18 (c) USE OF PREVIOUSLY APPROPRIATED FUNDS.—
19 Funding for the report required under subsection (a) shall
20 derive from discretionary funds of the departments and
21 agencies specified in such subsection.

SEC. 747. ADDRESSING HIV/AIDS IN THE AFRICAN-AMERICAN COMMUNITY.

(a) SENSE OF CONGRESS ON NATIONAL BLACK CLERGY HIV/AIDS AWARENESS SUNDAY.—It is the sense of Congress that—

(1) there should be established a National Black Clergy HIV/AIDS Awareness Sunday on which the Congress and the President call on members of the Black clergy—

(A) to become involved at the local community level in HIV/AIDS testing, policy, and advocacy;

(B) to discuss the HIV/AIDS epidemic with their congregations and the community at-large; and

(C) to urge members of their congregations to reduce risk factors, practice safe sex and other preventive measures, be tested for HIV/AIDS, and seek care when appropriate; and

(2) an appropriate Sunday should be selected for this occasion.

(b) SENSE OF CONGRESS ON FEDERAL AGENCIES WITH RESPONSIBILITY FOR PREVENTING, TESTING FOR, AND TREATING HIV/AIDS.—It is the sense of Congress that all Federal agencies with a responsibility for preventing, testing for, and treating HIV/AIDS should—

1 (1) adopt policies for prevention, testing, and
2 treatment that are consistent with the guidelines
3 issued in 2006 by the Centers for Disease Control
4 and Prevention, entitled ''Revised Recommendations
5 for HIV Testing of Adults, Adolescents, and Preg-
6 nant Women in Health-Care Settings''; and
7 (2) begin a systemic, aggressive approach to im-
8 plementing voluntary, routine testing as part of all
9 health exams, including in emergency rooms, clinics,
10 and private physician offices.
11 (c) SENSE OF CONGRESS ON FEDERAL BUREAU OF
12 PRISONS PROCEDURES FOR INMATES WITH HIV.—It is
13 the sense of Congress that the Federal Bureau of Prisons
14 should implement procedures for—
15 (1) voluntary HIV testing as a routine compo-
16 nent of inmate care; and
17 (2) referral to care as a routine component of
18 release planning for inmates with HIV/AIDS, includ-
19 ing referral to community-based care and faith-based
20 institutions.
21 **SEC. 748. NATIONAL BLACK CLERGY FOR THE ELIMI-**
22 **NATION OF HIV/AIDS.**
23 (a) SHORT TITLE.—This section may be cited as the
24 ''National Black Clergy for the Elimination of HIV/AIDS
25 Act of 2012''.

1 (b) FINDINGS.—Congress finds the following:
2 (1) It has been estimated that more than
3 1,200,000 people in the United States are living
4 with HIV/AIDS, and approximately 500,000 of them
5 are Black. Blacks are 8 times more likely to have
6 AIDS than their White counterparts. Within the
7 Black community, the subpopulation most dispropor-
8 tionately impacted by HIV/AIDS is Black men who
9 have sex with men (MSM) with prevalence rates
10 twice those of White MSM. Black women account
11 for the majority of new AIDS cases among women
12 and are 23 times more likely to be living with AIDS
13 than White women and 4 times more likely than
14 Latinas.
15 (2) On October 7–8, 2007, 186 Black clergy,
16 consisting of Baptist, COGIC, Methodist, Protes-
17 tant, AME, and Pentecostal, together with, medical,
18 policy, and AIDS leaders, were brought together by
19 the National Black Leadership Commission on
20 AIDS (NBLCA), the oldest and largest Black AIDS
21 organization of its kind in America, hosted by Time
22 Warner, Inc., with other foundation support, to par-
23 ticipate in the National Black Clergy Conclave On
24 HIV/AIDS Policy.

1 (3) The attendees included faith leaders across
2 traditional, mega, and activist churches representing
3 millions of congregants: the National Medical Asso-
4 ciation (NMA) representing 30,000 African-Amer-
5 ican physicians; the National Conference of Black
6 Mayors; the National Caucus of Black State Legisla-
7 tors; and the Health Brain Trust of the Congres-
8 sional Black Caucus and key African-American HIV/
9 AIDS advocates from across the United States. This
10 group developed a plan of action that has become
11 the National Black Clergy for the Elimination of
12 HIV/AIDS Act of 2012 to respond to the ''on the
13 ground'' emergency in prevention, care, and treat-
14 ment for AIDS in Black America.
15 (4) In August 2007, the NMA, the oldest and
16 largest organization representing 30,000 African-
17 American physicians, released a consensus report en-
18 titled ''Addressing The HIV/AIDS Crisis In The Af-
19 rican American Community: Fact, Fiction and Pol-
20 icy''; and specifically called on the next President of
21 the United States to declare HIV/AIDS in African-
22 American communities a public health emergency
23 and worked with NBLCA to organize clergy to advo-
24 cate for the specific needs of Black physicians, their
25 patients, and those at risk in African-American com-

1 munities; and have pledged to advocate and work
2 with clergy to develop, execute, and implement these
3 initiatives as a part of their rightful role of leader-
4 ship in African-American communities and culture.
5 (5) The National Conference of Black Mayors
6 has pledged to work with clergy, medical, and com-
7 munity leaders to develop and support these initia-
8 tives on a local level and to help them to continue
9 to develop a policy agenda leading to the elimination
10 of HIV/AIDS.
11 (6) The National Caucus of Black State Legis-
12 lators pledged to take the initiatives herein to their
13 body and develop plans of action for Black State
14 Legislators to work with local clergy, health depart-
15 ments, and CBOs to adopt and implement these ini-
16 tiatives on a national level.
17 (7) At their April 2008 annual meeting, the
18 National Policy Alliance (NPA), consisting of the
19 Joint Center For Political and Economic Studies
20 (secretariat) and the National Black Caucus of
21 School Board Members, National Black Caucus of
22 Local Elected Officials; the Judicial Council of the
23 National Bar Association; the National Association
24 of Black County Officials; Blacks in Government
25 and the CBC; NCBM; WCM, voted unanimously to

1 support, endorse, and encourage the passage of the
2 National Black Clergy for the Elimination of HIV/
3 AIDS Act of 2012 and to organize their respective
4 members to endorse and support the passage of this
5 bill.
6 (8) The World Conference of Black Mayors has
7 ratified its support of these initiatives and legisla-
8 tion, and pledged to assist the clergy to take them
9 internationally.
10 (9) The National Black Leadership Commission
11 on AIDS, the Balm in Gilead, and the Black AIDS
12 Institute have been recognized by the clergy for their
13 tradition and history of service and will work with
14 clergy to conduct community and policy develop-
15 ment, linkages to local departments of health and
16 other services, infrastructure development, education
17 media, and fund development activities.
18 (10) Bishop T.D. Jakes of the Potters House
19 in Dallas, Texas, and Rev. Calvin O. Butts of the
20 Abyssinian Baptist Church in Harlem, New York,
21 and chairman of the National Black Leadership
22 Commission on AIDS have been recognized as the
23 organizers of this group and will help guide and lead
24 the development efforts of fellow clergy through this
25 process.

1 (11) The National Conclave on HIV/AIDS for
2 Black Clergy calls upon the President, Congress,
3 and corporate America to declare the HIV/AIDS cri-
4 sis in the African-American community a "public
5 health emergency".

6 (12) The Black clergy will aggressively seek to
7 have every person under the sphere of their influence
8 tested for HIV in order to know the person's status.

9 (13) The Black clergy will promote HIV/AIDS
10 awareness to ensure that all Black clergy serving in
11 their denominations and other congregations are
12 equipped to address issues related to this disease in
13 a factual and scientifically sound manner.

14 (14) The Black clergy will use the ABC/D
15 model as a behavioral guideline for prevention initia-
16 tives:

17 (A) A–Abstain.

18 (B) B–Be Faithful.

19 (C) C–Use Condoms.

20 (D) D–Don't Engage in Risky Behaviors.

21 (c) DEFINITIONS APPLICABLE THROUGHOUT SEC-
22 TION.—In this section—

23 (1) the terms "HIV" and "HIV/AIDS" have
24 the meanings given to such terms in section 2689 of

1 the Public Health Service Act (42 U.S.C. 300ff–88);
2 and
3 (2) the term ''Secretary'' means the Secretary
4 of Health and Human Services.
5 (d) SERVICES TO REDUCE HIV/AIDS IN THE AFRI-
6 CAN-AMERICAN COMMUNITY.—For the purpose of reduc-
7 ing HIV/AIDS in the African-American community, the
8 Secretary, acting through the Deputy Assistant Secretary
9 for Minority Health, may make grants to public health
10 agencies and faith-based organizations to conduct—
11 (1) outreach activities related to HIV/AIDS
12 prevention and testing activities;
13 (2) HIV/AIDS prevention activities; and
14 (3) HIV/AIDS testing activities.
15 (e) GRANTS FOR SUBSTANCE ABUSE AND MENTAL
16 HEALTH SERVICES TO PUBLIC HEALTH AGENCIES AND
17 FAITH-BASED ORGANIZATIONS.—The Secretary, acting
18 through the Administrator of the Substance Abuse and
19 Mental Health Services Administration, may make grants
20 to public health agencies and faith-based organizations
21 to—
22 (1) conduct HIV/AIDS and sexually trans-
23 mitted disease outreach, prevention, and testing ac-
24 tivities that are targeted to the African-American
25 community; and

1 (2) in connection with such activities, provide
2 substance abuse testing and mental health services
3 to members of such community.
4 (f) SERVICES FOR HIV/AIDS AFFECTED YOUTH
5 WHO ARE SEPARATED FROM THEIR FAMILIES.—The
6 Secretary, acting through the Administrator of the Sub-
7 stance Abuse and Mental Health Services Administration,
8 may make grants to faith- and community-based organiza-
9 tions to provide family reunification services, mental
10 health counseling, HIV/AIDS and sexually transmitted
11 disease testing, and substance abuse testing and treatment
12 to youth who—
13 (1)(A) have run away from home;
14 (B) are homeless; or
15 (C) reside in a detention center or foster care;
16 and
17 (2) are HIV positive or at risk for HIV/AIDS,
18 including young men who have sex with men.
19 (g) PUBLIC HEALTH INTERVENTION AND PREVEN-
20 TION ACTIVITIES.—
21 (1) IN GENERAL.—For the purpose of reducing
22 HIV/AIDS, sexually transmitted diseases, tuber-
23 culosis, and viral hepatitis in African-American com-
24 munities, the Secretary, acting through the Director
25 of the Centers for Disease Control and Prevention,

1 may make grants to faith-based organizations for
2 public health intervention and prevention activities,
3 including the use of rapid testing in traditional and
4 nontraditional settings to increase the number of in-
5 dividuals who know their status at the point of care
6 and are put into treatment.
7 (2) PARTNERSHIPS.—In carrying out this sub-
8 section, the Secretary shall encourage grantees to
9 enter into partnerships with public health agencies.
10 (h) HIV/AIDS PREVENTION AND EDUCATION.—
11 (1) PREVENTION ACTIVITIES.—The Secretary,
12 acting through the Director of the Centers for Dis-
13 ease Control and Prevention, shall expand and inten-
14 sify HIV/AIDS prevention activities in African-
15 American communities. Such activities—
16 (A) shall be targeted to specific popu-
17 lations;
18 (B) shall be comprehensive and accurately
19 based on science and research; and
20 (C) shall include information on absti-
21 nence, the proper use of condoms, risks associ-
22 ated with unprotected sex, and the value of sex-
23 ual delay particularly among young adolescents
24 and teenagers.

1 (2) EDUCATION.—The Secretary, acting
2 through the Director of the Centers for Disease
3 Control and Prevention, shall expand and intensify
4 HIV/AIDS educational activities targeting Black
5 women, youth, and men who have sex with men.
6 (3) COORDINATION.—The Secretary shall carry
7 out this subsection in coordination with public
8 schools of all levels, Black organizations, historically
9 Black colleges and universities, and faith-based or-
10 ganizations and institutions.
11 (i) BUILDING CAPACITY OF COMMUNITIES.—
12 (1) IN GENERAL.—The Secretary, acting
13 through the Director of the Centers for Disease
14 Control and Prevention, shall expand funding to eli-
15 gible entities to build the capacity of African-Amer-
16 ican communities to respond to HIV/AIDS.
17 (2) EMPHASIS.—In carrying out this sub-
18 section, the Secretary shall emphasize the provision
19 of funding for policy development, education, tech-
20 nical assistance, and training—
21 (A) to national and local faith-based orga-
22 nizations; and
23 (B) to organizations with a significant his-
24 tory of working within the African-American
25 community on HIV/AIDS issues, an inter-

1 denominational center of seminaries specializing
2 in the training of African-American clergy, and
3 historically Black colleges and universities.
4 (3) DEFINITION.—In this subsection, the term
5 ''eligible entity'' means a national or community-
6 based organization with a history and tradition of
7 service to African-American communities.
8 (j) NATIONAL MEDIA OUTREACH CAMPAIGN.—
9 (1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall implement a national
12 media outreach campaign that urges all sexually ac-
13 tive individuals to be tested for and know their HIV/
14 AIDS status.
15 (2) REQUIREMENTS.—The national media out-
16 reach campaign under this subsection shall—
17 (A) be science-driven and targeted to Afri-
18 can-American men, women, and youth; and
19 (B) give special emphasis to Black women
20 and men who have sex with men.
21 (3) COORDINATION; CONSULTATION.—The Sec-
22 retary shall carry out this subsection—
23 (A) in coordination with Black media out-
24 lets for print, electronic, and Web-based media
25 and Black media associations, including the Na-

1 tional Association of Black Owned Broadcasters
2 and the National Newspaper Publishers Asso-
3 ciation; and
4 (B) in consultation with an advisory board
5 including representatives of the National Med-
6 ical Association, faith leaders, elected and ap-
7 pointed officials, social marketing experts, and
8 business and community stakeholders.
9 (k) RESEARCH TO DEVELOP BEHAVIORAL STRATE-
10 GIES TO REDUCE TRANSMISSION OF HIV/AIDS.—
11 (1) IN GENERAL.—The Secretary, acting
12 through the Director of the National Institutes of
13 Health, may conduct or support culturally competent
14 research to develop evidence-based behavioral strate-
15 gies to reduce the transmission of HIV/AIDS within
16 the African-American community.
17 (2) PRIORITY.—In carrying out this subsection,
18 the Secretary shall prioritize research that focuses
19 on populations within the African-American commu-
20 nity that are at increased risk for HIV/AIDS, in-
21 cluding—
22 (A) men who have sex with men; and
23 (B) women.
24 (l) STUDY OF BIOLOGICAL AND BEHAVIORAL FAC-
25 TORS.—The Secretary, acting through the Director of the

1 National Institute on Minority Health and Health Dis-
2 parities, may make grants for—
3 (1) the study of biological and behavioral fac-
4 tors that lead to increased HIV/AIDS prevalence in
5 the African-American community, to be conducted
6 by researchers with a history and tradition of service
7 to Black communities; and
8 (2) behavioral and structural network research
9 and interventions, in collaboration with other insti-
10 tutes and centers of the National Institutes of
11 Health, indigenous faith and national and commu-
12 nity-based organizations with a history and tradition
13 of conducting such research for Black communities,
14 with a special emphasis on Black women and Black
15 men who have sex with men.
16 (m) HEALTH CARE PROFESSIONALS TREATING INDI-
17 VIDUALS WITH HIV/AIDS.—Part E of title VII of the
18 Public Health Service Act (42 U.S.C. 294n et seq.) is
19 amended by adding at the end the following:

20 **"Subpart 4—Health Care Professionals Treating**
21 **Individuals With HIV/AIDS**

22 **"SEC. 781. BETTER CARE FOR INDIVIDUALS WITH HIV/AIDS.**

23 "(a) IN GENERAL.—The Secretary, acting through
24 the Administrator of the Health Resources and Services
25 Administration and in consultation with the African-

1 American church community, may award grants for any
2 of the following:
3 "(1) Development of curricula for training pri-
4 mary care providers in HIV/AIDS prevention and
5 care.
6 "(2) Training health care professionals with ex-
7 pertise in HIV/AIDS to provide care to individuals
8 with HIV/AIDS.
9 "(3) Development by grant recipients under
10 title XXVI and other persons of policies for pro-
11 viding culturally relevant and sensitive treatment to
12 individuals with HIV/AIDS, with particular empha-
13 sis on treatment to African-Americans and children
14 with HIV/AIDS.
15 "(4) Development and implementation of pro-
16 grams to increase the use of telemedicine to respond
17 to HIV/AIDS-specific health care needs in rural and
18 minority communities, with particular emphasis
19 given to medically underserved communities and the
20 southern States.
21 "(5) Creation of faith- and community-based
22 certification programs for providers in HIV/AIDS
23 care and support services.
24 "(6) Establishment of comfort care centers that
25 provide mental, emotional, and psychosocial coun-

1 seling for people with HIV/AIDS and implement ad-
2 ditional protocols to be carried out in the centers
3 that address the needs of children and young adults
4 who are infected with the disease and are
5 transitioning from childhood to adulthood.

6 ''(7) Incentive payments to health care pro-
7 viders supported by the Health Resources and Serv-
8 ices Administration to implement HIV/AIDS testing
9 consistent with the guidelines issued in 2006 by the
10 Centers for Disease Control and Prevention entitled
11 'Revised Recommendations for HIV Testing of
12 Adults, Adolescents, and Pregnant Women in
13 Health-Care Settings'.

14 ''(b) DEFINITIONS.—In this section—

15 ''(1) the term 'HIV/AIDS' has the meaning
16 given to such term in section 2689; and

17 ''(2) the term 'primary care' includes obstetrical
18 and gynecological care and psychiatric and mental
19 health care.''.

20 (n) REPORT ON IMPACT OF HIV/AIDS IN THE AFRI-
21 CAN-AMERICAN COMMUNITY.—

22 (1) IN GENERAL.—The Secretary shall submit
23 to Congress and the President an annual report on
24 the impact of HIV/AIDS in the African-American
25 community.

1 (2) CONTENTS.—The report under subsection
2 (a) shall include information on the—
3 (A) progress that has been made in reduc-
4 ing the impact of HIV/AIDS in such commu-
5 nity;
6 (B) opportunities that exist to make addi-
7 tional progress in reducing the impact of HIV/
8 AIDS in such community;
9 (C) challenges that may impede such addi-
10 tional progress; and
11 (D) Federal funding necessary to achieve
12 substantial reductions in HIV/AIDS in the Afri-
13 can-American community.

14 **SEC. 749. REDUCING THE SPREAD OF SEXUALLY TRANS-**
15 **MITTED INFECTIONS IN CORRECTIONAL FA-**
16 **CILITIES.**

17 (a) SHORT TITLE.—This section may be cited as the
18 ''Justice for the Unprotected Against Sexually Trans-
19 mitted Infections among the Confined and Exposed Act''
20 or the ''JUSTICE Act''.
21 (b) FINDINGS.—The Congress makes the following
22 findings:
23 (1) According to the Bureau of Justice Statis-
24 tics (BJS), 2,292,133 persons were incarcerated in
25 the United States as of the end of 2009. Between

1 1998 and 2008, the number of persons incarcerated
2 in Federal or State correctional facilities increased
3 by an average of 2.4 percent per year. One in every
4 32 United States residents was on probation, in jail
5 or prison, or on parole at the end of 2009.
6 (2) As of 2009, 66.8 percent of incarcerated
7 persons were racial or ethnic minorities. Based on
8 current incarceration rates, BJS estimates that Afri-
9 can-American males are 6 times more likely to be
10 held in custody than White males, while Hispanic
11 males are a little more than 2 times more likely to
12 be held in custody. Across all age categories, Afri-
13 can-American males were incarcerated at higher
14 rates than Hispanic or White males.
15 (3) There is a disproportionately high rate of
16 HIV/AIDS among incarcerated persons, especially
17 among minorities. Approximately 25 percent of the
18 HIV-positive population of the United States passes
19 through correctional facilities each year. BJS has
20 determined that the rate of confirmed AIDS cases is
21 2.4 times higher among incarcerated persons than in
22 the general population. Minorities account for the
23 majority of AIDS-related deaths among incarcerated
24 persons, with African-American incarcerated persons
25 2.8 times more likely than White incarcerated per-

1 sons and 1.4 times more likely than Hispanic incar-
2 cerated persons to die from AIDS-related causes.
3 Nearly two-thirds of AIDS-related deaths are among
4 Black, non-Hispanic males.
5 (4) Studies suggest that other sexually trans-
6 mitted infections (STIs), such as gonorrhea,
7 chlamydia, syphilis, genital herpes, viral hepatitis,
8 and human papillomavirus, also exist at a higher
9 rate among incarcerated persons than in the general
10 population. For instance, researchers have estimated
11 that the rate of hepatitis C (HCV) infection among
12 incarcerated persons is somewhere between 8 and 20
13 times higher than that of the general population.
14 (5) Correctional facilities lack a uniform system
15 of STI testing and reporting. Establishing a uniform
16 data collection system would assist in developing and
17 targeting counseling and treatment programs for in-
18 carcerated persons. Better developed and targeted
19 programs may reduce the spread of STIs.
20 (6) Although Congress has acted to reduce the
21 spread of sexual violence in correctional facilities by
22 enacting the National Prison Rape Elimination Act
23 (PREA) of 2003, BJS reported that approximately
24 4.4 percent of incarcerated persons in prisons and
25 3.1 percent of persons in jail reported experiencing

1 one or more incidents of sexual victimization by an-
2 other incarcerated person or correctional facility
3 staff in the previous year.

4 (7) Approximately 95 percent of all incarcer-
5 ated persons eventually return to society. According
6 to one study, every year approximately 100,000 per-
7 sons infected with both HIV and HCV are released
8 from correctional facilities. These individuals com-
9 prise approximately 50 percent of all persons with
10 both infections in the United States.

11 (8) According to the Centers for Disease Con-
12 trol and Prevention (CDC), latex condoms, when
13 used consistently and correctly, are highly effective
14 in preventing the transmission of HIV. Latex
15 condoms also reduce the risk of other STIs. Despite
16 the effectiveness of condoms in reducing the spread
17 of STIs, the Bureau of Prisons does not recommend
18 their use in correctional facilities.

19 (9) The distribution of condoms in correctional
20 facilities is currently legal in certain parts of the
21 United States and the world. The States of Vermont
22 and Mississippi and the District of Columbia allow
23 condom distribution programs in their correctional
24 facilities. The cities of New York, San Francisco,
25 Los Angeles, Washington DC, and Philadelphia also

1 allow condom distribution in their correctional facili-
2 ties. However, these States and cities operate fewer
3 than 1 percent of all correctional facilities.
4 (10) A 2007 report by the Massachusetts Gen-
5 eral Hospital Division of Infectious Diseases and the
6 University of California, San Francisco, found that
7 the proportion of European prison systems allowing
8 condoms rose from 53 percent in 1989 to 81 percent
9 in 1997. The same report also found that no prison
10 system allowing the distribution of condoms had re-
11 versed their decision, and no prison system reported
12 an increase in sexual activity among incarcerated
13 persons as a result of a decision to allow condom
14 distribution.
15 (11) In 2000 and 2001, researchers surveyed
16 300 incarcerated persons and 100 correctional offi-
17 cers at the Central Detention Facility, a correctional
18 facility operated by the District of Columbia at
19 which condoms are available. Researchers found that
20 both incarcerated persons and correctional officers
21 generally supported the condom distribution pro-
22 gram and considered it to be important. Further-
23 more, the researchers determined that the program
24 had not caused any major security infractions. In
25 Canada, the Expert Committee on AIDS and Pris-

1 ons surveyed more than 400 correctional officers in
2 the Federal prison system of Canada in 1995 and
3 reported that 82 percent of those responding indi-
4 cated that the availability of condoms had created no
5 problems at their facility.
6 (12) The American Public Health Association,
7 the United Nations Joint Program on HIV/AIDS,
8 and the World Health Organization have endorsed
9 the effectiveness of condom distribution programs in
10 correctional facilities.
11 (13) Many correctional facilities in the United
12 States do not provide comprehensive testing and
13 treatment programs to reduce the spread of STIs.
14 According to BJS surveys from 2005, only 996 of
15 the 1,821 Federal and State correctional facilities
16 (i.e. 54.7 percent) provided HIV/AIDS counseling
17 programs.
18 (14) Individuals who are enrolled in Medicaid
19 prior to incarceration face a suspension of their ben-
20 efits upon incarceration, and in some States a termi-
21 nation of their Medicaid eligibility. The Federal Gov-
22 ernment encourages States to automatically re-enroll
23 incarcerated persons on Medicaid upon their release
24 from a correctional facility, unless the State reaches

1 a determination that the individual is no longer eligi-
2 ble for reasons other than their prior incarceration.
3 (15) Formerly incarcerated individuals who are
4 newly released from correctional facilities often face
5 delays in the resumption of their Medicaid benefits
6 which may exacerbate any health issues which they
7 face.
8 (16) Incarcerated individuals living with HIV/
9 AIDS who are eligible for Medicaid would benefit
10 from prompt and automatic enrollment upon their
11 release in order to ensure their continued ability to
12 access health services, including antiretroviral treat-
13 ment.
14 (c) AUTHORITY TO ALLOW COMMUNITY ORGANIZA-
15 TIONS TO PROVIDE STI COUNSELING, STI PREVENTION
16 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-
17 VICES IN FEDERAL CORRECTIONAL FACILITIES.—
18 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not
19 later than 30 days after the date of enactment of
20 this Act, the Attorney General shall direct the Bu-
21 reau of Prisons to allow community organizations to
22 distribute sexual barrier protection devices and to
23 engage in STI counseling and STI prevention edu-
24 cation in Federal correctional facilities. These activi-
25 ties shall be subject to all relevant Federal laws and

1 regulations which govern visitation in correctional
2 facilities.

3 (2) INFORMATION REQUIREMENT.—Any com-
4 munity organization permitted to distribute sexual
5 barrier protection devices under paragraph (1) must
6 ensure that the persons to whom the devices are dis-
7 tributed are informed about the proper use and dis-
8 posal of sexual barrier protection devices in accord-
9 ance with established public health practices. Any
10 community organization conducting STI counseling
11 or STI prevention education under paragraph (1)
12 must offer comprehensive sexuality education.

13 (3) POSSESSION OF DEVICE PROTECTED.—No
14 Federal correctional facility may, because of the pos-
15 session or use of a sexual barrier protection device—

16 (A) take adverse action against an incar-
17 cerated person; or

18 (B) consider possession or use as evidence
19 of prohibited activity for the purpose of any
20 Federal correctional facility administrative pro-
21 ceeding.

22 (4) IMPLEMENTATION.—The Attorney General
23 and Bureau of Prisons shall implement this section
24 according to established public health practices in a
25 manner that protects the health, safety, and privacy

1 of incarcerated persons and of correctional facility
2 staff.
3 (d) SENSE OF CONGRESS REGARDING DISTRIBUTION
4 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
5 PRISON SYSTEMS.—It is the sense of Congress that States
6 should allow for the legal distribution of sexual barrier
7 protection devices in State correctional facilities to reduce
8 the prevalence and spread of STIs in those facilities.
9 (e) AUTOMATIC REINSTATEMENT OF MEDICAID BEN-
10 EFITS.—
11 (1) IN GENERAL.—Section 1902(e) of the So-
12 cial Security Act (42 U.S.C. 1396a(e)) is amended
13 by adding at the end the following:
14 "(15) ENROLLMENT OF EX-OFFENDERS.—
15 "(A) AUTOMATIC ENROLLMENT OR REIN-
16 STATEMENT.—
17 "(i) IN GENERAL.—The State plan
18 shall provide for the automatic enrollment
19 or reinstatement of enrollment of an eligi-
20 ble individual if—
21 "(I) such individual is scheduled
22 to be released from a public institu-
23 tion due to the completion of sen-
24 tence, not less than 30 days prior to
25 the scheduled date of the release; and

1 "(II) such individual is to be re-
2 leased from a public institution on pa-
3 role or on probation, as soon as pos-
4 sible after the date on which the de-
5 termination to release such individual
6 was made, and before the date such
7 individual is released.
8 "(ii) EXCEPTION.—If a State makes a
9 determination that an individual is not eli-
10 gible to be enrolled under the State plan—
11 "(I) on or before the date by
12 which the individual would be enrolled
13 under clause (i), such clause shall not
14 apply to such individual; or
15 "(II) after such date, the State
16 may terminate the enrollment of such
17 individual.
18 "(B) RELATIONSHIP OF ENROLLMENT TO
19 PAYMENT FOR SERVICES.—
20 "(i) IN GENERAL.—Subject to sub-
21 paragraph (A)(ii), an eligible individual
22 who is enrolled, or whose enrollment is re-
23 instated under subparagraph (A), shall be
24 eligible for medical assistance that is pro-
25 vided after the date that the eligible indi-

1 vidual is released from the public institu-
2 tion
3 "(ii) RELATIONSHIP TO PAYMENT
4 PROHIBITION FOR INMATES.—No provision
5 of this paragraph may be construed to per-
6 mit payment for care or services for which
7 payment is excluded under the subpara-
8 graph (A), following paragraph (29), of
9 section 1905(a).
10 "(C) TREATMENT OF CONTINUOUS ELIGI-
11 BILITY.—
12 "(i) SUSPENSION FOR INMATES.—Any
13 period of continuous eligibility under this
14 title shall be suspended on the date an in-
15 dividual enrolled under this title becomes
16 an inmate of a public institution (except as
17 a patient of a medical institution).
18 "(ii) DETERMINATION OF REMAINING
19 PERIOD.—Notwithstanding any changes to
20 State law related to continuous eligibility
21 during the time that an individual is an in-
22 mate of a public institution (except as a
23 patient of a medical institution), subject to
24 clause (iii), with respect to an eligible indi-
25 vidual who was subject to a suspension

1 under subclause (I), on the date that such
2 individual is released from a public institu-
3 tion the suspension of continuous eligibility
4 under such subclause shall be lifted for a
5 period that is equal to the time remaining
6 in the period of continuous eligibility for
7 such individual on the date that such pe-
8 riod was suspended under such subclause.
9 ''(iii) EXCEPTION.—If a State makes
10 a determination that an individual is not
11 eligible to be enrolled under the State
12 plan—
13 ''(I) on or before the date that
14 the suspension of continuous eligibility
15 is lifted under clause (ii), such clause
16 shall not apply to such individual; or
17 ''(II) after such date, the State
18 may terminate the enrollment of such
19 individual.
20 ''(D) AUTOMATIC ENROLLMENT OR REIN-
21 STATEMENT OF ENROLLMENT DEFINED.—For
22 purposes of this paragraph, the term 'automatic
23 enrollment or reinstatement of enrollment'
24 means that the State determines eligibility for
25 medical assistance under the State plan without

1 a program application from, or on behalf of, the
2 eligible individual, but an individual can only be
3 automatically enrolled in the State Medicaid
4 plan if the individual affirmatively consents to
5 being enrolled through affirmation in writing,
6 by telephone, orally, through electronic signa-
7 ture, or through any other means specified by
8 the Secretary.

9 ''(E) ELIGIBLE INDIVIDUAL DEFINED.—
10 For purposes of this paragraph, the term 'eligi-
11 ble individual' means an individual who is an
12 inmate of a public institution (except as a pa-
13 tient in a medical institution)—

14 ''(i) who was enrolled under the State
15 plan for medical assistance immediately be-
16 fore becoming an inmate of such an insti-
17 tution; or

18 ''(ii) is diagnosed with human im-
19 munodeficiency virus.''.

20 (2) SUPPLEMENTAL FUNDING FOR STATE IM-
21 PLEMENTATION OF AUTOMATIC REINSTATEMENT OF
22 MEDICAID BENEFITS.—

23 (A) IN GENERAL.—Subject to paragraph
24 (6), for each State for which the Secretary of
25 Health and Human Services has approved an

1 application under paragraph (3), the Federal
2 matching payments (including payments based
3 on the Federal medical assistance percentage)
4 made to such State under section 1903 of the
5 Social Security Act (42 U.S.C. 1396b) shall be
6 increased by 5.0 percentage points for pay-
7 ments to the State for the activities permitted
8 under paragraph (2) for a period of one year.
9 (B) USE OF FUNDS.—A State may only
10 use increased matching payments authorized
11 under paragraph (1)—
12 (i) to strengthen the State's enroll-
13 ment and administrative resources for the
14 purpose of improving processes for enroll-
15 ing (or reinstating the enrollment of) eligi-
16 ble individuals (as such term is defined in
17 section 1902(e)(15)(E) of the Social Secu-
18 rity Act); and
19 (ii) for medical assistance (as such
20 term is defined in section 1905(a) of the
21 Social Security Act) provided to such eligi-
22 ble individuals.
23 (C) APPLICATION AND AGREEMENT.—The
24 Secretary may only make payments to a State
25 in the increased amount if—

1 (i) the State has amended the State
2 plan under section 1902 of the Social Se-
3 curity Act to incorporate the requirements
4 of subsection (e)(15) of such section;
5 (ii) the State has submitted an appli-
6 cation to the Secretary that includes a plan
7 for implementing the requirements of sec-
8 tion 1902(e)(15) of the Social Security Act
9 under the State's amended State plan be-
10 fore the end of the 90-day period begin-
11 ning on the date that the State receives in-
12 creased matching payments under para-
13 graph (1);
14 (iii) the State's application meets the
15 satisfaction of the Secretary; and
16 (iv) the State enters an agreement
17 with the Secretary that states that—
18 (I) the State will only use the in-
19 creased matching funds for the uses
20 permitted under paragraph (2); and
21 (II) at the end of the period
22 under paragraph (1), the State will
23 submit to the Secretary, and make
24 publicly available, a report that con-

1 tains the information required under
2 paragraph (4).
3 (D) REQUIRED REPORT INFORMATION.—
4 The information that is required in the report
5 under paragraph (3)(D)(ii) includes—
6 (i) the results of an evaluation of the
7 impact of the implementation of the re-
8 quirements of section 1902(e)(15) of the
9 Social Security Act on improving the
10 State's processes for enrolling of individ-
11 uals who are released for public institu-
12 tions into the Medicaid program;
13 (ii) the number of individuals who
14 were automatically enrolled (or whose en-
15 rollment is reinstated) under such section
16 1902(e)(15) during the period under para-
17 graph (1); and
18 (iii) any other information that is re-
19 quired by the Secretary.
20 (E) INCREASE IN CAP ON MEDICAID PAY-
21 MENTS TO TERRITORIES.—Subject to para-
22 graph (6), the amounts otherwise determined
23 for Puerto Rico, the United States Virgin Is-
24 lands, Guam, the Commonwealth of the North-
25 ern Mariana Islands, and American Samoa

1 under subsections (f) and (g) of section 1108 of
2 the Social Security Act (42 U.S.C. 1308) shall
3 each be increased by the necessary amount to
4 allow for the increase in the Federal matching
5 payments under paragraph (1), but only for the
6 period under such paragraph for such State. In
7 the case of such an increase for a territory, sub-
8 section (a)(1) of such section 1108 shall be ap-
9 plied without regard to any increase in payment
10 made to the territory under part E of title IV
11 of such Act that is attributable to the increase
12 in Federal medical assistance percentage ef-
13 fected under paragraph (1) for the territory.
14 (F) LIMITATIONS.—
15 (i) TIMING.—With respect to a State,
16 at the end of the period under paragraph
17 (1), no increased matching payments may
18 be made to such State under this sub-
19 section.
20 (ii) MAINTENANCE OF ELIGIBILITY.—
21 (I) IN GENERAL.—Subject to
22 clause (ii), a State is not eligible for
23 an increase in its Federal matching
24 payments under paragraph (1), or an
25 increase in a cap amount under para-

1 graph (5), if eligibility standards,
2 methodologies, or procedures under its
3 State plan under title XIX of the So-
4 cial Security Act (including any waiv-
5 er under such title or under section
6 1115 of such Act (42 U.S.C. 1315))
7 are more restrictive than the eligibility
8 standards, methodologies, or proce-
9 dures, respectively, under such plan
10 (or waiver) as in effect on the date of
11 enactment of this Act.

12 (II) STATE REINSTATEMENT OF
13 ELIGIBILITY PERMITTED.—A State
14 that has restricted eligibility stand-
15 ards, methodologies, or procedures
16 under its State plan under title XIX
17 of the Social Security Act (including
18 any waiver under such title or under
19 section 1115 of such Act (42 U.S.C.
20 1315)) after the date of enactment of
21 this Act, is no longer ineligible under
22 clause (i) beginning with the first cal-
23 endar quarter in which the State has
24 reinstated eligibility standards, meth-
25 odologies, or procedures that are no

1 more restrictive than the eligibility
2 standards, methodologies, or proce-
3 dures, respectively, under such plan
4 (or waiver) as in effect on such date.
5 (iii) NO WAIVER AUTHORITY.—The
6 Secretary may not waive the application of
7 this subsection under section 1115 of the
8 Social Security Act or otherwise.
9 (iv) LIMITATION OF MATCHING PAY-
10 MENTS TO 100 PERCENT.—In no case shall
11 an increase in Federal matching payments
12 under this subsection result in Federal
13 matching payments that exceed 100 per-
14 cent.
15 (3) EFFECTIVE DATE.—
16 (A) IN GENERAL.—Except as provided in
17 paragraph (2), the amendments made by sub-
18 section (a) shall take effect 180 days after the
19 date of the enactment of this Act and shall
20 apply to services furnished on or after such
21 date.
22 (B) RULE FOR CHANGES REQUIRING
23 STATE LEGISLATION.—In the case of a State
24 plan for medical assistance under title XIX of
25 the Social Security Act which the Secretary of

1 Health and Human Services determines re-
2 quires State legislation (other than legislation
3 appropriating funds) in order for the plan to
4 meet the additional requirement imposed by the
5 amendments made by this subsection, the State
6 plan shall not be regarded as failing to comply
7 with the requirements of such title solely on the
8 basis of its failure to meet this additional re-
9 quirement before the first day of the first cal-
10 endar quarter beginning after the close of the
11 first regular session of the State legislature that
12 begins after the date of the enactment of this
13 Act. For purposes of the previous sentence, in
14 the case of a State that has a 2-year legislative
15 session, each year of such session shall be
16 deemed to be a separate regular session of the
17 State legislature.
18 (f) SURVEY OF AND REPORT ON CORRECTIONAL FA-
19 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
20 STIS.—
21 (1) SURVEY.—The Attorney General, after con-
22 sulting with the Secretary of Health and Human
23 Services, State officials, and community organiza-
24 tions, shall, to the maximum extent practicable, con-
25 duct a survey of all Federal and State correctional

1 facilities, no later than 180 days after the date of
2 enactment of this Act and annually thereafter for 5
3 years, to determine the following:
4 (A) PREVENTION EDUCATION OFFERED.—
5 The type of prevention education, information,
6 or training offered to incarcerated persons and
7 correctional facility staff regarding sexual vio-
8 lence and the spread of STIs, including whether
9 such education, information, or training—
10 (i) constitutes comprehensive sexuality
11 education;
12 (ii) is compulsory for new incarcerated
13 persons and for new staff; and
14 (iii) is offered on an ongoing basis.
15 (B) ACCESS TO SEXUAL BARRIER PROTEC-
16 TION DEVICES.—Whether incarcerated persons
17 can—
18 (i) possess sexual barrier protection
19 devices;
20 (ii) purchase sexual barrier protection
21 devices;
22 (iii) purchase sexual barrier protection
23 devices at a reduced cost; and
24 (iv) obtain sexual barrier protection
25 devices without cost.

1 (C) INCIDENCE OF SEXUAL VIOLENCE.—
2 The incidence of sexual violence and assault
3 committed by incarcerated persons and by cor-
4 rectional facility staff.
5 (D) COUNSELING, TREATMENT, AND SUP-
6 PORTIVE SERVICES.—Whether the correctional
7 facility requires incarcerated persons to partici-
8 pate in counseling, treatment, and supportive
9 services related to STIs, or whether it offers
10 such programs to incarcerated persons.
11 (E) STI TESTING.—Whether the correc-
12 tional facility tests incarcerated persons for
13 STIs or gives them the option to undergo such
14 testing—
15 (i) at intake;
16 (ii) on a regular basis; and
17 (iii) prior to release.
18 (F) STI TEST RESULTS.—The number of
19 incarcerated persons who are tested for STIs
20 and the outcome of such tests at each correc-
21 tional facility, disaggregated to include results
22 for—
23 (i) the type of sexually transmitted in-
24 fection tested for;

1 (ii) the race and/or ethnicity of individuals tested;
3 (iii) the age of individuals tested; and
4 (iv) the gender of individuals tested.
5 (G) PRE-RELEASE REFERRAL POLICY.—
6 Whether incarcerated persons are informed
7 prior to release about STI-related services or
8 other health services in their communities, in-
9 cluding free and low-cost counseling and treat-
10 ment options.
11 (H) PRE-RELEASE REFERRALS MADE.—
12 The number of referrals to community-based
13 organizations or public health facilities offering
14 STI-related or other health services provided to
15 incarcerated persons prior to release, and the
16 type of counseling or treatment for which the
17 referral was made.
18 (I) REINSTATEMENT OF MEDICAID BENE-
19 FITS.—Whether the correctional facility assists
20 incarcerated persons that were enrolled in the
21 State Medicaid program prior to their incarcer-
22 ation, in reinstating their enrollment upon re-
23 lease and whether such individuals receive refer-
24 rals as provided by paragraph (8) to entities

1 that accept the State Medicaid program, includ-
2 ing if applicable—
3 (i) the number of such individuals, in-
4 cluding those diagnosed with the human
5 immunodeficiency virus, that have been re-
6 instated;
7 (ii) a list of obstacles to reinstating
8 enrollment or to making determinations of
9 eligibility for reinstatement, if any; and
10 (iii) the number of individuals denied
11 enrollment.
12 (J) OTHER ACTIONS TAKEN.—Whether the
13 correctional facility has taken any other action,
14 in conjunction with community organizations or
15 otherwise, to reduce the prevalence and spread
16 of STIs in that facility.
17 (2) PRIVACY.—In conducting the survey, the
18 Attorney General shall not request or retain the
19 identity of any person who has sought or been of-
20 fered counseling, treatment, testing, or prevention
21 education information regarding an STI (including
22 information about sexual barrier protection devices),
23 or who has tested positive for an STI.
24 (3) REPORT.—The Attorney General shall
25 transmit to Congress and make publicly available

1 the results of the survey required under paragraph
2 (1), both for the Nation as a whole and
3 disaggregated as to each State and each correctional
4 facility. To the maximum extent possible, the Attor-
5 ney General shall issue the first report no later than
6 1 year after the date of enactment of this Act and
7 shall issue reports annually thereafter for 5 years.
8 (g) STRATEGY.—
9 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
10 Attorney General, in consultation with the Secretary
11 of Health and Human Services, State officials, and
12 community organizations, shall develop and imple-
13 ment a 5-year strategy to reduce the prevalence and
14 spread of STIs in Federal and State correctional fa-
15 cilities. To the maximum extent possible, the strat-
16 egy shall be developed, transmitted to Congress, and
17 made publicly available no later than 180 days after
18 the transmission of the first report required under
19 subsection (h)(3).
20 (2) CONTENTS OF STRATEGY.—The strategy
21 shall include the following:
22 (A) PREVENTION EDUCATION.—A plan for
23 improving prevention education, information,
24 and training offered to incarcerated persons
25 and correctional facility staff, including infor-

1 mation and training on sexual violence and the
2 spread of STIs, and comprehensive sexuality
3 education.
4 (B) SEXUAL BARRIER PROTECTION DEVICE
5 ACCESS.—A plan for expanding access to sexual
6 barrier protection devices in correctional facili-
7 ties.
8 (C) SEXUAL VIOLENCE REDUCTION.—A
9 plan for reducing the incidence of sexual vio-
10 lence among incarcerated persons and correc-
11 tional facility staff, developed in consultation
12 with the National Prison Rape Elimination
13 Commission.
14 (D) COUNSELING AND SUPPORTIVE SERV-
15 ICES.—A plan for expanding access to coun-
16 seling and supportive services related to STIs in
17 correctional facilities.
18 (E) TESTING.—A plan for testing incarcer-
19 ated persons for STIs during intake, during
20 regular health exams, and prior to release, and
21 that—
22 (i) is conducted in accordance with
23 guidelines established by the Centers for
24 Disease Control and Prevention;
25 (ii) includes pre-test counseling;

1 (iii) requires that incarcerated persons
2 are notified of their option to decline test-
3 ing at any time;
4 (iv) requires that incarcerated persons
5 are confidentially notified of their test re-
6 sults in a timely manner; and
7 (v) ensures that incarcerated persons
8 testing positive for STIs receive post-test
9 counseling, care, treatment, and supportive
10 services.
11 (F) TREATMENT.—A plan for ensuring
12 that correctional facilities have the necessary
13 medicine and equipment to treat and monitor
14 STIs and for ensuring that incarcerated per-
15 sons living with or testing positive for STIs re-
16 ceive and have access to care and treatment
17 services.
18 (G) STRATEGIES FOR DEMOGRAPHIC
19 GROUPS.—A plan for developing and imple-
20 menting culturally appropriate, sensitive, and
21 specific strategies to reduce the spread of STIs
22 among demographic groups heavily impacted by
23 STIs.
24 (H) LINKAGES WITH COMMUNITIES AND
25 FACILITIES.—A plan for establishing and

1 strengthening linkages to local communities and
2 health facilities that—
3 (i) provide counseling, testing, care,
4 and treatment services;
5 (ii) may receive persons recently re-
6 leased from incarceration who are living
7 with STIs; and
8 (iii) accept payment through the State
9 Medicaid program.
10 (I) ENROLLMENT IN STATE MEDICAID
11 PROGRAMS.—Plans to ensure that incarcerated
12 persons who were—
13 (i) enrolled in their State Medicaid
14 program prior to incarceration in a correc-
15 tional facility are automatically re-enrolled
16 in such program upon their release; and
17 (ii) not enrolled in their State Med-
18 icaid program prior to incarceration, but
19 who are diagnosed with the human im-
20 munodeficiency virus while incarcerated in
21 a correctional facility, are automatically
22 enrolled in such program upon their re-
23 lease.
24 (J) OTHER PLANS.—Any other plans de-
25 veloped by the Attorney General for reducing

1 the spread of STIs or improving the quality of
2 health care in correctional facilities.
3 (K) MONITORING SYSTEM.—A monitoring
4 system that establishes performance goals re-
5 lated to reducing the prevalence and spread of
6 STIs in correctional facilities and which, where
7 feasible, expresses such goals in quantifiable
8 form.
9 (L) MONITORING SYSTEM PERFORMANCE
10 INDICATORS.—Performance indicators that
11 measure or assess the achievement of the per-
12 formance goals described in subparagraph (I).
13 (M) COST ESTIMATE.—A detailed estimate
14 of the funding necessary to implement the
15 strategy at the Federal and State levels for all
16 5 years, including the amount of funds required
17 by community organizations to implement the
18 parts of the strategy in which they take part.
19 (3) REPORT.—The Attorney General shall
20 transmit to Congress and make publicly available an
21 annual progress report regarding the implementation
22 and effectiveness of the strategy described in sub-
23 section (a). The progress report shall include an
24 evaluation of the implementation of the strategy
25 using the monitoring system and performance indi-

1 cators provided for in subparagraphs (I) and (J) of
2 paragraph (2).
3 (h) DEFINITIONS.—For the purposes of this section:
4 (1) COMMUNITY ORGANIZATION.—The term
5 ''community organization'' means a public health
6 care facility or a nonprofit organization which pro-
7 vides health- or STI-related services according to es-
8 tablished public health standards.
9 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
10 The term ''comprehensive sexuality education''
11 means sexuality education that includes information
12 about abstinence and about the proper use and dis-
13 posal of sexual barrier protection devices and which
14 is—
15 (A) evidence-based;
16 (B) medically accurate;
17 (C) age and developmentally appropriate;
18 (D) gender and identity sensitive;
19 (E) culturally and linguistically appro-
20 priate; and
21 (F) structured to promote critical thinking,
22 self-esteem, respect for others, and the develop-
23 ment of healthy attitudes and relationships.
24 (3) CORRECTIONAL FACILITY.—The term ''cor-
25 rectional facility'' means any prison, penitentiary,

1 adult detention facility, juvenile detention facility,
2 jail, or other facility to which persons may be sent
3 after conviction of a crime or act of juvenile delin-
4 quency within the United States.

5 (4) INCARCERATED PERSON.—The term ''incar-
6 cerated person'' means any person who is serving a
7 sentence in a correctional facility after conviction of
8 a crime.

9 (5) SEXUALLY TRANSMITTED INFECTION.—The
10 term ''sexually transmitted infection'' or ''STI''
11 means any disease or infection that is commonly
12 transmitted through sexual activity, including HIV/
13 AIDS, gonorrhea, chlamydia, syphilis, genital her-
14 pes, viral hepatitis, and human papillomavirus.

15 (6) SEXUAL BARRIER PROTECTION DEVICE.—
16 The term ''sexual barrier protection device'' means
17 any FDA-approved physical device which has not
18 been tampered with and which reduces the prob-
19 ability of STI transmission or infection between sex-
20 ual partners, including female condoms, male
21 condoms, and dental dams.

22 (7) STATE.—The term ''State'' includes the
23 District of Columbia, American Samoa, the Com-
24 monwealth of the Northern Mariana Islands, Guam,
25 Puerto Rico, and the United States Virgin Islands.

1 **SEC. 750. STOP AIDS IN PRISON.**

2 (a) SHORT TITLE.—This section may be cited as the
3 ''Stop AIDS in Prison Act of 2012''.

4 (b) COMPREHENSIVE HIV/AIDS POLICY.—

5 (1) IN GENERAL.—The Bureau of Prisons
6 (hereinafter in this section referred to as the ''Bu-
7 reau'') shall develop a comprehensive policy to pro-
8 vide HIV testing, treatment, and prevention for in-
9 mates within the correctional setting and upon re-
10 entry.

11 (2) PURPOSE.—The purposes of such policy are
12 the following:

13 (A) To stop the spread of HIV/AIDS
14 among inmates.

15 (B) To protect prison guards and other
16 personnel from HIV/AIDS infection.

17 (C) To provide comprehensive medical
18 treatment to inmates who are living with HIV/
19 AIDS.

20 (D) To promote HIV/AIDS awareness and
21 prevention among inmates.

22 (E) To encourage inmates to take personal
23 responsibility for their health.

24 (F) To reduce the risk that inmates will
25 transmit HIV/AIDS to other persons in the
26 community following their release from prison.

1 (3) CONSULTATION.—The Bureau shall consult
2 with appropriate officials of the Department of
3 Health and Human Services, the Office of National
4 Drug Control Policy, the Office of National AIDS
5 Policy, and the Centers for Disease Control regard-
6 ing the development of such policy.
7 (4) TIME LIMIT.—The Bureau shall draft ap-
8 propriate regulations to implement such policy not
9 later than 1 year after the date of the enactment of
10 this Act.
11 (c) REQUIREMENTS FOR POLICY.—The policy cre-
12 ated under subsection (b) shall provide for the following:
13 (1) TESTING AND COUNSELING UPON IN-
14 TAKE.—
15 (A)(i) Subject to clause (ii), health care
16 personnel shall provide routine HIV testing to
17 all inmates as a part of a comprehensive med-
18 ical examination immediately following admis-
19 sion to a facility.
20 (ii) Health care personnel shall not be re-
21 quired to provide routine HIV testing to an in-
22 mate who is transferred to a facility from an-
23 other facility if the inmate's medical records are
24 transferred with the inmate and indicate that
25 the inmate has been tested previously.

1 (B) To all inmates admitted to a facility
2 prior to the effective date of this policy, health
3 care personnel shall provide routine HIV testing
4 within no more than 6 months. HIV testing for
5 these inmates may be performed in conjunction
6 with other health services provided to these in-
7 mates by health care personnel.
8 (C) All HIV tests under this paragraph
9 shall comply with paragraph (9).
10 (2) PRE-TEST AND POST-TEST COUNSELING.—
11 Health care personnel shall provide confidential pre-
12 test and post-test counseling to all inmates who are
13 tested for HIV. Counseling may be included with
14 other general health counseling provided to inmates
15 by health care personnel.
16 (3) HIV/AIDS PREVENTION EDUCATION.—
17 (A) Health care personnel shall improve
18 HIV/AIDS awareness through frequent edu-
19 cational programs for all inmates. HIV/AIDS
20 educational programs may be provided by com-
21 munity based organizations, local health depart-
22 ments, and inmate peer educators. Such HIV/
23 AIDS educational programs shall include infor-
24 mation on modes of transmission, including
25 transmission through tattooing, sexual contact,

1 and intravenous drug use; prevention methods;
2 treatment; and disease progression. HIV/AIDS
3 educational programs shall be culturally sen-
4 sitive, conducted in a variety of languages, and
5 present scientifically accurate information in a
6 clear and understandable manner.
7 (B) HIV/AIDS educational materials shall
8 be made available to all inmates at orientation,
9 at health care clinics, at regular educational
10 programs, and prior to release. Both written
11 and audio-visual materials shall be made avail-
12 able to all inmates. These materials shall be
13 culturally sensitive, written for low literacy lev-
14 els, and available in a variety of languages.
15 (4) HIV TESTING UPON REQUEST.—
16 (A) Health care personnel shall allow in-
17 mates to obtain HIV tests upon request once
18 per year or whenever an inmate has a reason to
19 believe the inmate may have been exposed to
20 HIV. Health care personnel shall, both orally
21 and in writing, inform inmates, during orienta-
22 tion and periodically throughout incarceration,
23 of their right to obtain HIV tests.
24 (B) Health care personnel shall encourage
25 inmates to request HIV tests if the inmate is

1 sexually active, has been raped, uses intra-
2 venous drugs, receives a tattoo, or if the inmate
3 is concerned that the inmate may have been ex-
4 posed to HIV/AIDS.
5 (C) An inmate's request for an HIV test
6 shall not be considered an indication that the
7 inmate has put himself or herself at risk of in-
8 fection or committed a violation of prison rules.
9 (5) HIV TESTING OF PREGNANT WOMAN.—
10 (A) Health care personnel shall provide
11 routine HIV testing to all inmates who become
12 pregnant.
13 (B) All HIV tests under this paragraph
14 shall comply with paragraph (9).
15 (6) COMPREHENSIVE TREATMENT.—
16 (A) Health care personnel shall provide all
17 inmates who test positive for HIV—
18 (i) timely, comprehensive medical
19 treatment;
20 (ii) confidential counseling on man-
21 aging their medical condition and pre-
22 venting its transmission to other persons;
23 and
24 (iii) voluntary partner notification
25 services.

(B) Medical care provided under this paragraph shall be consistent with current Department of Health and Human Services guidelines and standard medical practice. Health care personnel shall discuss treatment options, the importance of adherence to antiretroviral therapy, and the side effects of medications with inmates receiving treatment.

(C) Health care personnel and pharmacy personnel shall ensure that the facility formulary contains all Food and Drug Administration-approved medications necessary to provide comprehensive treatment for inmates living with HIV/AIDS, and that the facility maintains adequate supplies of such medications to meet inmates' medical needs. Health care personnel and pharmacy personnel shall also develop and implement automatic renewal systems for these medications to prevent interruptions in care.

(D) Correctional staff, health care personnel, and pharmacy personnel shall develop and implement distribution procedures to ensure timely and confidential access to medications.

(7) PROTECTION OF CONFIDENTIALITY.—

(A) Health care personnel shall develop and implement procedures to ensure the confidentiality of inmate tests, diagnoses, and treatment. Health care personnel and correctional staff shall receive regular training on the implementation of these procedures. Penalties for violations of inmate confidentiality by health care personnel or correctional staff shall be specified and strictly enforced.

(B) HIV testing, counseling, and treatment shall be provided in a confidential setting where other routine health services are provided and in a manner that allows the inmate to request and obtain these services as routine medical services.

(8) TESTING, COUNSELING, AND REFERRAL PRIOR TO REENTRY.—

(A)(i) Subject to clauses (ii) and (iii), health care personnel shall provide routine HIV testing to all inmates no more than 3 months prior to their release and reentry into the community.

(ii) Inmates who are already known to be infected shall not be required to be tested again.

1 (iii) The requirement under clause (i) may
2 be waived if an inmate's release occurs without
3 sufficient notice to the Bureau to allow health
4 care personnel to perform a routine HIV test
5 and notify the inmate of the results.

6 (B) All HIV tests under this paragraph
7 shall comply with paragraph (9).

8 (C) To all inmates who test positive for
9 HIV and all inmates who already are known to
10 have HIV/AIDS, health care personnel shall
11 provide—

12 (i) confidential prerelease counseling
13 on managing their medical condition in the
14 community, accessing appropriate treat-
15 ment and services in the community, and
16 preventing the transmission of their condi-
17 tion to family members and other persons
18 in the community;

19 (ii) referrals to appropriate health
20 care providers and social service agencies
21 in the community that meet the inmate's
22 individual needs, including voluntary part-
23 ner notification services and prevention
24 counseling services for people living with
25 HIV/AIDS; and

1 (iii) a 30-day supply of any medically
2 necessary medications the inmate is cur-
3 rently receiving.
4 (9) OPT-OUT PROVISION.—Inmates shall have
5 the right to refuse routine HIV testing. Inmates
6 shall be informed both orally and in writing of this
7 right. Oral and written disclosure of this right may
8 be included with other general health information
9 and counseling provided to inmates by health care
10 personnel. If an inmate refuses a routine test for
11 HIV, health care personnel shall make a note of the
12 inmate's refusal in the inmate's confidential medical
13 records. However, the inmate's refusal shall not be
14 considered a violation of prison rules or result in dis-
15 ciplinary action.
16 (10) EXCLUSION OF TESTS PERFORMED UNDER
17 SECTION 4014(b) FROM THE DEFINITION OF ROU-
18 TINE HIV TESTING.—HIV testing of an inmate
19 under section 4014(b) of title 18, United States
20 Code, is not routine HIV testing for the purposes of
21 paragraph (9). Health care personnel shall document
22 the reason for testing under section 4014(b) of title
23 18, United States Code, in the inmate's confidential
24 medical records.

1 (11) TIMELY NOTIFICATION OF TEST RE-
2 SULTS.—Health care personnel shall provide timely
3 notification to inmates of the results of HIV tests.
4 (d) CHANGES IN EXISTING LAW.—
5 (1) SCREENING IN GENERAL.—Section 4014(a)
6 of title 18, United States Code, is amended—
7 (A) by striking ''for a period of 6 months
8 or more'';
9 (B) by striking '', as appropriate,''; and
10 (C) by striking ''if such individual is deter-
11 mined to be at risk for infection with such virus
12 in accordance with the guidelines issued by the
13 Bureau of Prisons relating to infectious disease
14 management'' and inserting ''unless the indi-
15 vidual declines. The Attorney General shall also
16 cause such individual to be so tested before re-
17 lease unless the individual declines.''.
18 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
19 CIVIL AND CRIMINAL PROCEEDINGS.—Section
20 4014(d) of title 18, United States Code, is amended
21 by inserting ''or under the Stop AIDS in Prison Act
22 of 2012'' after ''under this section''.
23 (3) SCREENING AS PART OF ROUTINE SCREEN-
24 ING.—Section 4014(e) of title 18, United States
25 Code, is amended by adding at the end the fol-

1 lowing: "Such rules shall also provide that the initial
2 test under this section be performed as part of the
3 routine health screening conducted at intake.".
4 (e) REPORTING REQUIREMENTS.—
5 (1) REPORT ON HEPATITIS AND OTHER DIS-
6 EASES.—Not later than 1 year after the date of the
7 enactment of this Act, the Bureau shall provide a re-
8 port to the Congress on Bureau policies and proce-
9 dures to provide testing, treatment, and prevention
10 education programs for hepatitis and other diseases
11 transmitted through sexual activity and intravenous
12 drug use. The Bureau shall consult with appropriate
13 officials of the Department of Health and Human
14 Services, the Office of National Drug Control Policy,
15 the Office of National AIDS Policy, and the Centers
16 for Disease Control and Prevention regarding the
17 development of this report.
18 (2) ANNUAL REPORTS.—
19 (A) GENERALLY.—Not later than 2 years
20 after the date of the enactment of this Act, and
21 then annually thereafter, the Bureau shall re-
22 port to Congress on the incidence among in-
23 mates of diseases transmitted through sexual
24 activity and intravenous drug use.

1 (B) MATTERS PERTAINING TO VARIOUS
2 DISEASES.—Reports under subparagraph (A)
3 shall discuss—
4 (i) the incidence among inmates of
5 HIV/AIDS, hepatitis, and other diseases
6 transmitted through sexual activity and in-
7 travenous drug use; and
8 (ii) updates on Bureau testing, treat-
9 ment, and prevention education programs
10 for these diseases.
11 (C) MATTERS PERTAINING TO HIV/AIDS
12 ONLY.—Reports under subparagraph (A) shall
13 also include—
14 (i) the number of inmates who tested
15 positive for HIV upon intake;
16 (ii) the number of inmates who tested
17 positive prior to reentry;
18 (iii) the number of inmates who were
19 not tested prior to reentry because they
20 were released without sufficient notice;
21 (iv) the number of inmates who opted-
22 out of taking the test;
23 (v) the number of inmates who were
24 tested under section 4014(b) of title 18,
25 United States Code; and

1 (vi) the number of inmates under
2 treatment for HIV/AIDS.
3 (D) CONSULTATION.—The Bureau shall
4 consult with appropriate officials of the Depart-
5 ment of Health and Human Services, the Office
6 of National Drug Control Policy, the Office of
7 National AIDS Policy, and the Centers for Dis-
8 ease Control and Prevention regarding the de-
9 velopment of reports under subparagraph (A).
10 **SEC. 751. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
11 **ETHNIC MINORITY COMMUNITIES.**
12 For the purpose of reducing HIV/AIDS in racial and
13 ethnic minority communities, the Secretary, acting
14 through the Deputy Assistant Secretary for Minority
15 Health, may make grants to public health agencies and
16 faith-based organizations to conduct—
17 (1) outreach activities related to HIV/AIDS
18 prevention and testing activities;
19 (2) HIV/AIDS prevention activities; and
20 (3) HIV/AIDS testing activities.
21 **SEC. 752. HEALTH CARE PROFESSIONALS TREATING INDI-**
22 **VIDUALS WITH HIV/AIDS.**
23 Part E of title VII of the Public Health Service Act
24 (42 U.S.C. 294n et seq.) is amended by adding at the end
25 the following:

1 **“Subpart 5—Health Care Professionals Treating**
2 **Individuals With HIV/AIDS**

3 **“SEC. 785. HEALTH CARE PROFESSIONALS TREATING INDI-**
4 **VIDUALS WITH HIV/AIDS.**

5 ‘‘(a) IN GENERAL.—The Secretary, acting through
6 the Administrator of the Health Resources and Services
7 Administration and in consultation with racial and ethnic
8 minority community organizations, may award grants for
9 any of the following:

10 ‘‘(1) Development of curricula for training pri-
11 mary care providers in HIV/AIDS prevention and
12 care.

13 ‘‘(2) Training health care professionals with ex-
14 pertise in HIV/AIDS to provide care to individuals
15 with HIV/AIDS.

16 ‘‘(3) Development by grant recipients under
17 title XXVI and other persons of policies for pro-
18 viding culturally relevant and sensitive treatment to
19 individuals with HIV/AIDS, with particular empha-
20 sis on treatment to racial and ethnic minorities, men
21 who have sex with men, and women and children
22 with HIV/AIDS.

23 ‘‘(4) Development and implementation of pro-
24 grams to increase the use of telemedicine to respond
25 to HIV/AIDS-specific health care needs in rural and
26 minority communities, with particular emphasis

1 given to medically underserved communities and in-
2 sular areas.

3 "(5) Creation of faith- and community-based
4 certification programs for providers in HIV/AIDS
5 care and support services.

6 "(6) Establishment of comfort care centers that
7 provide mental, emotional, and psychosocial coun-
8 seling for people with HIV/AIDS and implement ad-
9 ditional protocols to be carried out in the centers
10 that address the needs of children and young adults
11 who are infected with the disease and are
12 transitioning from childhood to adulthood.

13 "(7) Incentive payments to health care pro-
14 viders supported by the Health Resources and Serv-
15 ices Administration to implement HIV/AIDS testing
16 consistent with the guidelines issued in 2006 by the
17 Centers for Disease Control and Prevention entitled
18 'Revised Recommendations for HIV Testing of
19 Adults, Adolescents, and Pregnant Women in
20 Health-Care Settings'.

21 "(b) DEFINITIONS.—In this section—

22 "(1) the term 'HIV/AIDS' has the meaning
23 given to such term in section 2689; and

1 "(2) the term 'primary care' includes obstetrical
2 and gynecological care and psychiatric and mental
3 health care.".

4 **SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN RACIAL AND**
5 **ETHNIC MINORITY COMMUNITIES.**

6 (a) IN GENERAL.—The Secretary shall submit to the
7 Congress and the President an annual report on the im-
8 pact of HIV/AIDS in racial and ethnic minority commu-
9 nities.

10 (b) CONTENTS.—The report under subsection (a)
11 shall include information on the—
12 (1) progress that has been made in reducing
13 the impact of HIV/AIDS in such communities;
14 (2) opportunities that exist to make additional
15 progress in reducing the impact of HIV/AIDS in
16 such communities;
17 (3) challenges that may impede such additional
18 progress; and
19 (4) Federal funding necessary to achieve sub-
20 stantial reductions in HIV/AIDS in racial and ethnic
21 minority communities.

22 **SEC. 754. STUDY ON STATUS OF HIV/AIDS EPIDEMIC AMONG**
23 **AFRICAN-AMERICANS.**

24 The Secretary shall—

1 (1) seek to enter into an agreement with the In-
2 stitute of Medicine to document, in collaboration
3 with an academic organization which specializes in
4 the identification and reduction of health disparities
5 within the African-American community, all aspects
6 of the HIV/AIDS epidemic among African-Ameri-
7 cans, including the role that historical racial or eth-
8 nic barriers play in sustaining the epidemic among
9 African-Americans;
10 (2) submit a report to the President, the Direc-
11 tor of the Office of National AIDS Policy Coordina-
12 tion, the Director of the White House Domestic Pol-
13 icy Council, the Director of White House Office of
14 Faith-Based and Neighborhood Partnerships, key
15 Federal agencies, and the relevant committees of the
16 Congress on the status of the HIV/AIDS epidemic
17 among African-Americans in the United States; and
18 (3) include in such report—
19 (A) specific recommendations on the imple-
20 mentation of Federal policies to reduce the bur-
21 den of HIV/AIDS in the African-American com-
22 munity; and
23 (B) a special focus on the Black clergy and
24 the church as a unique resource in the African-
25 American community.

Subtitle F—Diabetes

SEC. 755. TREATMENT OF DIABETES IN MINORITY COMMUNITIES.

(a) SHORT TITLE.—This subtitle may be cited as the ''Minority Diabetes Initiative Act''.

(b) GRANTS REGARDING TREATMENT OF DIABETES IN MINORITY COMMUNITIES.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330L the following:

''SEC. 330M. GRANTS REGARDING TREATMENT OF DIABETES IN MINORITY COMMUNITIES.

''(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private health care providers for the purpose of providing treatment for diabetes in minority communities.

''(b) RECIPIENTS OF GRANTS.—The public and nonprofit private health care providers to whom grants may be made under subsection (a) include physicians, podiatrists, community-based organizations, health care organizations, community health centers, and State, local, and tribal health departments.

''(c) SCOPE OF TREATMENT ACTIVITIES.—The Secretary shall ensure that grants under subsection (a) cover a variety of diabetes-related health care services, including routine care for diabetic patients, public education on dia-

1 betes prevention and control, eye care, foot care, and
2 treatment for kidney disease and other complications of
3 diabetes.

4 "(d) APPROPRIATE CULTURAL CONTEXT.—A condi-
5 tion for the receipt of a grant under subsection (a) is that
6 the applicant involved agrees that, in the program carried
7 out with the grant, services will be provided in the lan-
8 guages most appropriate for, and with consideration for
9 the cultural backgrounds of, the individuals for whom the
10 services are provided.

11 "(e) OUTREACH SERVICES.—A condition for the re-
12 ceipt of a grant under subsection (a) is that the applicant
13 involved agrees to provide outreach activities to inform the
14 public of the services of the program, and to provide offsite
15 information on diabetes.

16 "(f) REPORTING OF DATA.—A condition for the re-
17 ceipt of a grant under subsection (a) is that the applicant
18 involved agrees—

19 "(1) to collect and report data, on a time basis
20 determined appropriate by the Secretary, on race,
21 ethnicity, sex, gender, primary language, disability
22 status, and socioeconomic status; and

23 "(2) to develop research methodologies that en-
24 sure reporting of data stratified as described in
25 paragraph (1).

1 ''(g) APPLICATION FOR GRANT.—A grant may be
2 made under subsection (a) only if an application for the
3 grant is submitted to the Secretary and the application
4 is in such form, is made in such manner, and contains
5 such agreements, assurances, and information as the Sec-
6 retary determines to be necessary to carry out this sec-
7 tion.''.

8 **SEC. 756. ELIMINATING DISPARITIES IN DIABETES PREVEN-**
9 **TION ACCESS AND CARE.**

10 (a) RESEARCH, TREATMENT, AND EDUCATION.—
11 (1) IN GENERAL.—Subpart 3 of part C of title
12 IV of the Public Health Service Act (42 U.S.C. 285c
13 et seq.) is amended by adding at the end the fol-
14 lowing new section:

15 **''SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

16 ''(a) IN GENERAL.—The Director of the National In-
17 stitutes of Health shall expand, intensify, and support on-
18 going research and other activities with respect to pre-dia-
19 betes and diabetes, particularly type 2, in minority popu-
20 lations, including research to identify clinical, socio-
21 economic, geographical, cultural, and organizational fac-
22 tors that contribute to type 2 diabetes in such populations.
23 ''(b) CERTAIN ACTIVITIES.—Activities under sub-
24 section (a) regarding type 2 diabetes in minority popu-
25 lations shall include the following:

1 "(1) Continuing research on behavior and obe-
2 sity, including through the obesity research center
3 that is sponsored by the National Institutes of
4 Health.
5 "(2) Research on environmental factors that
6 may contribute to the increase in type 2 diabetes.
7 "(3) Support for new methods to identify envi-
8 ronmental triggers and genetic interactions that lead
9 to the development of type 2 diabetes in minority
10 newborns. Such research should follow the newborns
11 through puberty, an increasingly high-risk period for
12 developing type 2 diabetes.
13 "(4) Research to identify genes that predispose
14 individuals to the onset of developing type 1 and
15 type 2 diabetes and to the development of complica-
16 tions.
17 "(5) Research to prevent complications in indi-
18 viduals who have already developed diabetes, such as
19 research that attempts to identify the genes that
20 predispose individuals with diabetes to the develop-
21 ment of complications.
22 "(6) Research methods and alternative thera-
23 pies to control blood glucose.
24 "(7) Support of ongoing research efforts exam-
25 ining the level of glycemia at which adverse out-

1 comes develop during pregnancy and to address the
2 many clinical issues associated with minority moth-
3 ers and fetuses during diabetic and gestational dia-
4 betic pregnancies.
5 ''(c) EDUCATION.—The Director of the National In-
6 stitutes of Health shall—
7 ''(1) through the National Institute on Minority
8 Health and Health Disparities and the National Di-
9 abetes Education Program—
10 ''(A) make grants to programs funded
11 under section 485F (relating to centers of ex-
12 cellence) for the purpose of establishing a men-
13 toring program for health care professionals to
14 be more involved in weight counseling, obesity
15 research, and nutrition; and
16 ''(B) provide for the participation of mi-
17 nority health professionals in diabetes-focused
18 research programs; and
19 ''(2) make grants for programs to establish a
20 pipeline from high school to professional school that
21 will increase minority representation in diabetes-fo-
22 cused health fields by expanding Minority Access to
23 Research Careers (MARC) program internships and
24 mentoring opportunities for recruitment.
25 ''(d) COLLECTION AND REPORTING OF DATA.—

1 "(1) IN GENERAL.—The Secretary shall ensure
2 that research and other activities undertaken pursu-
3 ant to this section include the collection and report-
4 ing, on a time basis determined appropriate by the
5 Secretary, data on race, ethnicity, sex, gender, pri-
6 mary language, disability status and socioeconomic
7 status.
8 "(2) GRANTS.—To qualify for a grant under
9 this section, grantees shall develop research meth-
10 odologies that ensure annual reporting of data
11 stratified as described in paragraph (1).
12 "(e) DEFINITION.—For purposes of this section, the
13 term 'minority population' means a racial and ethnic mi-
14 nority group, as defined in section 1707(g).".
15 (2) DIABETES MELLITUS INTERAGENCY CO-
16 ORDINATING COMMITTEE.—Section 429 of the Pub-
17 lic Health Service Act (42 U.S.C. 285c–3) is amend-
18 ed by adding at the end the following new sub-
19 section:
20 "(c)(1) The Diabetes Mellitus Interagency Coordi-
21 nating Committee shall submit to the Secretary a biennial
22 report that shall include an assessment of the Federal ac-
23 tivities and programs related to diabetes in minority popu-
24 lations. Such assessment shall—

1 "(A) compile the current activities of all current
2 Federal health programs to allow for the assessment
3 of their adequacy as a systemic method of address-
4 ing the impact of diabetes mellitus on minority pop-
5 ulations;
6 "(B) develop strategic planning activities to de-
7 velop an effective and comprehensive Federal plan to
8 address diabetes mellitus within minority popu-
9 lations which will involve all appropriate Federal
10 health programs and shall—
11 "(i) include steps to address issues includ-
12 ing type 1 and type 2 diabetes in children and
13 the disproportionate impact of diabetes mellitus
14 on minority populations; and
15 "(ii) remain consistent with the programs
16 and activities identified in section 399O, as well
17 as remaining consistent with the intent of the
18 Eliminating Disparities in Diabetes Prevention
19 Access and Care Act of 2010; and
20 "(C) assess the implementation of such a plan
21 throughout Federal health programs.
22 "(2) For the purposes of this subsection, the term
23 'minority population' means a racial and ethnic minority
24 group, as defined in section 1707(g).".

1 (b) RESEARCH, EDUCATION, AND OTHER ACTIVI-
2 TIES.—Part B of title III of the Public Health Service
3 Act (42 U.S.C. 243 et seq.) is amended by inserting after
4 section 317T the following section:

5 **"SEC. 317U. DIABETES IN MINORITY POPULATIONS.**

6 "(a) RESEARCH AND OTHER ACTIVITIES.—
7 "(1) IN GENERAL.—The Secretary, acting
8 through the Director of the Centers for Disease
9 Control and Prevention, shall conduct and support
10 research and other activities with respect to diabetes
11 in minority populations.
12 "(2) CERTAIN ACTIVITIES.—Activities under
13 paragraph (1) regarding diabetes in minority popu-
14 lations shall include the following:
15 "(A) Expanding the National Diabetes
16 Laboratory capacity for translational research
17 and the identification of genetic and
18 immunological risk factors associated with dia-
19 betes.
20 "(B) Improving the understanding of dia-
21 betes prevalence among Asian-American, Native
22 Hawaiian and other Pacific Islanders by en-
23 hancing data in the National Health and Nutri-
24 tion Examination Survey by oversampling these
25 populations in appropriate geographic areas, or

1 by another method determined appropriate to
2 collect this data.
3 "(C) Within the Division of Diabetes
4 Translation, providing for prevention research
5 to better understand how to influence health
6 care systems changes to improve quality of care
7 being delivered to such populations, and within
8 the Division of Diabetes Translation, carrying
9 out model demonstration projects to design, im-
10 plement, and evaluate effective diabetes preven-
11 tion and control intervention for such popu-
12 lations.
13 "(D) Through the Division of Diabetes
14 Translation, carrying out culturally appropriate
15 community-based interventions designed to ad-
16 dress issues and problems experienced by such
17 populations.
18 "(E) Conducting applied research within
19 the Division of Diabetes Translation to reduce
20 health disparities within such populations with
21 diabetes.
22 "(F) Conducting applied research on pri-
23 mary prevention within the Division of Diabetes
24 Translation to specifically focus on such popu-
25 lations with pre-diabetes.

1 "(b) EDUCATION.—
2 "(1) IN GENERAL.—The Secretary, acting
3 through the Director of the Centers for Disease
4 Control and Prevention, shall direct the Division of
5 Diabetes Translation to conduct and support pro-
6 grams to educate the public on the causes and ef-
7 fects of diabetes in minority populations.
8 "(2) CERTAIN ACTIVITIES.—Programs under
9 paragraph (1) regarding education on diabetes in
10 minority populations shall include carrying out pub-
11 lic awareness campaigns directed toward such popu-
12 lations to aggressively emphasize the importance and
13 impact of physical activity and diet in regard to dia-
14 betes and diabetes-related complications through the
15 National Diabetes Education Program.
16 "(c) DIABETES; HEALTH PROMOTION, PREVENTION
17 ACTIVITIES, AND ACCESS.—
18 "(1) IN GENERAL.—The Secretary, acting
19 through the Director of the Centers for Disease
20 Control and Prevention, shall carry out culturally
21 appropriate diabetes health promotion and preven-
22 tion programs for minority populations.
23 "(2) CERTAIN ACTIVITIES.—Activities regard-
24 ing culturally appropriate diabetes health promotion

1 and prevention programs for minority populations
2 shall include the following:
3 ''(A) Expanding the Diabetes Prevention
4 and Control Program (currently existing in all
5 the States and territories) and providing funds
6 for education and community outreach on dia-
7 betes.
8 ''(B) Providing funds for an expansion of
9 the Diabetes Prevention Program Initiative that
10 focuses on physical inactivity and diet and its
11 relation to type 2 diabetes within such popu-
12 lations.
13 ''(C) Providing funds to strengthen exist-
14 ing surveillance systems to improve the quality,
15 accuracy, and timeliness of morbidity and mor-
16 tality diabetes data for such populations.
17 ''(d) COLLECTION AND REPORTING OF DATA.—The
18 Secretary shall ensure that research and other activities
19 undertaken pursuant to this section include the collection
20 and reporting, on a time basis determined appropriate by
21 the Secretary, data on race, ethnicity, sex, gender, primary
22 language, disability status and socioeconomic status.
23 ''(e) DEFINITION.—For purposes of this section, the
24 term 'minority population' means a racial and ethnic mi-
25 nority group, as defined in section 1707(g).''.

1 (c) RESEARCH, EDUCATION, AND OTHER ACTIVI-
2 TIES.—Part P of title III of the Public Health Service
3 Act is amended—
4 (1) by redesignating the section 399R inserted
5 by section 2 of Public Law 110–373 as section
6 399S;
7 (2) by redesignating the section 399R inserted
8 by section 3 of Public Law 110–374 as section
9 399T; and
10 (3) by adding at the end the following new sec-
11 tion:

12 **"SEC. 399V–8. PROGRAMS TO EDUCATE HEALTH PRO-**
13 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
14 **ABETES IN MINORITY POPULATIONS.**

15 "(a) IN GENERAL.—The Secretary, acting through
16 the Director of the Health Resources and Services Admin-
17 istration, shall conduct and support programs described
18 in subsection (b) to educate health professionals on the
19 causes and effects of diabetes in minority populations.
20 "(b) PROGRAMS.—Programs described in this sub-
21 section, with respect to education on diabetes in minority
22 populations, shall include the following:
23 "(1) Making grants for diabetes-focused edu-
24 cation classes or training programs on cultural sen-

1 sitivity and patient care within such populations for
2 health care providers.
3 ‘‘(2) Providing funds to community health cen-
4 ters for programs that provide diabetes services and
5 screenings.
6 ‘‘(3) Providing additional funds for the Health
7 Careers Opportunity Program, Centers for Excel-
8 lence, and the Minority Faculty Fellowship Program
9 to partner with the Office of Minority Health under
10 section 1707 and the National Institutes of Health
11 to strengthen programs for career opportunities
12 within minority populations focused on diabetes
13 treatment and care.
14 ‘‘(4) Developing a diabetes focus within, and
15 providing additional funds for, the National Health
16 Service Corps Scholarship program to place individ-
17 uals in areas that are disproportionately affected by
18 diabetes and to provide health care services to such
19 areas.
20 ‘‘(5) Establishing a diabetes ambassador pro-
21 gram for recruitment efforts to increase the number
22 of underrepresented minorities currently serving in
23 student, faculty, or administrative positions in insti-
24 tutions of higher learning, hospitals, and community
25 health centers.

1 "(6) Establishing a loan repayment program
2 that focuses on diabetes care and prevention in mi-
3 nority populations.
4 "(c) COLLECTION AND REPORTING OF DATA.—
5 "(1) IN GENERAL.—The Secretary shall ensure
6 that research and other activities undertaken pursu-
7 ant to this section include the collection and report-
8 ing, on a time basis determined appropriate by the
9 Secretary, data on race, ethnicity, sex, gender, pri-
10 mary language, disability status and socioeconomic
11 status.
12 "(2) GRANTS.—To qualify for a grant under
13 this section, grantees shall develop research meth-
14 odologies that ensure annual reporting of data
15 stratified as described in paragraph (1).".
16 (d) RESEARCH, EDUCATION, AND OTHER ACTIVI-
17 TIES.—Part P of title III of the Public Health Service
18 Act (42 U.S.C. 280g et seq.), as amended by subsection
19 (c), is further amended by adding at the end the following
20 section:
21 **"SEC. 399V–9. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
22 **TIES REGARDING DIABETES IN MINORITY**
23 **POPULATIONS.**
24 "(a) RESEARCH AND OTHER ACTIVITIES.—

1 "(1) IN GENERAL.—In addition to activities
2 under sections 317U and 434B, the Secretary shall
3 conduct and support research and other activities
4 with respect to diabetes within minority populations.
5 "(2) CERTAIN ACTIVITIES.—Activities under
6 paragraph (1) regarding diabetes in minority popu-
7 lations shall include the following:
8 "(A) Through the National Center on Mi-
9 nority Health and Health Disparities, the Office
10 of Minority Health under section 1707, the
11 Health Resources and Services Administration,
12 the Centers for Disease Control and Prevention,
13 and the Indian Health Service, establishing
14 partnerships within minority populations to
15 conduct studies on cultural, familial, and social
16 factors that may influence health promotion, di-
17 abetes management, and prevention.
18 "(B) Through the Indian Health Service,
19 in collaboration with other appropriate Federal
20 agencies, coordinating the collection of data on
21 ethnic and culturally appropriate diabetes treat-
22 ment, care, prevention, and services by health
23 care professionals to the American Indian popu-
24 lation.

1 "(3) PROGRAMS RELATING TO CLINICAL RE-
2 SEARCH.—
3 "(A) EDUCATION REGARDING CLINICAL
4 TRIALS.—The Secretary shall carry out edu-
5 cation and awareness programs designed to in-
6 crease participation of minority populations in
7 clinical trials.
8 "(B) MINORITY RESEARCHERS.—The Sec-
9 retary shall carry out mentorship programs for
10 minority researchers who are conducting or in-
11 tend to conduct research on diabetes in minor-
12 ity populations.
13 "(C) SUPPLEMENTING CLINICAL RE-
14 SEARCH REGARDING CHILDREN.—The Sec-
15 retary shall make grants to supplement clinical
16 research programs to assist such programs in
17 obtaining the services of health professionals
18 and other resources to provide specialized care
19 for children with type 1 and type 2 diabetes.
20 "(4) ADDITIONAL PROGRAMS.—Activities under
21 paragraph (1) regarding education on diabetes shall
22 include providing funds for new and existing diabe-
23 tes-focused education grants and programs for
24 present and future students and clinicians in the

1 medical field from minority populations, including
2 for the following:
3 ‘‘(A) For Federal and State loan repay-
4 ment programs for health profession students
5 within communities of color.
6 ‘‘(B) For the Office of Minority Health
7 under section 1707 for training health profes-
8 sion students to focus on diabetes within such
9 populations.
10 ‘‘(b) COLLECTION AND REPORTING OF DATA.—
11 ‘‘(1) IN GENERAL.—The Secretary shall ensure
12 that research and other activities undertaken pursu-
13 ant to this section include the collection and report-
14 ing, on a time basis determined appropriate by the
15 Secretary, data on race, ethnicity, sex, gender, pri-
16 mary language, disability status and socioeconomic
17 status.
18 ‘‘(2) GRANTS.—To qualify for a grant under
19 this section, grantees shall develop research meth-
20 odologies that ensure annual reporting of data
21 stratified as described in paragraph (1).
22 ‘‘(c) DEFINITION.—For purposes of this section, the
23 term ‘minority population’ means a racial and ethnic mi-
24 nority group as defined in section 1707(g).’’.

1 (e) SENSE OF THE CONGRESS.—It is the sense of the
2 Congress that States and localities are encourage to recog-
3 nize established times of diabetes awareness, such as
4 American Diabetes Month (November), American Diabe-
5 tes Alert Day (annually on the 4th Tuesday of March),
6 and World Diabetes Day (November 14th).

7 **Subtitle G—Lung Disease**

8 **SEC. 761. EXPANSION OF THE NATIONAL ASTHMA EDU-**
9 **CATION AND PREVENTION PROGRAM.**

10 (a) IN GENERAL.—Not later than 2 years after the
11 date of the enactment of this Act, the Secretary of Health
12 and Human Services shall convene a working group com-
13 prised of patient groups, nonprofit organizations, medical
14 societies, and other relevant governmental and nongovern-
15 mental entities, including those that participate in the Na-
16 tional Asthma Education and Prevention Program, to de-
17 velop a report to Congress that—
18 (1) catalogs, with respect to asthma prevention,
19 management, and surveillance—
20 (A) the activities of the Federal Govern-
21 ment, including identifying all Federal pro-
22 grams that carry out asthma-related activities,
23 as well as assessment of the progress of the
24 Federal Government and States, with respect to

1 achieving the goals of the Healthy People 2020
2 initiative; and
3 (B) the activities of other entities that par-
4 ticipate in the program, including nonprofit or-
5 ganizations, patient advocacy groups, and med-
6 ical societies; and
7 (2) makes recommendations for the future di-
8 rection of asthma activities, in consultation with re-
9 searchers from the National Institutes of Health and
10 other member bodies of the National Asthma Edu-
11 cation and Prevention Program who are qualified to
12 review and analyze data and evaluate interventions,
13 including—
14 (A) description of how the Federal Govern-
15 ment may better coordinate and improve its re-
16 sponse to asthma including identifying any bar-
17 riers that may exist;
18 (B) description of how the Federal Govern-
19 ment may continue, expand, and improve its
20 private-public partnerships with respect to asth-
21 ma including identifying any barriers that may
22 exist;
23 (C) identification of steps that may be
24 taken to reduce the—

1 (i) morbidity, mortality, and overall
2 prevalence of asthma;
3 (ii) financial burden of asthma on so-
4 ciety;
5 (iii) burden of asthma on dispropor-
6 tionately affected areas, particularly those
7 in medically underserved populations (as
8 defined in section 330(b)(3) of the Public
9 Health Service Act (42 U.S.C.
10 254b(b)(3)); and
11 (iv) burden of asthma as a chronic
12 disease;
13 (D) identification of programs and policies
14 that have achieved the steps described in sub-
15 paragraph (C), and steps that may be taken to
16 expand such programs and policies to benefit
17 larger populations; and
18 (E) recommendations for future research
19 and interventions.
20 (b) REPORT TO CONGRESS.—At the end of the 5-year
21 period following the submission of the report under sub-
22 section (a), the National Asthma Education and Preven-
23 tion Program shall evaluate the analyses and rec-
24 ommendations under such report and determine whether

a new report to the Congress is necessary, and make appropriate recommendations to the Congress.

SEC. 762. ASTHMA-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

Section 317I of the Public Health Service Act (42 U.S.C. 247b–10) is amended to read as follows:

"SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

"(a) PROGRAM FOR PROVIDING INFORMATION AND EDUCATION TO THE PUBLIC.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall collaborate with State and local health departments to conduct activities, including the provision of information and education to the public regarding asthma including—

"(1) deterring the harmful consequences of uncontrolled asthma; and

"(2) disseminating health education and information regarding prevention of asthma episodes and strategies for managing asthma.

"(b) DEVELOPMENT OF STATE ASTHMA PLANS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall collaborate with State and local health departments to develop State plans incorporating public health responses to reduce the burden

1 of asthma, particularly regarding disproportionately af-
2 fected populations.
3 ''(c) COMPILATION OF DATA.—The Secretary, acting
4 through the Director of the Centers for Disease Control
5 and Prevention, shall, in cooperation with State and local
6 public health officials—
7 ''(1) conduct asthma surveillance activities to
8 collect data on the prevalence and severity of asth-
9 ma, the effectiveness of public health asthma inter-
10 ventions, and the quality of asthma management, in-
11 cluding—
12 ''(A) collection of household data on the
13 local burden of asthma;
14 ''(B) surveillance of health care facilities;
15 and
16 ''(C) collection of data not containing indi-
17 vidually identifiable information from electronic
18 health records or other electronic communica-
19 tions;
20 ''(2) compile and annually publish data regard-
21 ing the prevalence and incidence of childhood asth-
22 ma, the child mortality rate, and the number of hos-
23 pital admissions and emergency department visits by
24 children associated with asthma nationally and in
25 each State and at the county level by age, sex, race,

1 and ethnicity, as well as lifetime and current preva-
2 lence; and
3 "(3) compile and annually publish data regard-
4 ing the prevalence and incidence of adult asthma,
5 the adult mortality rate, and the number of hospital
6 admissions and emergency department visits by
7 adults associated with asthma nationally and in each
8 State and at the county level by age, sex, race, eth-
9 nicity, industry, and occupation, as well as lifetime
10 and current prevalence.
11 "(d) COORDINATION OF DATA COLLECTION.—The
12 Director of the Centers for Disease Control and Preven-
13 tion, in conjunction with State and local health depart-
14 ments, shall coordinate data collection activities under
15 subsection (c)(2) so as to maximize comparability of re-
16 sults.
17 "(e) COLLABORATION.—The Centers for Disease
18 Control and Prevention are encouraged to collaborate with
19 national, State, and local nonprofit organizations to pro-
20 vide information and education about asthma, and to
21 strengthen such collaborations when possible.".
22 **SEC. 763. INFLUENZA AND PNEUMONIA VACCINATION CAM-**
23 **PAIGN.**
24 (a) IN GENERAL.—The Secretary of Health and
25 Human Services shall—

1 (1) enhance the annual campaign by the De-
2 partment of Health and Human Services to increase
3 the number of people vaccinated each year for influ-
4 enza and pneumonia; and
5 (2) include in such campaign the use of written
6 educational materials, public service announcements,
7 physician education, and any other means which the
8 Secretary deems effective.
9 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
10 out the annual campaign described in subsection (a), the
11 Secretary of Health and Human Services shall ensure
12 that—
13 (1) educational materials and public service an-
14 nouncements are readily and widely available in
15 communities experiencing disparities in the incidence
16 and mortality rates of influenza and pneumonia; and
17 (2) the campaign uses targeted, culturally ap-
18 propriate messages and messengers to reach under-
19 served communities.

20 **SEC. 764. CHRONIC OBSTRUCTIVE PULMONARY DISEASE**
21 **ACTION PLAN.**

22 (a) IN GENERAL.—The Director of the Centers for
23 Disease Control and Prevention shall conduct, support,
24 and expand public health strategies, prevention, diagnosis,

1 surveillance, and public and professional awareness activi-
2 ties regarding chronic obstructive pulmonary disease.
3 (b) NATIONAL ACTION PLAN.—
4 (1) DEVELOPMENT.—Not later than 2 years
5 after the date of the enactment of this Act, the Di-
6 rector of the National Heart, Lung, and Blood Insti-
7 tute, in consultation with the Director of the Centers
8 for Disease Control and Prevention, shall develop a
9 national action plan to address chronic obstructive
10 pulmonary disease in the United States with partici-
11 pation from patients, caregivers, health profes-
12 sionals, patient advocacy organizations, researchers,
13 providers, public health professionals, and other
14 stakeholders.
15 (2) CONTENTS.—At a minimum, such plan
16 shall include recommendations for—
17 (A) public health interventions for the pur-
18 pose of implementation of the national plan;
19 (B) biomedical, health services, and public
20 health research on chronic obstructive pul-
21 monary disease; and
22 (C) inclusion of chronic obstructive pul-
23 monary disease in the health data collections of
24 all Federal agencies.

1 (3) CONSIDERATION.—In developing such plan,
2 the Director of the National Heart, Lung, and Blood
3 Institute shall consider the recommendations and
4 findings of the Institute of Medicine in the report
5 entitled ''A Nationwide Framework for Surveillance
6 of Cardiovascular and Chronic Lung Diseases'' (July
7 22, 2011).
8 (c) CHRONIC DISEASE PREVENTION PROGRAMS.—
9 The Director of the National Heart, Lung, and Blood In-
10 stitute shall carry out the following:
11 (1) Conduct public education and awareness ac-
12 tivities with patient and professional organizations
13 to stimulate earlier diagnosis and improve patient
14 outcomes from treatment of chronic obstructive pul-
15 monary disease. To the extent known and relevant,
16 such public education and awareness activities shall
17 reflect differences in chronic obstructive pulmonary
18 disease by cause (tobacco, environmental, occupa-
19 tional, biological, and genetic) and include a focus
20 on outreach to undiagnosed and, as appropriate, mi-
21 nority populations.
22 (2) Supplement and expand upon the activities
23 of the National Heart, Lung, and Blood Institute by
24 making grants to nonprofit organizations, State and
25 local jurisdictions, and Indian tribes for the purpose

1 of reducing the burden of chronic obstructive pul-
2 monary disease, especially in disproportionately im-
3 pacted communities, through public health interven-
4 tions and related activities.
5 (3) Coordinate with the Centers for Disease
6 Control and Prevention, the Indian Health Service,
7 the Health Resources and Services Administration,
8 and the Department of Veterans Affairs to develop
9 pilot programs to demonstrate best practices for the
10 diagnosis and management of chronic obstructive
11 pulmonary disease.
12 (4) Develop improved techniques and identify
13 best practices, in coordination with the Secretary of
14 Veterans Affairs, for assisting chronic obstructive
15 pulmonary disease patients to successfully stop
16 smoking, including identification of subpopulations
17 with different needs. Initiatives under this para-
18 graph may include research to determine whether
19 successful smoking cessation strategies are different
20 for chronic obstructive pulmonary disease patients
21 compared to such strategies for patients with other
22 chronic diseases.
23 (d) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
24 PROGRAMS.—The Director of the Centers for Disease
25 Control and Prevention shall—

1 (1) support research into the environmental and
2 occupational causes and biological mechanisms that
3 contribute to chronic obstructive pulmonary disease;
4 and
5 (2) develop and disseminate public health inter-
6 ventions that will lessen the impact of environmental
7 and occupational causes of chronic obstructive pul-
8 monary disease.
9 (e) DATA COLLECTION.—Not later than 180 days
10 after the enactment of this Act, the Director of the Na-
11 tional Heart, Lung, and Blood Institute and the Director
12 of the Centers for Disease Control and Prevention, acting
13 jointly, shall assess the depth and quality of information
14 on chronic obstructive pulmonary disease that is collected
15 in surveys and population studies conducted by the Cen-
16 ters for Disease Control and Prevention, including wheth-
17 er there are additional opportunities for information to be
18 collected in the National Health and Nutrition Examina-
19 tion Survey, the National Health Interview Survey, and
20 the Behavioral Risk Factors Surveillance System surveys.
21 The Director of the National Heart, Lung, and Blood In-
22 stitute shall include the results of such assessment in the
23 national action plan under subsection (b).

TITLE VIII—HEALTH INFORMATION TECHNOLOGY

Subtitle A—Reducing Health Disparities Through Health IT

SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR PROMOTION OF HEALTH IT.

The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall expand and intensify the programs and activities of the Administration (directly or through grants or contracts) to provide technical assistance and resources to health centers (as defined in section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a)) to adopt and meaningfully use certified EHR technology (as defined in section 3000(1) of such Act (42 U.S.C. 300jj(1)) for the management of chronic diseases and health conditions.

SEC. 802. ASSESSMENT OF USE OF HEALTH IT IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

(a) NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.—

(1) IN GENERAL.—The National Coordinator for Health Information Technology shall conduct an evaluation of the level of use and accessibility of

1 electronic health records in racial and ethnic minor-
2 ity communities.
3 (2) CONTENT.—In conducting the evaluation
4 under paragraph (1), the National Coordinator shall
5 publish the results of a study regarding the 100,000
6 providers recruited by the Regional Extension Cen-
7 ter established under section 3012 of the Public
8 Health Service Act (42 U.S.C. 300jj–32), including
9 the race and ethnicity of such providers and the pop-
10 ulations served by such providers.
11 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—
12 As soon as practicable after the date of enactment of this
13 Act, the Director of the National Center for Health Statis-
14 tics shall provide to Congress a more detailed analysis of
15 the data presented in the Data Brief 79 published by such
16 Center in November 2011 (entitled "Electronic Health
17 Record Systems and Intent to Apply for Meaningful Use
18 Incentives Among Office-Based Physician Practices").
19 (c) INSTITUTE OF MEDICINE.—The Secretary of
20 Health and Human Services may enter into an agreement
21 with the Institute of Medicine of the National Academies
22 that provides such Institute will evaluate the impact of
23 health information technology in racial and ethnic minor-
24 ity communities and publish a report regarding such eval-
25 uation.

Subtitle B—Modifications to Achieve Parity in Existing Programs

SEC. 811. EXTENDING FUNDING TO STRENGTHEN THE HEALTH IT INFRASTRUCTURE IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

Section 3011 of the Public Health Service Act (42 U.S.C. 300jj–31) is amended—

(1) in subsection (a), by adding at the end the following new paragraph:

"(8) Activities described in the previous paragraphs of this subsection with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)).''; and

(2) by adding at the end the following new subsection:

"(e) ANNUAL REPORT ON EXPENDITURES.—The National Coordinator shall report annually to the Congress on activities and expenditures under this section.''.

SEC. 812. PRIORITIZING REGIONAL EXTENSION CENTER ASSISTANCE TO RACIAL AND ETHNIC MINORITY GROUPS.

(a) IN GENERAL.—Section 3012(c)(4)(C) of the Public Health Service Act (42 U.S.C. 300jj–32(c)(4)(C)) is

1 amended by inserting ''or individuals from racial and eth-
2 nic minority groups (as defined in section 1707(g))'' after
3 ''medically underserved individuals''.
4 (b) BIENNIAL EVALUATION.—Section 3012(c)(8) of
5 such Act (42 U.S.C. 300jj–32(c)(8)) is amended—
6 (1) by inserting: ''Each evaluation panel shall
7 include at least one consumer advocate from a racial
8 and ethnic minority community served by the center
9 involved and at least one representative of a minor-
10 ity-serving institution.'' after '' 'and of Federal offi-
11 cials.''; and
12 (2) by inserting ''and shall determine the de-
13 gree to which such center provides outreach and as-
14 sistance to providers predominantly serving racial
15 and ethnic minority groups (as defined in section
16 1707(g))'' after ''specified in paragraph (3)''.
17 **SEC. 813. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
18 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
19 **TATE ADOPTION OF CERTIFIED EHR TECH-**
20 **NOLOGY BY PROVIDERS SERVING RACIAL**
21 **AND ETHNIC MINORITY GROUPS.**
22 Section 3014(e) of the Public Health Service Act (42
23 U.S.C. 300jj–34(e)) is amended—
24 (1) in paragraph (3), by striking at the end
25 ''or'';

1 (2) in paragraph (4), by striking the period at
2 the end and inserting "; or"; and
3 (3) by adding at the end the following new
4 paragraph:
5 "(5) carry out any of the activities described in
6 a previous paragraph of this subsection with respect
7 to communities with a high proportion of individuals
8 from racial and ethnic minority groups (as defined
9 in section 1707(g)).".

10 Subtitle C—Additional Research 11 and Studies

12 **SEC. 821. DATA COLLECTION AND ASSESSMENTS CON-**
13 **DUCTED IN COORDINATION WITH MINORITY-**
14 **SERVING INSTITUTIONS.**

15 Section 3001(c)(6) of the Public Health Service Act
16 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
17 end the following new subparagraph:
18 "(F) DATA COLLECTION AND ASSESS-
19 MENTS CONDUCTED IN COORDINATION WITH
20 MINORITY-SERVING INSTITUTIONS.—
21 "(i) IN GENERAL.—In carrying out
22 subparagraph (C) with respect to commu-
23 nities with a high proportion of individuals
24 from racial and ethnic minority groups (as
25 defined in section 1707(g)), the National

1 Coordinator shall, to the greatest extent
2 possible, coordinate with an entity de-
3 scribed in clause (ii).
4 "(ii) MINORITY-SERVING INSTITU-
5 TIONS.—For purposes of clause (i), an en-
6 tity described in this clause is a historically
7 Black college or university, an Hispanic-
8 serving institution, a tribal college or uni-
9 versity, or an Asian-American-, Native
10 American-, and Pacific Islander-serving in-
11 stitution with an accredited public health,
12 health policy, or health services research
13 program.".

14 **SEC. 822. IOM STUDY AND REPORT ON PRIVACY CONCERNS**
15 **OF CERTAIN MINORITY POPULATIONS.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services shall seek to enter into an agreement
18 with the Institute of Medicine of the National Academies
19 to—
20 (1) complete a study—
21 (A) on the privacy concerns, relating to the
22 exchange of health information, of individuals
23 described in subsection (b);
24 (B) on how such concerns may create bar-
25 riers for such individuals to access health care

1 or participate in the exchange of health infor-
2 mation; and
3 (C) including recommendations for over-
4 coming such barriers for such individuals; and
5 (2) not later than 24 months after the date of
6 the enactment of this Act, submit to Congress a re-
7 port on the results of such study.
8 If such Institute declines to conduct the study and submit
9 the report, the Secretary shall enter into an agreement
10 with another appropriate public or nonprofit private entity
11 to conduct the study and submit the report.
12 (b) INDIVIDUALS DESCRIBED.—For purposes of sub-
13 section (a), the individuals described in this subsection are
14 individuals from racial and ethnic minority groups (as de-
15 fined in section 1707(g)), including such individuals
16 who—
17 (1) are immigrants, as well as citizens living
18 within immigrant households (''mixed-status'' house-
19 holds) in the United States;
20 (2) are lesbian, gay, bisexual, or transgender; or
21 (3) have a mental health disability or a record
22 of a mental health disability or treatment for a men-
23 tal health disability.

1 **SEC. 823. STUDY OF HEALTH INFORMATION TECHNOLOGY**
2 **IN MEDICALLY UNDERSERVED AREAS.**

3 (a) IN GENERAL.—Not later than 24 months after
4 the date of enactment of this Act, the Secretary of Health
5 and Human Services shall—

6 (1) enter into an agreement with the Institute
7 of Medicine of the National Academies (or, if the In-
8 stitute of Medicine declines, another appropriate
9 public or nonprofit private entity) to conduct a study
10 on the development, implementation, and effective-
11 ness of health information technology within medi-
12 cally underserved areas (as described in subsection
13 (c)); and

14 (2) submit a report to Congress describing the
15 results of such study, including any recommenda-
16 tions for legislative or administrative action.

17 (b) STUDY.—The study described in subsection
18 (a)(1) shall—

19 (1) identify barriers to successful implementa-
20 tion of health information technology in medically
21 underserved areas;

22 (2) examine the impact of health information
23 technology on providing quality care and reducing
24 the cost of care to individuals in such areas, includ-
25 ing the impact of such technology on improved
26 health outcomes for individuals;

1 (3) examine the impact of health information
2 technology on improving health care-related deci-
3 sions by both patients and providers in such areas;
4 (4) identify specific best practices for using
5 health information technology to foster the con-
6 sistent provision of physical accessibility and reason-
7 able policy accommodations in health care to individ-
8 uals with disabilities in such areas;
9 (5) assess the feasibility and costs associated
10 with the use of health information technology in
11 such areas;
12 (6) evaluate whether the adoption and use of
13 qualified electronic health records (as described in
14 section 3000(13) of the Public Health Service Act
15 (42 U.S.C. 300jj(13)) is effective in reducing health
16 disparities, including analysis of clinical quality
17 measures reported by Medicare and Medicaid pro-
18 viders pursuant to programs to encourage the adop-
19 tion and use of certified EHR technology;
20 (7) identify providers in medically underserved
21 areas that are not electing to adopt and use elec-
22 tronic health records and determine what barriers
23 are preventing those providers from adopting and
24 using such records; and

1 (8) examine urban and rural community health
2 systems and determine the impact that health infor-
3 mation technology may have on the capacity of pri-
4 mary health providers in those systems.
5 (c) MEDICALLY UNDERSERVED AREA.—The term
6 ''medically underserved area'' means—
7 (1) a population that has been designated as a
8 medically underserved population under section
9 330(b)(3) of the Public Health Service Act (42
10 U.S.C. 254b(b)(3));
11 (2) an area that has been designated as a
12 health professional shortage area under section 332
13 of the Public Health Service Act (42 U.S.C. 254e);
14 (3) an area or population that has been des-
15 ignated as a medically underserved community under
16 section 799B(6) of the Public Health Service Act
17 (42 U.S.C. 295p(6)); or
18 (4) an area or population that—
19 (A) is not described in paragraphs (1)
20 through (3) of this subsection;
21 (B) experiences significant barriers to ac-
22 cessing quality health services; and
23 (C) has a high prevalence of diseases or
24 conditions described in title VII of this Act,
25 with such diseases or conditions having a dis-

1 proportionate impact on racial and ethnic mi-
2 nority groups (as defined in section 1707(g) of
3 the Public Health Service Act (42 U.S.C. 300u-
4 6(g))) or a subgroup of people with disabilities
5 who have specific functional impairments.

6 Subtitle D—Closing Gaps in 7 Funding To Adopt Certified EHRs

8 SEC. 831. APPLICATION OF MEDICARE HITECH PAYMENTS 9 TO HOSPITALS IN PUERTO RICO.

10 (a) IN GENERAL.—Subsection (n)(6)(B) of section
11 1886 of the Social Security Act (42 U.S.C. 1395ww) is
12 amended by striking ‘‘subsection (d) hospital’’ and insert-
13 ing ‘‘hospital that is a subsection (d) hospital or a sub-
14 section (d) Puerto Rico hospital’’.
15 (b) OFFSETTING REDUCTION.—Subsection (n)(2) of
16 such section is amended by adding at the end the following
17 new subparagraph:
18 ‘‘(H) BUDGET NEUTRALITY ADJUST-
19 MENT.—The Secretary shall reduce the applica-
20 ble amounts that would otherwise be deter-
21 mined under this subsection with respect to—
22 ‘‘(i) the first fiscal year to which this
23 subparagraph applies by an amount that
24 the Secretary estimates would ensure that
25 estimated aggregate payments under this

subsection for such fiscal year are not increased as a result of the amendments made by subsection (a) of section 831 of the Health Equity and Accountability Act of 2012; or

"(ii) a succeeding fiscal year by an amount that the Secretary estimates would ensure that estimated aggregate payments under this subsection for such fiscal year are not increased as a result of the amendments made by subsections (a) and (c) of such section.".

(c) CONFORMING AMENDMENTS.—(1) Subsection (b)(3)(B)(ix) of such section is amended—

(A) in subclause (I), by striking "(n)(6)(A)" and inserting "(n)(6)(B)"; and

(B) in subclause (II), by striking "subsection (d) hospital" and inserting "an eligible hospital".

(2) Paragraphs (2) and (4)(A) of section 1853(m) of the Social Security Act (42 U.S.C. 1395w–23(m)) are each amended by striking "1886(n)(6)(A)" and inserting "1886(n)(6)(B)".

(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by sub-

1 sections (a), (b) and (c) by program instruction or other-
2 wise.
3 (e) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to payments for payment years for
5 fiscal years beginning after the date of the enactment of
6 this Act.
7 **SEC. 832. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**
8 **FOR MEDICAID ELECTRONIC HEALTH**
9 **RECORD INCENTIVE PAYMENTS.**
10 (a) IN GENERAL.—Section 1903(t)(3)(B)(v) of the
11 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is
12 amended by striking ''insofar as the assistant is prac-
13 ticing'' and all that follows through ''so led''.
14 (b) EFFECTIVE DATE.—The amendment made by
15 subsection (a) shall apply with respect to amounts ex-
16 pended under 1903(a)(3)(F) of the Social Security Act
17 (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters begin-
18 ning on or after the date of the enactment of this Act.

TITLE IX—ACCOUNTABILITY AND EVALUATION

SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL ASSISTED HEALTH CARE SERVICES AND RESEARCH PROGRAMS ON THE BASIS OF SEX, RACE, COLOR, NATIONAL ORIGIN, SEXUAL ORIENTATION, GENDER IDENTITY, OR DISABILITY STATUS.

No person in the United States shall, on the basis of sex, race, color, national origin, sexual orientation, gender identity, or disability status, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health care service or research program or activity receiving Federal financial assistance.

SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.

A payment to a provider of services, physician, or other supplier under part B, C, or D of title XVIII of the Social Security Act shall be deemed a grant, and not a contract of insurance or guaranty, for the purposes of title VI of the Civil Rights Act of 1964.

1 **SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
2 **THE DEPARTMENT OF HEALTH AND HUMAN**
3 **SERVICES.**

4 Title XXXIV of the Public Health Service Act, as
5 amended by titles I, II, and III of this Act, is further
6 amended by inserting after subtitle B the following:

7 "Subtitle C—Strengthening
8 Accountability

9 **"SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

10 "(a) IN GENERAL.—The Secretary shall establish
11 within the Office for Civil Rights an Office of Health Dis-
12 parities, which shall be headed by a director to be ap-
13 pointed by the Secretary.

14 "(b) PURPOSE.—The Office of Health Disparities
15 shall ensure that the health programs, activities, and oper-
16 ations of health entities which receive Federal financial as-
17 sistance are in compliance with title VI of the Civil Rights
18 Act, which prohibits discrimination on the basis of race,
19 color, or national origin. The activities of the Office shall
20 include the following:

21 "(1) The development and implementation of
22 an action plan to address racial and ethnic health
23 care disparities, which shall address concerns relat-
24 ing to the Office for Civil Rights as released by the
25 United States Commission on Civil Rights in the re-
26 port entitled 'Health Care Challenge: Acknowledging

1 Disparity, Confronting Discrimination, and Ensur-
2 ing Equity' (September 1999) in conjunction with
3 the reports by the Institute of Medicine entitled 'Un-
4 equal Treatment: Confronting Racial and Ethnic
5 Disparities in Health Care', 'Crossing the Quality
6 Chasm: A New Health System for the 21st Cen-
7 tury', and 'In the Nation's Compelling Interest: En-
8 suring Diversity in the Health Care Workforce', and
9 'The National Partnership for Action to End Health
10 Disparities', and other related reports by the Insti-
11 tute of Medicine. This plan shall be publicly dis-
12 closed for review and comment and the final plan
13 shall address any comments or concerns that are re-
14 ceived by the Office.
15 ''(2) Investigative and enforcement actions
16 against intentional discrimination and policies and
17 practices that have a disparate impact on minorities.
18 ''(3) The review of racial, ethnic, and primary
19 language health data collected by Federal health
20 agencies to assess health care disparities related to
21 intentional discrimination and policies and practices
22 that have a disparate impact on minorities.
23 ''(4) Outreach and education activities relating
24 to compliance with title VI of the Civil Rights Act.

"(5) The provision of technical assistance for health entities to facilitate compliance with title VI of the Civil Rights Act.

"(6) Coordination and oversight of activities of the civil rights compliance offices established under section 3442.

"(7) Ensuring compliance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race, Ethnicity and the available language standards.

"(c) FUNDING AND STAFF.—The Secretary shall ensure the effectiveness of the Office of Health Disparities by ensuring that the Office is provided with—

"(1) adequate funding to enable the Office to carry out its duties under this section; and

"(2) staff with expertise in—

"(A) epidemiology;

"(B) statistics;

"(C) health quality assurance;

"(D) minority health and health disparities;

"(E) cultural and linguistic competency; and

"(F) civil rights.

1 "(d) REPORT.—Not later than December 31, 2012,
2 and annually thereafter, the Secretary, in collaboration
3 with the Director of the Office for Civil Rights and the
4 Deputy Assistant Secretary for Minority Health, shall
5 submit a report to the Committee on Health, Education,
6 Labor, and Pensions of the Senate and the Committee on
7 Energy and Commerce of the House of Representatives
8 that includes—
9 "(1) the number of cases filed, broken down by
10 category;
11 "(2) the number of cases investigated and
12 closed by the office;
13 "(3) the outcomes of cases investigated;
14 "(4) the staffing levels of the office including
15 staff credentials;
16 "(5) the number of other lingering and emerg-
17 ing cases in which civil rights inequities can be dem-
18 onstrated; and
19 "(6) the number of cases remaining open and
20 an explanation for their open status.
21 **"SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OF-**
22 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**
23 **HEALTH AND HUMAN SERVICES AGENCIES.**
24 "(a) IN GENERAL.—The Secretary shall establish
25 civil rights compliance offices in each agency within the

1 Department of Health and Human Services that admin-
2 isters health programs.
3 “(b) PURPOSE OF OFFICES.—Each office established
4 under subsection (a) shall ensure that recipients of Fed-
5 eral financial assistance under Federal health programs
6 administer their programs, services, and activities in a
7 manner that—
8 “(1) does not discriminate, either intentionally
9 or in effect, on the basis of race, national origin, lan-
10 guage, ethnicity, sex, age, disability, sexual orienta-
11 tion, and gender identity; and
12 “(2) promotes the reduction and elimination of
13 disparities in health and health care based on race,
14 national origin, language, ethnicity, sex, age, dis-
15 ability, sexual orientation, and gender identity.
16 “(c) POWERS AND DUTIES.—The offices established
17 in subsection (a) shall have the following powers and du-
18 ties:
19 “(1) The establishment of compliance and pro-
20 gram participation standards for recipients of Fed-
21 eral financial assistance under each program admin-
22 istered by an agency within the Department of
23 Health and Human Services including the establish-
24 ment of disparity reduction standards to encompass
25 disparities in health and health care related to race,

1 national origin, language, ethnicity, sex, age, dis-
2 ability, sexual orientation, and gender identity.
3 ''(2) The development and implementation of
4 program-specific guidelines that interpret and apply
5 Department of Health and Human Services guid-
6 ance under title VI of the Civil Rights Act of 1964
7 and section 1557 of the Patient Protection and Af-
8 fordable Care Act to each Federal health program
9 administered by the agency.
10 ''(3) The development of a disparity-reduction
11 impact analysis methodology that shall be applied to
12 every rule issued by the agency and published as
13 part of the formal rulemaking process under sections
14 555, 556, and 557 of title 5, United States Code.
15 ''(4) Oversight of data collection, analysis, and
16 publication requirements for all recipients of Federal
17 financial assistance under each Federal health pro-
18 gram administered by the agency, and compliance
19 with the 1997 Office of Management and Budget
20 Standards for Maintaining, Collecting, and Pre-
21 senting Federal Data on Race and Ethnicity and the
22 available language standards.
23 ''(5) The conduct of publicly available studies
24 regarding discrimination within Federal health pro-
25 grams administered by the agency as well as dis-

1 parity reduction initiatives by recipients of Federal
2 financial assistance under Federal health programs.
3 "(6) Annual reports to the Committee on
4 Health, Education, Labor, and Pensions and the
5 Committee on Finance of the Senate and the Com-
6 mittee on Energy and Commerce and the Committee
7 on Ways and Means of the House of Representatives
8 on the progress in reducing disparities in health and
9 health care through the Federal programs adminis-
10 tered by the agency.
11 "(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
12 IN THE DEPARTMENT OF JUSTICE.—
13 "(1) DEPARTMENT OF HEALTH AND HUMAN
14 SERVICES.—The Office for Civil Rights in the De-
15 partment of Health and Human Services shall pro-
16 vide standard-setting and compliance review inves-
17 tigation support services to the Civil Rights Compli-
18 ance Office for each agency.
19 "(2) DEPARTMENT OF JUSTICE.—The Office
20 for Civil Rights in the Department of Justice shall
21 continue to maintain the power to institute formal
22 proceedings when an agency Office for Civil Rights
23 determines that a recipient of Federal financial as-
24 sistance is not in compliance with the disparity re-
25 duction standards of the agency.

1 "(e) DEFINITION.—In this section, the term 'Federal
2 health programs' mean programs—
3 "(1) under the Social Security Act (42 U.S.C.
4 301 et seq.) that pay for health care and services;
5 and
6 "(2) under this Act that provide Federal finan-
7 cial assistance for health care, biomedical research,
8 health services research, and programs designed to
9 improve the public's health.".

10 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

11 Section 3 of the Civil Rights Commission Act of 1983
12 (42 U.S.C. 1975a) is amended—
13 (1) in paragraph (1), by striking "and" at the
14 end;
15 (2) in paragraph (2), by striking the period at
16 the end and inserting "; and"; and
17 (3) by adding at the end the following:
18 "(3) shall, with respect to activities carried out
19 in health care and correctional facilities toward the
20 goal of eliminating health disparities between the
21 general population and members of racial or ethnic
22 minority groups, coordinate such activities of—
23 "(A) the Office for Civil Rights within the
24 Department of Justice;

1 ''(B) the Office of Justice Programs within
2 the Department of Justice;
3 ''(C) the Office for Civil Rights within the
4 Department of Health and Human Services;
5 and
6 ''(D) the Office of Minority Health within
7 the Department of Health and Human Services
8 (headed by the Deputy Assistant Secretary for
9 Minority Health).''.

10 **SEC. 905. SENSE OF CONGRESS CONCERNING FULL FUND-**
11 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
12 **AND ETHNIC HEALTH DISPARITIES.**

13 (a) FINDINGS.—Congress makes the following find-
14 ings:
15 (1) The health status of the American populace
16 is declining and the United States currently ranks
17 below most industrialized nations in health status
18 measured by longevity, sickness, and mortality.
19 (2) Racial and ethnic minority populations tend
20 have the poorest health status and face substantial
21 cultural, social, and economic barriers to obtaining
22 quality health care.
23 (3) Efforts to improve minority health have
24 been limited by inadequate resources (funding, staff-
25 ing, and stewardship) and accountability.

1 (b) SENSE OF CONGRESS.—It is the sense of Con-
2 gress that—
3 (1) funding should be doubled by fiscal year
4 2013 for the National Institute for Minority Health
5 Disparities, the Office of Civil Rights in the Depart-
6 ment of Health and Human Services, the National
7 Institute of Nursing Research, and the Office of Mi-
8 nority Health;
9 (2) adequate funding by fiscal year 2013, and
10 subsequent funding increases, should be provided for
11 health professions training programs, the Racial and
12 Ethnic Approaches to Community Health (REACH)
13 at the Centers for Disease Control and Prevention,
14 the Minority HIV/AIDS Initiative, and the Excel-
15 lence Centers to Eliminate Ethnic/Racial Disparities
16 (EXCEED) Program at the Agency for Healthcare
17 Research and Quality;
18 (3) funding should be restored to the Racial
19 and Ethnic Approaches to Community Health
20 (REACH) program at the Centers for Disease Con-
21 trol and Prevention, which has been a successful
22 program at the community health level;
23 (4) current and newly created health disparity
24 elimination incentives, programs, agencies, and de-
25 partments under this Act (and the amendments

1 made by this Act) should receive adequate staffing
2 and funding by fiscal year 2013; and
3 (5) stewardship and accountability should be
4 provided to the Congress and the President for
5 measurable and sustainable progress toward health
6 disparity elimination.

7 **SEC. 906. GAO AND NIH REPORTS.**

8 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-
9 NIC DIVERSITY.—
10 (1) IN GENERAL.—The Comptroller General of
11 the United States shall conduct a study on the racial
12 and ethnic diversity among the following groups:
13 (A) All applicants for grants, contracts,
14 and cooperative agreements awarded by the Na-
15 tional Institutes of Health during the period be-
16 ginning January 1, 1990, and ending December
17 31, 2011.
18 (B) All recipients of such grants, con-
19 tracts, and cooperative agreements.
20 (C) All members of the peer review panels
21 of such applicants and recipients, respectively.
22 (2) REPORT.—Not later than six months after
23 the date of the enactment of this Act, the Comp-
24 troller General shall complete the study under para-

1 graph (1) and submit to Congress a report con-
2 taining the results of such study.
3 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
4 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
5 DISPARITIES.—Not later than six months after the date
6 of the enactment of this Act, and biennially thereafter, the
7 Director of the National Institutes of Health, in collabora-
8 tion with the Director of the National Institute on Minor-
9 ity Health and Health Disparities, shall submit to Con-
10 gress a report that details and evaluates—
11 (1) the steps taken during the applicable report
12 period by the Director of the National Institutes of
13 Health to enforce the expanded planning, coordina-
14 tion, review, and evaluation authority provided the
15 National Institute on Minority Health and Health
16 Disparities under section 464z–3(h) of the Public
17 Health Service Act (42 U.S.C. 285(h)), as added by
18 section 10334(c) of the Patient Protection and Af-
19 fordable Care Act, over all minority health and
20 health disparity research that is conducted or sup-
21 ported by the Institutes and Centers at the National
22 Institutes of Health; and
23 (2) the outcomes of such steps.
24 (c) GAO REPORT RELATED TO RECIPIENTS OF
25 PPACA FUNDING.—Not later than one year after the

1 date of the enactment of this Act and biennially thereafter
2 until 2020, the Comptroller General of the United States
3 shall submit to Congress a report that identifies, with re-
4 spect to minority community-based organizations that ap-
5 plied during the applicable report period for Federal fund-
6 ing provided pursuant to the provisions of (and amend-
7 ments made by) the Patient Protection and Affordable
8 Care Act for purposes of achieving health equity and elimi-
9 nating health disparities, the percentage of such organiza-
10 tions that were awarded such funding.

11 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
12 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
13 PARITIES.—The Director of the National Institute on Mi-
14 nority Health and Health Disparities shall prepare an an-
15 nual report on the activities carried out or to be carried
16 out by the Institute, and shall submit each such report
17 to the Committee on Health, Education, Labor, and Pen-
18 sions of the Senate, the Committee on Energy and Com-
19 merce of the House of Representatives, the Secretary of
20 Health and Human Services, and the Director of the Na-
21 tional Institutes of Health. With respect to the fiscal year
22 involved, the report shall—

23 (1) describe and evaluate the progress made in
24 health disparities research conducted or supported

1 by institutes and centers of the National Institutes
2 of Health;
3 (2) summarize and analyze expenditures made
4 for activities with respect to health disparities re-
5 search conducted or supported by the National Insti-
6 tutes of Health;
7 (3) include a separate statement applying the
8 requirements of paragraphs (1) and (2) specifically
9 to minority health disparities research; and
10 (4) contain such recommendations as the Direc-
11 tor of the Institute considers appropriate.

12 TITLE X—ADDRESSING SOCIAL 13 DETERMINANTS AND IM- 14 PROVING ENVIRONMENTAL 15 JUSTICE

16 SEC. 1001. CODIFICATION OF EXECUTIVE ORDER 12898.

17 (a) IN GENERAL.—The President of the United
18 States is authorized and directed to execute, administer,
19 and enforce as a matter of Federal law the provisions of
20 Executive Order 12898, dated February 11, 1994 (''Fed-
21 eral Actions To Address Environmental Justice In Minor-
22 ity Populations and Low-Income Populations''), with such
23 modifications as are provided in this section.

1 (b) DEFINITION OF ENVIRONMENTAL JUSTICE.—For
2 purposes of carrying out the provisions of Executive Order
3 12898, the following definitions shall apply:
4 (1) The term ''environmental justice'' means
5 the fair treatment and meaningful involvement of all
6 people regardless of race, color, national origin, edu-
7 cational level, or income with respect to the develop-
8 ment, implementation, and enforcement of environ-
9 mental laws and regulations in order to ensure
10 that—
11 (A) minority and low-income communities
12 have access to public information relating to
13 human health and environmental planning, reg-
14 ulations, and enforcement; and
15 (B) no minority or low-income population
16 is forced to shoulder a disproportionate burden
17 of the negative human health and environ-
18 mental impacts of pollution or other environ-
19 mental hazard.
20 (2) The term ''fair treatment'' means policies
21 and practices that ensure that no group of people,
22 including racial, ethnic, or socioeconomic groups
23 bear disproportionately high and adverse human
24 health or environmental effects resulting from Fed-
25 eral agency programs, policies, and activities.

1 (c) JUDICIAL REVIEW AND RIGHTS OF ACTION.—
2 The provisions of section 6–609 of Executive Order 12898
3 shall not apply for purposes of this Act.

4 **SEC. 1002. IMPLEMENTATION OF RECOMMENDATIONS BY**
5 **ENVIRONMENTAL PROTECTION AGENCY.**

6 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The
7 Administrator of the Environmental Protection Agency
8 shall, as promptly as practicable, carry out each of the
9 following recommendations of the Inspector General of the
10 agency as set forth in Report No. 2006–P–00034 entitled
11 ''EPA needs to conduct environmental justice reviews of
12 its programs, policies and activities'':

13 (1) The recommendation that the Agency's pro-
14 gram and regional offices identify which programs,
15 policies, and activities need environmental justice re-
16 views and require these offices to establish a plan to
17 complete the necessary reviews.

18 (2) The recommendation that the Administrator
19 of the Agency ensure that these reviews determine
20 whether the programs, policies, and activities may
21 have a disproportionately high and adverse health or
22 environmental impact on minority and low-income
23 populations.

24 (3) The recommendation that each program
25 and regional office develop specific environmental

1 justice review guidance for conducting environmental
2 justice reviews.

3 (4) The recommendation that the Administrator
4 designate a responsible office to compile results of
5 environmental justice reviews and recommend appro-
6 priate actions.

7 (b) GAO RECOMMENDATIONS.—In developing rules
8 under laws administered by the Environmental Protection
9 Agency, the Administrator of the Agency shall, as prompt-
10 ly as practicable, carry out each of the following rec-
11 ommendations of the Comptroller General of the United
12 States as set forth in GAO Report numbered GAO–05–
13 289 entitled "EPA Should Devote More Attention to En-
14 vironmental Justice when Developing Clean Air Rules":

15 (1) The recommendation that the Administrator
16 ensure that workgroups involved in developing a rule
17 devote attention to environmental justice while draft-
18 ing and finalizing the rule.

19 (2) The recommendation that the Administrator
20 enhance the ability of such workgroups to identify
21 potential environmental justice issues through such
22 steps as providing workgroup members with guid-
23 ance and training to helping them identify potential
24 environmental justice problems and involving envi-

1 ronmental justice coordinators in the workgroups
2 when appropriate.

3 (3) The recommendation that the Administrator
4 improve assessments of potential environmental jus-
5 tice impacts in economic reviews by identifying the
6 data and developing the modeling techniques needed
7 to assess such impacts.

8 (4) The recommendation that the Administrator
9 direct appropriate Agency officers and employees to
10 respond fully when feasible to public comments on
11 environmental justice, including improving the Agen-
12 cy's explanation of the basis for its conclusions, to-
13 gether with supporting data.

14 (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-
15 ministrator of the Environmental Protection Agency shall,
16 as promptly as practicable, carry out each of the following
17 recommendations of the Inspector General of the Agency
18 as set forth in the report entitled ''EPA Needs to Consist-
19 ently Implement the Intent of the Executive Order on En-
20 vironmental Justice'' (Report No. 2004–P–00007):

21 (1) The recommendation that the Agency clear-
22 ly define the mission of the Office of Environmental
23 Justice (OEJ) and provide Agency staff with an un-
24 derstanding of the roles and responsibilities of the
25 Office.

(2) The recommendation that the Agency establish (through issuing guidance or a policy statement from the Administrator) specific time frames for the development of definitions, goals, and measurements regarding environmental justice and provide the regions and program offices a standard and consistent definition for a minority and low-income community, with instructions on how the Agency will implement and operationalize environmental justice into the Agency's daily activities.

(3) The recommendation that the Agency ensure the comprehensive training program currently under development includes standard and consistent definitions of the key environmental justice concepts (such as ''low-income'', ''minority'', and ''disproportionately impacted'') and instructions for implementation of those concepts.

The Administrator shall submit an initial report to Congress within 6 months after the enactment of this Act regarding the Administrator's strategy for implementing the recommendations referred to in paragraphs (1), (2), and (3). Thereafter, the Administrator shall provide semi-annual reports to Congress regarding the Administrator's progress in implementing such recommendations and modifying the Administrator's emergency management

1 procedures to incorporate environmental justice in the
2 Agency's Incident Command Structure (in accordance
3 with the December 18, 2006, letter from the Deputy Ad-
4 ministrator to the Acting Inspector General of the Agen-
5 cy).

6 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,
7 PROTECTING PEOPLE AND THEIR FAMILIES FROM
8 RADON.—

9 (1) IN GENERAL.—Because radon is a naturally
10 occurring radioactive gas that is recognized as the
11 leading cause of lung cancer among nonsmokers and
12 is a particular environmental threat for low-income
13 and minority individuals because of the lack of infor-
14 mation about radon levels in their own homes, the
15 Administrator of the Environmental Protection
16 Agency shall within 6 months after the date of the
17 enactment of this Act, implement the action plan en-
18 titled ''Protecting People and Families from Radon:
19 A Federal Action Plan for Saving Lives'' (June 20,
20 2011), working with the Secretary of Health and
21 Human Services acting through the Director of the
22 Centers for Disease Control and Prevention, and
23 with the other Federal agencies mentioned in and as
24 set forth in the action plan.

1 (2) SPECIFIC STEPS.—In carrying out para-
2 graph (1), the Administrator shall take steps to
3 achieve each of the following:
4 (A) The recommendation that the
5 workgroup comprised of the Federal agencies
6 participating in the development of the action
7 plan referred to in paragraph (1) implement
8 specific steps within the current authority and
9 activities of each Federal agency to reduce ex-
10 posure to radon.
11 (B) The recommendation that such
12 workgroup meet on the 1-year anniversary of
13 the plan to assess and recognize achievements
14 of the plan.
15 (3) REPORT.—The Administrator shall report
16 to the Congress on the 1-year assessment of the
17 plan's implementation, including the challenges re-
18 maining and the progress in reducing radon expo-
19 sure particularly to low-income and minority fami-
20 lies.
21 **SEC. 1003. GRANT PROGRAM.**
22 (a) DEFINITIONS.—In this section:
23 (1) DIRECTOR.—The term "Director" means
24 the Director of the Centers for Disease Control and
25 Prevention, acting in collaboration with the Adminis-

1 trator of the Environmental Protection Agency and
2 the Director of the National Institute of Environ-
3 mental Health Sciences.
4 (2) ELIGIBLE ENTITY.—The term ''eligible enti-
5 ty'' means a State or local community that—
6 (A) bears a disproportionate burden of ex-
7 posure to environmental health hazards;
8 (B) has established a coalition—
9 (i) with not less than 1 community-
10 based organization; and
11 (ii) with not less than 1—
12 (I) public health entity;
13 (II) health care provider organi-
14 zation; or
15 (III) academic institution, includ-
16 ing any minority-serving institution
17 (including an Hispanic-serving institu-
18 tion, a historically Black college or
19 university, and a tribal college or uni-
20 versity);
21 (C) ensures planned activities and funding
22 streams are coordinated to improve community
23 health; and
24 (D) submits an application in accordance
25 with subsection (c).

1 (b) ESTABLISHMENT.—The Director shall establish a
2 grant program under which eligible entities shall receive
3 grants to conduct environmental health improvement ac-
4 tivities.
5 (c) APPLICATION.—To receive a grant under this sec-
6 tion, an eligible entity shall submit an application to the
7 Director at such time, in such manner, and accompanied
8 by such information as the Director may require.
9 (d) COOPERATIVE AGREEMENTS.—An eligible entity
10 may use a grant under this section—
11 (1) to promote environmental health; and
12 (2) to address environmental health disparities.
13 (e) AMOUNT OF COOPERATIVE AGREEMENT.—
14 (1) IN GENERAL.—The Director shall award
15 grants to eligible entities at the 2 different funding
16 levels described in this subsection.
17 (2) LEVEL 1 COOPERATIVE AGREEMENTS.—
18 (A) IN GENERAL.—An eligible entity
19 awarded a grant under this paragraph shall use
20 the funds to identify environmental health prob-
21 lems and solutions by—
22 (i) establishing a planning and
23 prioritizing council in accordance with sub-
24 paragraph (B); and

1 (ii) conducting an environmental
2 health assessment in accordance with sub-
3 paragraph (C).
4 (B) PLANNING AND PRIORITIZING COUN-
5 CIL.—
6 (i) IN GENERAL.—A prioritizing and
7 planning council established under sub-
8 paragraph (A)(i) (referred to in this para-
9 graph as a ''PPC'') shall assist the envi-
10 ronmental health assessment process and
11 environmental health promotion activities
12 of the eligible entity.
13 (ii) MEMBERSHIP.—Membership of a
14 PPC shall consist of representatives from
15 various organizations within public health,
16 planning, development, and environmental
17 services and shall include stakeholders
18 from vulnerable groups such as children,
19 the elderly, disabled, and minority ethnic
20 groups that are often not actively involved
21 in democratic or decisionmaking processes.
22 (iii) DUTIES.—A PPC shall—
23 (I) identify key stakeholders and
24 engage and coordinate potential part-
25 ners in the planning process;

1 (II) establish a formal advisory
2 group to plan for the establishment of
3 services;
4 (III) conduct an in-depth review
5 of the nature and extent of the need
6 for an environmental health assess-
7 ment, including a local epidemiological
8 profile, an evaluation of the service
9 provider capacity of the community,
10 and a profile of any target popu-
11 lations; and
12 (IV) define the components of
13 care and form essential programmatic
14 linkages with related providers in the
15 community.
16 (C) ENVIRONMENTAL HEALTH ASSESS-
17 MENT.—
18 (i) IN GENERAL.—A PPC shall carry
19 out an environmental health assessment to
20 identify environmental health concerns.
21 (ii) ASSESSMENT PROCESS.—The
22 PPC shall—
23 (I) define the goals of the assess-
24 ment;

1 (II) generate the environmental
2 health issue list;
3 (III) analyze issues with a sys-
4 tems framework;
5 (IV) develop appropriate commu-
6 nity environmental health indicators;
7 (V) rank the environmental
8 health issues;
9 (VI) set priorities for action;
10 (VII) develop an action plan;
11 (VIII) implement the plan; and
12 (IX) evaluate progress and plan-
13 ning for the future.
14 (D) EVALUATION.—Each eligible entity
15 that receives a grant under this paragraph shall
16 evaluate, report, and disseminate program find-
17 ings and outcomes.
18 (E) TECHNICAL ASSISTANCE.—The Direc-
19 tor may provide such technical and other non-
20 financial assistance to eligible entities as the
21 Director determines to be necessary.
22 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—
23 (A) ELIGIBILITY.—

1 (i) IN GENERAL.—The Director shall
2 award grants under this paragraph to eli-
3 gible entities that have already—
4 (I) established broad-based col-
5 laborative partnerships; and
6 (II) completed environmental as-
7 sessments.
8 (ii) NO LEVEL 1 REQUIREMENT.—To
9 be eligible to receive a grant under this
10 paragraph, an eligible entity is not re-
11 quired to have successfully completed a
12 Level 1 Cooperative Agreement (as de-
13 scribed in paragraph (2)).
14 (B) USE OF GRANT FUNDS.—An eligible
15 entity awarded a grant under this paragraph
16 shall use the funds to further activities to carry
17 out environmental health improvement activi-
18 ties, including—
19 (i) addressing community environ-
20 mental health priorities in accordance with
21 paragraph (2)(C)(ii), including—
22 (I) air quality;
23 (II) water quality;
24 (III) solid waste;
25 (IV) land use;

1 (V) housing;
2 (VI) food safety;
3 (VII) crime;
4 (VIII) injuries; and
5 (IX) health care services;
6 (ii) building partnerships between
7 planning, public health, and other sectors,
8 to address how the built environment im-
9 pacts food availability and access and
10 physical activity to promote healthy behav-
11 iors and lifestyles and reduce overweight
12 and obesity, asthma, respiratory condi-
13 tions, dental, oral and mental health condi-
14 tions, poverty, and related co-morbidities;
15 (iii) establishing programs to ad-
16 dress—
17 (I) how environmental and social
18 conditions of work and living choices
19 influence physical activity and dietary
20 intake; or
21 (II) how those conditions influ-
22 ence the concerns and needs of people
23 who have impaired mobility and use
24 assistance devices, including wheel-
25 chairs and lower limb prostheses; and

1 (iv) convening intervention programs
2 that examine the role of the social environ-
3 ment in connection with the physical and
4 chemical environment in—
5 (I) determining access to nutri-
6 tional food; and
7 (II) improving physical activity to
8 reduce morbidity and increase quality
9 of life.

10 **SEC. 1004. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
11 **BETWEEN THE BUILT ENVIRONMENT AND**
12 **THE HEALTH OF COMMUNITY RESIDENTS.**

13 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
14 section, the term ''eligible institution'' means a public or
15 private nonprofit institution that submits to the Secretary
16 of Health and Human Services (in this section referred
17 to as the ''Secretary'') and the Administrator of the Envi-
18 ronmental Protection Agency (in this section referred to
19 as the ''Administrator'') an application for a grant under
20 the grant program authorized under subsection (b)(2) at
21 such time, in such manner, and containing such agree-
22 ments, assurances, and information as the Secretary and
23 Administrator may require.

24 (b) RESEARCH GRANT PROGRAM.—

1 (1) DEFINITION OF HEALTH.—In this section,
2 the term ''health'' includes—
3 (A) levels of physical activity;
4 (B) consumption of nutritional foods;
5 (C) rates of crime;
6 (D) air, water, and soil quality;
7 (E) risk of injury;
8 (F) accessibility to health care services;
9 and
10 (G) other indicators as determined appro-
11 priate by the Secretary.
12 (2) GRANTS.—The Secretary, in collaboration
13 with the Administrator, shall provide grants to eligi-
14 ble institutions to conduct and coordinate research
15 on the built environment and its influence on indi-
16 vidual and population-based health.
17 (3) RESEARCH.—The Secretary shall support
18 research that—
19 (A) investigates and defines the causal
20 links between all aspects of the built environ-
21 ment and the health of residents;
22 (B) examines—
23 (i) the extent of the impact of the
24 built environment (including the various

1 characteristics of the built environment) on
2 the health of residents;
3 (ii) the variance in the health of resi-
4 dents by—
5 (I) location (such as inner cities,
6 inner suburbs, and outer suburbs);
7 and
8 (II) population subgroup (such as
9 children, the elderly, the disadvan-
10 taged); or
11 (iii) the importance of the built envi-
12 ronment to the total health of residents,
13 which is the primary variable of interest
14 from a public health perspective;
15 (C) is used to develop—
16 (i) measures to address health and the
17 connection of health to the built environ-
18 ment; and
19 (ii) efforts to link the measures to
20 travel and health databases; and
21 (D) distinguishes carefully between per-
22 sonal attitudes and choices and external influ-
23 ences on observed behavior to determine how
24 much an observed association between the built
25 environment and the health of residents, versus

1 the lifestyle preferences of the people that
2 choose to live in the neighborhood, reflects the
3 physical characteristics of the neighborhood;
4 and
5 (E)(i) identifies or develops effective inter-
6 vention strategies to promote better health
7 among residents with a focus on behavioral
8 interventions and enhancements of the built en-
9 vironment that promote increased use by resi-
10 dents; and
11 (ii) in developing the intervention strate-
12 gies under clause (i), ensures that the interven-
13 tion strategies will reach out to high-risk popu-
14 lations, including racial and ethnic minorities
15 and low-income urban and rural communities.
16 (4) PRIORITY.—In providing assistance under
17 the grant program authorized under paragraph (2),
18 the Secretary and the Administrator shall give pri-
19 ority to research that incorporates—
20 (A) minority-serving institutions as grant-
21 ees;
22 (B) interdisciplinary approaches; or
23 (C) the expertise of the public health,
24 physical activity, urban planning, and transpor-

1 tation research communities in the United
2 States and abroad.

3 **SEC. 1005. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**
4 **TION.**

5 (a) FINDINGS.—
6 (1) GENERAL FINDINGS.—The Congress finds
7 as follows:
8 (A) As human beings, we share our envi-
9 ronment with a wide variety of habitats and
10 ecosystems that nurture and sustain a diversity
11 of species.
12 (B) The abundance of natural resources in
13 our environment forms the basis for our econ-
14 omy and has greatly contributed to human de-
15 velopment throughout history.
16 (C) The accelerated pace of human devel-
17 opment over the last several hundred years has
18 significantly impacted our natural environment
19 and its resources, the health and diversity of
20 plant and animal wildlife, the availability of
21 critical habitats, the quality of our air and our
22 water, and our global climate.
23 (D) The intervention of the Federal Gov-
24 ernment is necessary to minimize and mitigate
25 human impact on the environment for the ben-

1 efit of public health, to maintain air quality and
2 water quality, to sustain the diversity of plants
3 and animals, to combat global climate change,
4 and to protect the environment.
5 (E) Laws and regulations in the United
6 States have been created and promulgated to
7 minimize and mitigate human impact on the en-
8 vironment for the benefit of public health, to
9 maintain air quality and water quality, to sus-
10 tain wildlife, and to protect the environment.
11 (F) Such laws include the Antiquities Act
12 of 1906 (16 U.S.C. 431 et seq.) initiated by
13 President Theodore Roosevelt to create the na-
14 tional park system, the National Environmental
15 Policy Act of 1969 (42 U.S.C. 4321 et seq.),
16 the Clean Air Act (42 U.S.C. 7401 et seq.), the
17 Federal Water Pollution Control Act (33 U.S.C.
18 1251 et seq.), the Comprehensive Environ-
19 mental Response, Compensation, and Liability
20 Act of 1980 (Public Law 96–510), the Endan-
21 gered Species Act of 1973 (Public Law 93–
22 205), and the National Forest Management Act
23 of 1976 (Public Law 94–588).
24 (G) Attempts to repeal or weaken key envi-
25 ronmental safeguards pose dangers to the pub-

1 lic health, air quality, water quality, wildlife,
2 and the environment.
3 (2) FINDINGS ON CHANGES AND PROPOSED
4 CHANGES IN LAW.—The Congress finds that, since
5 2001, the following changes and proposed changes
6 to existing law or regulations have negatively im-
7 pacted or will negatively impact the environment and
8 public health:
9 (A) CLEAN WATER.—
10 (i) On May 9, 2002, the Environ-
11 mental Protection Agency (EPA) and the
12 Army Corps of Engineers put forth a final
13 rule that reconciled regulations imple-
14 menting section 404 of the Federal Water
15 Pollution Control Act by redefining the
16 term ''fill material'' and amending the def-
17 inition of the term ''discharge of fill mate-
18 rial'', reversing a 25-year-old regulation.
19 The new rule fails to restrict the dumping
20 of hardrock mining waste, construction de-
21 bris, and other industrial wastes into riv-
22 ers, streams, lakes, and wetlands. The rule
23 further allows destructive mountaintop re-
24 moval coal mining companies to dump
25 waste into streams and lakes, polluting the

1 surrounding natural habitat and poisoning
2 plants and animals that depend on those
3 water sources.
4 (ii) On February 12, 2003, the Envi-
5 ronmental Protection Agency published the
6 rule ‘‘National Pollutant Discharge Elimi-
7 nation System Permit Regulation and Ef-
8 fluent Limitation Guidelines and Stand-
9 ards for Concentrated Animal Feeding Op-
10 erations’’, new livestock waste regulations
11 that aimed to control factory farm pollu-
12 tion but which would severely undermine
13 existing protections under the Federal
14 Water Pollution Control Act. This regula-
15 tion allows large-scale animal factories to
16 foul the Nation’s waters with animal
17 waste, allows livestock owners to draft
18 their own pollution-management plans and
19 avoid ground water monitoring, legalizes
20 the discharge of contaminated runoff water
21 rich in nitrogen, phosphorus, bacteria, and
22 metals, and ensures that large factory
23 farms are not held liable for the environ-
24 mental damage they cause. In a 2005 Fed-
25 eral court decision (‘‘Waterkeeper Alliance,

1 et al. v. Environmental Protection Agen-
2 cy'', 399 F.3d 486 (2nd Cir. 2005)), major
3 parts of the rule were upheld, others va-
4 cated, and still others remanded back to
5 the EPA. On November 20, 2008, the En-
6 vironmental Protection Agency published a
7 revised final rule which undermines envi-
8 ronmental protection provisions by remov-
9 ing mandatory permitting requirements
10 and allowing large animal farms to self-
11 certify the absence of pollutant discharge
12 activity.

13 (iii) On March 19, 2003, the Environ-
14 mental Protection Agency published a new
15 rule regarding the Total Maximum Daily
16 Load program of the Federal Water Pollu-
17 tion Control Act that regulates the max-
18 imum amount of a particular pollutant
19 that can be present in a body of water and
20 still meet water quality standards. The new
21 rule withdrew the existing regulation put
22 forth on July 13, 2000, and halted mo-
23 mentum in cleaning up polluted waterways
24 throughout the Nation. By abandoning the
25 existing rule, the Environmental Protection

1 Agency is undermining the effectiveness of
2 clean-up plans and is allowing States to
3 avoid cleaning polluted waters entirely by
4 dropping them from their clean-up lists.
5 Waterways play a crucial role in the lives
6 of the people of the United States and are
7 critical to the livelihood of fish and wildlife.
8 The result of dropping the July 2000 rule
9 is that the restoration of polluted rivers,
10 shorelines, and lakes will be delayed, harm-
11 ing more fish and wildlife and worsening
12 the quality of drinking water.
13 (iv) On December 2, 2008, the Envi-
14 ronmental Protection Agency and the
15 Army Corps of Engineers jointly issued a
16 guidance document in the form of a legal
17 memorandum, titled ''Clean Water Act Ju-
18 risdiction Following the U.S. Supreme
19 Court's Decision in Rapanos v. United
20 States & Carabell v. United States''. This
21 new guidance dictates enforcement actions
22 under the Federal Water Pollution Control
23 Act and calls for a complicated ''case-by-
24 case'' analysis to determine jurisdiction for
25 waterways that do not flow all year. Such

1 actions endanger small streams and wet-
2 lands that serve as important habitats for
3 aquatic life, which play a fundamental role
4 in safeguarding sources of clean drinking
5 water and mitigate the risks and effects of
6 floods and droughts. Further, the defini-
7 tion provided therein for "waters of the
8 United States" is applicable to the Federal
9 Water Pollution Control Act as a whole,
10 potentially affecting programs that control
11 industrial pollution and sewage levels, pre-
12 vent oil spills, and set water quality stand-
13 ards for all waters in the United States
14 protected under the Federal Water Pollu-
15 tion Control Act.
16 (B) FORESTS AND LAND MANAGEMENT.—
17 (i) On December 3, 2003, the Presi-
18 dent signed into law the Healthy Forests
19 Restoration Act of 2003 (Public Law 108–
20 148; 16 U.S.C. 6501 et seq.). Although the
21 law attempts to reduce the risk of cata-
22 strophic forest fires, it provides a boon to
23 timber companies by accelerating the ag-
24 gressive thinning of backcountry forests
25 that are far from at-risk communities. The

1 law allows for increased logging of large,
2 fire-resistant trees that are not in close
3 proximity of homes and communities; it
4 undermines critical protections for endan-
5 gered species by exempting Federal land
6 management agencies from consulting with
7 the United States Fish and Wildlife Serv-
8 ice before approving any action that could
9 harm endangered plants or wildlife; and it
10 limits public participation by reducing the
11 number of environmental project reviews.
12 (ii) On April 21, 2008, the Depart-
13 ment of Agriculture issued a Final Plan-
14 ning Rule and Record of Decision for Na-
15 tional Forest System Land Management
16 Planning. Similar to rules enacted by the
17 Administration on January 5, 2005, later
18 remanded back to the agency in Federal
19 district court for violating the National
20 Environmental Policy Act of 1969, the En-
21 dangered Species Act of 1973, and the Ad-
22 ministrative Procedure Act (''Citizens for
23 Better Forestry v. United States Depart-
24 ment of Agriculture'', 481 F. Supp. 2d
25 1059 (N.D. Cal. 2007)), this revised rule

1 eliminates strict forest planning standards
2 established in 1982, and opens millions of
3 acres of public lands to damaging and
4 invasive logging, mining, and drilling oper-
5 ations. These regulations would reverse
6 more than 20 years of protection for wild-
7 life and national forests by removing the
8 overall goal of ensuring ecological sustain-
9 ability in managing the national forest sys-
10 tem, weakening the National Forest Man-
11 agement Act of 1976, and effectively end-
12 ing the review of forest management plans
13 under the National Environmental Policy
14 Act of 1969.
15 (iii) On September 20, 2006, the Dis-
16 trict Court for the Northern District of
17 California vacated the Protection of Inven-
18 toried Roadless Areas rule, enacted on May
19 13, 2005, which gave State Governors 18
20 months to petition the Federal Government
21 to either restore the previous rule for their
22 States, or submit a new management and
23 development plan for national forest areas
24 inventoried under the rule. Despite the
25 enjoinment of the Administration's 2005

1 rule, and the subsequent restoration of the
2 original Roadless Area Conservation Rule,
3 the U.S. Forest Service has continued to
4 allow States to petition for a special rule
5 under the authority of the Administrative
6 Procedure Act, publishing a final special
7 rule for Idaho on October 16, 2008. As a
8 result, 58.5 million acres of wild national
9 forests are still vulnerable to logging, road
10 building, and other developments that may
11 fragment natural habitats and negatively
12 impact fish and wildlife.
13 (iv) On November 17, 2008, the De-
14 partment of the Interior's Bureau of Land
15 Management (BLM) signed the Record of
16 Decision (ROD) amending 12 resource
17 management plans in Colorado, Utah, and
18 Wyoming, opening 2,000,000 acres of pub-
19 lic lands to commercial tar sands and oil
20 shale exploration and development. On No-
21 vember 18, 2008, the BLM published a
22 final rule for Oil Shale Management set-
23 ting the policies and procedures for a com-
24 mercial leasing program for the manage-
25 ment of federally owned oil shale in those

1 three States. Previously barred by a con-
2 gressional moratorium on the commercial
3 leasing regulations for oil shale until Sep-
4 tember 30, 2008, the development of oil
5 shale on public lands poses a serious threat
6 to land conservation, endangered and
7 threatened species, and critical habitat.
8 Domestic shale oil production allowed by
9 these regulations is highly water and en-
10 ergy intensive, the impacts of which will in-
11 tensify existing water scarcity in the arid
12 Western Region and potentially degrade
13 air and water quality for surrounding pop-
14 ulations.
15 (C) SCIENTIFIC REVIEW.—On December
16 16, 2008, the United States Fish and Wildlife
17 Service of the Department of the Interior and
18 the National Oceanic and Atmospheric Admin-
19 istration of the Department of Commerce joint-
20 ly issued a new rule amending regulations gov-
21 erning interagency cooperation under section 7
22 of the Endangered Species Act of 1973 (ESA).
23 This rule undermines the intention of the ESA
24 to protect species and the ecosystems upon
25 which they depend by allowing Federal agencies

1 to carry out, permit, or fund an action without
2 proper environmental review and expert third-
3 party consultation from Federal wildlife ex-
4 perts. Under this new rule, Federal agencies
5 can unilaterally circumvent the formal review
6 process, eliminating longstanding and scientif-
7 ically grounded safeguards that serve to protect
8 the biodiversity of our Nation's ecosystems and
9 avert harm to thousands of endangered and
10 threatened species.

11 (b) STATEMENT OF POLICY.—It is the policy of the
12 United States Government to work in conjunction with
13 States, territories, tribal governments, international orga-
14 nizations, and foreign governments in order to act as a
15 steward of the environment for the benefit of public
16 health, to maintain air quality and water quality, to sus-
17 tain the diversity of plant and animal species, to combat
18 global climate change, and to protect the environment for
19 future generations to enjoy.

20 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
21 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
22 TIONS, LAWS, OR PROPOSED LAWS.—

23 (1) STUDY.—Not later than 30 days after the
24 date of enactment of this Act, the President shall
25 enter into an arrangement under which the National

1 Academy of Sciences will conduct a study to deter-
2 mine the impact on public health, air quality, water
3 quality, wildlife, and the environment of the fol-
4 lowing regulations, laws, and proposed laws:

5 (A) CLEAN WATER.—

6 (i) Final revisions to the Federal
7 Water Pollution Control Act regulatory
8 definitions of "fill material" and "dis-
9 charge of fill material", finalized and pub-
10 lished in the Federal Register on May 9,
11 2002 (67 FR 31129), amending part 232
12 of title 40, Code of Federal Regulations.

13 (ii) Revised National Pollutant Dis-
14 charge Elimination System Permit Regula-
15 tion and Effluent Limitation Guidelines
16 and Standards for Concentrated Animal
17 Feeding Operations in response to the
18 "Waterkeeper Alliance, et al. v. Environ-
19 mental Protection Agency" decision, final-
20 ized and published in the Federal Register
21 on November 20, 2008 (73 FR 225),
22 amending parts 9, 122, and 412 of title
23 40, Code of Federal Regulations.

24 (iii) A March 19, 2003, rule published
25 in the Federal Register (68 FR 13608)

1 withdrawing a July 13, 2000, rule revising
2 the Total Maximum Daily Load program
3 of the Federal Water Pollution Control Act
4 (65 FR 43586), amending parts 9, 122,
5 123, 124, and 130 of title 40, Code of
6 Federal Regulations.
7 (iv) Official Guidance Document,
8 "Clean Water Act Jurisdiction Following
9 the United States Supreme Court's Deci-
10 sion in Rapanos v. United States &
11 Carabell v. United States", issued on De-
12 cember 2, 2008, relating to jurisdiction
13 under section 404 of the Federal Water
14 Pollution Control Act.
15 (B) FORESTS AND LAND MANAGEMENT.—
16 (i) Healthy Forests Restoration Act of
17 2003, signed into law on December 3,
18 2003 (Public Law 108–148; 16 U.S.C.
19 6501 et seq.).
20 (ii) National Forest System Land
21 Management Planning Rule, finalized and
22 published in the Federal Register on April
23 21, 2008 (73 FR 21468), replacing the
24 2005 final rule (70 FR 1022, Jan. 5,
25 2005), as amended March 3, 2006 (71 FR

1 10837) and the 2000 final rule adopted on
2 November 9, 2000 (65 FR 67514) as
3 amended on September 29, 2004 (69 FR
4 58055), amending title 36, Code of Fed-
5 eral Regulations, part 219.
6 (iii) The application of the Adminis-
7 trative Procedure Act (5 U.S.C. 551 to
8 559, 701 to 706, et seq.), such that States
9 may petition for a special rule for the
10 roadless areas in all or part of said State.
11 (iv) Record of Decision, "Oil Shale
12 and Tar Sands Resources Resource Man-
13 agement Plan Amendments", issued on
14 November 17, 2008, along with the Final
15 Rule, Oil Shale Management-General, pub-
16 lished in the Federal Register on Novem-
17 ber 18, 2008 (73 FR 223), amending title
18 43, Code of Federal Regulations, parts
19 3900, 3910, 3920, and 3930.
20 (C) SCIENTIFIC REVIEW.—Final Rule,
21 Interagency Cooperation Under the Endangered
22 Species Act, published in the Federal Register
23 on December 16, 2008, amending title 50, Code
24 of Federal Regulations, part 402.

1 (2) METHOD.—In conducting the study under
2 paragraph (1), the National Academy of Sciences
3 may utilize and compare existing scientific studies
4 regarding the regulations, laws, and proposed laws
5 listed in paragraph (1).
6 (3) REPORT.—Under the arrangement entered
7 into under paragraph (1), not later than 270 days
8 after the date on which such arrangement is entered
9 into, the National Academy of Sciences shall make
10 publicly available and shall submit to the Congress
11 and to the head of each department and agency of
12 the Federal Government that issued, implements, or
13 would implement a regulation, law, or proposed law
14 listed in paragraph (1), a report containing—
15 (A) a description of the impact of all such
16 regulations, laws, and proposed laws on public
17 health, air quality, water quality, wildlife, and
18 the environment, compared to the impact of
19 preexisting regulations, or laws in effect, includ-
20 ing—
21 (i) any negative impacts to air quality
22 or water quality;
23 (ii) any negative impacts to wildlife;

1 (iii) any delays in hazardous waste
2 cleanup that are projected to be hazardous
3 to public health; and
4 (iv) any other negative impact on pub-
5 lic health or the environment; and
6 (B) any recommendations that the Na-
7 tional Academy of Sciences considers appro-
8 priate to maintain, restore, or improve in whole
9 or in part protections for public health, air
10 quality, water quality, wildlife, and the environ-
11 ment for each of the regulations, laws, and pro-
12 posed laws listed in paragraph (1), which may
13 include recommendations for the adoption of
14 any regulation or law in place or proposed prior
15 to January 1, 2001.
16 (d) DEPARTMENT AND AGENCY REVISION OF EXIST-
17 ING RULES, REGULATIONS, OR LAWS.—Not later than
18 180 days after the date on which the report is submitted
19 pursuant to subsection (c)(3), the head of each depart-
20 ment and agency that has issued or implemented a regula-
21 tion or law listed in subsection (c)(1) shall submit to the
22 Congress a plan describing the steps such department or
23 such agency will take, or has taken, to restore or improve
24 protections for public health and the environment in whole

1 or in part that were in existence prior to the issuance of
2 such regulation or law.

3 **SEC. 1006. HEALTHY FOOD FINANCING INITIATIVE.**

4 (a) IN GENERAL.—Subtitle D of the Department of
5 Agriculture Reorganization Act of 1994 (7 U.S.C. 6951)
6 is amended by adding at the end the following:

7 **"SEC. 242. HEALTHY FOOD FINANCING INITIATIVE.**

8 ''(a) PURPOSE.—The purpose of this section is to es-
9 tablish a program to improve access to healthy foods in
10 underserved areas, to create and preserve quality jobs, and
11 to revitalize low-income communities by providing loans
12 and grants to eligible fresh, healthy food retailers to over-
13 come the higher costs and initial barriers to entry in un-
14 derserved, urban, suburban, and rural areas.

15 ''(b) DEFINITIONS.—In this section:

16 ''(1) COMMUNITY DEVELOPMENT FINANCIAL IN-
17 STITUTION.—The term 'community development fi-
18 nancial institution' has the meaning given the term
19 in section 103 of the Community Development
20 Banking and Financial Institutions Act of 1994 (12
21 U.S.C. 4702).

22 ''(2) FOOD ACCESS ORGANIZATION.—The term
23 'food access organization' means a nonprofit organi-
24 zation with expertise in improving access to healthy
25 food in underserved communities.

1 "(3) INITIATIVE.—The term 'Initiative' means
2 the Healthy Food Financing Initiative established in
3 the Department by subsection (c)(1).
4 "(4) LOCAL FUNDS.—The term 'local funds'
5 means the allocation of national funds and any other
6 forms of financial assistance (including grants,
7 loans, and equity investments) that are raised by
8 partnerships to carry out the purposes of this sec-
9 tion.
10 "(5) NATIONAL FUNDS.—The term 'national
11 funds' means any Federal appropriation made to
12 carry out this section and any other forms of finan-
13 cial assistance (including grants, loans, and equity
14 investments) that are raised by the national fund
15 manager to carry out the purposes of this section.
16 "(6) NATIONAL FUND MANAGER.—The term
17 'national fund manager' means a community devel-
18 opment financial institution in existence as of the
19 date of enactment of this section and certified by the
20 Community Development Financial Institutions
21 Fund of the Department of the Treasury that is des-
22 ignated by the Secretary to manage the Initiative for
23 purposes of—
24 "(A) raising private capital;

1 "(B) providing financial and technical as-
2 sistance to partnerships; and
3 "(C) funding eligible projects directly at
4 the request of partnerships to attract fresh,
5 healthy food retailers to underserved urban,
6 suburban, and rural areas, in accordance with
7 this section.
8 "(7) PARTNERSHIP.—
9 "(A) IN GENERAL.—The term 'partner-
10 ship' means a regional, State, or local public
11 and private partnership that is organized to im-
12 prove access to fresh, healthy foods by pro-
13 viding financial and technical assistance to eli-
14 gible projects.
15 "(B) INCLUSIONS.—The term 'partnership'
16 includes—
17 "(i) an unit of State, local, or tribal
18 government or a quasi-public State or local
19 government agency;
20 "(ii) a food access or community
21 health organization committed to improv-
22 ing access to healthy foods;
23 "(iii) a community development finan-
24 cial institution or other organization that
25 is capable of administering a loan and

1 grant program in accordance with this sec-
2 tion; and
3 ‘‘(iv) other organizations interested in
4 improving access to healthy foods in under-
5 served areas.
6 ‘‘(c) ESTABLISHMENT.—
7 ‘‘(1) IN GENERAL.—There is established in the
8 Department a Healthy Food Financing Initiative.
9 ‘‘(2) MANAGEMENT.—Not later than 1 year
10 after the date of enactment of this section, the Sec-
11 retary shall select and enter into a grant agreement
12 with a national fund manager who shall be respon-
13 sible for the management of the Initiative nationally.
14 ‘‘(3) ELIGIBLE PROJECTS.—
15 ‘‘(A) IN GENERAL.—Subject to the re-
16 quirements of this paragraph, the national fund
17 manager shall establish the eligibility criteria
18 for projects to be assisted by the Initiative.
19 ‘‘(B) REQUIREMENTS.—To be eligible to
20 receive assistance through the Initiative, a
21 project shall—
22 ‘‘(i) include a supermarket, grocery
23 store, farmers market, or other fresh,
24 healthy food retailer;

1 "(ii) consist of a for-profit business
2 enterprise, a member- or worker-owned co-
3 operative, or a nonprofit organization;
4 "(iii) meet the eligibility criteria es-
5 tablished under this section;
6 "(iv) continue to be a viable business
7 enterprise with a financial viability plan;
8 "(v) require an investment of public
9 funding to move forward and be competi-
10 tive;
11 "(vi) operate on a self-service basis;
12 "(vii) in accordance with subpara-
13 graph (C), expand or preserve the avail-
14 ability of healthy, fresh, high quality un-
15 prepared and unprocessed foods, particu-
16 larly fresh fruits and vegetables, in under-
17 served areas; and
18 "(viii) agree to accept benefits under
19 the supplemental nutrition assistance pro-
20 gram established under the Food and Nu-
21 trition Act of 2008 (7 U.S.C. 2011 et
22 seq.).
23 "(C) REQUIREMENTS.—
24 "(i) DEFINITIONS.—In this subpara-
25 graph:

1 "(I) PERISHABLE FOOD.—
2 "(aa) IN GENERAL.—The
3 term 'perishable food' means food
4 that is fresh, refrigerated, or fro-
5 zen.
6 "(bb) EXCLUSION.—The
7 term 'perishable food' does not
8 include packaged or canned
9 goods.
10 "(II) STAPLE FOOD.—
11 "(aa) IN GENERAL.—The
12 term 'staple food' means food
13 that is a basic dietary item, in-
14 cluding bread, flour, fruits, vege-
15 tables, and meat.
16 "(bb) EXCLUSIONS.—The
17 term 'staple food' does not in-
18 clude snack or accessory food
19 (such as chips, soda, coffee, con-
20 diments, and spices) or ready-to-
21 eat, prepared food.
22 "(III) VARIETY.—The term 'vari-
23 ety' means an assortment of different
24 types of food items.

1 "(ii) IN GENERAL.—For purposes of
2 subparagraph (B)(vii), to expand or pre-
3 serve the availability of fresh fruits and
4 vegetables in underserved areas shall
5 mean, with respect to a project, that the
6 project maintains a store that—
7 "(I) carries a full line of fresh
8 produce, as defined by the national
9 fund manager to reflect differences in
10 project size and overall store size;
11 "(II) sells food for home prepara-
12 tion and consumption; and
13 "(III) at a minimum—
14 "(aa) offers for sale at least
15 3 different varieties of food in
16 each of the 4 staple food groups
17 (bread and grains, dairy, fruits
18 and vegetables, and meat, poul-
19 try, and fish), with perishable
20 food in at least 2 categories, on
21 a daily basis; or
22 "(bb) has a store at which
23 at least 50 percent of the total
24 sales of the store (including food
25 and nonfood items or services)

1 are from the sale of eligible sta-
2 ple food.
3 "(D) INCOME CRITERIA.—Each eligible
4 project shall be located in—
5 "(i) a low- or moderate-income census
6 tract, as determined by the Bureau of the
7 Census of the Department of Commerce;
8 "(ii) a population census tract that is
9 treated as a low-income community under
10 section 45D(e) of the Internal Revenue
11 Code of 1986; or
12 "(iii) an area that significantly serves
13 an adjacent area that meets the criteria
14 described in clause (i) or (ii), as approved
15 by the national fund manager.
16 "(E) UNDERSERVED CRITERIA.—
17 "(i) IN GENERAL.—Each eligible
18 project shall be located in an underserved
19 area, as determined by the partnerships
20 according to criteria established by the na-
21 tional fund manager.
22 "(ii) FACTORS.—In determining
23 whether an area is an underserved area,
24 the following factors shall be taken into
25 consideration:

1 "(I) Population density.
2 "(II) Below average supermarket
3 density or sales.
4 "(III) Car ownership.
5 "(IV) Geographical or physical
6 barriers, such as highways, moun-
7 tains, major parks, or bodies of water.
8 "(iii) LOCATIONS.—On an annual
9 basis, the national fund manager shall col-
10 lect data and publish maps that show the
11 location of underserved areas.
12 "(4) PRIORITY PROJECTS.—
13 "(A) IN GENERAL.—Priority shall be given
14 to projects that—
15 "(i) are located in severely distressed
16 low-income communities, as defined by the
17 Community Development Financial Insti-
18 tutions Fund of the Department of the
19 Treasury; and
20 "(ii) include 1 or more of the fol-
21 lowing characteristics:
22 "(I) The project will create or re-
23 tain quality jobs in the community, as
24 determined in accordance with sub-
25 paragraph (B).

1 "(II) The project has community
2 support in terms of store quality, af-
3 fordability, site location, and coordina-
4 tion with local community plans or
5 other programs promoting community
6 and economic development.
7 "(III) The project supports re-
8 gional food systems and locally grown
9 foods, to the extent available.
10 "(IV) In major metropolitan
11 areas, the project is associated with a
12 transit-oriented development project.
13 "(V) In areas with public transit,
14 the project is accessible by public
15 transit.
16 "(VI) The project involves the
17 reuse of a building that is listed in or
18 eligible for the National Register of
19 Historic Places.
20 "(VII) The project involves a
21 brownfield or grayfield (as those
22 terms are used in the Comprehensive
23 Environmental Response, Compensa-
24 tion, and Liability Act of 1980 (42
25 U.S.C. 9601 et seq.)).

1 "(VIII) The estimated energy
2 consumption of the project, calculated
3 using building energy software ap-
4 proved by the Department of Energy,
5 will qualify the project for designation
6 under the Energy Star program estab-
7 lished by section 324A of the Energy
8 Policy and Conservation Act (42
9 U.S.C. 6294a).
10 "(IX) The project involves
11 women- and minority-owned busi-
12 nesses.
13 "(B) QUALITY JOBS.—For purposes of
14 subparagraph (A)(ii)(I), a quality job is a job
15 that—
16 "(i) provides wages that are com-
17 parable to or better than similar positions
18 in existing businesses of similar size in
19 similar local economies;
20 "(ii) offers benefits that are com-
21 parable to or better than what is offered
22 for similar positions in existing local busi-
23 nesses of similar size in similar local econo-
24 mies; and

1 ''(iii) is targeted for residents of
2 neighborhoods with a high proportion of
3 persons of low income (as that term is de-
4 fined in section 102(a) of the Housing and
5 Community Development Act of 1974 (42
6 U.S.C. 5302(a))) through local targeted
7 hiring programs.
8 ''(d) DUTIES OF THE SECRETARY.—
9 ''(1) IN GENERAL.—The Secretary shall—
10 ''(A) designate a national fund manager to
11 manage national funds;
12 ''(B) oversee the Initiative nationally;
13 ''(C) work closely with the designated na-
14 tional fund manager—
15 ''(i) to ensure that funds are used ap-
16 propriately and in the most effective man-
17 ner practicable; and
18 ''(ii) to develop the program strategy
19 into a detailed work plan, program, and
20 operating budget;
21 ''(D) review and approve the operating
22 budget for the national fund manager to ensure
23 that the administrative costs are—
24 ''(i) reasonable (not more than 5 per-
25 cent of the total budget);

1 "(ii) connected to the costs of oper-
2 ations; and
3 "(iii) reflect efficient operations by the
4 national fund manager; and
5 "(E) make available to the public an an-
6 nual report, using data obtained from the De-
7 partment of Agriculture, the Department of
8 Health and Human Services, and the Commu-
9 nity Development Financial Institutions, that
10 describes the impacts of the Initiative, including
11 tracking health and economic development indi-
12 cators at the local, State, and national levels to
13 determine the impacts of individual projects
14 and the collective impact in local areas and
15 statewide of funded projects and the Initiative
16 overall.
17 "(2) NATIONAL FUND MANAGER.—The Sec-
18 retary shall—
19 "(A) select the national fund manager
20 through a competitive process from among com-
21 munity development financial institutions that
22 have a proven and recent track record of suc-
23 cess and effectiveness in—
24 "(i) attracting private capital;

1 "(ii) developing and managing pro-
2 grams that provide grants and loans to
3 support supermarkets and other fresh,
4 healthy food retail business enterprises in
5 low- and moderate-income communities, in-
6 cluding the development of grocery stores,
7 farmers markets, and other fresh, healthy
8 food retail models;
9 "(iii) making and servicing loans that
10 are similar to loans proposed in the Initia-
11 tive or having a record of otherwise suc-
12 cessfully investing in fresh, healthy food
13 retail development projects;
14 "(iv) effectively managing multiple
15 contracts and subcontractors;
16 "(v) effectively managing large capital
17 pools, of at least $100,000,000; and
18 "(vi) providing or contracting for the
19 provision of technical assistance; and
20 "(B) administer the Initiative by approving
21 the disbursement of funds to the national fund
22 manager in a manner that facilitates the imple-
23 mentation of the overall Initiative.
24 "(3) COORDINATION.—

1 "(A) IN GENERAL.—Not later than 45
2 days after the date of receipt of an award, the
3 national fund manager shall develop, with guid-
4 ance from and in consultation with the Sec-
5 retary, and submit to the Secretary, a detailed
6 work plan.
7 "(B) APPROVAL REQUIRED.—The Sec-
8 retary shall review and approve the work plan,
9 program budget, and administrative costs under
10 subsection (e)(4)(C) prior to entering into an
11 agreement with the national fund manager to
12 administer the Initiative.
13 "(4) PERFORMANCE TARGETS.—
14 "(A) IN GENERAL.—The Secretary shall
15 conduct financial audits of, and establish per-
16 formance targets for, the national fund man-
17 ager, which shall include, at a minimum, the re-
18 quirements described in this paragraph.
19 "(B) GEOGRAPHIC SPREAD.—Partnerships
20 funded by the Initiative shall be geographically
21 diverse and representative of the underserved
22 areas across the United States.
23 "(C) FOCUS ON LOW-INCOME COMMU-
24 NITIES.—A substantial portion of the projects
25 funded by partnerships shall serve very low-

1 and low-income communities, as defined by the
2 Bureau of the Census of the Department of
3 Commerce.

4 "(D) FINANCIAL EFFECTIVENESS OF THE
5 NATIONAL FUND MANAGER.—The national fund
6 manager and any local financial institution in-
7 volved in a partnership shall demonstrate on-
8 going capacity and timeliness in raising private
9 capital and disbursing funds as required under
10 the Initiative.

11 "(E) TECHNICAL ASSISTANCE EFFECTIVE-
12 NESS OF THE NATIONAL FUND MANAGER.—The
13 provision of technical assistance by the national
14 fund manager shall be evaluated based on—

15 "(i) the responsiveness of the national
16 fund manager to requests for assistance;
17 and

18 "(ii) the ability of the national fund
19 manager to craft programs that develop
20 needed new capacities in partnerships.

21 "(F) IMPACT.—Performance targets shall
22 address the allocation of funds by the national
23 fund manager to partnerships and the tracking
24 and reporting of the impacts of the funds in im-

1 proving access to fresh, healthy foods and in
2 achieving other related impacts.
3 “(e) DUTIES OF THE NATIONAL FUND MANAGER.—
4 “(1) ALLOCATION OF FUNDS.—
5 “(A) IN GENERAL.—The national fund
6 manager shall—
7 “(i) allocate at least 70 percent of any
8 Federal appropriation made to carry out
9 this section to partnerships that are se-
10 lected based on the criteria described in
11 paragraph (3); and
12 “(ii) retain not more than 30 percent
13 of any Federal appropriation made to
14 carry out this section to undertake financ-
15 ing activities described in subparagraph
16 (C), including a reasonable amount for ad-
17 ministrative costs (not to exceed 5 percent)
18 approved by the Secretary in accordance
19 with paragraph (4)(C).
20 “(B) USE OF THE NATIONAL FUNDS BY
21 PARTNERSHIP PROGRAMS.—
22 “(i) IN GENERAL.—As a condition on
23 the receipt of funds, each partnership shall
24 use—

1 "(I) the national funds received
2 from the national fund manager under
3 subparagraph (A)(i) to create 1 or
4 more revolving loan programs or other
5 revolving pools of capital or other
6 products to facilitate financing of local
7 projects as determined by the agree-
8 ment between the partnership and the
9 national fund manager; and
10 "(II) any remaining funds for
11 grants, or, as approved, for innovative
12 financing mechanisms.
13 "(ii) LIMITATIONS.—
14 "(I) IN GENERAL.—Use of funds
15 for administrative costs and other
16 purposes shall be—
17 "(aa) limited in accordance
18 with the terms of the agreement
19 negotiated between the national
20 fund manager and partnerships;
21 "(bb) based on whether ad-
22 ministrative costs are reasonable,
23 connected to the costs of oper-
24 ation, and reflect efficient oper-
25 ations by the partnership; and

1 “(cc) determined using cri-
2 teria including geographic cov-
3 erage, program duration, and
4 total funding amount.
5 “(II) GOAL.—The goal of this
6 clause to limit administrative costs to
7 the maximum extent practicable, but
8 in no case may the amount used for
9 administrative costs exceed 10 percent
10 of the Federal funds allocated.
11 “(C) USE OF THE NATIONAL FUNDS BY
12 THE NATIONAL FUND MANAGER.—The national
13 fund manager shall use national funds de-
14 scribed in subparagraph (A)(ii) to undertake fi-
15 nancing and other activities to enhance and
16 maximize the effectiveness of the Initiative, as
17 determined by the agreement with the Sec-
18 retary, including—
19 “(i) attracting other forms of financial
20 assistance to match or leverage the na-
21 tional funds;
22 “(ii) awarding national funds to part-
23 nerships in accordance with paragraph (3);
24 “(iii) creating and managing pools of
25 grant or loan capital that blend or leverage

1 national funds with other forms of finan-
2 cial assistance, including capital in the
3 form of tax credits under section 45D of
4 the Internal Revenue Code of 1986, for the
5 benefit of partnerships;
6 "(iv) creating and managing pools of
7 grant or loan capital that blend or leverage
8 the national funds with other forms of fi-
9 nancial assistance, including capital in the
10 form of tax credits under section 45D of
11 the Internal Revenue Code of 1986, to fi-
12 nance eligible local projects identified by
13 partnerships or the national fund manager
14 that have special or unique characteristics;
15 "(v) providing loans or grants directly
16 to eligible local projects as matching funds
17 if requested by a partnership;
18 "(vi) providing credit enhancement or
19 other financial products and instruments
20 for the benefit of partnerships or eligible
21 local projects;
22 "(vii) providing technical assistance;
23 and

1 "(viii) funding reasonable administra-
2 tive costs approved by the Secretary in ac-
3 cordance with paragraph (4)(C).
4 "(2) RESPONSIBILITIES OF THE NATIONAL
5 FUND MANAGER.—The designated national fund
6 manager shall—
7 "(A) raise other forms of financial assist-
8 ance to match or leverage the national funds;
9 "(B) use administrative funds to develop
10 appropriate training programs and offer tech-
11 nical assistance services to—
12 "(i) partnerships;
13 "(ii) State, local, and tribal govern-
14 ments;
15 "(iii) the food retail industry; and
16 "(iv) food access and health advocacy
17 organizations to augment local capacities;
18 "(C) develop financial products such as
19 loans, grants, and credit enhancement tools
20 that can be used by partnerships to incentivize
21 and support the development and retention of
22 supermarkets and other fresh, healthy food re-
23 tail in underserved areas;

1 "(D) award Initiative funds to eligible
2 partnerships through an annual competitive
3 process in accordance with paragraph (3);
4 "(E) contract with a national food access
5 organization to assist in the review of applica-
6 tions from partnerships and to provide technical
7 assistance to local food access organizations in
8 the proposed partnerships;
9 "(F) award and disburse funds to partner-
10 ships or eligible local projects in a timely man-
11 ner;
12 "(G) create and meet performance bench-
13 marks and reporting guidelines, as approved by
14 the Secretary, including for—
15 "(i) the amount of capital raised and
16 leveraged from financial institutions, part-
17 nerships, and other resources;
18 "(ii) the geographic diversity of part-
19 nerships; and
20 "(iii) the proportion of projects fund-
21 ed by the partnership that are in severely
22 distressed low-income communities;
23 "(H) develop program guidelines and oper-
24 ating procedures for the Initiative, including—

1 ''(i) maximum grant and loan
2 amounts for projects;
3 ''(ii) eligible uses of funds;
4 ''(iii) prudent underwriting criteria;
5 ''(iv) performance targets;
6 ''(v) reporting guidelines;
7 ''(vi) limits on administrative costs;
8 and
9 ''(vii) implementation milestones;
10 ''(I) monitor the performance of partner-
11 ships; and
12 ''(J) collect data, compile information, and
13 conduct such research studies as the national
14 fund manager determines to be relevant to the
15 successful implementation of the Initiative, in-
16 cluding—
17 ''(i) to assess national and local mar-
18 ket conditions;
19 ''(ii) to determine barriers to market
20 entry; and
21 ''(iii) to identify opportunities for the
22 development or retention of supermarkets
23 and other fresh, healthy food retail enter-
24 prises in underserved communities.

1 "(3) CRITERIA FOR AWARDING NATIONAL
2 FUNDS TO PARTNERSHIPS.—
3 "(A) IN GENERAL.—The national fund
4 manager shall award national funds to partner-
5 ships through a competitive process on an an-
6 nual basis.
7 "(B) FIRST ROUND PRIORITY.—In the
8 first round of funding, the national fund man-
9 ager shall give priority to existing partnerships
10 that have demonstrable capacity to implement
11 fresh food financing programs in underserved
12 areas quickly.
13 "(C) ADDITIONAL ROUNDS.—Additional
14 rounds shall be designed to promote geographic
15 diversity.
16 "(D) CRITERIA.—In awarding national
17 funds to partnerships, the national fund man-
18 ager shall consider—
19 "(i) the amount of funds and other
20 resources pledged by a partnership to
21 match or leverage national funds;
22 "(ii) the degree of State, local, or trib-
23 al government support of the partnership
24 as evidenced by matching grant and loan
25 funds or other types of support, such as al-

location of tax-exempt bonds, loan guarantees, and coordination of resources from other State or local economic development programs;

"(iii) the capacity of the partnership to successfully develop and manage loan and grant programs;

"(iv) the lack of supermarkets and other fresh, healthy food retail enterprises in low- and moderate-income areas that would be served by the partnership;

"(v) the experience of the food access or community health organization of the partnership in outreach about access to healthy foods and local healthy food access issues;

"(vi) the degree of community engagement and support in the development and retention of supermarkets and other fresh, healthy food retail enterprises; and

"(vii) the contribution of the program of the partnership to the overall geographic diversity of the Initiative.

"(4) ADMINISTRATIVE COSTS.—

1 "(A) IN GENERAL.—Not later than 45
2 days after the date of receipt of an award, the
3 national fund manager shall submit to the Sec-
4 retary for approval a 3-year program and oper-
5 ating budget and detailed work plan that shall
6 include—
7 "(i) costs for research and evaluation,
8 technical assistance, and training; and
9 "(ii) program and operating costs.
10 "(B) EARNED REVENUES.—Earned reve-
11 nues from loan fees and interest may be ex-
12 pended on program and operating costs in ac-
13 cordance with the budget approved by the Sec-
14 retary.
15 "(C) BASIS OF REVIEW.—The Secretary
16 shall base the review under subparagraph (A)
17 on—
18 "(i) the likelihood of the plan and ex-
19 penditures to further the purposes of this
20 section; and
21 "(ii) whether the administrative costs
22 are reasonable, connected to the costs of
23 operation, and reflect efficient operations
24 by the national fund manager.
25 "(f) PARTNERSHIPS.—

1 "(1) IN GENERAL.—Each partnership that re-
2 ceives assistance through the Initiative shall provide
3 financial and technical assistance to eligible fresh,
4 healthy food retail projects in underserved areas
5 within the defined communities of the partnership.
6 "(2) ADMINISTRATION.—Each partnership shall
7 designate a community development financial insti-
8 tution or other organization that is capable of ad-
9 ministering a loan and grant program—
10 "(A) to execute grant agreements with the
11 national fund manager; and
12 "(B) to serve as the manager of local
13 funds.
14 "(3) RESPONSIBILITIES OF PARTNERSHIPS.—A
15 partnership shall—
16 "(A) raise other forms of financial assist-
17 ance to match the national funds received by
18 the partnership;
19 "(B) provide marketing and outreach to
20 communities, the supermarket industry, other
21 fresh, healthy food retailers, State and local
22 government officials, and civic and public inter-
23 est organizations—

1 "(i) to solicit applications from under-
2 served areas from across the State or local-
3 ity to be served by the partnership; and
4 "(ii) to inform the communities and
5 other persons about the availability of
6 grants, loans, training, and technical as-
7 sistance;
8 "(C) review and underwrite projects to de-
9 termine whether—
10 "(i) a proposed project meets the cri-
11 teria for eligible projects under subsection
12 (c)(3); and
13 "(ii) a proposed project meets the cri-
14 teria for priority projects under subsection
15 (c)(4);
16 "(D) provide technical assistance services
17 to eligible fresh, healthy food retail operators
18 and developers;
19 "(E) track and report outcomes, includ-
20 ing—
21 "(i) the number of jobs created or re-
22 tained;
23 "(ii) the quantity of fresh, healthy
24 food retail space created or retained; and

1 "(iii) such other health and economic
2 indicators as are required by the national
3 fund manager;
4 "(F) monitor and audit funded projects to
5 ensure compliance with the Initiative, the na-
6 tional fund manager, and partnership program
7 requirements for a period of at least 3 years;
8 "(G) submit an annual report to the na-
9 tional fund manager that describes—
10 "(i) the activities of the partnership;
11 "(ii) the expenditure of local funds;
12 and
13 "(iii) success in meeting performance
14 targets and satisfying such other terms
15 and conditions as are specified in the
16 agreement between the partnership and the
17 national fund manager; and
18 "(H) coordinate with the national fund
19 manager for the smooth operation of the Initia-
20 tive.
21 "(4) ADMINISTRATIVE COSTS.—
22 "(A) IN GENERAL.—As a condition on the
23 receipt of assistance under this section, each
24 partnership shall submit to the national fund
25 manager for approval a 3-year budget and plan

1 for all program and operating costs, includ-
2 ing—
3 ‘‘(i) costs for research and evaluation,
4 technical assistance, and training; and
5 ‘‘(ii) administrative and operating
6 costs.
7 ‘‘(B) EARNED REVENUES.—Earned reve-
8 nues from loan fees and interest may be ex-
9 pended on program and operating costs in ac-
10 cordance with the budget approved by the na-
11 tional fund manager.
12 ‘‘(C) BASIS OF REVIEW.—The national
13 fund manager shall base the review under sub-
14 paragraph (A) on the likelihood of the budget
15 and plan to further the purposes of this section.
16 ‘‘(g) EVALUATION AND MONITORING.—
17 ‘‘(1) IN GENERAL.—Program evaluation and fi-
18 nancial audits shall occur at all levels of the Initia-
19 tive to ensure that—
20 ‘‘(A) national and local funds are used
21 properly; and
22 ‘‘(B) the objectives of the Initiative are
23 met.
24 ‘‘(2) PROGRAM EVALUATION AND FINANCIAL
25 AUDITS.—

1 "(A) IN GENERAL.—The Secretary shall—
2 "(i) conduct periodic program evalua-
3 tions and financial audits of the national
4 fund manager, partnerships, and projects
5 funded by the Initiative; and
6 "(ii) share with the national fund
7 manager the results of the evaluations and
8 audits.
9 "(B) FUNDED PROJECTS.—The Secretary
10 or the national fund manager shall evaluate
11 partnerships to assess the health and economic
12 impacts of projects funded by the Initiative.
13 "(C) OTHER IMPACTS.—
14 "(i) SECRETARY OF HEALTH AND
15 HUMAN SERVICES.—The Secretary of
16 Health and Human Services shall conduct
17 research studies and evaluate the health
18 impacts of the Initiative.
19 "(ii) COMMUNITY DEVELOPMENT FI-
20 NANCIAL INSTITUTIONS.—Representatives
21 of the Community Development Financial
22 Institutions shall conduct research studies
23 and evaluate the economic impacts of the
24 Initiative.
25 "(D) PARTNERSHIPS.—

1 "(i) IN GENERAL.—Each partnership
2 shall—
3 "(I) conduct periodic administra-
4 tive and financial audits of projects
5 funded by the Initiative; and
6 "(II) share with the national
7 fund manager the results of the au-
8 dits.
9 "(ii) FAILURE OF PARTNERSHIP.—In
10 a case in which a partnership fails, the na-
11 tional fund manager shall take over the
12 portfolio of the failed partnership.
13 "(h) ADMINISTRATIVE PROVISIONS.—Not later than
14 180 days after the date of enactment of this section, the
15 Secretary shall promulgate such regulations as may be
16 necessary to carry out this section, including regulations—
17 "(1) for the conduct of a performance evalua-
18 tion at the end of the initial 5-year period;
19 "(2) to terminate the contract for cause; and
20 "(3) to extend the contract for an additional 5-
21 year period.".
22 (b) CONFORMING AMENDMENT.—Section 296(b) of
23 the Department of Agriculture Reorganization Act of
24 1994 (7 U.S.C. 7014(b)) is amended—

1 (1) in paragraph (6)(C), by striking ''or'' at the
2 end;
3 (2) in paragraph (7), by striking the period at
4 the end and inserting ''; or''; and
5 (3) by adding at the end the following:
6 ''(8) the authority of the Secretary to establish
7 in the Department the Healthy Food Financing Ini-
8 tiative in accordance with section 242.''.

9 **SEC. 1007. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
10 **WATER HORIZON OIL RIG EXPLOSION IN THE**
11 **GULF COAST.**

12 (a) STUDY.—The Comptroller General of the United
13 States shall conduct a study on the type and scope of
14 health care services administered through the Department
15 of Health and Human Services addressing the provision
16 of health care to racial and ethnic minorities (whether
17 residents, clean-up workers, or volunteers) affected by the
18 explosion of the mobile offshore drilling unit Deepwater
19 Horizon that occurred on April 20, 2010.
20 (b) SPECIFIC COMPONENTS; REPORTING.—In car-
21 rying out subsection (a), the Comptroller General shall—
22 (1) assess the type, size, and scope of programs
23 administered by the Department of Health and
24 Human Services that focus on provision of health
25 care to communities in the Gulf Coast;

1 (2) identify the merits and disadvantages asso-
2 ciated with each the programs;
3 (3) perform an analysis of the costs and bene-
4 fits of the programs;
5 (4) determine whether there is any duplication
6 of programs; and
7 (5) not later than 180 days after the date of
8 the enactment of this Act, report findings and rec-
9 ommendations for improving access to health care
10 for racial and ethnic minorities to the Congress.