

116TH CONGRESS
2D SESSION

H. R. 6637

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

IN THE HOUSE OF REPRESENTATIVES

APRIL 28, 2020

Mr. GARCÍA of Illinois (for himself, Ms. PRESSLEY, Ms. JUDY CHU of California, Mr. RICHMOND, Mr. ESPAILLAT, Mr. VELA, Mr. VARGAS, Ms. BARRAGÁN, Ms. ROYBAL-ALLARD, Mr. SOTO, Ms. TLAIB, Mr. HIGGINS of New York, Mr. HUFFMAN, Mr. GREEN of Texas, Ms. NORTON, Ms. GARCIA of Texas, Mr. TAKANO, Mr. SERRANO, Ms. JACKSON LEE, Mrs. BEATTY, Mr. BISHOP of Georgia, Mr. THOMPSON of Mississippi, Mr. LEWIS, Ms. WILSON of Florida, Ms. SEWELL of Alabama, Mr. GOMEZ, Ms. MOORE, Mr. CARSON of Indiana, Ms. LEE of California, Mrs. DAVIS of California, Mr. SABLAN, Mrs. HAYES, Mrs. NAPOLITANO, Ms. BONAMICI, Ms. CLARKE of New York, Ms. KELLY of Illinois, Mrs. WATSON COLEMAN, Mr. DOGGETT, Ms. OMAR, Ms. BLUNT ROCHESTER, Mrs. TRAHAN, Ms. OCASIO-CORTEZ, Ms. SÁNCHEZ, Ms. ESCOBAR, Mr. CARBAJAL, Mr. CASTRO of Texas, Mr. CÁRDENAS, Mr. GRIJALVA, Ms. CASTOR of Florida, Mr. MCNERNEY, Mr. CORREA, Ms. MENG, Mr. RUSH, Ms. VELÁZQUEZ, Ms. JAYAPAL, Mr. EVANS, Mr. CASTEN of Illinois, Mr. GALLEGO, Mr. SARBANES, Mr. MEEKS, Ms. JOHNSON of Texas, Mr. BROWN of Maryland, Ms. LOFGREN, Mr. BUTTERFIELD, Mr. NADLER, Mr. ENGEL, Mr. KENNEDY, Mr. MCGOVERN, Mr. HASTINGS, Mrs. CAROLYN B. MALONEY of New York, Mr. MCEACHIN, Mr. SIRES, Mr. PAYNE, Mr. SCHIFF, Mr. JOHNSON of Georgia, Mr. KHANNA, Mr. HORSFORD, Mr. SAN NICOLAS, Ms. BASS, and Mr. DANNY K. DAVIS of Illinois) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Agriculture, Oversight and Reform, Ways and Means, Education and Labor, the Judiciary, the Budget, Veterans' Affairs, Natural Resources, Armed Services, and Homeland Security, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To 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 2020”.

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

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

- Sec. 1. Short title.
- Sec. 2. Table of contents.
- Sec. 3. Findings.

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- Sec. 203. Ensuring standards for culturally and linguistically appropriate services in health care.
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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-
11 minants of health—including the environment, the
12 physical structure of communities, nutrition and
13 food options, educational attainment, employment,
14 race, ethnicity, sex, geography, language preference,
15 immigrant or citizenship status, sexual orientation,
16 gender identity, socioeconomic status, or disability
17 status—that directly and indirectly affect the health,
18 health care, and wellness of individuals and commu-
19 nities.

20 (3) Over the next few decades, the United
21 States will face a shortage of health care providers
22 and allied health workers.

23 (4) All efforts to reduce health disparities and
24 barriers to quality health services require better and
25 more consistent data, and better and more con-
26 sistent collection of and access to data.

1 (5) A full range of culturally and linguistically
2 appropriate health care and public health services
3 must be available and accessible in every community.

4 (6) Racial and ethnic minorities and under-
5 served populations must be included early and equi-
6 tably in health reform innovations.

7 (7) Efforts to improve minority health have
8 been limited by inadequate resources in funding,
9 staffing, stewardship, and accountability. Targeted
10 investments that are focused on disparities elimi-
11 nation must be made in providing care and services
12 that are community-based, including prevention and
13 policies addressing social determinants of health.

14 (8) In 2011, the Department of Health and
15 Human Services developed the HHS Action Plan to
16 Reduce Racial and Ethnic Health Disparities and
17 the National Stakeholder Strategy for Achieving
18 Health Equity, which are 2 strategic plans that rep-
19 resent the first coordinated roadmap in the United
20 States to reducing health disparities. These com-
21 prehensive plans, along with the National Prevention
22 Strategy issued by the National Prevention Council
23 of the Department of Health and Human Services,
24 Healthy People 2030, and the National Quality
25 Strategy of the Agency for Healthcare Research and

1 Quality, as well as critical resources such as the
2 2012 National Healthcare Quality and Disparities
3 Reports, will work to increase the number of people
4 in the United States who are healthy at every stage
5 of life.

6 (9) The Secretary of Health and Human Serv-
7 ices has also reviewed and advanced updated clinical
8 guidelines and developed other strategic planning
9 documents to combat health disparities with a high
10 impact on minority populations and to provide high-
11 quality family planning services. Such guidelines and
12 documents include the National HIV/AIDS Strategy,
13 the Action Plan for the Prevention, Care, and Treat-
14 ment of Viral Hepatitis, and recommendations of the
15 Centers for Disease Control and Prevention and the
16 Office of Population Affairs.

17 (10) The Patient Protection and Affordable
18 Care Act (Public Law 111–148), as amended by the
19 Health Care and Education Reconciliation Act (Pub-
20 lic Law 111–152), represents the biggest advance-
21 ment for minority health in the 40 years imme-
22 diately preceding the enactment of this Act.

23 (11) The Health Information Technology for
24 Educational and Clinical Health Act of 2009, part
25 of the American Recovery and Reinvestment Act of

1 2009 (Public Law 111–5), provides that the nation-
2 wide health information exchange infrastructure be
3 developed and used to reduce health disparities,
4 among other purposes.

5 **TITLE I—DATA COLLECTION**
6 **AND REPORTING**

7 **SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
8 **ACT.**

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

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

19 **“Subtitle C—Strengthening Data**
20 **Collection, Improving Data**
21 **Analysis, and Expanding Data**
22 **Reporting**

23 **“SEC. 3431. HEALTH DISPARITY DATA.**

24 **“(a) REQUIREMENTS.—**

1 “(1) IN GENERAL.—Each health-related pro-
2 gram 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, age, and
7 socioeconomic status of each applicant for and
8 recipient of health-related assistance under such
9 program, including—

10 “(i) using, at a minimum, standards
11 for data collection on race, ethnicity, sex,
12 primary language, sexual orientation, gen-
13 der identity, age, socioeconomic status, and
14 disability status as each are developed
15 under section 3101;

16 “(ii) collecting data for additional
17 population groups if such groups can be
18 aggregated into the race and ethnicity cat-
19 egories outlined by standards developed
20 under section 3101;

21 “(iii) using, where practicable, the
22 standards developed by the Health and
23 Medicine Division of the National Acad-
24 emies of Sciences, Engineering, and Medi-
25 cine (formerly known as the ‘Institute of

1 Medicine’) in the 2009 publication, entitled
2 ‘Race, Ethnicity, and Language Data:
3 Standardization for Health Care Quality
4 Improvement’; and

5 “(iv) where practicable, collecting
6 such data through self-reporting;

7 “(B) with respect to the collection of the
8 data described in subparagraph (A), for appli-
9 cants and recipients who are minors, require
10 communication assistance in speech or writing,
11 and for applicants and recipients who are other-
12 wise legally incapacitated, require that—

13 “(i) such data be collected from the
14 parent or legal guardian of such an appli-
15 cant or recipient; and

16 “(ii) the primary language of the par-
17 ent or legal guardian of such an applicant
18 or recipient be collected;

19 “(C) systematically analyze such data
20 using the smallest appropriate units of analysis
21 feasible to detect racial and ethnic disparities,
22 as well as disparities along the lines of primary
23 language, sex, disability status, sexual orienta-
24 tion, gender identity, age, and socioeconomic
25 status in health and health care, and report the

1 results of such analysis to the Secretary, the
2 Director of the Office for Civil Rights, each
3 agency listed in section 3101(c)(1), the Com-
4 mittee on Health, Education, Labor, and Pen-
5 sions and the Committee on Finance of the
6 Senate, and the Committee on Energy and
7 Commerce and the Committee on Ways and
8 Means of the House of Representatives;

9 “(D) provide such data to the Secretary on
10 at least an annual basis; and

11 “(E) ensure that the provision of assist-
12 ance to an applicant or recipient of assistance
13 is not denied or otherwise adversely affected be-
14 cause of the failure of the applicant or recipient
15 to provide race, ethnicity, primary language,
16 sex, sexual orientation, disability status, gender
17 identity, age, and socioeconomic status data.

18 “(2) RULES OF CONSTRUCTION.—Nothing in
19 this subsection shall be construed to—

20 “(A) permit the use of information col-
21 lected under this subsection in a manner that
22 would adversely affect any individual providing
23 any such information; or

24 “(B) diminish any requirements, including
25 such requirements in effect on or after the date

1 of enactment of this section, on health care pro-
2 viders to collect data.

3 “(3) NO COMPELLED DISCLOSURE OF DATA.—

4 This title does not authorize any health care pro-
5 vider, Federal official, or other entity to compel the
6 disclosure of any data collected under this title. The
7 disclosure of any such data by an individual pursu-
8 ant to this title shall be strictly voluntary.

9 “(b) PROTECTION OF DATA.—The Secretary shall
10 ensure (through the promulgation of regulations or other-
11 wise) that all data collected pursuant to subsection (a) are
12 protected—

13 “(1) under the same privacy protections as the
14 Secretary applies to other health data under the reg-
15 ulations promulgated under section 264(c) of the
16 Health Insurance Portability and Accountability Act
17 of 1996 relating to the privacy of individually identi-
18 fiable health information and other protections; and

19 “(2) from all inappropriate internal use by any
20 entity that collects, stores, or receives the data, in-
21 cluding use of such data in determinations of eligi-
22 bility (or continued eligibility) in health plans, and
23 from other inappropriate uses, as defined by the
24 Secretary.

1 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
2 Secretary shall develop and implement a national plan to
3 ensure the collection of data in a culturally and linguis-
4 tically appropriate manner, to improve the collection, anal-
5 ysis, and reporting of racial, ethnic, sex, primary lan-
6 guage, sexual orientation, disability status, gender iden-
7 tity, age, and socioeconomic status data at the Federal,
8 State, territorial, Tribal, and local levels, including data
9 to be collected under subsection (a), and to ensure that
10 data collection activities carried out under this section are
11 in compliance with standards developed under section
12 3101. The Data Council of the Department of Health and
13 Human Services, in consultation with the National Com-
14 mittee on Vital Health Statistics, the Office of Minority
15 Health, Office on Women’s Health, and other appropriate
16 public and private entities, shall make recommendations
17 to the Secretary concerning the development, implementa-
18 tion, and revision of the national plan. Such plan shall
19 include recommendations on how to—

20 “(1) implement subsection (a) while minimizing
21 the cost and administrative burdens of data collec-
22 tion and reporting;

23 “(2) expand knowledge among Federal agen-
24 cies, States, territories, Indian Tribes, counties, mu-
25 nicipalities, health providers, health plans, and the

1 general public that data collection, analysis, and re-
2 porting by race, ethnicity, sex, primary language,
3 sexual orientation, gender identity, age, socio-
4 economic status, and disability status is legal and
5 necessary to assure equity and nondiscrimination in
6 the quality of health care services;

7 “(3) ensure that future patient record systems
8 follow Federal standards promulgated under the
9 Health Information Technology for Economic and
10 Clinical Health Act for the collection and meaningful
11 use of electronic health data on race, ethnicity, sex,
12 primary language, sexual orientation, gender iden-
13 tity, age, socioeconomic status, and disability status;

14 “(4) improve health and health care data collec-
15 tion and analysis for more population groups if such
16 groups can be aggregated into the minimum race
17 and ethnicity categories, including exploring the fea-
18 sibility of enhancing collection efforts in States,
19 counties, and municipalities for racial and ethnic
20 groups that comprise a significant proportion of the
21 population of the State, county, or municipality;

22 “(5) provide researchers with greater access to
23 racial, ethnic, primary language, sex, sexual orienta-
24 tion, gender identity, age, socioeconomic status data,
25 and disability status data, subject to all applicable

1 privacy and confidentiality requirements, including
2 HIPAA privacy and security law as defined in sec-
3 tion 3009; and

4 “(6) safeguard and prevent the misuse of data
5 collected under subsection (a).

6 “(d) COMPLIANCE WITH STANDARDS.—Data col-
7 lected under subsection (a) shall be obtained, maintained,
8 and presented (including for reporting purposes) in ac-
9 cordance with standards developed under section 3101.

10 “(e) ANALYSIS OF HEALTH DISPARITY DATA.—The
11 Secretary, acting through the Director of the Agency for
12 Healthcare Research and Quality and in coordination with
13 the Assistant Secretary for Planning and Evaluation, the
14 Administrator of the Centers for Medicare & Medicaid
15 Services, the Director of the National Center for Health
16 Statistics, and the Director of the National Institutes of
17 Health, shall provide technical assistance to agencies of
18 the Department of Health and Human Services in meeting
19 Federal standards for health disparity data collection and
20 for analysis of racial, ethnic, and other disparities in
21 health and health care in programs conducted or sup-
22 ported by such agencies by—

23 “(1) identifying appropriate quality assurance
24 mechanisms to monitor for health disparities;

1 “(2) specifying the clinical, diagnostic, or thera-
2 peutic measures which should be monitored;

3 “(3) developing new quality measures relating
4 to racial and ethnic disparities and their overlap
5 with other disparity factors in health and health
6 care;

7 “(4) identifying the level at which data analysis
8 should be conducted; and

9 “(5) sharing data with external organizations
10 for research and quality improvement purposes.

11 “(f) DEFINITIONS.—In this section—

12 “(1) the term ‘health-related program’ means a
13 program that is operated by the Secretary, or that
14 receives funding or reimbursement, in whole or in
15 part, either directly or indirectly from the Sec-
16 retary—

17 “(A) for activities under the Social Secu-
18 rity Act for health care services; or

19 “(B) for providing Federal financial assist-
20 ance for health care, biomedical research, or
21 health services research or for otherwise im-
22 proving the health of the public;

23 “(2) the term ‘primary language data’ includes
24 spoken and written primary language data; and

1 “(1) enhance or upgrade computer technology
2 that will facilitate collection, analysis, and reporting
3 of racial, ethnic, primary language, sexual orienta-
4 tion, sex, gender identity, socioeconomic status, and
5 disability status data;

6 “(2) improve methods for health data collection
7 and analysis, including additional population groups
8 if such groups can be aggregated into the race and
9 ethnicity categories outlined by standards developed
10 under section 3101;

11 “(3) develop mechanisms for submitting col-
12 lected data subject to any applicable privacy and
13 confidentiality regulations; and

14 “(4) develop educational programs to inform
15 health plans, health providers, health-related agen-
16 cies, and the general public that data collection and
17 reporting by race, ethnicity, primary language, sex-
18 ual orientation, sex, gender identity, disability sta-
19 tus, and socioeconomic status are legal and essential
20 for eliminating health and health care disparities.

21 “(c) ELIGIBLE ENTITY.—To be eligible for grants
22 under this section, an entity shall be a State, territory,
23 Indian Tribe, municipality, county, health provider, health
24 care organization, or health plan making a demonstrated

1 effort to bring data collections into compliance with sec-
2 tion 3431.

3 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2021 through 2025.

7 **“SEC. 3433. OVERSAMPLING OF UNDERREPRESENTED**
8 **GROUPS IN FEDERAL HEALTH SURVEYS.**

9 “(a) NATIONAL STRATEGY.—

10 “(1) IN GENERAL.—The Secretary, acting
11 through the Director of the National Center for
12 Health Statistics of the Centers for Disease Control
13 and Prevention, and other agencies within the De-
14 partment of Health and Human Services as the Sec-
15 retary determines appropriate, shall develop and im-
16 plement an ongoing and sustainable national strat-
17 egy for oversampling underrepresented populations
18 within the categories of race, ethnicity, sex, primary
19 language, sexual orientation, disability status, gen-
20 der identity, and socioeconomic status as determined
21 appropriate by the Secretary in Federal health sur-
22 veys and program data collections. Such national
23 strategy shall include a strategy for oversampling of
24 Asian Americans, Native Hawaiians, and Pacific Is-
25 landers.

1 “(2) CONSULTATION.—In developing and imple-
2 menting a national strategy, as described in para-
3 graph (1), not later than 180 days after the date of
4 the enactment of this section, the Secretary shall—

5 “(A) consult with representatives of com-
6 munity groups, nonprofit organizations, non-
7 governmental organizations, and government
8 agencies working with underrepresented popu-
9 lations;

10 “(B) solicit the participation of representa-
11 tives from other Federal departments and agen-
12 cies, including subagencies of the Department
13 of Health and Human Services; and

14 “(C) consult on, and use as models, the
15 2014 National Health Interview Survey over-
16 sample of Native Hawaiian and Pacific Islander
17 populations and the 2017 Behavioral Risk Fac-
18 tor Surveillance System oversample of American
19 Indian and Alaska Native communities.

20 “(b) PROGRESS REPORT.—Not later than 2 years
21 after the date of the enactment of this section, the Sec-
22 retary shall submit to the Congress a progress report,
23 which shall include the national strategy described in sub-
24 section (a)(1).

1 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there are authorized to be appro-
3 priated such sums as may be necessary for fiscal years
4 2021 through 2025.”.

5 **SEC. 102. ELIMINATION OF PREREQUISITE OF DIRECT AP-**
6 **PROPRIATIONS FOR DATA COLLECTION AND**
7 **ANALYSIS.**

8 Section 3101 of the Public Health Service Act (42
9 U.S.C. 300kk) is amended—

10 (1) by striking subsection (h); and

11 (2) by redesignating subsection (i) as subsection
12 (h).

13 **SEC. 103. COLLECTION OF DATA FOR THE MEDICARE PRO-**
14 **GRAM.**

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

18 “COLLECTION OF DATA FOR THE MEDICARE PROGRAM

19 “SEC. 1150C.

20 “(a) REQUIREMENT.—

21 “(1) IN GENERAL.—The Commissioner of So-
22 cial Security, in consultation with the Administrator
23 of the Centers for Medicare & Medicaid Services,
24 shall collect data on the race, ethnicity, sex, primary
25 language, sexual orientation, gender identity, socio-
26 economic status, and disability status of all appli-

1 cants for Social Security benefits under title II or
2 Medicare benefits under title XVIII.

3 “(2) DATA COLLECTION STANDARDS.—In col-
4 lecting data under paragraph (1), the Commissioner
5 of Social Security shall at least use the standards
6 for data collection developed under section 3101 of
7 the Public Health Service Act or the standards de-
8 veloped by the Office of Management and Budget,
9 whichever is more disaggregated. In the event there
10 are no standards for the demographic groups listed
11 under paragraph (1), the Commissioner shall consult
12 with stakeholder groups representing the various
13 identities as well as with the Office of Minority
14 Health within the Centers for Medicare & Medicaid
15 Services to develop appropriate standards.

16 “(3) DATA FOR ADDITIONAL POPULATION
17 GROUPS.—Where practicable, the information col-
18 lected by the Commissioner of Social Security under
19 paragraph (1) shall include data for additional popu-
20 lation groups if such groups can be aggregated into
21 the race and ethnicity categories outlined by the
22 data collection standards described in paragraph (2).

23 “(4) COLLECTION OF DATA FOR MINORS AND
24 LEGALLY INCAPACITATED INDIVIDUALS.—With re-
25 spect to the collection of the data described in para-

1 graph (1) of applicants who are under 18 years of
2 age or otherwise legally incapacitated, the Commis-
3 sioner of Social Security shall require that—

4 “(A) such data be collected from the par-
5 ent or legal guardian of such an applicant; and

6 “(B) the primary language of the parent
7 or legal guardian of such an applicant or recipi-
8 ent be used in collecting the data.

9 “(5) QUALITY OF DATA.—The Commissioner of
10 Social Security shall periodically review the quality
11 and completeness of the data collected under para-
12 graph (1) and make adjustments as necessary to im-
13 prove both.

14 “(6) TRANSMISSION OF DATA.—Upon enroll-
15 ment in Medicare benefits under title XVIII, the
16 Commissioner of Social Security shall transmit an
17 individual’s demographic data as collected under
18 paragraph (1) to the Centers for Medicare & Med-
19 icaid Services.

20 “(7) ANALYSIS AND REPORTING OF DATA.—
21 With respect to data transmitted under paragraph
22 (5), the Administrator of the Centers for Medicare
23 & Medicaid Services, in consultation with the Com-
24 missioner of Social Security shall—

1 “(A) require that such data be uniformly
2 analyzed and that such analysis be reported at
3 least annually to Congress;

4 “(B) incorporate such data in other anal-
5 ysis and reporting on health disparities as ap-
6 propriate;

7 “(C) make such data available to research-
8 ers, under the protections outlined in paragraph
9 (7);

10 “(D) provide opportunities to individuals
11 enrolled in Medicare to submit updated data;
12 and

13 “(E) ensure that the provision of assist-
14 ance or benefits to an applicant is not denied
15 or otherwise adversely affected because of the
16 failure of the applicant to provide any of the
17 data collected under paragraph (1).

18 “(8) PROTECTION OF DATA.—The Commis-
19 sioner of Social Security shall ensure (through the
20 promulgation of regulations or otherwise) that all
21 data collected pursuant to subsection (a) is pro-
22 tected—

23 “(A) under the same privacy protections as
24 the Secretary applies to health data under the
25 regulations promulgated under section 264(c) of

1 the Health Insurance Portability and Account-
2 ability Act of 1996 (relating to the privacy of
3 individually identifiable health information and
4 other protections); and

5 “(B) from all inappropriate internal use by
6 any entity that collects, stores, or receives the
7 data, including use of such data in determina-
8 tions of eligibility (or continued eligibility) in
9 health plans, and from other inappropriate
10 uses, as defined by the Secretary.

11 “(b) RULE OF CONSTRUCTION.—Nothing in this sec-
12 tion shall be construed to permit the use of information
13 collected under this section in a manner that would ad-
14 versely affect any individual providing any such informa-
15 tion.

16 “(c) TECHNICAL ASSISTANCE.—The Secretary may,
17 either directly or by grant or contract, provide technical
18 assistance to enable any entity to comply with the require-
19 ments of this section or with regulations implementing this
20 section.

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 \$500 million for 2020 and \$100 million for each fiscal
24 year thereafter.”.

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

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

9 (1) the use, at a minimum, of standards for
10 data collection on race, ethnicity, primary language,
11 disability, sex, sexual orientation, gender identity,
12 and socioeconomic status developed under section
13 3101 of the Public Health Service Act (42 U.S.C.
14 300kk); and

15 (2) in consultation with the Office of the Na-
16 tional Coordinator for Health Information Tech-
17 nology, the designation of the appropriate racial,
18 ethnic, primary language, disability, sex, and other
19 code sets as required for claims and enrollment data.

20 (b) DISSEMINATION.—The Secretary of Health and
21 Human Services shall disseminate the new standards de-
22 veloped under subsection (a) to all entities that are subject
23 to the regulations described in such subsection and provide
24 technical assistance with respect to the collection of the
25 data involved.

1 (c) COMPLIANCE.—The Secretary of Health and
2 Human Services shall require that entities comply with the
3 new standards developed under subsection (a) not later
4 than 2 years after the final promulgation of such stand-
5 ards.

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

7 Section 306(n) of the Public Health Service Act (42
8 U.S.C. 242k(n)) is amended—

9 (1) in paragraph (1), by striking “2003” and
10 inserting “2022”;

11 (2) in paragraph (2), in the first sentence, by
12 striking “2003” and inserting “2022”; and

13 (3) in paragraph (3), by striking “2002” and
14 inserting “2022”.

15 **SEC. 106. DISPARITIES DATA COLLECTED BY THE FEDERAL**
16 **GOVERNMENT.**

17 (a) REPOSITORY OF GOVERNMENT DATA.—The Sec-
18 retary of Health and Human Services, in coordination
19 with the departments, agencies, or offices described in
20 subsection (b), shall establish a centralized electronic re-
21 pository of Government data on factors related to the
22 health and well-being of the population of the United
23 States.

24 (b) COLLECTION; SUBMISSION.—Not later than 180
25 days after the date of the enactment of this Act, and Jan-

1 uary 31 of each year thereafter, each department, agency,
2 and office of the Federal Government that has collected
3 data on race, ethnicity, sex, primary language, sexual ori-
4 entation, disability status, gender identity, age, or socio-
5 economic status during the preceding calendar year shall
6 submit such data to the repository of Government data
7 established under subsection (a).

8 (c) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
9 Not later than April 30, 2021, and April 30 of each year
10 thereafter, the Secretary of Health and Human Services,
11 acting through the Assistant Secretary for Planning and
12 Evaluation, the Assistant Secretary for Health, the Direc-
13 tor of the Agency for Healthcare Research and Quality,
14 the Director of the National Center for Health Statistics,
15 the Administrator of the Centers for Medicare & Medicaid
16 Services, the Director of the National Institute on Minor-
17 ity Health and Health Disparities, and the Deputy Assist-
18 ant Secretary for Minority Health, shall—

19 (1) prepare and make available datasets for
20 public use that relate to disparities in health status,
21 health care access, health care quality, health out-
22 comes, public health, and other areas of health and
23 well-being by factors that include race, ethnicity,
24 sex, primary language, sexual orientation, disability
25 status, gender identity, and socioeconomic status;

1 (2) ensure that these datasets are publicly iden-
2 tified on the repository established under subsection
3 (a) as “disparities” data; and

4 (3) submit a report to the Congress on the
5 availability and use of such data by public stake-
6 holders.

7 **SEC. 107. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**
8 **NORITY-SERVING INSTITUTIONS.**

9 (a) **AUTHORITY.**—The Secretary of Health and
10 Human Services, acting through the Director of the Na-
11 tional Institute on Minority Health and Health Disparities
12 and the Deputy Assistant Secretary for Minority Health,
13 shall award grants to eligible entities to access and analyze
14 racial and ethnic data on disparities in health and health
15 care, and where possible other data on disparities in health
16 and health care, to monitor and report on progress to re-
17 duce and eliminate disparities in health and health care.

18 (b) **ELIGIBLE ENTITY.**—In this section, the term “el-
19 igible entity” means an entity that has an accredited pub-
20 lic health, health policy, or health services research pro-
21 gram and is any of the following:

22 (1) A part B institution, as defined in section
23 322 of the Higher Education Act of 1965 (20
24 U.S.C. 1061).

1 (2) A Hispanic-serving institution, as defined in
2 section 502 of such Act (20 U.S.C. 1101a).

3 (3) A Tribal College or University, as defined in
4 section 316 of such Act (20 U.S.C. 1059c).

5 (4) An Asian American and Native American
6 Pacific Islander-serving institution, as defined in
7 section 371(c) of such Act (20 U.S.C. 1067q(c)).

8 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
9 out this section, there are authorized to be appropriated
10 such sums as may be necessary for fiscal years 2021
11 through 2025.

12 **SEC. 108. STANDARDS FOR MEASURING SEXUAL ORIENTA-**
13 **TION, GENDER IDENTITY, AND SOCIO-**
14 **ECONOMIC STATUS IN COLLECTION OF**
15 **HEALTH DATA.**

16 Section 3101(a) of the Public Health Service Act (42
17 U.S.C. 300kk(a)) is amended—

18 (1) in paragraph (1)(A), by inserting “sexual
19 orientation, gender identity, socioeconomic status,”
20 before “and disability status”;

21 (2) in paragraph (1)(C), by inserting “sexual
22 orientation, gender identity, socioeconomic status,”
23 before “and disability status”; and

1 (3) in paragraph (2)(B), by inserting “sexual
2 orientation, gender identity, socioeconomic status,”
3 before “and disability status”.

4 **SEC. 109. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
5 **RESPECT TO RACIAL AND ETHNIC BACK-**
6 **GROUND.**

7 (a) IN GENERAL.—Chapter V of the Federal Food,
8 Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amend-
9 ed by adding after section 505F the following:

10 **“SEC. 505G. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
11 **RESPECT TO RACIAL AND ETHNIC BACK-**
12 **GROUND.**

13 “(a) PREAPPROVAL STUDIES.—If there is evidence
14 that there may be a disparity on the basis of racial or
15 ethnic background as to the safety or effectiveness of a
16 drug or biological product, then—

17 “(1)(A) in the case of a drug, the investigations
18 required under section 505(b)(1)(A) shall include
19 adequate and well-controlled investigations of the
20 disparity; or

21 “(B) in the case of a biological product, the evi-
22 dence required under section 351(a) of the Public
23 Health Service Act for approval of a biologics license
24 application for the biological product shall include

1 adequate and well-controlled investigations of the
2 disparity; and

3 “(2) if the investigations described in subpara-
4 graph (A) or (B) of paragraph (1) confirm that
5 there is such a disparity, the labeling of the drug or
6 biological product shall include appropriate informa-
7 tion about the disparity.

8 “(b) POSTMARKET STUDIES.—

9 “(1) IN GENERAL.—If there is evidence that
10 there may be a disparity on the basis of racial or
11 ethnic background as to the safety or effectiveness
12 of a drug for which there is an approved application
13 under section 505 of this Act or of a biological prod-
14 uct for which there is an approved license under sec-
15 tion 351 of the Public Health Service Act, the Sec-
16 retary may by order require the holder of the ap-
17 proved application or license to conduct, by a date
18 specified by the Secretary, postmarket studies to in-
19 vestigate the disparity.

20 “(2) LABELING.—If the Secretary determines
21 that the postmarket studies confirm that there is a
22 disparity described in paragraph (1), the labeling of
23 the drug or biological product shall include appro-
24 priate information about the disparity.

1 “(3) STUDY DESIGN.—The Secretary may, in
2 an order under paragraph (1), specify all aspects of
3 the design of the postmarket studies required under
4 such paragraph for a drug or biological product, in-
5 cluding the number of studies and study partici-
6 pants, and the other demographic characteristics of
7 the study participants.

8 “(4) MODIFICATIONS OF STUDY DESIGN.—The
9 Secretary may, by order and as necessary, modify
10 any aspect of the design of a postmarket study re-
11 quired in an order under paragraph (1) after issuing
12 such order.

13 “(5) STUDY RESULTS.—The results from a
14 study required under paragraph (1) shall be sub-
15 mitted to the Secretary as a supplement to the drug
16 application or biologics license application.

17 “(c) APPLICATIONS UNDER SECTION 505(j).—

18 “(1) IN GENERAL.—A drug for which an appli-
19 cation has been submitted or approved under section
20 505(j) shall not be considered ineligible for approval
21 under that section or misbranded under section 502
22 on the basis that the labeling of the drug omits in-
23 formation relating to a disparity on the basis of ra-
24 cial or ethnic background as to the safety or effec-
25 tiveness of the drug, whether derived from investiga-

1 tions or studies required under this section or de-
2 rived from other sources, when the omitted informa-
3 tion is protected by patent or by exclusivity under
4 section 505(j)(5)(F).

5 “(2) LABELING.—Notwithstanding paragraph
6 (1), the Secretary may require that the labeling of
7 a drug approved under section 505(j) that omits in-
8 formation relating to a disparity on the basis of ra-
9 cial or ethnic background as to the safety or effec-
10 tiveness of the drug include a statement of any ap-
11 propriate contraindications, warnings, or precautions
12 related to the disparity that the Secretary considers
13 necessary.

14 “(d) DEFINITION.—The term ‘evidence that there
15 may be a disparity on the basis of racial or ethnic back-
16 ground as to the safety or effectiveness’, with respect to
17 a drug or biological product, includes—

18 “(1) evidence that there is a disparity on the
19 basis of racial or ethnic background as to safety or
20 effectiveness of a drug or biological product in the
21 same chemical class as the drug or biological prod-
22 uct;

23 “(2) evidence that there is a disparity on the
24 basis of racial or ethnic background in the way the
25 drug or biological product is metabolized; and

1 “(3) other evidence as the Secretary may deter-
2 mine appropriate.”.

3 (b) ENFORCEMENT.—Section 502 of the Federal
4 Food, Drug, and Cosmetic Act (21 U.S.C. 352) is amend-
5 ed by adding at the end the following:

6 “(ee) If it is a drug and the holder of the approved
7 application under section 505 or license under section 351
8 of the Public Health Service Act for the drug has failed
9 to complete the investigations or studies, or comply with
10 any other requirement, of section 505G.”.

11 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
12 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
13 379h(a)(1)(A)(ii)) is amended by inserting after “are not
14 required” the following: “, including postmarket studies
15 required under section 505G”.

16 **SEC. 110. IMPROVING HEALTH DATA REGARDING NATIVE**
17 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

18 Part B of title III of the Public Health Service Act
19 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
20 tion 317U the following:

21 **“SEC. 317V. NATIVE HAWAIIAN AND OTHER PACIFIC IS-**
22 **LANDER HEALTH DATA.**

23 “(a) DEFINITIONS.—In this section:

24 “(1) COMMUNITY GROUP.—The term ‘commu-
25 nity group’ means a group of NHOPI who are orga-

1 nized at the community level, and may include a
2 church group, social service group, national advocacy
3 organization, or cultural group.

4 “(2) NONPROFIT, NONGOVERNMENTAL ORGANI-
5 ZATION.—The term ‘nonprofit, nongovernmental or-
6 ganization’ means a group of NHOPI with a dem-
7 onstrated history of addressing NHOPI issues, in-
8 cluding a NHOPI coalition.

9 “(3) DESIGNATED ORGANIZATION.—The term
10 ‘designated organization’ means an entity estab-
11 lished to represent NHOPI populations and which
12 has statutory responsibilities to provide, or has com-
13 munity support for providing, health care.

14 “(4) GOVERNMENT REPRESENTATIVES OF
15 NHOPI POPULATIONS.—The term ‘government rep-
16 resentatives of NHOPI populations’ means rep-
17 resentatives from Hawaii, American Samoa, the
18 Commonwealth of the Northern Mariana Islands,
19 the Federated States of Micronesia, Guam, the Re-
20 public of Palau, and the Republic of the Marshall Is-
21 lands.

22 “(5) NATIVE HAWAIIANS AND OTHER PACIFIC
23 ISLANDERS (NHOPI).—The term ‘Native Hawaiians
24 and Other Pacific Islanders’ or ‘NHOPI’ means peo-
25 ple having origins in any of the original peoples of

1 American Samoa, the Commonwealth of the North-
2 ern Mariana Islands, the Federated States of Micro-
3 nesia, Guam, Hawaii, the Republic of the Marshall
4 Islands, the Republic of Palau, or any other Pacific
5 Island.

6 “(6) INSULAR AREA.—The term ‘insular area’
7 means Guam, the Commonwealth of Northern Mar-
8 iana Islands, American Samoa, the United States
9 Virgin Islands, the Federated States of Micronesia,
10 the Republic of Palau, or the Republic of the Mar-
11 shall Islands.

12 “(b) NATIONAL STRATEGY.—

13 “(1) IN GENERAL.—The Secretary, acting
14 through the Director of the National Center for
15 Health Statistics (referred to in this section as
16 ‘NCHS’) of the Centers for Disease Control and
17 Prevention, and other agencies within the Depart-
18 ment of Health and Human Services as the Sec-
19 retary determines appropriate, shall develop and im-
20 plement an ongoing and sustainable national strat-
21 egy for identifying and evaluating the health status
22 and health care needs of NHOPI populations living
23 in the continental United States, Hawaii, American
24 Samoa, the Commonwealth of the Northern Mariana
25 Islands, the Federated States of Micronesia, Guam,

1 the Republic of Palau, and the Republic of the Mar-
2 shall Islands.

3 “(2) CONSULTATION.—In developing and imple-
4 menting a national strategy, as described in para-
5 graph (1), not later than 180 days after the date of
6 enactment of the Health Equity and Accountability
7 Act of 2020, the Secretary—

8 “(A) shall consult with representatives of
9 community groups, designated organizations,
10 and nonprofit, nongovernmental organizations
11 and with government representatives of NHOPI
12 populations; and

13 “(B) may solicit the participation of rep-
14 resentatives from other Federal departments.

15 “(c) PRELIMINARY HEALTH SURVEY.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Director of NCHS, shall conduct a pre-
18 liminary health survey in order to identify the major
19 areas and regions in the continental United States,
20 Hawaii, American Samoa, the Commonwealth of the
21 Northern Mariana Islands, the Federated States of
22 Micronesia, Guam, the Republic of Palau, and the
23 Republic of the Marshall Islands in which NHOPI
24 people reside.

1 “(2) CONTENTS.—The health survey described
2 in paragraph (1) shall include health data and any
3 other data the Secretary determines to be—

4 “(A) useful in determining health status
5 and health care needs; or

6 “(B) required for developing or imple-
7 menting a national strategy.

8 “(3) METHODOLOGY.—Methodology for the
9 health survey described in paragraph (1), including
10 plans for designing questions, implementation, sam-
11 pling, and analysis, shall be developed in consulta-
12 tion with community groups, designated organiza-
13 tions, nonprofit, nongovernmental organizations, and
14 government representatives of NHOPI populations,
15 as determined by the Secretary.

16 “(4) TIMEFRAME.—The survey required under
17 this subsection shall be completed not later than 18
18 months after the date of enactment of the Health
19 Equity and Accountability Act of 2020.

20 “(d) PROGRESS REPORT.—Not later than 2 years
21 after the date of enactment of the Health Equity and Ac-
22 countability Act of 2020, the Secretary shall submit to
23 Congress a progress report, which shall include the na-
24 tional strategy described in subsection (b)(1).

1 “(e) STUDY AND REPORT BY THE HEALTH AND
2 MEDICINE DIVISION.—

3 “(1) IN GENERAL.—The Secretary shall enter
4 into an agreement with the Health and Medicine Di-
5 vision of the National Academies of Sciences, Engi-
6 neering, and Medicine to conduct a study, with input
7 from stakeholders in insular areas, on each of the
8 following:

9 “(A) The standards and definitions of
10 health care applied to health care systems in in-
11 sular areas and the appropriateness of such
12 standards and definitions.

13 “(B) The status and performance of health
14 care systems in insular areas, evaluated based
15 upon standards and definitions, as the Sec-
16 retary determines appropriate.

17 “(C) The effectiveness of donor aid in ad-
18 dressing health care needs and priorities in in-
19 sular areas.

20 “(D) The progress toward implementation
21 of recommendations of the Committee on
22 Health Care Services in the United States—As-
23 sociated Pacific Basin that are set forth in the
24 1998 report entitled ‘Pacific Partnerships for
25 Health: Charting a New Course’.

1 “(2) REPORT.—An agreement described in
2 paragraph (1) shall require the Health and Medicine
3 Division to submit to the Secretary and to Congress,
4 not later than 2 years after the date of the enact-
5 ment of the Health Equity and Accountability Act of
6 2020, a report containing a description of the results
7 of the study conducted under paragraph (1), includ-
8 ing the conclusions and recommendations of the
9 Health and Medicine Division for each of the items
10 described in subparagraphs (A) through (D) of such
11 paragraph.

12 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
13 carry out this section, there are authorized to be appro-
14 priated such sums as may be necessary for fiscal years
15 2021 through 2025.”.

16 **SEC. 111. CLARIFICATION OF SIMPLIFIED ADMINISTRATIVE**
17 **REPORTING REQUIREMENT.**

18 Section 11(a) of the Food and Nutrition Act of 2008
19 (7 U.S.C. 2020(a)) is amended by adding at the end the
20 following:

21 “(5) SIMPLIFIED ADMINISTRATIVE REPORTING
22 REQUIREMENT.—With respect to any obligation of a
23 State agency to comply with the notification require-
24 ment under paragraph (2) of section 421(e) of the
25 Personal Responsibility and Work Opportunity Rec-

1 conciliation Act of 1996 (8 U.S.C. 1631(e)), notwith-
2 standing the requirement to include in that notifica-
3 tion the names of the sponsor and the sponsored
4 alien involved, the State agency shall be considered
5 to have complied with the notification requirement if
6 the State agency submits to the Attorney General a
7 report that includes the aggregate number of excep-
8 tions granted by the State agency under paragraph
9 (1) of that section.”.

10 **TITLE II—CULTURALLY AND LIN-**
11 **GUISTICALLY APPROPRIATE**
12 **HEALTH AND HEALTH CARE**

13 **SEC. 201. DEFINITIONS; FINDINGS.**

14 (a) **DEFINITIONS.**—In this title, the definitions in
15 section 3400 of the Public Health Service Act, as added
16 by section 204, shall apply.

17 (b) **FINDINGS.**—Congress finds the following:

18 (1) Effective communication is essential to
19 meaningful access to quality physical and mental
20 health care.

21 (2) Research indicates that the lack of appro-
22 priate language services creates language barriers
23 that result in increased risk of misdiagnosis, ineffec-
24 tive treatment plans, and poor health outcomes for
25 individuals with limited English proficiency and indi-

1 individuals with communication disabilities such as cog-
2 nitive, hearing, vision, or print impairments.

3 (3) The number of limited English speaking
4 residents in the United States who speak English
5 less than very well and, therefore, cannot effectively
6 communicate with health and social service providers
7 continues to increase significantly.

8 (4) The responsibility to fund language services
9 in the provision of health care and health-care-re-
10 lated services to individuals with limited English
11 proficiency and individuals with communication dis-
12 abilities such as cognitive hearing, vision, or print
13 impairments is a societal one that cannot fairly be
14 placed solely upon the health care, public health, or
15 social services community.

16 (5) Title VI of the Civil Rights Act of 1964 (42
17 U.S.C. 2000d et seq.) prohibits discrimination based
18 on the grounds of race, color, or national origin by
19 any entity receiving Federal financial assistance. In
20 order to avoid discrimination on the grounds of na-
21 tional origin, all programs or activities administered
22 by the Federal Government must take adequate
23 steps to ensure that their policies and procedures do
24 not deny or have the effect of denying individuals

1 with limited English proficiency with equal access to
2 benefits and services for which such persons qualify.

3 (6) Both the Americans with Disabilities Act of
4 1990 (42 U.S.C. 12101 et seq.) and the Rehabilita-
5 tion Act of 1973 (29 U.S.C. 701 et seq.) prohibit
6 discrimination on the basis of disability and require
7 the provision of appropriate auxiliary aids and serv-
8 ices necessary to ensure effective communication
9 with individuals with disabilities. The type of auxil-
10 iary aid or service necessary to ensure effective com-
11 munication will vary in accordance with the method
12 of communication used by the individual; the nature,
13 length, and complexity of the communication in-
14 volved; and the context in which the communication
15 is taking place. A public accommodation should con-
16 sult with individuals with disabilities whenever pos-
17 sible to determine what type of auxiliary aid is need-
18 ed to ensure effective communication. The public ac-
19 commodation should use the person's preferred
20 method of communication whenever possible, unless
21 it would be an undue burden to the public accommo-
22 dation and an alternative would provide an equally
23 effective means of communication. The ultimate de-
24 cision as to what measures to take rests with the

1 public accommodation, provided that the method
2 chosen results in effective communication.

3 (7) Section 1557 of the Patient Protection and
4 Affordable Care Act (42 U.S.C. 18116) builds on
5 Title VI of the Civil Rights Act of 1964 (42 U.S.C.
6 2000d et seq.) and the Rehabilitation Act of 1973
7 (29 U.S.C. 701 et seq.), prohibits discrimination on
8 the basis of race, color, national origin, disability,
9 sex, and age, requires the provision of language serv-
10 ices to ensure effective communication with individ-
11 uals with limited English proficiency, and requires
12 the provision of appropriate auxiliary aids and serv-
13 ices necessary to ensure effective communication
14 with individuals with disabilities.

15 (8) Linguistic diversity in the health care and
16 health-care-related services workforce is important
17 for providing all patients the environment most con-
18 ducive to positive health outcomes.

19 (9) All members of the health care and health-
20 care-related services community should continue to
21 educate their staff and constituents about limited
22 English proficient and disability communication
23 issues and help them identify resources to improve
24 access to quality care for individuals with limited
25 English proficiency and individuals with communica-

1 tion disabilities such as cognitive, hearing, vision, or
2 print impairments.

3 (10) Access to English as a second language,
4 foreign language, and sign language interpreters,
5 translated and alternative format documents, read-
6 ers, and other auxiliary aids and services, are essen-
7 tial to ensure effective communication and eliminate
8 the language barriers that impede access to health
9 care.

10 (11) Competent language services in health care
11 settings should be available as a matter of course.

12 **SEC. 202. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
13 **UALS WITH LIMITED ENGLISH PROFICIENCY.**

14 (a) PURPOSE.—Consistent with the goals provided in
15 Executive Order 13166 (42 U.S.C. 2000d–1 note; relating
16 to improving access to services for persons with limited
17 English proficiency), it is the purpose of this section—

18 (1) to improve Federal agency performance re-
19 garding access to federally conducted and federally
20 assisted programs and activities for individuals with
21 limited English proficiency;

22 (2) to require each Federal agency to examine
23 the services it provides and develop and implement
24 a system by which individuals with limited English
25 proficiency can obtain culturally competence services

1 and meaningful access to those services consistent
2 with, and without substantially burdening, the fun-
3 damental mission of the agency;

4 (3) to require each Federal agency to ensure
5 that recipients of Federal financial assistance pro-
6 vide culturally competence services and meaningful
7 access to applicants and beneficiaries that are indi-
8 viduals with limited English proficiency;

9 (4) to ensure that recipients of Federal finan-
10 cial assistance take reasonable steps, consistent with
11 the guidelines set forth in the “Guidance to Federal
12 Financial Assistance Recipients Regarding Title VI
13 Prohibition Against National Origin Discrimination
14 Affecting Limited English Proficient Persons (67
15 Fed. Reg. 41455 (June 18, 2002))”, to ensure cul-
16 turally and linguistically appropriate access to their
17 programs and activities by individuals with limited
18 English proficiency; and

19 (5) to ensure compliance with title VI of the
20 Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
21 and section 1557 of the Patient Protection and Af-
22 fordable Care Act (42 U.S.C. 18116) as published in
23 the Federal Register on May 18, 2016, that health
24 care providers and organizations do not discriminate
25 in the provision of services.

1 (b) FEDERALLY CONDUCTED PROGRAMS AND AC-
2 TIVITIES.—

3 (1) IN GENERAL.—Not later than 120 days
4 after the date of enactment of this Act, each Federal
5 agency providing financial assistance to, or admin-
6 istering, a health program or activity described in
7 section 203(a) shall prepare a plan or update their
8 current plan to improve culturally and linguistically
9 appropriate access to such program or activity with
10 respect to individuals with limited English pro-
11 ficiency. Not later than 1 year after the date of en-
12 actment of this title, each such Federal agency shall
13 ensure that such plan is fully implemented.

14 (2) PLAN REQUIREMENT.—Each plan under
15 paragraph (1) shall include—

16 (A) the steps the agency will take to en-
17 sure that individuals with limited English pro-
18 ficiency have access to each health program or
19 activity supported or administered by the agen-
20 cy;

21 (B) the policies and procedures for identi-
22 fying, assessing, and meeting the culturally and
23 linguistically appropriate language needs of its
24 beneficiaries that are individuals with limited

1 English proficiency served by such program or
2 activity;

3 (C) the steps the agency will take for such
4 program or activity to be culturally and linguis-
5 tically appropriate by providing a range of lan-
6 guage assistance options, notice to individuals
7 with limited English proficiency of the right to
8 competent language services, periodic training
9 of staff, monitoring and quality assessment of
10 the language services and, in appropriate cir-
11 cumstances, the translation of written mate-
12 rials;

13 (D) the steps the agency will take for such
14 program or activity to provide reasonable ac-
15 commodations necessary for individuals with
16 limited English proficiency and communication
17 disabilities to understand communications from
18 the agency;

19 (E) the steps the agency will take to en-
20 sure that applications, forms, and other rel-
21 evant documents for such program or activity
22 are competently translated into the primary
23 language of a client that is an individual with
24 limited English proficiency where such mate-

1 rials are needed to improve access of such client
2 to such program or activity;

3 (F) the resources the agency will provide
4 to improve cultural and linguistic appropriate-
5 ness to assist recipients of Federal funds to im-
6 prove access to health-care-related programs
7 and activities for individuals with limited
8 English proficiency;

9 (G) the resources the agency will provide
10 to ensure that competent language assistance is
11 provided to patients that are individuals with
12 limited English proficiency by interpreters or
13 trained bilingual staff; and

14 (H) the resources the agency will provide
15 to ensure that family, particularly minor chil-
16 dren, and friends are not used to provide inter-
17 pretation services, except as permitted under
18 regulations implementing section 1557 of the
19 Patient Protection and Affordable Care Act (42
20 U.S.C. 18116) as published in the Federal Reg-
21 ister on May 18, 2016.

22 (3) SUBMISSION OF PLAN TO DOJ.—Each agen-
23 cy that is required to prepare a plan under para-
24 graph (1) shall send a copy of such plan to the At-

1 torney General, which shall serve as the central re-
2 pository of all such plans.

3 **SEC. 203. ENSURING STANDARDS FOR CULTURALLY AND**
4 **LINGUISTICALLY APPROPRIATE SERVICES IN**
5 **HEALTH CARE.**

6 (a) **APPLICABILITY.**—This section shall apply to any
7 health program or activity, any part of which is receiving
8 Federal financial assistance, including credits, subsidies,
9 or contracts of insurance, or any program or activity that
10 is administered by an executive agency or any entity estab-
11 lished under title I of the Patient Protection and Afford-
12 able Care Act (42 U.S.C. 18001 et seq.) (or amendments
13 made thereby).

14 (b) **STANDARDS.**—Each program or activity de-
15 scribed in subsection (a)—

16 (1) shall implement strategies to recruit, retain,
17 and promote individuals at all levels to maintain a
18 diverse staff and leadership that can provide cul-
19 turally and linguistically appropriate health care to
20 patient populations of the service area of the pro-
21 gram or activity;

22 (2) shall educate and train governance, leader-
23 ship, and workforce at all levels and across all dis-
24 ciplines of the program or activity in culturally and

1 linguistically appropriate policies and practices on an
2 ongoing basis at least yearly;

3 (3) shall offer and provide language assistance,
4 including trained and competent bilingual staff and
5 interpreter services, to individuals with limited
6 English proficiency or who have other communica-
7 tion needs, at no cost to the individual at all points
8 of contact, and during all hours of operation, to fa-
9 cilitate timely access to health care services and
10 health-care-related services;

11 (4) shall for each language group consisting of
12 individuals with limited English proficiency that con-
13 stitutes 5 percent or 500 individuals, whichever is
14 less, of the population of persons eligible to be
15 served or likely to be affected or encountered in the
16 service area of the program or activity, make avail-
17 able at a fifth grade reading level—

18 (A) easily understood patient-related mate-
19 rials, including print and multimedia materials,
20 in the language of such language group;

21 (B) information or notices about termi-
22 nation of benefits in such language;

23 (C) signage; and

24 (D) any other documents or types of docu-
25 ments designated by the Secretary;

1 (5) shall develop and implement clear goals,
2 policies, operational plans, and management, ac-
3 countability, and oversight mechanisms to provide
4 culturally and linguistically appropriate services and
5 infuse them throughout the planning and operations
6 of the program or activity;

7 (6) shall conduct initial and ongoing organiza-
8 tional assessments of culturally and linguistically ap-
9 propriate services-related activities and integrate
10 valid linguistic, competence-related National Stand-
11 ards for Culturally and Linguistically Appropriate
12 Services (CLAS) measures into the internal audits,
13 performance improvement programs, patient satis-
14 faction assessments, continuous quality improvement
15 activities, and outcomes-based evaluations of the
16 program or activity and develop ways to standardize
17 the assessments, and such assessments must occur
18 at least yearly;

19 (7) shall ensure that, consistent with the pri-
20 vacy protections provided for under the regulations
21 promulgated under section 264(c) of the Health In-
22 surance Portability and Accountability Act of 1996
23 (42 U.S.C. 1320–2 note), data on an individual re-
24 quired to be collected pursuant to section 3101, in-

1 including the individual's alternative format pref-
2 erences and policy modification needs, are—

3 (A) collected in health records;

4 (B) integrated into the management infor-
5 mation systems of the program or activity; and

6 (C) periodically updated;

7 (8) shall maintain a current demographic, cul-
8 tural, and epidemiological profile of the community,
9 conduct regular assessments of community health
10 assets and needs, and use the results of such assess-
11 ments to accurately plan for and implement services
12 that respond to the cultural and linguistic character-
13 istics of the service area of the program or activity;

14 (9) shall develop participatory, collaborative
15 partnerships with communities and utilize a variety
16 of formal and informal mechanisms to facilitate
17 community and patient involvement in designing,
18 implementing, and evaluating policies and practices
19 to ensure culturally and linguistically appropriate
20 service-related activities;

21 (10) shall ensure that conflict and grievance
22 resolution processes are culturally and linguistically
23 appropriate and capable of identifying, preventing,
24 and resolving cross-cultural conflicts or complaints
25 by patients;

1 (11) shall regularly make available to the public
2 information about their progress and successful in-
3 novations in implementing the standards under this
4 section and provide public notice in their commu-
5 nities about the availability of this information; and

6 (12) shall, if requested, regularly make avail-
7 able to the head of each Federal entity from which
8 Federal funds are provided, information about the
9 progress and successful innovations of the program
10 or activity in implementing the standards under this
11 section as required by the head of such entity.

12 (c) COMMENTS ACCEPTED THROUGH NOTICE AND
13 COMMENT RULEMAKING.—An agency carrying out a pro-
14 gram described in subsection (a) shall ensure that com-
15 ments with respect to such program that are accepted
16 through notice and comment rulemaking be accepted in
17 all languages, may not require such comments to be sub-
18 mitted only in English, and must ensure these comments
19 are considered equally as comments submitted in English
20 during the agency’s review of comments submitted.

21 **SEC. 204. CULTURALLY AND LINGUISTICALLY APPRO-**
22 **PRIATE HEALTH CARE IN THE PUBLIC**
23 **HEALTH SERVICE ACT.**

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

1 **“TITLE XXXIV—CULTURALLY**
2 **AND LINGUISTICALLY APPRO-**
3 **PRIATE HEALTH CARE**

4 **“SEC. 3400. DEFINITIONS.**

5 “(a) IN GENERAL.—In this title:

6 “(1) BILINGUAL.—The term ‘bilingual’, with
7 respect to an individual, means a person who has
8 sufficient degree of proficiency in 2 languages.

9 “(2) CULTURAL.—The term ‘cultural’ means
10 relating to integrated patterns of human behavior
11 that include the language, thoughts, communica-
12 tions, actions, customs, beliefs, values, and institu-
13 tions of racial, ethnic, religious, or social groups, in-
14 cluding lesbian, gay, bisexual, transgender, queer,
15 and questioning individuals, and individuals with
16 physical and mental disabilities.

17 “(3) CULTURALLY AND LINGUISTICALLY AP-
18 PROPRIATE.—The term ‘culturally and linguistically
19 appropriate’ means being respectful of and respon-
20 sive to the cultural and linguistic needs of all indi-
21 viduals.

22 “(4) EFFECTIVE COMMUNICATION.—The term
23 ‘effective communication’ means an exchange of in-
24 formation between the provider of health care or
25 health-care-related services and the recipient of such

1 services who is limited in English proficiency, or has
2 a communication impairment such as a hearing, vi-
3 sion, speaking, or learning impairment, that enables
4 access to, understanding of, and benefit from health
5 care or health-care-related services, and full partici-
6 pation in the development of their treatment plan.

7 “(5) GRIEVANCE RESOLUTION PROCESS.—The
8 term ‘grievance resolution process’ means all aspects
9 of dispute resolution including filing complaints,
10 grievance and appeal procedures, and court action.

11 “(6) HEALTH CARE GROUP.—The term ‘health
12 care group’ means a group of physicians organized,
13 at least in part, for the purposes of providing physi-
14 cian services under the Medicaid program under title
15 XIX of the Social Security Act, the State Children’s
16 Health Insurance Program under title XXI of such
17 Act, or the Medicare program under title XVIII of
18 such Act and may include a hospital and any other
19 individual or entity furnishing services covered under
20 any such program that is affiliated with the health
21 care group.

22 “(7) HEALTH CARE SERVICES.—The term
23 ‘health care services’ means services that address
24 physical as well as mental health conditions in all
25 care settings.

1 “(8) HEALTH-CARE-RELATED SERVICES.—The
2 term ‘health-care-related services’ means human or
3 social services programs or activities that provide ac-
4 cess, referrals, or links to health care.

5 “(9) HEALTH EDUCATOR.—The term ‘health
6 educator’ includes a professional with a bacca-
7 laurate degree who is responsible for designing, im-
8 plementing, and evaluating individual and population
9 health promotion and chronic disease prevention pro-
10 grams.

11 “(10) INDIAN; INDIAN TRIBE.—The terms ‘In-
12 dian’ and ‘Indian Tribe’ have the meanings given
13 such terms in section 4 of the Indian Self-Deter-
14 mination and Education Assistance Act.

15 “(11) INDIVIDUAL WITH A DISABILITY.—The
16 term ‘individual with a disability’ means any indi-
17 vidual who has a disability as defined for the pur-
18 pose of section 504 of the Rehabilitation Act of
19 1973.

20 “(12) INDIVIDUAL WITH LIMITED ENGLISH
21 PROFICIENCY.—The term ‘individual with limited
22 English proficiency’ means an individual whose pri-
23 mary language for communication is not English
24 and who has a limited ability to read, write, speak,
25 or understand English.

1 “(13) INTEGRATED HEALTH CARE DELIVERY
2 SYSTEM.—The term ‘integrated health care delivery
3 system’ means an interdisciplinary system that
4 brings together providers from the primary health,
5 mental health, substance use disorder, and related
6 disciplines to improve the health outcomes of an in-
7 dividual. Such providers may include hospitals,
8 health, mental health, or substance use disorder clin-
9 ics and providers, home health agencies, ambulatory
10 surgery centers, skilled nursing facilities, rehabilita-
11 tion centers, and employed, independent, or con-
12 tracted physicians.

13 “(14) INTERPRETING; INTERPRETATION.—The
14 terms ‘interpreting’ and ‘interpretation’ mean the
15 transmission of a spoken, written, or signed message
16 from one language or format into another, faithfully,
17 accurately, and objectively.

18 “(15) LANGUAGE ACCESS.—The term ‘language
19 access’ means the provision of language services to
20 an individual with limited English proficiency or an
21 individual with communication disabilities designed
22 to enhance that individual’s access to, understanding
23 of, or benefit from health care services or health-
24 care-related services.

1 “(16) LANGUAGE ASSISTANCE SERVICES.—The
2 term ‘language assistance services’ includes—

3 “(A) oral language assistance, including in-
4 terpretation in non-English languages provided
5 in-person or remotely by a qualified interpreter
6 for an individual with limited English pro-
7 ficiency, and the use of qualified bilingual or
8 multilingual staff to communicate directly with
9 individuals with limited English proficiency;

10 “(B) written translation, performed by a
11 qualified and competent translator, of written
12 content in paper or electronic form into lan-
13 guages other than English; and

14 “(C) taglines.

15 “(17) MINORITY.—

16 “(A) IN GENERAL.—The terms ‘minority’
17 and ‘minorities’ refer to individuals from a mi-
18 nority group.

19 “(B) POPULATIONS.—The term ‘minority’,
20 with respect to populations, refers to racial and
21 ethnic minority groups, members of sexual and
22 gender minority groups, and individuals with a
23 disability.

1 “(18) MINORITY GROUP.—The term ‘minority
2 group’ has the meaning given the term ‘racial and
3 ethnic minority group’.

4 “(19) ONSITE INTERPRETATION.—The term
5 ‘onsite interpretation’ means a method of inter-
6 preting or interpretation for which the interpreter is
7 in the physical presence of the provider of health
8 care services or health-care-related services and the
9 recipient of such services who is limited in English
10 proficiency or has a communication impairment such
11 as an impairment in hearing, vision, or learning.

12 “(20) QUALIFIED INDIVIDUAL WITH A DIS-
13 ABILITY.—The term ‘qualified individual with a dis-
14 ability’ means, with respect to a health program or
15 activity, an individual with a disability who, with or
16 without reasonable modifications to policies, prac-
17 tices, or procedures, the removal of architectural,
18 communication, or transportation barriers, or the
19 provision of auxiliary aids and services, meets the es-
20 sential eligibility requirements for the receipt of aids,
21 benefits, or services offered or provided by the health
22 program or activity.

23 “(21) QUALIFIED INTERPRETER FOR AN INDI-
24 VIDUAL WITH A DISABILITY.—The term ‘qualified

1 interpreter for an individual with a disability’, for an
2 individual with a disability—

3 “(A) means an interpreter who by means
4 of a remote interpreting service or an onsite ap-
5 pearance—

6 “(i) adheres to generally accepted in-
7 terpreter ethics principles, including client
8 confidentiality; and

9 “(ii) is able to interpret effectively, ac-
10 curately, and impartially, both receptively
11 and expressively, using any necessary spe-
12 cialized vocabulary, terminology, and phra-
13 seology; and

14 “(B) may include sign language inter-
15 preters, oral transliterators (individuals who
16 represent or spell in the characters of another
17 alphabet), and cued language transliterators
18 (individuals who represent or spell by using a
19 small number of handshapes).

20 “(22) QUALIFIED INTERPRETER FOR AN INDI-
21 VIDUAL WITH LIMITED ENGLISH PROFICIENCY.—

22 The term ‘qualified interpreter for an individual with
23 limited English proficiency’ means an interpreter
24 who via a remote interpreting service or an onsite
25 appearance—

1 “(A) adheres to generally accepted inter-
2 preter ethics principles, including client con-
3 fidentiality;

4 “(B) has demonstrated proficiency in
5 speaking and understanding both spoken
6 English and one or more other spoken lan-
7 guages; and

8 “(C) is able to interpret effectively, accu-
9 rately, and impartially, both receptively and ex-
10 pressly, to and from such languages and
11 English, using any necessary specialized vocab-
12 ulary, terminology, and phraseology.

13 “(23) QUALIFIED TRANSLATOR.—The term
14 ‘qualified translator’ means a translator who—

15 “(A) adheres to generally accepted trans-
16 lator ethics principles, including client confiden-
17 tiality;

18 “(B) has demonstrated proficiency in writ-
19 ing and understanding both written English
20 and one or more other written non-English lan-
21 guages; and

22 “(C) is able to translate effectively, accu-
23 rately, and impartially to and from such lan-
24 guages and English, using any necessary spe-

1 cialized vocabulary, terminology, and phrase-
2 ology.

3 “(24) RACIAL AND ETHNIC MINORITY GROUP.—

4 The term ‘racial and ethnic minority group’ means
5 Indians and Alaska Natives, African Americans (in-
6 cluding Caribbean Blacks, Africans, and other
7 Blacks), Asian Americans, Hispanics (including
8 Latinos), and Native Hawaiians and other Pacific
9 Islanders.

10 “(25) SEXUAL AND GENDER MINORITY

11 GROUP.—The term ‘sexual and gender minority
12 group’ encompasses lesbian, gay, bisexual, and
13 transgender populations, as well as those whose sex-
14 ual orientation, gender identity and expression, or
15 reproductive development varies from traditional, so-
16 cietal, cultural, or physiological norms.

17 “(26) SIGHT TRANSLATION.—The term ‘sight

18 translation’ means the transmission of a written
19 message in one language into a spoken or signed
20 message in another language, or an alternative for-
21 mat in English or another language.

22 “(27) STATE.—Notwithstanding section 2, the

23 term ‘State’ means each of the several States, the
24 District of Columbia, the Commonwealth of Puerto
25 Rico, the United States Virgin Islands, Guam,

1 American Samoa, and the Commonwealth of the
2 Northern Mariana Islands.

3 “(28) TELEPHONIC INTERPRETATION.—The
4 term ‘telephonic interpretation’ (also known as ‘over
5 the phone interpretation’ or ‘OPI’) means, with re-
6 spect to interpretation for an individual with limited
7 English proficiency, a method of interpretation in
8 which the interpreter is not in the physical presence
9 of the provider of health care services or health-care-
10 related services and such individual receiving such
11 services, but the interpreter is connected via tele-
12 phone.

13 “(29) TRANSLATION.—The term ‘translation’
14 means the transmission of a written message in one
15 language into a written or signed message in an-
16 other language, and includes translation into an-
17 other language or alternative format, such as large
18 print font, Braille, audio recording, or CD.

19 “(30) VIDEO REMOTE INTERPRETING SERV-
20 ICES.—The term ‘video remote interpreting services’
21 means the provision, in health care services or
22 health-care-related services, through a qualified in-
23 terpreter for an individual with limited English pro-
24 ficiency, of video remote interpreting services that
25 are—

1 “(A) in real-time, full-motion video, and
2 audio over a dedicated high-speed, wide-band-
3 width video connection or wireless connection
4 that delivers high-quality video images that do
5 not produce lags, choppy, blurry, or grainy im-
6 ages, or irregular pauses in communication; and

7 “(B) in a sharply delineated image that is
8 large enough to display.

9 “(31) VITAL DOCUMENT.—The term ‘vital doc-
10 ument’ includes applications for government pro-
11 grams that provide health care services, medical or
12 financial consent forms, financial assistance docu-
13 ments, letters containing important information re-
14 garding patient instructions (such as prescriptions,
15 referrals to other providers, and discharge plans)
16 and participation in a program (such as a Medicaid
17 managed care program), notices pertaining to the
18 reduction, denial, or termination of services or bene-
19 fits, notices of the right to appeal such actions, and
20 notices advising individuals with limited English pro-
21 ficiency with communication disabilities of the avail-
22 ability of free language services, alternative formats,
23 and other outreach materials.

24 “(b) REFERENCE.—In any reference in this title to
25 a regulatory provision applicable to a ‘handicapped indi-

1 vidual’, the term ‘handicapped individual’ in such provi-
 2 sion shall have the same meaning as the term ‘individual
 3 with a disability’ as defined in subsection (a).

4 **“Subtitle A—Resources and Innova-**
 5 **tion for Culturally and Linguis-**
 6 **tically Appropriate Health Care**

7 **“SEC. 3401. ROBERT T. MATSUI CENTER FOR CULTURALLY**
 8 **AND LINGUISTICALLY APPROPRIATE HEALTH**
 9 **CARE.**

10 “(a) ESTABLISHMENT.—The Secretary, acting
 11 through the Director of the Agency for Healthcare Re-
 12 search and Quality, shall establish and support a center
 13 to be known as the ‘Robert T. Matsui Center for Cul-
 14 turally and Linguistically Appropriate Health Care’ (re-
 15 ferred to in this section as the ‘Center’) to carry out each
 16 of the following activities:

17 “(1) INTERPRETATION SERVICES.—The Center
 18 shall provide resources via the internet to identify
 19 and link health care providers to competent inter-
 20 preter and translation services.

21 “(2) TRANSLATION OF WRITTEN MATERIAL.—
 22 “(A) VITAL DOCUMENTS.—The Center
 23 shall provide, directly or through contract, vital
 24 documents from competent translation services
 25 for providers of health care services and health-

1 care-related services at no cost to such pro-
2 viders. Such documents may be submitted by
3 covered entities (as defined in section 92.4 of
4 title 42, Code of Federal Regulations, as in ef-
5 fect on May 16, 2016) for translation into non-
6 English languages or alternative formats at a
7 fifth-grade reading level. Such translation serv-
8 ices shall be provided in a timely and reason-
9 able manner. The quality of such translation
10 services shall be monitored and reported pub-
11 licly.

12 “(B) FORMS.—For each form developed or
13 revised by the Secretary that will be used by in-
14 dividuals with limited English proficiency in
15 health care or health-care-related settings, the
16 Center shall translate the form, at a minimum,
17 into the top 15 non-English languages in the
18 United States according to the most recent data
19 from the American Community Survey or its re-
20 placement. The translation shall be completed
21 within 45 calendar days of the Secretary receiv-
22 ing final approval of the form from the Office
23 of Management and Budget. The Center shall
24 post all translated forms on its website so that
25 other entities may use the same translations.

1 “(3) TOLL-FREE CUSTOMER SERVICE TELE-
2 PHONE NUMBER.—The Center shall provide,
3 through a toll-free number, a customer service line
4 for individuals with limited English proficiency—

5 “(A) to obtain information about federally
6 conducted or funded health programs, including
7 the Medicare program under title XVIII of the
8 Social Security Act, the Medicaid program
9 under title XIX of such Act, and the State Chil-
10 dren’s Health Insurance Program under title
11 XXI of such Act, marketplace coverage avail-
12 able pursuant to title XXVII of this Act and
13 the Patient Protection and Affordable Care Act,
14 and other sources of free or reduced care in-
15 cluding federally qualified health centers, title
16 X clinics, and public health departments;

17 “(B) to obtain assistance with applying for
18 or accessing these programs and understanding
19 Federal notices written in English; and

20 “(C) to learn how to access language serv-
21 ices.

22 “(4) HEALTH INFORMATION CLEARING-
23 HOUSE.—

24 “(A) IN GENERAL.—The Center shall de-
25 velop and maintain an information clearing-

1 house to facilitate the provision of language
2 services by providers of health care services and
3 health-care-related services to reduce medical
4 errors, improve medical outcomes, improve cul-
5 tural competence, reduce health care costs
6 caused by miscommunication with individuals
7 with limited English proficiency, and reduce or
8 eliminate the duplication of efforts to translate
9 materials. The clearinghouse shall include the
10 information described in subparagraphs (B)
11 through (F) and make such information avail-
12 able on the internet and in print.

13 “(B) DOCUMENT TEMPLATES.—The Cen-
14 ter shall collect and evaluate for accuracy, de-
15 velop, and make available templates for stand-
16 ard documents that are necessary for patients
17 and consumers to access and make educated de-
18 cisions about their health care, including tem-
19 plates for each of the following:

20 “(i) Administrative and legal docu-
21 ments, including—

22 “(I) intake forms;

23 “(II) forms related to the Medi-
24 care program under title XVIII of the
25 Social Security Act, the Medicaid pro-

1 gram under title XIX of such Act,
2 and the State Children’s Health In-
3 surance Program under title XXI of
4 such Act, including eligibility informa-
5 tion for such programs;

6 “(III) forms informing patients
7 of the compliance and consent re-
8 quirements pursuant to the regula-
9 tions under section 264(c) of the
10 Health Insurance Portability and Ac-
11 countability Act of 1996 (42 U.S.C.
12 1320–2 note); and

13 “(IV) documents concerning in-
14 formed consent, advanced directives,
15 and waivers of rights.

16 “(ii) Clinical information, such as how
17 to take medications, how to prevent trans-
18 mission of a contagious disease, and other
19 prevention and treatment instructions.

20 “(iii) Public health, patient education,
21 and outreach materials, such as immuniza-
22 tion notices, health warnings, or screening
23 notices.

1 “(iv) Additional health or health-care-
2 related materials as determined appro-
3 priate by the Director of the Center.

4 “(C) STRUCTURE OF FORMS.—In oper-
5 ating the clearinghouse, the Center shall—

6 “(i) ensure that the documents posted
7 in English and non-English languages are
8 culturally and linguistically appropriate;

9 “(ii) allow public review of the docu-
10 ments before dissemination in order to en-
11 sure that the documents are understand-
12 able and culturally and linguistically ap-
13 propriate for the target populations;

14 “(iii) allow health care providers to
15 customize the documents for their use;

16 “(iv) facilitate access to these docu-
17 ments;

18 “(v) provide technical assistance with
19 respect to the access and use of such infor-
20 mation; and

21 “(vi) carry out any other activities the
22 Secretary determines to be useful to fulfill
23 the purposes of the clearinghouse.

24 “(D) LANGUAGE ASSISTANCE PRO-
25 GRAMS.—The Center shall provide for the col-

1 lection and dissemination of information on cur-
2 rent examples of language assistance programs
3 and strategies to improve language services for
4 individuals with limited English proficiency, in-
5 cluding case studies using de-identified patient
6 information, program summaries, and program
7 evaluations.

8 “(E) CULTURALLY AND LINGUISTICALLY
9 APPROPRIATE MATERIALS.—The Center shall
10 provide information relating to culturally and
11 linguistically appropriate health care for minor-
12 ity populations residing in the United States to
13 all health care providers and health-care-related
14 services at no cost. Such information shall in-
15 clude—

16 “(i) tenets of culturally and linguis-
17 tically appropriate care;

18 “(ii) culturally and linguistically ap-
19 propriate self-assessment tools;

20 “(iii) culturally and linguistically ap-
21 propriate training tools;

22 “(iv) strategic plans to increase cul-
23 tural and linguistic appropriateness in dif-
24 ferent types of providers of health care
25 services and health-care-related services,

1 including regional collaborations among
2 health care organizations; and

3 “(v) culturally and linguistically ap-
4 propriate information for educators, practi-
5 tioners, and researchers.

6 “(F) TRANSLATION GLOSSARIES.—The
7 Center shall—

8 “(i) develop and publish on its website
9 translation glossaries that provide stand-
10 ardized translations of commonly used
11 terms and phrases utilized in documents
12 translated by the Center; and

13 “(ii) make these glossaries available—

14 “(I) free of charge;

15 “(II) in the 15 languages in
16 which the Center translates materials;
17 and

18 “(III) in alternative formats in
19 accordance with the Americans with
20 Disabilities Act of 1990 (42 U.S.C.
21 12101 et seq.).

22 “(G) INFORMATION ABOUT PROGRESS.—
23 The Center shall regularly collect and make
24 publicly available information about the
25 progress of entities receiving grants under sec-

1 tion 3402 regarding successful innovations in
2 implementing the obligations under this sub-
3 section and provide public notice in the entities’
4 communities about the availability of this infor-
5 mation.

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

10 “(c) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
11 rector shall collaborate with the Deputy Assistant Sec-
12 retary for Minority Health, the Administrator of the Cen-
13 ters for Medicare & Medicaid Services, and the Adminis-
14 trator of the Health Resources and Services Administra-
15 tion to notify health care providers and health care organi-
16 zations about the availability of language access services
17 by the Center.

18 “(d) EDUCATION.—The Secretary, directly or
19 through contract, shall undertake a national education
20 campaign to inform providers, individuals with limited
21 English proficiency, individuals with hearing or vision im-
22 pairments, health professionals, graduate schools, and
23 community health centers about—

24 “(1) Federal and State laws and guidelines gov-
25 erning access to language services;

1 “(2) the value of using trained and competent
2 interpreters and the risks associated with using fam-
3 ily members, friends, minors, and untrained bilin-
4 gual staff;

5 “(3) funding sources for developing and imple-
6 menting language services; and

7 “(4) promising practices to effectively provide
8 language services.

9 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section
11 \$5,000,000 for each of fiscal years 2021 through 2025.

12 **“SEC. 3402. INNOVATIONS IN CULTURALLY AND LINGUIS-**
13 **TICALLY APPROPRIATE HEALTH CARE**
14 **GRANTS.**

15 “(a) IN GENERAL.—

16 “(1) GRANTS.—The Secretary, acting through
17 the Director of the Agency for Healthcare Research
18 and Quality, shall award grants to eligible entities to
19 enable such entities to design, implement, and evalu-
20 ate innovative, cost-effective programs to improve
21 culturally and linguistically appropriate access to
22 health care services for individuals with limited
23 English proficiency.

24 “(2) COORDINATION.—The Director of the
25 Agency for Healthcare Research and Quality shall

1 coordinate with, and ensure the participation of,
2 other agencies including the Health Resources and
3 Services Administration, the National Institute on
4 Minority Health and Health Disparities at the Na-
5 tional Institutes of Health, and the Office of Minor-
6 ity Health, regarding the design and evaluation of
7 the grants program.

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

10 “(1) be—

11 “(A) a city, county, Indian Tribe, State, or
12 subdivision thereof;

13 “(B) an organization described in section
14 501(c)(3) of the Internal Revenue Code of 1986
15 and exempt from tax under section 501(a) of
16 such Code;

17 “(C) a community health, mental health,
18 or substance use disorder center or clinic;

19 “(D) a solo or group physician practice;

20 “(E) an integrated health care delivery
21 system;

22 “(F) a public hospital;

23 “(G) a health care group, university, or
24 college; or

1 “(H) any other entity designated by the
2 Secretary; and

3 “(2) prepare and submit to the Secretary an
4 application, at such time, in such manner, and con-
5 taining such additional information as the Secretary
6 may reasonably require.

7 “(c) USE OF FUNDS.—An entity shall use funds re-
8 ceived through a grant under this section to—

9 “(1) develop, implement, and evaluate models of
10 providing competent interpretation services through
11 onsite interpretation, telephonic interpretation, or
12 video remote interpreting services;

13 “(2) implement strategies to recruit, retain, and
14 promote individuals at all levels of the organization
15 to maintain a diverse staff and leadership that can
16 promote and provide language services to patient
17 populations of the service area of the entity;

18 “(3) develop and maintain a needs assessment
19 that identifies the current demographic, cultural,
20 and epidemiological profile of the community to ac-
21 curately plan for and implement language services
22 needed in the service area of the entity;

23 “(4) develop a strategic plan to implement lan-
24 guage services;

1 “(5) develop participatory, collaborative part-
2 nerships with communities encompassing the patient
3 populations of individuals with limited English pro-
4 ficiency served by the grant to gain input in design-
5 ing and implementing language services;

6 “(6) develop and implement grievance resolu-
7 tion processes that are culturally and linguistically
8 appropriate and capable of identifying, preventing,
9 and resolving complaints by individuals with limited
10 English proficiency;

11 “(7) develop short-term medical and mental
12 health interpretation training courses and incentives
13 for bilingual health care staff who are asked to pro-
14 vide interpretation services in the workplace;

15 “(8) develop formal training programs, includ-
16 ing continued professional development and edu-
17 cation programs as well as supervision, for individ-
18 uals interested in becoming dedicated health care in-
19 terpreters and culturally and linguistically appro-
20 priate providers;

21 “(9) provide staff language training instruction,
22 which shall include information on the practical limi-
23 tations of such instruction for nonnative speakers;

1 “(10) develop policies that address compensa-
2 tion in salary for staff who receive training to be-
3 come either a staff interpreter or bilingual provider;

4 “(11) develop other language assistance services
5 as determined appropriate by the Secretary;

6 “(12) develop, implement, and evaluate models
7 of improving cultural competence, including cultural
8 competence programs for community health workers;
9 and

10 “(13) ensure that, consistent with the privacy
11 protections provided for under the regulations pro-
12 mulgated under section 264(c) of the Health Insur-
13 ance Portability and Accountability Act of 1996 and
14 any applicable State privacy laws, data on the indi-
15 vidual patient or recipient’s race, ethnicity, and pri-
16 mary language are collected (and periodically up-
17 dated) in health records and integrated into the or-
18 ganization’s information management systems or
19 any similar system used to store and retrieve data.

20 “(d) PRIORITY.—In awarding grants under this sec-
21 tion, the Secretary shall give priority to entities that pri-
22 marily engage in providing direct care and that have devel-
23 oped partnerships with community organizations or with
24 agencies with experience in improving language access.

25 “(e) EVALUATION.—

1 “(1) BY GRANTEES.—An entity that receives a
2 grant under this section shall submit to the Sec-
3 retary an evaluation that describes, in the manner
4 and to the extent required by the Secretary, the ac-
5 tivities carried out with funds received under the
6 grant, and how such activities improved access to
7 health care services and health-care-related services
8 and the quality of health care for individuals with
9 limited English proficiency. Such evaluation shall be
10 collected and disseminated through the Robert T.
11 Matsui Center for Culturally and Linguistically Ap-
12 propriate Health Care established under section
13 3401. The Director of the Agency for Healthcare
14 Research and Quality shall notify grantees of the
15 availability of technical assistance for the evaluation
16 and provide such assistance upon request.

17 “(2) BY SECRETARY.—The Director of the
18 Agency for Healthcare Research and Quality shall
19 evaluate or arrange with other individuals or organi-
20 zations to evaluate projects funded under this sec-
21 tion.

22 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
23 is authorized to be appropriated to carry out this section
24 \$5,000,000 for each of fiscal years 2021 through 2025.

1 **“SEC. 3403. 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 services.

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 conduct such re-
11 search.

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

15 “(1) To identify the barriers to mental and be-
16 havioral services that are faced by individuals with
17 limited English proficiency.

18 “(2) To identify health care providers’ and
19 health administrators’ attitudes, knowledge, and
20 awareness of the barriers to quality health care serv-
21 ices that are faced by individuals with limited
22 English proficiency.

23 “(3) To identify optimal approaches for deliv-
24 ering language access.

25 “(4) To identify best practices for data collec-
26 tion, including—

1 “(A) the collection by providers of health
2 care services and health-care-related services of
3 data on the race, ethnicity, and primary lan-
4 guage of recipients of such services, taking into
5 account existing research conducted by the Gov-
6 ernment or private sector;

7 “(B) the development and implementation
8 of data collection and reporting systems; and

9 “(C) effective privacy safeguards for col-
10 lected data.

11 “(5) To develop a minimum data collection set
12 for primary language.

13 “(6) To evaluate the most effective ways in
14 which the Secretary can create or coordinate, and
15 subsidize or otherwise fund, telephonic interpretation
16 services for health care providers, taking into consid-
17 eration, among other factors, the flexibility necessary
18 for such a system to accommodate variations in—

19 “(A) provider type;

20 “(B) languages needed and their frequency
21 of use;

22 “(C) type of encounter;

23 “(D) time of encounter, including regular
24 business hours and after hours; and

25 “(E) location of encounter.

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$5,000,000 for each of fiscal years 2021 through 2025.”.

4 **SEC. 205. PILOT PROGRAM FOR IMPROVEMENT AND DE-**
5 **VELOPMENT OF STATE MEDICAL INTER-**
6 **PRETING SERVICES.**

7 (a) GRANTS AUTHORIZED.—The Secretary of Health
8 and Human Services shall award 1 grant in accordance
9 with this section to each of 3 States (to be selected by
10 the Secretary) to assist each such State in designing, im-
11 plementing, and evaluating a statewide program to provide
12 onsite interpreter services under the State Medicaid plan.

13 (b) GRANT PERIOD.—A grant awarded under this
14 section is authorized for the period of 3 fiscal years begin-
15 ning on October 1, 2021, and ending on September 30,
16 2024.

17 (c) PREFERENCE.—In awarding a grant under this
18 section, the Secretary shall give preference to a State—

19 (1) that has a high proportion of qualified LEP
20 enrollees, as determined by the Secretary;

21 (2) that has a large number of qualified LEP
22 enrollees, as determined by the Secretary;

23 (3) that has a high growth rate of the popu-
24 lation of individuals with limited English proficiency,
25 as determined by the Secretary; and

1 (4) that has a population of qualified LEP en-
2 rollees that is linguistically diverse, requiring inter-
3 preter services in at least 200 non-English lan-
4 guages.

5 (d) USE OF FUNDS.—A State receiving a grant under
6 this section shall use the grant funds to—

7 (1) ensure that all health care providers in the
8 State participating in the State Medicaid plan have
9 access to onsite interpreter services, for the purpose
10 of enabling effective communication between such
11 providers and qualified LEP enrollees during the
12 furnishing of items and services and administrative
13 interactions;

14 (2) establish, expand, procure, or contract for—

15 (A) a statewide health care information
16 technology system that is designed to achieve
17 efficiencies and economies of scale with respect
18 to onsite interpreter services provided to health
19 care providers in the State participating in the
20 State Medicaid plan; and

21 (B) an entity to administer such system,
22 the duties of which shall include—

23 (i) procuring and scheduling inter-
24 preter services for qualified LEP enrollees;

1 (ii) procuring and scheduling inter-
2 preter services for individuals with limited
3 English proficiency seeking to enroll in the
4 State Medicaid plan;

5 (iii) ensuring that interpreters receive
6 payment for interpreter services rendered
7 under the system; and

8 (iv) consulting regularly with organi-
9 zations representing consumers, inter-
10 preters, and health care providers; and

11 (3) develop mechanisms to establish, improve,
12 and strengthen the competency of the medical inter-
13 pretation workforce that serves qualified LEP enroll-
14 ees in the State, including a national certification
15 process that is valid, credible, and vendor-neutral.

16 (e) APPLICATION.—To receive a grant under this sec-
17 tion, a State shall submit an application at such time and
18 containing such information as the Secretary may require,
19 which shall include the following:

20 (1) A description of the language access needs
21 of individuals in the State enrolled in the State Med-
22 icaid plan.

23 (2) A description of the extent to which the
24 program will—

1 (A) use the grant funds for the purposes
2 described in subsection (d);

3 (B) meet the health care needs of rural
4 populations of the State; and

5 (C) collect information that accurately
6 tracks the language services requested by con-
7 sumers as compared to the language services
8 provided by health care providers in the State
9 participating in the State Medicaid plan.

10 (3) A description of how the program will be
11 evaluated, including a proposal for collaboration with
12 organizations representing interpreters, consumers,
13 and individuals with limited English proficiency.

14 (f) DEFINITIONS.—In this section:

15 (1) QUALIFIED LEP ENROLLEE.—The term
16 “qualified LEP enrollee” means an individual—

17 (A) who is limited English proficient; and

18 (B) who is enrolled in a State Medicaid
19 plan.

20 (2) STATE.—The term “State” has the mean-
21 ing given the term in section 1101(a)(1) of the So-
22 cial Security Act (42 U.S.C. 1301(a)(1)), for pur-
23 poses of title XIX of such Act (42 U.S.C. 1396 et
24 seq.).

1 (3) STATE MEDICAID PLAN.—The term “State
2 Medicaid plan” means a State plan under title XIX
3 of the Social Security Act (42 U.S.C. 1396 et seq.)
4 or a waiver of such a plan.

5 (4) UNITED STATES.—The term “United
6 States” has the meaning given the term in section
7 1101(a)(2) of the Social Security Act (42 U.S.C.
8 1301(a)(2)), for purposes of title XIX of such Act
9 (42 U.S.C. 1396 et seq.).

10 (g) CONTINUATION PAST DEMONSTRATION.—Any
11 State receiving a grant under this section must agree to
12 directly pay for language services in Medicaid for all Med-
13 icaid providers by the end of the grant period.

14 (h) FUNDING.—

15 (1) AUTHORIZATION OF APPROPRIATIONS.—
16 There is authorized to be appropriated \$5,000,000
17 to carry out this section.

18 (2) AVAILABILITY OF FUNDS.—Amounts appro-
19 priated pursuant to the authorization in paragraph
20 (1) are authorized to remain available without fiscal
21 year limitation.

22 (3) INCREASED FEDERAL FINANCIAL PARTICI-
23 PATION.—Section 1903(a)(2)(E) of the Social Secu-
24 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended by
25 inserting “(or, in the case of a State that was

1 awarded a grant under section 203 of the Health
2 Equity and Accountability Act of 2020, 100 percent
3 for each quarter occurring during the grant period
4 specified in subsection (b) of such section)” after
5 “75 percent”.

6 (i) LIMITATION.—No Federal funds awarded under
7 this section may be used to provide interpreter services
8 from a location outside the United States.

9 **SEC. 206. TRAINING TOMORROW'S DOCTORS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE: GRADUATE MEDICAL EDUCATION.**

13 (a) DIRECT GRADUATE MEDICAL EDUCATION.—Sec-
14 tion 1886(h)(4) of the Social Security Act (42 U.S.C.
15 1395ww(h)(4)) is amended by adding at the end the fol-
16 lowing new subparagraph:

17 “(L) TREATMENT OF CULTURALLY AND
18 LINGUISTICALLY APPROPRIATE TRAINING.—In
19 determining a hospital’s number of full-time
20 equivalent residents for purposes of this sub-
21 section, all the time that is spent by an intern
22 or resident in an approved medical residency
23 training program for education and training in
24 culturally and linguistically appropriate service
25 delivery, which shall include all diverse popu-

1 lations including people with disabilities and the
2 Lesbian, gay, bisexual, transgender, queer,
3 questioning, questioning and intersex
4 (LGBTQIA) community, shall be counted to-
5 ward the determination of full-time equiva-
6 lency.”.

7 (b) INDIRECT MEDICAL EDUCATION.—Section
8 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
9 1395ww(d)(5)(B)) is amended—

10 (1) by redesignating the clause (x) added by
11 section 5505(b) of the Patient Protection and Af-
12 fordable Care Act as clause (xi); and

13 (2) by adding at the end the following new
14 clause:

15 “(xii) The provisions of subparagraph (L) of
16 subsection (h)(4) shall apply under this subpara-
17 graph in the same manner as they apply under such
18 subsection.”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 subsections (a) and (b) shall apply with respect to pay-
21 ments made to hospitals on or after the date that is one
22 year after the date of the enactment of this Act.

1 **SEC. 207. FEDERAL REIMBURSEMENT FOR CULTURALLY**
2 **AND LINGUISTICALLY APPROPRIATE SERV-**
3 **ICES UNDER THE MEDICARE, MEDICAID, AND**
4 **STATE CHILDREN'S HEALTH INSURANCE**
5 **PROGRAMS.**

6 (a) LANGUAGE ACCESS GRANTS FOR MEDICARE
7 PROVIDERS.—

8 (1) ESTABLISHMENT.—

9 (A) IN GENERAL.—Not later than 6
10 months after the date of the enactment of this
11 Act, the Secretary of Health and Human Serv-
12 ices, acting through the Centers for Medicare &
13 Medicaid Services and in consultation with the
14 Center for Medicare and Medicaid Innovation
15 (as referred to in section 1115A of the Social
16 Security Act (42 U.S.C. 1315a)), shall establish
17 a demonstration program under which the Sec-
18 retary shall award grants to eligible Medicare
19 service providers to improve communication be-
20 tween such providers and Medicare beneficiaries
21 who are limited English proficient, including
22 beneficiaries who live in diverse and under-
23 served communities.

24 (B) APPLICATION OF INNOVATION
25 RULES.—The demonstration project under sub-
26 paragraph (A) shall be conducted in a manner

1 that is consistent with the applicable provisions
2 of subsections (b), (c), and (d) of section 1115A
3 of the Social Security Act (42 U.S.C. 1315a).

4 (C) NUMBER OF GRANTS.—To the extent
5 practicable, the Secretary shall award not less
6 than 24 grants under this subsection.

7 (D) GRANT PERIOD.—Except as provided
8 under paragraph (2)(D), each grant awarded
9 under this subsection shall be for a 3-year pe-
10 riod.

11 (2) ELIGIBILITY REQUIREMENTS.—To be eligi-
12 ble for a grant under this subsection, an entity must
13 meet the following requirements:

14 (A) MEDICARE PROVIDER.—The entity
15 must be—

16 (i) a provider of services under part A
17 of title XVIII of the Social Security Act
18 (42 U.S.C. 1395c et seq.);

19 (ii) a provider of services under part
20 B of such title (42 U.S.C. 1395j et seq.);

21 (iii) a Medicare Advantage organiza-
22 tion offering a Medicare Advantage plan
23 under part C of such title (42 U.S.C.
24 1395w–21 et seq.); or

1 (iv) a PDP sponsor offering a pre-
2 scription drug plan under part D of such
3 title (42 U.S.C. 1395w–101 et seq.).

4 (B) UNDERSERVED COMMUNITIES.—The
5 entity must serve a community that, with re-
6 spect to necessary language services for improv-
7 ing access and utilization of health care among
8 English learners, is disproportionately under-
9 served.

10 (C) APPLICATION.—The entity must pre-
11 pare and submit to the Secretary an applica-
12 tion, at such time, in such manner, and accom-
13 panied by such additional information as the
14 Secretary may require.

15 (D) REPORTING.—In the case of a grantee
16 that received a grant under this subsection in
17 a previous year, such grantee is only eligible for
18 continued payments under a grant under this
19 subsection if the grantee met the reporting re-
20 quirements under paragraph (9) for such year.
21 If a grantee fails to meet the requirement of
22 such paragraph for the first year of a grant, the
23 Secretary may terminate the grant and solicit
24 applications from new grantees to participate in
25 the demonstration program.

1 (3) DISTRIBUTION.—To the extent feasible, the
2 Secretary shall award—

3 (A) at least 6 grants to providers of serv-
4 ices described in paragraph (2)(A)(i);

5 (B) at least 6 grants to service providers
6 described in paragraph (2)(A)(ii);

7 (C) at least 6 grants to organizations de-
8 scribed in paragraph (2)(A)(iii); and

9 (D) at least 6 grants to sponsors described
10 in paragraph (2)(A)(iv).

11 (4) CONSIDERATIONS IN AWARDING GRANTS.—

12 (A) VARIATION IN GRANTEES.—In award-
13 ing grants under this subsection, the Secretary
14 shall select grantees to ensure the following:

15 (i) The grantees provide many dif-
16 ferent types of language services.

17 (ii) The grantees serve Medicare bene-
18 ficiaries who speak different languages,
19 and who, as a population, have differing
20 needs for language services.

21 (iii) The grantees serve Medicare
22 beneficiaries in both urban and rural set-
23 tings.

1 (iv) The grantees serve Medicare
2 beneficiaries in at least two geographic re-
3 gions, as defined by the Secretary.

4 (v) The grantees serve Medicare bene-
5 ficiaries in at least two large metropolitan
6 statistical areas with racial, ethnic, sexual,
7 gender, disability, and economically diverse
8 populations.

9 (B) PRIORITY FOR PARTNERSHIPS WITH
10 COMMUNITY ORGANIZATIONS AND AGENCIES.—
11 In awarding grants under this subsection, the
12 Secretary shall give priority to eligible entities
13 that have a partnership with—

14 (i) a community organization; or
15 (ii) a consortia of community organi-
16 zations, State agencies, and local agencies,
17 that has experience in providing language serv-
18 ices.

19 (5) USE OF FUNDS FOR COMPETENT LANGUAGE
20 SERVICES.—

21 (A) IN GENERAL.—Subject to subpara-
22 graph (E), a grantee may only use grant funds
23 received under this subsection to pay for the
24 provision of competent language services to

1 Medicare beneficiaries who are English learn-
2 ers.

3 (B) COMPETENT LANGUAGE SERVICES DE-
4 FINED.—For purposes of this subsection, the
5 term “competent language services” means—

6 (i) interpreter and translation services
7 that—

8 (I) subject to the exceptions
9 under subparagraph (C)—

10 (aa) if the grantee operates
11 in a State that has statewide
12 health care interpreter standards,
13 meet the State standards cur-
14 rently in effect; or

15 (bb) if the grantee operates
16 in a State that does not have
17 statewide health care interpreter
18 standards, utilizes competent in-
19 terpreters who follow the Na-
20 tional Council on Interpreting in
21 Health Care’s Code of Ethics and
22 Standards of Practice and com-
23 ply with the requirements of sec-
24 tion 1557 of the Patient Protec-
25 tion and Affordable Care Act (42

1 U.S.C. 18116) as published in
2 the Federal Register on May 18,
3 2016; and

4 (II) that, in the case of inter-
5 preter services, are provided
6 through—

7 (aa) onsite interpretation;

8 (bb) telephonic interpreta-
9 tion; or

10 (cc) video interpretation;

11 and

12 (ii) the direct provision of health care
13 or health-care-related services by a com-
14 petent bilingual health care provider.

15 (C) EXCEPTIONS.—The requirements of
16 subparagraph (B)(i)(I) do not apply, with re-
17 spect to interpreter and translation services and
18 a grantee—

19 (i) in the case of a Medicare bene-
20 ficiary who is an English learner if—

21 (I) such beneficiary has been in-
22 formed, in the beneficiary's primary
23 language, of the availability of free in-
24 terpreter and translation services and
25 the beneficiary instead requests that a

1 family member, friend, or other per-
2 son provide such services; and

3 (II) the grantee documents such
4 request in the beneficiary's medical
5 record; or

6 (ii) in the case of a medical emergency
7 where the delay directly associated with ob-
8 taining a competent interpreter or trans-
9 lation services would jeopardize the health
10 of the patient.

11 Clause (ii) shall not be construed to exempt
12 emergency rooms or similar entities that regu-
13 larly provide health care services in medical
14 emergencies to patients who are English learn-
15 ers from any applicable legal or regulatory re-
16 quirements related to providing competent in-
17 terpreter and translation services without undue
18 delay.

19 (D) MEDICARE ADVANTAGE ORGANIZA-
20 TIONS AND PDP SPONSORS.—If a grantee is a
21 Medicare Advantage organization offering a
22 Medicare Advantage plan under part C of title
23 XVIII of the Social Security Act (42 U.S.C.
24 1395w–21 et seq.) or a PDP sponsor offering
25 a prescription drug plan under part D of such

1 title (42 U.S.C. 1395w–101 et seq.), such entity
2 must provide at least 50 percent of the grant
3 funds that the entity receives under this sub-
4 section directly to the entity’s network providers
5 (including all health providers and pharmacists)
6 for the purpose of providing support for such
7 providers to provide competent language serv-
8 ices to Medicare beneficiaries who are English
9 learners.

10 (E) ADMINISTRATIVE AND REPORTING
11 COSTS.—A grantee may use up to 10 percent of
12 the grant funds to pay for administrative costs
13 associated with the provision of competent lan-
14 guage services and for reporting required under
15 paragraph (9).

16 (6) DETERMINATION OF AMOUNT OF GRANT
17 PAYMENTS.—

18 (A) IN GENERAL.—Payments to grantees
19 under this subsection shall be calculated based
20 on the estimated numbers of Medicare bene-
21 ficiaries who are English learners in a grantee’s
22 service area utilizing—

23 (i) data on the numbers of English
24 learners who speak English less than “very
25 well” from the most recently available data

1 from the Bureau of the Census or other
2 State-based study the Secretary determines
3 likely to yield accurate data regarding the
4 number of such individuals in such service
5 area; or

6 (ii) data provided by the grantee, if
7 the grantee routinely collects data on the
8 primary language of the Medicare bene-
9 ficiaries that the grantee serves and the
10 Secretary determines that the data is accu-
11 rate and shows a greater number of
12 English learners than would be estimated
13 using the data under clause (i).

14 (B) DISCRETION OF SECRETARY.—Subject
15 to subparagraph (C), the amount of payment
16 made to a grantee under this subsection may be
17 modified annually at the discretion of the Sec-
18 retary, based on changes in the data under sub-
19 paragraph (A) with respect to the service area
20 of a grantee for the year.

21 (C) LIMITATION ON AMOUNT.—The
22 amount of a grant made under this subsection
23 to a grantee may not exceed \$500,000 for the
24 period under paragraph (1)(D).

1 (7) ASSURANCES.—Grantees under this sub-
2 section shall, as a condition of receiving a grant
3 under this subsection—

4 (A) ensure that clinical and support staff
5 receive appropriate ongoing education and
6 training in linguistically appropriate service de-
7 livery;

8 (B) ensure the linguistic competence of bi-
9 lingual providers;

10 (C) offer and provide appropriate language
11 services at no additional charge to each patient
12 who is an English learner for all points of con-
13 tact between the patient and the grantee, in a
14 timely manner during all hours of operation;

15 (D) notify Medicare beneficiaries of their
16 right to receive language services in their pri-
17 mary language;

18 (E) post signage in the primary languages
19 commonly used by the patient population in the
20 service area of the organization; and

21 (F) ensure that—

22 (i) primary language data are col-
23 lected for recipients of language services
24 and such data are consistent with stand-
25 ards developed under title XXXIV of the

1 Public Health Service Act, as added by
2 section 202 of this Act, to the extent such
3 standards are available upon the initiation
4 of the demonstration program; and

5 (ii) consistent with the privacy protec-
6 tions provided under the regulations pro-
7 mulgated pursuant to section 264(c) of the
8 Health Insurance Portability and Account-
9 ability Act of 1996 (42 U.S.C. 1320d-2
10 note), if the recipient of language services
11 is a minor or is incapacitated, primary lan-
12 guage data are collected on the parent or
13 legal guardian of such recipient.

14 (8) NO COST SHARING.—Medicare beneficiaries
15 who are English learners shall not have to pay cost
16 sharing or co-payments for competent language serv-
17 ices provided under this demonstration program.

18 (9) REPORTING REQUIREMENTS FOR GRANT-
19 EES.—Not later than the end of each calendar year,
20 a grantee that receives funds under this subsection
21 in such year shall submit to the Secretary a report
22 that includes the following information:

23 (A) The number of Medicare beneficiaries
24 to whom competent language services are pro-
25 vided.

1 (B) The primary languages of those Medi-
2 care beneficiaries.

3 (C) The types of language services pro-
4 vided to such beneficiaries.

5 (D) Whether such language services were
6 provided by employees of the grantee or
7 through a contract with external contractors or
8 agencies.

9 (E) The types of interpretation services
10 provided to such beneficiaries, and the approxi-
11 mate length of time such service is provided to
12 such beneficiaries.

13 (F) The costs of providing competent lan-
14 guage services.

15 (G) An account of the training or accredi-
16 tation of bilingual staff, interpreters, and trans-
17 lators providing services funded by the grant
18 under this subsection.

19 (10) EVALUATION AND REPORT TO CON-
20 GRESS.—Not later than 1 year after the completion
21 of a 3-year grant under this subsection, the Sec-
22 retary shall conduct an evaluation of the demonstra-
23 tion program under this subsection and shall submit
24 to the Congress a report that includes the following:

1 (A) An analysis of the patient outcomes
2 and the costs of furnishing care to the Medicare
3 beneficiaries who are English learners partici-
4 pating in the project as compared to such out-
5 comes and costs for such Medicare beneficiaries
6 not participating, based on the data provided
7 under paragraph (9) and any other information
8 available to the Secretary.

9 (B) The effect of delivering language serv-
10 ices on—

11 (i) Medicare beneficiary access to care
12 and utilization of services;

13 (ii) the efficiency and cost effective-
14 ness of health care delivery;

15 (iii) patient satisfaction;

16 (iv) health outcomes; and

17 (v) the provision of culturally appro-
18 priate services provided to such bene-
19 ficiaries.

20 (C) The extent to which bilingual staff, in-
21 terpreters, and translators providing services
22 under such demonstration were trained or ac-
23 credited and the nature of accreditation or
24 training needed by type of provider, service, or
25 other category as determined by the Secretary

1 to ensure the provision of high-quality interpre-
2 tation, translation, or other language services to
3 Medicare beneficiaries if such services are ex-
4 panded pursuant to section 1115A(c) of the So-
5 cial Security Act (42 U.S.C. 1315a(c)).

6 (D) Recommendations, if any, regarding
7 the extension of such project to the entire Medi-
8 care Program, subject to the provisions of such
9 section 1115A(c).

10 (11) APPROPRIATIONS.—There is appropriated
11 to carry out this subsection, in equal parts from the
12 Federal Hospital Insurance Trust Fund under sec-
13 tion 1817 of the Social Security Act (42 U.S.C.
14 1395i) and the Federal Supplementary Medical In-
15 surance Trust Fund under section 1841 of such Act
16 (42 U.S.C. 1395t), \$16,000,000 for each fiscal year
17 of the demonstration program.

18 (12) ENGLISH LEARNER DEFINED.—In this
19 subsection, the term “English learner” has the
20 meaning given such term in section 8101(20) of the
21 Elementary and Secondary Education Act of 1965,
22 except that subparagraphs (A), (B), and (D) of such
23 section shall not apply.

24 (b) LANGUAGE ASSISTANCE SERVICES UNDER THE
25 MEDICARE PROGRAM.—

1 (1) INCLUSION AS RURAL HEALTH CLINIC
2 SERVICES.—Section 1861 of the Social Security Act
3 (42 U.S.C. 1395x) is amended—

4 (A) in subsection (aa)(1)—

5 (i) in subparagraph (B), by striking
6 “and” at the end;

7 (ii) by adding “and” at the end of
8 subparagraph (C); and

9 (iii) by inserting after subparagraph
10 (C) the following new subparagraph:

11 “(D) language assistance services as defined in
12 subsection (jjj)(1),”; and

13 (B) by adding at the end the following new
14 subsection:

15 “Language Assistance Services and Related Terms

16 “(kkk)(1) The term ‘language assistance services’
17 means ‘language access’ or ‘language assistance services’
18 (as those terms are defined in section 3400 of the Public
19 Health Service Act) furnished by a ‘qualified interpreter
20 for an individual with limited English proficiency’ or a
21 ‘qualified translator’ (as those terms are defined in such
22 section 3400) to an ‘individual with limited English pro-
23 ficiency’ (as defined in such section 3400) or an ‘English
24 learner’ (as defined in paragraph (2)).

1 “(2) The term ‘English learner’ has the meaning
2 given that term in section 8101(20) of the Elementary and
3 Secondary Education Act of 1965, except that subpara-
4 graphs (A), (B), and (D) of such section shall not apply.”.

5 (2) COVERAGE.—Section 1832(a)(2) of the So-
6 cial Security Act (42 U.S.C. 1395k(a)(2)) is amend-
7 ed—

8 (A) by striking “and” at the end of sub-
9 paragraph (I);

10 (B) by striking the period at the end of
11 subparagraph (J) and inserting “; and”; and

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

14 “(K) language assistance services (as de-
15 fined in section 1861(jjj)(1)).”.

16 (3) PAYMENT.—Section 1833(a) of the Social
17 Security Act (42 U.S.C. 1395l(a)) is amended—

18 (A) by striking “and” at the end of para-
19 graph (8);

20 (B) by striking the period at the end of
21 paragraph (9) and inserting “; and”; and

22 (C) by inserting after paragraph (9) the
23 following new paragraph:

24 “(10) in the case of language assistance serv-
25 ices (as defined in section 1861(jjj)(1)), 100 percent

1 of the reasonable charges for such services, as deter-
2 mined in consultation with the Medicare Payment
3 Advisory Commission.”.

4 (4) WAIVER OF BUDGET NEUTRALITY.—For
5 the 3-year period beginning on the date of enact-
6 ment of this section, the budget neutrality provision
7 of section 1848(c)(2)(B)(ii) of the Social Security
8 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not
9 apply with respect to language assistance services
10 (as defined in section 1861(kkk)(1) of such Act).

11 (c) MEDICARE PARTS C AND D.—

12 (1) IN GENERAL.—Medicare Advantage plans
13 under part C of title XVIII of the Social Security
14 Act (42 U.S.C. 1395w-21 et seq.) and prescription
15 drug plans under part D of such title (42 U.S.C.
16 1395q-101) shall comply with title VI of the Civil
17 Rights Act of 1964 (42 U.S.C. 2000d et seq.) and
18 section 1557 of the Patient Protection and Afford-
19 able Care Act (42 U.S.C. 18116) to provide effective
20 language services to enrollees of such plans.

21 (2) MEDICARE ADVANTAGE PLANS AND PRE-
22 SCRIPTION DRUG PLANS REPORTING REQUIRE-
23 MENT.—Section 1857(e) of the Social Security Act
24 (42 U.S.C. 1395w-27(e)) is amended by adding at
25 the end the following new paragraph:

1 “(5) REPORTING REQUIREMENTS RELATING TO
2 EFFECTIVE LANGUAGE SERVICES.—A contract under
3 this part shall require a Medicare Advantage organi-
4 zation (and, through application of section 1860D–
5 12(b)(3)(D), a contract under section 1860D–12
6 shall require a PDP sponsor) to annually submit
7 (for each year of the contract) a report that contains
8 information on the internal policies and procedures
9 of the organization (or sponsor) related to recruit-
10 ment and retention efforts directed to workforce di-
11 versity 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 2020,
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 language services
23 programs and services offered by the organiza-
24 tion (or sponsor) with respect to the enrollee

1 population, such as through analysis of com-
2 plaints or satisfaction survey results.

3 “(D) Methods by which the plan provides
4 to the Secretary information regarding the eth-
5 nic diversity of the enrollee population.

6 “(E) The periodic provision of educational
7 information to plan enrollees on the language
8 services and programs offered by the organiza-
9 tion (or sponsor).”.

10 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID
11 AND CHIP.—

12 (1) PAYMENTS TO STATES.—Section
13 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
14 1396b(a)(2)(E)), as amended by section 203(g)(3),
15 is further amended by—

16 (A) striking “75” and inserting “95”;

17 (B) striking “translation or interpretation
18 services” and inserting “language assistance
19 services”; and

20 (C) striking “children of families” and in-
21 serting “individuals”.

22 (2) STATE PLAN REQUIREMENTS.—Section
23 1902(a)(10)(A) of the Social Security Act (42
24 U.S.C. 1396a(a)(10)(A)) is amended by striking
25 “and (29)” and inserting “(29), and (30)”.

1 (3) DEFINITION OF MEDICAL ASSISTANCE.—
2 Section 1905(a) of the Social Security Act (42
3 U.S.C. 1396d(a)) is amended—

4 (A) in paragraph (29), by striking “and”
5 at the end;

6 (B) by redesignating paragraph (30) as
7 paragraph (31); and

8 (C) by inserting after paragraph (29) the
9 following new paragraph:

10 “(30) language assistance services, as such
11 term is defined in section 1861(kkk)(1), provided in
12 a timely manner to individuals with limited English
13 proficiency as defined in section 3400 of the Public
14 Health Service Act; and”.

15 (4) USE OF DEDUCTIONS AND COST SHAR-
16 ING.—Section 1916(a)(2) of the Social Security Act
17 (42 U.S.C. 1396o(a)(2)) is amended—

18 (A) by striking “or” at the end of subpara-
19 graph (D);

20 (B) by striking “; and” at the end of sub-
21 paragraph (E) and inserting “, or”; and

22 (C) by adding at the end the following new
23 subparagraph:

24 “(F) language assistance services described
25 in section 1905(a)(29); and”.

1 (5) CHIP COVERAGE REQUIREMENTS.—Section
2 2103 of the Social Security Act (42 U.S.C. 1397cc)
3 is amended—

4 (A) in subsection (a), in the matter before
5 paragraph (1), by striking “and (7)” and in-
6 serting “(7), and (10)”;

7 (B) in subsection (c), by adding at the end
8 the following new paragraph:

9 “(10) LANGUAGE ASSISTANCE SERVICES.—The
10 child health assistance provided to a targeted low-in-
11 come child shall include coverage of language assist-
12 ance services, as such term is defined in section
13 1861(jjj)(1), provided in a timely manner to individ-
14 uals with limited English proficiency (as defined in
15 section 3400 of the Public Health Service Act).”;

16 and

17 (C) in subsection (e)(2)—

18 (i) in the heading, by striking “PRE-
19 VENTIVE” and inserting “CERTAIN”; and

20 (ii) by inserting “or subsection
21 (c)(10)” after “subsection (c)(1)(D)”.

22 (6) DEFINITION OF CHILD HEALTH ASSIST-
23 ANCE.—Section 2110(a)(27) of the Social Security
24 Act (42 U.S.C. 1397jj(a)(27)) is amended by strik-

1 ing “translation” and inserting “language assistance
2 services as described in section 2103(c)(10)”.

3 (7) STATE DATA COLLECTION.—Pursuant to
4 the reporting requirement described in section
5 2107(b)(1) of the Social Security Act (42 U.S.C.
6 1397gg(b)(1)), the Secretary of Health and Human
7 Services shall require that States collect data on—

8 (A) the primary language of individuals re-
9 ceiving child health assistance under title XXI
10 of the Social Security Act (42 U.S.C. 1397aa et
11 seq.); and

12 (B) in the case of such individuals who are
13 minors or incapacitated, the primary language
14 of the individual’s parent or guardian.

15 (8) CHIP PAYMENTS TO STATES.—Section
16 2105 of the Social Security Act (42 U.S.C. 1397ee)
17 is amended—

18 (A) in subsection (a)(1), by striking “75”
19 and inserting “90”; and

20 (B) in subsection (c)(2)(A), by inserting
21 before the period at the end the following: “,
22 except that expenditures pursuant to clause (iv)
23 of subparagraph (D) of such paragraph shall
24 not count towards this total”.

1 (e) FUNDING LANGUAGE ASSISTANCE SERVICES
2 FURNISHED BY PROVIDERS OF HEALTH CARE AND
3 HEALTH-CARE-RELATED SERVICES THAT SERVE HIGH
4 RATES OF UNINSURED LEP INDIVIDUALS.—

5 (1) PAYMENT OF COSTS.—

6 (A) IN GENERAL.—Subject to subpara-
7 graph (B), the Secretary of Health and Human
8 Services (referred to in this subsection as the
9 “Secretary”) shall make payments (on a quar-
10 terly basis) directly to eligible entities to sup-
11 port the provision of language assistance serv-
12 ices to English learners in an amount equal to
13 an eligible entity’s eligible costs for providing
14 such services for the quarter.

15 (B) FUNDING.—Out of any funds in the
16 Treasury not otherwise appropriated, there are
17 appropriated to the Secretary of Health and
18 Human Services such sums as may be nec-
19 essary for each of fiscal years 2021 through
20 2025.

21 (C) RELATION TO MEDICAID DSH.—Pay-
22 ments under this subsection shall not offset or
23 reduce payments under section 1923 of the So-
24 cial Security Act (42 U.S.C. 1396r–4), nor
25 shall payments under such section be consid-

1 ered when determining uncompensated costs as-
2 sociated with the provision of language assist-
3 ance services for the purposes of this section.

4 (2) METHODODOLOGY FOR PAYMENT OF
5 CLAIMS.—

6 (A) IN GENERAL.—The Secretary shall es-
7 tablish a methodology to determine the average
8 per person cost of language assistance services.

9 (B) DIFFERENT ENTITIES.—In estab-
10 lishing such methodology, the Secretary may es-
11 tablish different methodologies for different
12 types of eligible entities.

13 (C) NO INDIVIDUAL CLAIMS.—The Sec-
14 retary may not require eligible entities to sub-
15 mit individual claims for language assistance
16 services for individual patients as a requirement
17 for payment under this subsection.

18 (3) DATA COLLECTION INSTRUMENT.—For pur-
19 poses of this subsection, the Secretary shall create a
20 standard data collection instrument that is con-
21 sistent with any existing reporting requirements by
22 the Secretary or relevant accrediting organizations
23 regarding the number of individuals to whom lan-
24 guage access are provided.

1 (4) GUIDELINES.—Not later than 6 months
2 after the date of enactment of this Act, the Sec-
3 retary shall establish and distribute guidelines con-
4 cerning the implementation of this subsection.

5 (5) REPORTING REQUIREMENTS.—

6 (A) REPORT TO SECRETARY.—Entities re-
7 ceiving payment under this subsection shall pro-
8 vide the Secretary with a quarterly report on
9 how the entity used such funds. Such report
10 shall contain aggregate (and may not contain
11 individualized) data collected using the instru-
12 ment under paragraph (3) and shall otherwise
13 be in a form and manner determined by the
14 Secretary.

15 (B) REPORT TO CONGRESS.—Not later
16 than 2 years after the date of enactment of this
17 Act, and every 2 years thereafter, the Secretary
18 shall submit a report to Congress concerning
19 the implementation of this subsection.

20 (6) DEFINITIONS.—In this subsection:

21 (A) ELIGIBLE COSTS.—The term “eligible
22 costs” means, with respect to an eligible entity
23 that provides language assistance services to
24 English learners, the product of—

1 (i) the average per person cost of lan-
2 guage assistance services, determined ac-
3 cording to the methodology devised under
4 paragraph (2); and

5 (ii) the number of English learners
6 who are provided language assistance serv-
7 ices by the entity and for whom no reim-
8 bursement is available for such services
9 under the amendments made by subsection
10 (a), (b), (c), or (d) or by private health in-
11 surance.

12 (B) ELIGIBLE ENTITY.—The term “eligible
13 entity” means an entity that—

14 (i) is a Medicaid provider that is—

15 (I) a physician;

16 (II) a hospital with a low-income
17 utilization rate (as defined in section
18 1923(b)(3) of the Social Security Act
19 (42 U.S.C. 1396r-4(b)(3))) of greater
20 than 25 percent; or

21 (III) a federally qualified health
22 center (as defined in section
23 1905(l)(2)(B) of the Social Security
24 Act (42 U.S.C. 1396d(l)(2)(B)));

1 (ii) not later than 6 months after the
2 date of the enactment of this Act, provides
3 language assistance services to not less
4 than 8 percent of the entity's total number
5 of patients; and

6 (iii) prepares and submits an applica-
7 tion to the Secretary, at such time, in such
8 manner, and accompanied by such infor-
9 mation as the Secretary may require, to
10 ascertain the entity's eligibility for funding
11 under this subsection.

12 (C) ENGLISH LEARNER.—The term
13 “English learner” has the meaning given such
14 term in section 8101(20) of the Elementary
15 and Secondary Education Act of 1965 (20
16 U.S.C. 7801(20)), except that subparagraphs
17 (A), (B), and (D) of such section shall not
18 apply.

19 (D) LANGUAGE ASSISTANCE SERVICES.—
20 The term “language assistance services” has
21 the meaning given such term in section
22 1861(kkk)(1) of the Social Security Act, as
23 added by subsection (b).

24 (f) APPLICATION OF CIVIL RIGHTS ACT OF 1964,
25 SECTION 1557 OF THE AFFORDABLE CARE ACT, AND

1 OTHER LAWS.—Nothing in this section shall be construed
2 to limit otherwise existing obligations of recipients of Fed-
3 eral financial assistance under title VI of the Civil Rights
4 Act of 1964 (42 U.S.C. 2000d et seq.), section 1557 of
5 the Affordable Care Act, or other laws that protect the
6 civil rights of individuals.

7 (g) EFFECTIVE DATE.—

8 (1) IN GENERAL.—Except as otherwise pro-
9 vided and subject to paragraph (2), the amendments
10 made by this section shall take effect on January 1,
11 2021.

12 (2) EXCEPTION IF STATE LEGISLATION RE-
13 QUIRED.—In the case of a State plan for medical as-
14 sistance under title XIX of the Social Security Act
15 (42 U.S.C. 1396 et seq.) which the Secretary of
16 Health and Human Services determines requires
17 State legislation (other than legislation appro-
18 priating funds) in order for the plan to meet the ad-
19 ditional requirement imposed by the amendments
20 made by this section, the State plan shall not be re-
21 garded as failing to comply with the requirements of
22 such title solely on the basis of its failure to meet
23 this additional requirement before the first day of
24 the first calendar quarter beginning after the close
25 of the first regular session of the State legislature

1 that begins after the date of the enactment of this
2 Act. For purposes of the previous sentence, in the
3 case of a State that has a 2-year legislative session,
4 each year of such session shall be deemed to be a
5 separate regular session of the State legislature.

6 **SEC. 208. INCREASING UNDERSTANDING OF AND IMPROV-**
7 **ING HEALTH LITERACY.**

8 (a) IN GENERAL.—The Secretary, acting through the
9 Director of the Agency for Healthcare Research and Qual-
10 ity with respect to grants under subsection (c)(1) and
11 through the Administrator of the Health Resources and
12 Services Administration with respect to grants under sub-
13 section (c)(2), in consultation with the Director of the Na-
14 tional Institute on Minority Health and Health Disparities
15 and the Deputy Assistant Secretary for Minority Health,
16 shall award grants to eligible entities to improve health
17 care for patient populations that have low functional
18 health literacy.

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

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

24 (2) prepare and submit to the Secretary an ap-
25 plication at such time, in such manner, and con-

1 taining such information as the Secretary may rea-
2 sonably require.

3 (c) USE OF FUNDS.—

4 (1) AGENCY FOR HEALTHCARE RESEARCH AND
5 QUALITY.—A grant awarded under subsection (a)
6 through the Director of the Agency for Healthcare
7 Research and Quality shall be used—

8 (A) to define and increase the under-
9 standing of health literacy;

10 (B) to investigate the correlation between
11 low health literacy and health and health care;

12 (C) to clarify which aspects of health lit-
13 eracy have an effect on health outcomes; and

14 (D) for any other activity determined ap-
15 propriate by the Director.

16 (2) HEALTH RESOURCES AND SERVICES ADMIN-
17 ISTRATION.—A grant awarded under subsection (a)
18 through the Administrator of the Health Resources
19 and Services Administration shall be used to conduct
20 demonstration projects for interventions for patients
21 with low health literacy that may include—

22 (A) the development of new disease man-
23 agement programs for patients with low health
24 literacy;

1 (B) the tailoring of disease management
2 programs addressing mental, physical, oral, and
3 behavioral health conditions for patients with
4 low health literacy;

5 (C) the translation of written health mate-
6 rials for patients with low health literacy;

7 (D) the identification, implementation, and
8 testing of low health literacy screening tools;

9 (E) the conduct of educational campaigns
10 for patients and providers about low health lit-
11 eracy;

12 (F) the conduct of educational campaigns
13 concerning health directed specifically at pa-
14 tients with mental disabilities, including those
15 with cognitive and intellectual disabilities, de-
16 signed to reduce the incidence of low health lit-
17 eracy among these populations, which shall
18 have instructional materials in the plain lan-
19 guage standards promulgated under the Plain
20 Writing Act of 2010 (5 U.S.C. 301 note) for
21 Federal agencies; and

22 (G) other activities determined appropriate
23 by the Administrator.

24 (d) DEFINITIONS.—In this section, the term “low
25 health literacy” means the inability of an individual to ob-

1 tain, process, and understand basic health information
2 and services needed to make appropriate health decisions.

3 (e) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2021 through 2025.

7 **SEC. 209. REQUIREMENTS FOR HEALTH PROGRAMS OR AC-**
8 **TIVITIES RECEIVING FEDERAL FUNDS.**

9 (a) COVERED ENTITY; COVERED PROGRAM OR AC-
10 TIVITY.—In this section—

11 (1) the term “covered entity” has the meaning
12 given such term in section 92.4 of title 42, Code of
13 Federal Regulations, as in effect on May 16, 2016;
14 and

15 (2) the term “covered program or activity” has
16 the meaning given such term in section 92.4 of title
17 42, Code of Federal Regulations, as in effect on May
18 16, 2016.

19 (b) REQUIREMENTS.—A covered entity, in order to
20 ensure the right of individuals with limited English pro-
21 ficiency to receive access to high-quality health care
22 through the covered program or activity, shall—

23 (1) ensure that appropriate clinical and support
24 staff receive ongoing education and training in cul-
25 turally and linguistically appropriate service delivery;

1 (2) offer and provide appropriate language as-
2 sistance services at no additional charge to each pa-
3 tient that is an individual with limited English pro-
4 ficiency at all points of contact, in a timely manner
5 during all hours of operation;

6 (3) notify patients of their right to receive lan-
7 guage services in their primary language; and

8 (4) utilize only qualified interpreters for an in-
9 dividual with limited English proficiency or qualified
10 translators, except as provided in subsection (c).

11 (c) EXEMPTIONS.—The requirements of subsection
12 (b)(4) shall not apply as follows:

13 (1) When a patient requests the use of family,
14 friends, or other persons untrained in interpretation
15 or translation if each of the following conditions are
16 met:

17 (A) The interpreter requested by the pa-
18 tient is over the age of 18.

19 (B) The covered entity informs the patient
20 in the primary language of the patient that he
21 or she has the option of having the entity pro-
22 vide to the patient an interpreter and trans-
23 lation services without charge.

24 (C) The covered entity informs the patient
25 that the entity may not require an individual

1 with a limited English proficiency to use a fam-
2 ily member or friend as an interpreter.

3 (D) The covered entity evaluates whether
4 the person the patient wishes to use as an in-
5 terpreter is competent. If the covered entity has
6 reason to believe that such person is not com-
7 petent as an interpreter, the entity provides its
8 own interpreter to protect the covered entity
9 from liability if the patient's interpreter is later
10 found not competent.

11 (E) If the covered entity has reason to be-
12 lieve that there is a conflict of interest between
13 the interpreter and patient, the covered entity
14 may not use the patient's interpreter.

15 (F) The covered entity has the patient sign
16 a waiver, witnessed by at least 1 individual not
17 related to the patient, that includes the infor-
18 mation stated in subparagraphs (A) through
19 (E) and is translated into the patient's primary
20 language.

21 (2) When a medical emergency exists and the
22 delay directly associated with obtaining competent
23 interpreter or translation services would jeopardize
24 the health of the patient, but only until a competent
25 interpreter or translation service is available.

1 (d) RULE OF CONSTRUCTION.—Subsection (c)(2)
2 shall not be construed to mean that emergency rooms or
3 similar entities that regularly provide health care services
4 in medical emergencies are exempt from legal or regu-
5 latory requirements related to competent interpreter serv-
6 ices.

7 **SEC. 210. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
8 **TURALLY AND LINGUISTICALLY APPRO-**
9 **PRIATE HEALTH CARE SERVICES.**

10 (a) REPORT.—Not later than 1 year after the date
11 of enactment of this Act and annually thereafter, the Sec-
12 retary of Health and Human Services shall enter into a
13 contract with the National Academy of Medicine for the
14 preparation and publication of a report that describes
15 Federal efforts to ensure that all individuals with limited
16 English proficiency have meaningful access to health care
17 services and health-care-related services that are culturally
18 and linguistically appropriate. Such report shall include—

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

21 (2) a description and analysis of best practices,
22 model programs, guidelines, and other effective
23 strategies for providing access to culturally and lin-
24 guistically appropriate health care services;

1 (3) recommendations on the development and
2 implementation of policies and practices by providers
3 of health care services and health-care-related serv-
4 ices for individuals with limited English proficiency,
5 including people with cognitive, hearing, vision, or
6 print impairments;

7 (4) recommend guidelines or standards for
8 health literacy and plain language, informed consent,
9 discharge instructions, and written communications,
10 and for improvement of health care access;

11 (5) a description of the effect of providing lan-
12 guage services on quality of health care and access
13 to care; and

14 (6) a description of the costs associated with or
15 savings related to the provision of language services.

16 (b) **AUTHORIZATION OF APPROPRIATIONS.**—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2021 through 2025.

20 **SEC. 211. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.**

21 (a) **GRANTS AUTHORIZED.**—The Secretary of Edu-
22 cation is authorized to provide grants to eligible entities
23 for the provision of English as a second language (in this
24 section referred to as “ESL”) instruction and shall deter-
25 mine, after consultation with appropriate stakeholders, the

1 mechanism for administering and distributing such
2 grants.

3 (b) ELIGIBLE ENTITY DEFINED.—In this section,
4 the term “eligible entity” means a State or community-
5 based organization that employs and serves minority popu-
6 lations.

7 (c) APPLICATION.—An eligible entity may apply for
8 a grant under this section by submitting such information
9 as the Secretary of Education may require and in such
10 form and manner as the Secretary may require.

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

13 (1) develop and implement a plan for assuring
14 the availability of ESL instruction that effectively
15 integrates information about the nature of the
16 United States health care system, how to access
17 care, and any special language skills that may be re-
18 quired for individuals to access and regularly nego-
19 tiate the system effectively;

20 (2) develop a plan, including, where appro-
21 priate, public-private partnerships, for making ESL
22 instruction progressively available to all individuals
23 seeking instruction; and

24 (3) maintain current ESL instruction efforts by
25 using funds available under this section to supple-

1 ment rather than supplant any funds expended for
2 ESL instruction in the State as of January 1, 2020.

3 (e) ADDITIONAL DUTIES OF THE SECRETARY.—The
4 Secretary of Education shall—

5 (1) collect and publicize annual data on how
6 much Federal, State, and local governments spend
7 on ESL instruction;

8 (2) collect data from State and local govern-
9 ments to identify the unmet needs of English lan-
10 guage learners for appropriate ESL instruction, in-
11 cluding—

12 (A) the preferred written and spoken lan-
13 guage of such English language learners;

14 (B) the extent of waiting lists for ESL in-
15 struction, including how many programs main-
16 tain waiting lists and, for programs that do not
17 have waiting lists, the reasons why not;

18 (C) the availability of programs to geo-
19 graphically isolated communities;

20 (D) the impact of course enrollment poli-
21 cies, including open enrollment, on the avail-
22 ability of ESL instruction;

23 (E) the number individuals in the State
24 and each participating locality;

1 (F) the effectiveness of the instruction in
2 meeting the needs of individuals receiving in-
3 struction and those needing instruction;

4 (G) as assessment of the need for pro-
5 grams that integrate job training and ESL in-
6 struction, to assist individuals to obtain better
7 jobs; and

8 (H) the availability of ESL slots by State
9 and locality;

10 (3) determine the cost and most appropriate
11 methods of making ESL instruction available to all
12 English language learners seeking instruction; and

13 (4) not later than 1 year after the date of en-
14 actment of this Act, issue a report to Congress that
15 assesses the information collected in paragraphs (1),
16 (2), and (3) and makes recommendations on steps
17 that should be taken to progressively realize the goal
18 of making ESL instruction available to all English
19 language learners seeking instruction.

20 (f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to the Secretary of Edu-
22 cation \$250,000,000 for each of fiscal years 2021 through
23 2024 to carry out this section.

24 **SEC. 212. IMPLEMENTATION.**

25 (a) GENERAL PROVISIONS.—

1 (1) IMMUNITY.—A State shall not be immune
2 under the 11th Amendment to the Constitution of
3 the United States from suit in Federal court for a
4 violation of this title (including an amendment made
5 by this title).

6 (2) REMEDIES.—In a suit against a State for
7 a violation of this title (including an amendment
8 made by this title), remedies (including remedies
9 both at law and in equity) are available for such a
10 violation to the same extent as such remedies are
11 available for such a violation in a suit against any
12 public or private entity other than a State.

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

18 **SEC. 213. LANGUAGE ACCESS SERVICES.**

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

23 “(K) Language access services, including
24 oral interpretation and written translations.”.

1 (b) EMPLOYER-SPONSORED MINIMUM ESSENTIAL
2 COVERAGE.—

3 (1) IN GENERAL.—Section 36B(e)(2)(C) of the
4 Internal Revenue Code of 1986 is amended by redesi-
5 gnating clauses (iii) and (iv) as clauses (iv) and (v),
6 respectively, and by inserting after clause (ii) the fol-
7 lowing new clause:

8 “(iii) COVERAGE MUST INCLUDE LAN-
9 GUAGE ACCESS AND SERVICES.—Except as
10 provided in clause (iv), an employee shall
11 not be treated as eligible for minimum es-
12 sential coverage if such coverage consists
13 of an eligible employer-sponsored plan (as
14 defined in section 5000A(f)(2)) and the
15 plan does not provide coverage for lan-
16 guage access services, including oral inter-
17 pretation and written translations.”.

18 (2) CONFORMING AMENDMENTS.—

19 (A) Section 36B(e)(2)(C) of such Code is
20 amended by striking “clause (iii)” each place it
21 appears in clauses (i) and (ii) and inserting
22 “clause (iv)”.

23 (B) Section 36B(e)(2)(C)(iv) of such Code,
24 as redesignated by this subsection, is amended

1 by striking “(i) and (ii)” and inserting “(i), (ii),
2 and (iii)”.

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 54.9815–2719(e) of title
21 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 the requirements for pro-
11 viding relevant notices in a culturally and linguis-
12 tically appropriate manner in the applicable non-
13 English languages, to apply a threshold that 5 per-
14 cent of the population, or not less than 500 individ-
15 uals, in the county is literate only in the same non-
16 English language in order for the language to be
17 considered an applicable non-English language.

18 (e) DATA COLLECTION AND REPORTING.—The Sec-
19 retary of Health and Human Services shall—

20 (1) amend the single streamlined application
21 form developed pursuant to section 1413 of the Pa-
22 tient Protection and Affordable Care Act (42 U.S.C.
23 18083) to collect the preferred spoken and written
24 language for each household member applying for
25 coverage under a qualified health plan through an

1 Exchange under title I of such Act (42 U.S.C.
2 18001 et seq.);

3 (2) require navigators, certified application
4 counselors, and other individuals assisting with en-
5 rollment to collect and report requests for language
6 assistance; and

7 (3) require the toll-free telephone hotlines es-
8 tablished pursuant to section 1311(d)(4)(B) of the
9 Patient Protection and Affordable Care Act (42
10 U.S.C. 18031(d)(4)(B)) to submit an annual report
11 documenting the number of language assistance re-
12 quests, the types of languages requested, the range
13 and average wait time for a consumer to speak with
14 an interpreter, and any steps the hotline, and any
15 entity contracting with the Secretary to provide lan-
16 guage services, have taken to actively address some
17 of the consumer complaints.

18 (f) EFFECTIVE DATE.—The amendments made by
19 this section shall not apply to plans beginning prior to the
20 date of the enactment of this Act.

21 **SEC. 214. MEDICALLY UNDERSERVED POPULATIONS.**

22 Section 330(a) of the Public Health Service Act (42
23 U.S.C. 254b(a)) is amended by adding at the end the fol-
24 lowing new paragraph:

1 “(3) **MEDICALLY UNDERSERVED.**—The term
2 ‘medically underserved’, with respect to a popu-
3 lation, means—

4 “(A) the population of an urban or rural
5 area designated by the Secretary as—

6 “(i) an area with a shortage of per-
7 sonal health services; or

8 “(ii) a population group having a
9 shortage of such services; or

10 “(B) a population of individuals, not con-
11 fined to a particular urban or rural area, who
12 are designated by the Secretary as having a
13 shortage of personal health services due to a
14 specific demographic trait.”.

15 **TITLE III—HEALTH WORKFORCE**
16 **DIVERSITY**

17 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
18 **ACT.**

19 Title XXXIV of the Public Health Service Act, as
20 added by section 204, is amended by adding at the end
21 the following:

1 **“Subtitle B—Diversifying the**
2 **Health Care Workplace**

3 **“SEC. 3411. NATIONAL WORKING GROUP ON WORKFORCE**
4 **DIVERSITY.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Bureau of Health Workforce of the Health Resources
7 and Services Administration, shall award a grant to an
8 entity determined appropriate by the Secretary for the es-
9 tablishment of a national working group on workforce di-
10 versity.

11 “(b) REPRESENTATION.—In establishing the national
12 working group under subsection (a):

13 “(1) The grantee shall ensure that the group
14 has representatives of each of the following:

15 “(A) The Health Resources and Services
16 Administration.

17 “(B) The Department of Health and
18 Human Services Data Council.

19 “(C) The Office of Minority Health of the
20 Department of Health and Human Services.

21 “(D) The Substance Abuse and Mental
22 Health Services Administration.

23 “(E) The Bureau of Labor Statistics of
24 the Department of Labor.

1 “(F) The National Institute on Minority
2 Health and Health Disparities.

3 “(G) The Agency for Healthcare Research
4 and Quality.

5 “(H) The Institute of Medicine Study
6 Committee for the 2004 workforce diversity re-
7 port.

8 “(I) The Indian Health Service.

9 “(J) The Department of Education.

10 “(K) Minority-serving academic institu-
11 tions.

12 “(L) Consumer organizations.

13 “(M) Health professional associations, in-
14 cluding those that represent underrepresented
15 minority populations.

16 “(N) Researchers in the area of health
17 workforce.

18 “(O) Health workforce accreditation enti-
19 ties.

20 “(P) Private (including nonprofit) founda-
21 tions that have sponsored workforce diversity
22 initiatives.

23 “(Q) Local and State health departments.

24 “(R) Representatives of community mem-
25 bers to be included on admissions committees

1 for health profession schools pursuant to sub-
2 section (c)(9).

3 “(S) National community-based organiza-
4 tions that serve as a national intermediary to
5 their urban affiliate members and have dem-
6 onstrated capacity to train health care profes-
7 sionals.

8 “(T) The Veterans Health Administration.

9 “(U) Other entities determined appropriate
10 by the Secretary.

11 “(2) The grantee shall ensure that, in addition
12 to the representatives under paragraph (1), the
13 working group has not less than 5 health professions
14 students representing various health profession fields
15 and levels of training.

16 “(c) ACTIVITIES.—The working group established
17 under subsection (a) shall convene at least twice each year
18 to complete the following activities:

19 “(1) Review public and private health workforce
20 diversity initiatives.

21 “(2) Identify successful health workforce diver-
22 sity programs and practices.

23 “(3) Examine challenges relating to the devel-
24 opment and implementation of health workforce di-
25 versity initiatives.

1 “(4) Draft a national strategic work plan for
2 health workforce diversity, including recommenda-
3 tions for public and private sector initiatives.

4 “(5) Develop a framework and methods for the
5 evaluation of current and future health workforce di-
6 versity initiatives.

7 “(6) Develop recommended standards for work-
8 force diversity that could be applicable to all health
9 professions programs and programs funded under
10 this Act.

11 “(7) Develop guidelines to train health profes-
12 sionals to care for a diverse population.

13 “(8) Develop a workforce data collection or
14 tracking system to identify where racial and ethnic
15 minority health professionals practice.

16 “(9) Develop a strategy for the inclusion of
17 community members on admissions committees for
18 health profession schools.

19 “(10) Help with monitoring and implementation
20 of standards for diversity, equity, and inclusion.

21 “(11) Other activities determined appropriate
22 by the Secretary.

23 “(d) ANNUAL REPORT.—Not later than 1 year after
24 the establishment of the working group under subsection
25 (a), and annually thereafter, the working group shall pre-

1 pare and make available to the general public for com-
2 ment, an annual report on the activities of the working
3 group. Such report shall include the recommendations of
4 the working group for improving health workforce diver-
5 sity.

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2021 through 2025.

10 **“SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH**
11 **WORKFORCE DIVERSITY.**

12 “(a) IN GENERAL.—The Secretary, acting through
13 the Deputy Assistant Secretary for Minority Health, and
14 in collaboration with the Bureau of Health Workforce
15 within the Health Resources and Services Administration
16 and the National Institute on Minority Health and Health
17 Disparities, shall establish a technical clearinghouse on
18 health workforce diversity within the Office of Minority
19 Health and coordinate current and future clearinghouses
20 related to health workforce diversity.

21 “(b) INFORMATION AND SERVICES.—The clearing-
22 house established under subsection (a) shall offer the fol-
23 lowing information and services:

24 “(1) Information on the importance of health
25 workforce diversity.

1 “(2) Statistical information relating to under-
2 represented minority representation in health and al-
3 lied health professions and occupations.

4 “(3) Model health workforce diversity practices
5 and programs, including integrated models of care.

6 “(4) Admissions policies that promote health
7 workforce diversity and are in compliance with Fed-
8 eral and State laws.

9 “(5) Retainment policies that promote comple-
10 tion of health profession degrees for underserved
11 populations.

12 “(6) Lists of scholarship, loan repayment, and
13 loan cancellation grants as well as fellowship infor-
14 mation for underserved populations for health pro-
15 fessions schools.

16 “(7) Foundation and other large organizational
17 initiatives relating to health workforce diversity.

18 “(c) CONSULTATION.—In carrying out this section,
19 the Secretary shall consult with non-Federal entities which
20 may include minority health professional associations and
21 minority sections of major health professional associations
22 to ensure the adequacy and accuracy of information.

23 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of fiscal years
2 2021 through 2025.

3 **“SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO**
4 **WORKFORCE DIVERSITY, EQUITY, AND IN-**
5 **CLUSION.**

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

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

13 “(1) be an educational institution or entity that
14 historically produces or trains meaningful numbers
15 of underrepresented minority health professionals,
16 including—

17 “(A) part B institutions, as defined in sec-
18 tion 322 of the Higher Education Act of 1965;

19 “(B) Hispanic-serving health professions
20 schools;

21 “(C) Hispanic-serving institutions, as de-
22 fined in section 502 of such Act;

23 “(D) Tribal Colleges or Universities, as de-
24 fined in section 316 of such Act;

1 “(E) Asian American and Native American
2 Pacific Islander-serving institutions, as defined
3 in section 371(c) of such Act;

4 “(F) institutions that have programs to re-
5 cruit and retain underrepresented minority
6 health professionals, in which a significant
7 number of the enrolled participants are under-
8 represented minorities;

9 “(G) health professional associations,
10 which may include underrepresented minority
11 health professional associations; and

12 “(H) institutions, including national and
13 regional community-based organizations with
14 demonstrated commitment to a diversified
15 workforce—

16 “(i) located in communities with pre-
17 dominantly underrepresented minority pop-
18 ulations;

19 “(ii) with whom partnerships have
20 been formed for the purpose of increasing
21 workforce diversity; and

22 “(iii) in which at least 20 percent of
23 the enrolled participants are underrep-
24 resented minorities; and

1 “(2) 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 a
5 grant under subsection (a) shall be used to expand existing
6 workforce diversity programs, implement new workforce
7 diversity programs, or evaluate existing or new workforce
8 diversity programs, including with respect to mental
9 health care professions. Such programs shall enhance di-
10 versity by considering minority status as part of an indi-
11 vidualized consideration of qualifications. Possible activi-
12 ties may include—

13 “(1) educational outreach programs relating to
14 opportunities in the health professions;

15 “(2) scholarship, fellowship, grant, loan repay-
16 ment, and loan cancellation programs;

17 “(3) postbaccalaureate programs;

18 “(4) academic enrichment programs, particu-
19 larly targeting those who would not be competitive
20 for health professions schools;

21 “(5) supporting workforce diversity in kinder-
22 garten through 12th grade and other health pipeline
23 programs;

24 “(6) mentoring programs;

1 “(7) internship or rotation programs involving
2 hospitals, health systems, health plans, and other
3 health entities;

4 “(8) community partnership development for
5 purposes relating to workforce diversity; or

6 “(9) leadership training.

7 “(d) **REPORTS.**—Not later than 1 year after receiving
8 a grant under this section, and annually for the term of
9 the grant, a grantee shall submit to the Secretary a report
10 that summarizes and evaluates all activities conducted
11 under the grant.

12 “(e) **AUTHORIZATION OF APPROPRIATIONS.**—There
13 is authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2021 through 2025.

16 **“SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND**
17 **RESEARCHERS.**

18 “(a) **IN GENERAL.**—The Secretary, acting through
19 the Director of the National Institutes of Health, the Di-
20 rector of the Centers for Disease Control and Prevention,
21 the Commissioner of Food and Drugs, the Director of the
22 Agency for Healthcare Research and Quality, and the Ad-
23 ministrator of the Health Resources and Services Admin-
24 istration, shall award grants that expand existing opportu-
25 nities for scientists and researchers and promote the inclu-

1 sion of underrepresented minorities in the health profes-
2 sions.

3 “(b) RESEARCH FUNDING.—The head of each agency
4 listed in subsection (a) shall establish or expand existing
5 programs to provide research funding to scientists and re-
6 searchers in training. Under such programs, the head of
7 each such entity shall give priority in allocating research
8 funding to support health research in traditionally under-
9 served communities, including underrepresented minority
10 communities, and research classified as community or
11 participatory.

12 “(c) DATA COLLECTION.—The head of each agency
13 listed in subsection (a) shall collect data on the number
14 (expressed as an absolute number and a percentage) of
15 underrepresented minority and nonminority applicants
16 who receive and are denied agency funding at every stage
17 of review. Such data shall be reported annually to the Sec-
18 retary and the appropriate committees of Congress.

19 “(d) STUDENT LOAN REIMBURSEMENT.—The Sec-
20 retary shall establish a student loan reimbursement pro-
21 gram to provide student loan reimbursement assistance to
22 researchers who focus on racial and ethnic disparities in
23 health. The Secretary shall promulgate regulations to de-
24 fine the scope and procedures for the program under this
25 subsection.

1 “(b) ELIGIBILITY.—To be eligible to receive a grant
2 under subsection (a), an individual shall—

3 “(1) be a student in a health professions school,
4 a graduate of such a school who is working in a
5 health profession, an individual working in a health
6 or wellness profession (including mental and behav-
7 ioral health), or a faculty member of such a school;
8 and

9 “(2) submit to the Secretary an application at
10 such time, in such manner, and containing such in-
11 formation as the Secretary may require.

12 “(c) USE OF FUNDS.—An individual shall use
13 amounts received under a grant under this section to—

14 “(1) support the individual’s health activities or
15 projects that involve underserved communities, in-
16 cluding racial and ethnic minority communities;

17 “(2) support health-related career advancement
18 activities;

19 “(3) to pay, or as reimbursement for payments
20 of, student loans or training or credentialing costs
21 for individuals who are health professionals and are
22 focused on health issues affecting underserved com-
23 munities, including racial and ethnic minority com-
24 munities; and

1 ties to expand research on the link between health work-
2 force diversity and quality health care.

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

5 “(1) be a clinical, public health, or health serv-
6 ices research entity or other entity determined ap-
7 propriate by the Director; and

8 “(2) submit to the Secretary an application at
9 such time, in such manner, and containing such in-
10 formation as the Secretary may require.

11 “(c) USE OF FUNDS.—Amounts received under a
12 grant awarded under subsection (a) shall be used to sup-
13 port research that investigates the effect of health work-
14 force diversity on—

15 “(1) language access;

16 “(2) cultural competence;

17 “(3) patient satisfaction;

18 “(4) timeliness of care;

19 “(5) safety of care;

20 “(6) effectiveness of care;

21 “(7) efficiency of care;

22 “(8) patient outcomes;

23 “(9) community engagement;

24 “(10) resource allocation;

25 “(11) organizational structure;

1 “(12) compliance of care; or

2 “(13) other topics determined appropriate by
3 the Director.

4 “(d) PRIORITY.—In awarding grants under sub-
5 section (a), the Director shall give individualized consider-
6 ation to all relevant aspects of the applicant’s background.
7 Consideration of prior research experience involving the
8 health of underserved communities shall be such a factor.

9 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
10 is authorized to be appropriated to carry out this section
11 such sums as may be necessary for each of fiscal years
12 2021 through 2025.

13 **“SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.**

14 “(a) ESTABLISHMENT.—The Secretary, acting
15 through the Office of Minority Health, in collaboration
16 with the National Institute on Minority Health and Health
17 Disparities, the Office for Civil Rights, the Centers for
18 Disease Control and Prevention, the Centers for Medicare
19 & Medicaid Services, the Health Resources and Services
20 Administration, and other appropriate public and private
21 entities, shall establish and coordinate a health and health
22 care disparities education program to support, develop,
23 and implement educational initiatives and outreach strate-
24 gies that inform health care professionals and the public

1 about the existence of and methods to reduce racial and
2 ethnic disparities in health and health care.

3 “(b) ACTIVITIES.—The Secretary, through the edu-
4 cation program established under subsection (a), shall,
5 through the use of public awareness and outreach cam-
6 paigns targeting the general public and the medical com-
7 munity at large—

8 “(1) disseminate scientific evidence for the ex-
9 istence and extent of racial and ethnic disparities in
10 health care, including disparities that are not other-
11 wise attributable to known factors such as access to
12 care, patient preferences, or appropriateness of
13 intervention, as described in the 2002 Institute of
14 Medicine Report entitled ‘Unequal Treatment: Con-
15 fronting Racial and Ethnic Disparities in Health
16 Care’, as well as the impact of disparities related to
17 age, disability status, socioeconomic status, sex, gen-
18 der identity, and sexual orientation on racial and
19 ethnic minorities;

20 “(2) disseminate new research findings to
21 health care providers and patients to assist them in
22 understanding, reducing, and eliminating health and
23 health care disparities;

24 “(3) disseminate information about the impact
25 of linguistic and cultural barriers on health care

1 quality and the obligation of health providers who
2 receive Federal financial assistance to ensure that
3 individuals with limited English proficiency have ac-
4 cess to language access services;

5 “(4) disseminate information about the impor-
6 tance and legality of racial, ethnic, disability status,
7 socioeconomic status, sex, gender identity, and sex-
8 ual orientation, and primary language data collec-
9 tion, analysis, and reporting;

10 “(5) design and implement specific educational
11 initiatives to health care providers relating to health
12 and health care disparities;

13 “(6) assess the impact of the programs estab-
14 lished under this section in raising awareness of
15 health and health care disparities and providing in-
16 formation on available resources; and

17 “(7) design and implement specific educational
18 initiatives to educate the health care workforce relat-
19 ing to unconscious bias.

20 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2021 through 2025.”.

1 **SEC. 302. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
2 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
3 **ASIAN AMERICAN AND NATIVE AMERICAN PA-**
4 **CIFIC ISLANDER-SERVING INSTITUTIONS,**
5 **TRIBAL COLLEGES, REGIONAL COMMUNITY-**
6 **BASED ORGANIZATIONS, AND NATIONAL MI-**
7 **NORITY MEDICAL ASSOCIATIONS.**

8 (a) IN GENERAL.—Part B of title VII of the Public
9 Health Service Act (42 U.S.C. 293 et seq.) is amended
10 by adding at the end the following:

11 **“SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
12 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
13 **ASIAN AMERICAN AND NATIVE AMERICAN PA-**
14 **CIFIC ISLANDER-SERVING INSTITUTIONS,**
15 **AND TRIBAL COLLEGES.**

16 “(a) IN GENERAL.—The Secretary, acting through
17 the Administrator of the Health Resources and Services
18 Administration and in consultation with the Secretary of
19 Education, shall award grants to Hispanic-serving institu-
20 tions, historically Black colleges and universities, Asian
21 American and Native American Pacific Islander-serving
22 institutions, Tribal Colleges or Universities, regional com-
23 munity-based organizations, and national minority med-
24 ical associations, for counseling, mentoring and providing
25 information on financial assistance to prepare underrep-
26 resented minority individuals to enroll in and graduate

1 from health professional schools and to increase services
2 for underrepresented minority students including—

3 “(1) mentoring with underrepresented health
4 professionals; and

5 “(2) providing financial assistance information
6 for continued education and applications to health
7 professional schools.

8 “(b) DEFINITIONS.—In this section:

9 “(1) ASIAN AMERICAN AND NATIVE AMERICAN
10 PACIFIC ISLANDER-SERVING INSTITUTION.—The
11 term ‘Asian American and Native American Pacific
12 Islander-serving institution’ has the meaning given
13 such term in section 320(b) of the Higher Education
14 Act of 1965.

15 “(2) HISPANIC-SERVING INSTITUTION.—The
16 term ‘Hispanic-serving institution’ means an entity
17 that—

18 “(A) is a school or program for which
19 there is a definition under section 799B;

20 “(B) has an enrollment of full-time equiva-
21 lent students that is made up of at least 9 per-
22 cent Hispanic students;

23 “(C) has been effective in carrying out pro-
24 grams to recruit Hispanic individuals to enroll
25 in and graduate from the school;

1 “(D) has been effective in recruiting and
2 retaining Hispanic faculty members;

3 “(E) has a significant number of graduates
4 who are providing health services to medically
5 underserved populations or to individuals in
6 health professional shortage areas; and

7 “(F) is a Hispanic Center of Excellence in
8 Health Professions Education designated under
9 section 736(d)(2) of the Public Health Service
10 Act (42 U.S.C. 293(d)(2)).

11 “(3) HISTORICALLY BLACK COLLEGE AND UNI-
12 VERSITY.—The term ‘historically Black college and
13 university’ has the meaning given the term ‘part B
14 institution’ as defined in section 322 of the Higher
15 Education Act of 1965.

16 “(4) TRIBAL COLLEGE OR UNIVERSITY.—The
17 term ‘Tribal College or University’ has the meaning
18 given such term in section 316(b) of the Higher
19 Education Act of 1965.

20 “(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In
21 carrying out the National Health Service Corps Loan Re-
22 payment Program established under subpart III of part
23 D of title III and the loan repayment program under sec-
24 tion 317F, the Secretary shall ensure, notwithstanding
25 such subpart or section, that loan repayments of not less

1 than \$50,000 per year per person are awarded for repay-
2 ment of loans incurred for enrollment or participation of
3 underrepresented minority individuals in health profes-
4 sional schools and other health programs described in this
5 section.

6 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2021 through 2026.”.

10 **SEC. 303. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
11 **DISEASE CONTROL AND PREVENTION.**

12 Section 317F(c)(1) of the Public Health Service Act
13 (42 U.S.C. 247b–7(c)(1)) is amended—

14 (1) by striking “and” after “1994,”; and

15 (2) by inserting before the period at the end the
16 following: “, \$750,000 for fiscal year 2020, and such
17 sums as may be necessary for each of the fiscal
18 years 2021 through 2025”.

19 **SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
20 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
21 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

22 Part B of title VII of the Public Health Service Act
23 (42 U.S.C. 293 et seq.), as amended by section 302, is
24 further amended by adding at the end the following:

1 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
2 **GREE PROGRAMS.**

3 “(a) COOPERATIVE AGREEMENTS.—The Secretary,
4 acting through the Administrator of the Health Resources
5 and Services Administration, in consultation with the Di-
6 rector of the Centers for Disease Control and Prevention,
7 the Director of the Agency for Healthcare Research and
8 Quality, and the Deputy Assistant Secretary for Minority
9 Health, shall enter into cooperative agreements with
10 schools of public health and schools of allied health to de-
11 sign and implement online degree programs.

12 “(b) PRIORITY.—In entering into cooperative agree-
13 ments under this section, the Secretary shall give priority
14 to any school of public health or school of allied health
15 that has an established track record of serving medically
16 underserved communities.

17 “(c) REQUIREMENTS.—As a condition of entering
18 into a cooperative agreement with the Secretary under this
19 section, a school of public health or school of allied health
20 shall agree to design and implement an online degree pro-
21 gram that meets the following restrictions:

22 “(1) Enrollment of individuals who have ob-
23 tained a secondary school diploma or its recognized
24 equivalent.

1 viduals who are members of multiple minority or special
2 population groups.

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

4 Subtitle B of title XXXIV of the Public Health Serv-
5 ice Act, as added by section 301, is further amended by
6 inserting after section 3417 the following:

7 **“SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
8 **SERVICES CORPS.**

9 “(a) IN GENERAL.—The Director of the Centers for
10 Disease Control and Prevention, in collaboration with the
11 Administrator of the Health Resources and Services Ad-
12 ministration and the Deputy Assistant Secretary for Mi-
13 nority Health, shall award grants to eligible entities to in-
14 crease awareness among secondary and postsecondary stu-
15 dents of career opportunities in the health professions.

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

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

23 “(2) serve a health professional shortage area,
24 as determined by the Secretary;

1 “(3) work with students, including those from
2 racial and ethnic minority backgrounds, that have
3 expressed an interest in the health professions; and

4 “(4) submit to the Secretary an application at
5 such time, in such manner, and containing such in-
6 formation as the Secretary may require.

7 “(c) USE OF FUNDS.—Grant awards under sub-
8 section (a) shall be used to support internships that will
9 increase awareness among students of non-research-based,
10 career opportunities in the following health professions:

11 “(1) Medicine.

12 “(2) Nursing.

13 “(3) Public health.

14 “(4) Pharmacy.

15 “(5) Health administration and management.

16 “(6) Health policy.

17 “(7) Psychology.

18 “(8) Dentistry.

19 “(9) International health.

20 “(10) Social work.

21 “(11) Allied health.

22 “(12) Psychiatry.

23 “(13) Hospice care.

24 “(14) Community health, patient navigation,
25 and peer support.

1 “(15) Other professions determined appropriate
2 by the Director of the Centers for Disease Control
3 and Prevention.

4 “(d) PRIORITY.—In awarding grants under sub-
5 section (a), the Director of the Centers for Disease Con-
6 trol and Prevention shall give priority to those entities
7 that—

8 “(1) serve a high proportion of individuals from
9 disadvantaged backgrounds;

10 “(2) have experience in health disparity elimi-
11 nation programs;

12 “(3) facilitate the entry of disadvantaged indi-
13 viduals into institutions of higher education; and

14 “(4) provide counseling or other services de-
15 signed to assist disadvantaged individuals in success-
16 fully completing their education at the postsecondary
17 level.

18 “(e) STIPENDS.—

19 “(1) IN GENERAL.—Subject to paragraph (2),
20 an entity receiving a grant under this section may
21 use the funds made available through such grant to
22 award stipends for educational and living expenses
23 to students participating in the internship supported
24 by the grant.

1 “(2) LIMITATIONS.—A stipend awarded under
2 paragraph (1) to an individual—

3 “(A) may not be provided for a period that
4 exceeds 6 months; and

5 “(B) may not exceed \$20 per day for an
6 individual (notwithstanding any other provision
7 of law regarding the amount of a stipend).

8 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2021 through 2026.

12 **“SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
13 **PROGRAM.**

14 “(a) IN GENERAL.—The Director of the Centers for
15 Disease Control and Prevention, in collaboration with the
16 Deputy Assistant Secretary for Minority Health, shall
17 award scholarships to eligible individuals under subsection
18 (b) who seek a career in public health.

19 “(b) ELIGIBILITY.—To be eligible to receive a schol-
20 arship under subsection (a), an individual shall—

21 “(1) have interest, knowledge, or skill in public
22 health research or public health practice, or other
23 health professions as determined appropriate by the
24 Director of the Centers for Disease Control and Pre-
25 vention;

1 “(2) reside in a health professional shortage
2 area as determined by the Secretary;

3 “(3) demonstrate promise for becoming a leader
4 in public health;

5 “(4) secure admission to a 4-year institution of
6 higher education; and

7 “(5) submit to the Secretary an application at
8 such time, in such manner, and containing such in-
9 formation as the Secretary may require.

10 “(c) USE OF FUNDS.—Amounts received under an
11 award under subsection (a) shall be used to support oppor-
12 tunities for students to become public health professionals.

13 “(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Director shall give priority to those stu-
15 dents that—

16 “(1) are from disadvantaged backgrounds;

17 “(2) have secured admissions to a minority-
18 serving institution; and

19 “(3) have identified a health professional as a
20 mentor at their school or institution and an aca-
21 demic advisor to assist in the completion of their
22 baccalaureate degree.

23 “(e) SCHOLARSHIPS.—The Secretary may approve
24 payment of scholarships under this section for such indi-
25 viduals for any period of education in student under-

1 graduate tenure, except that such a scholarship may not
2 be provided to an individual for more than 4 years, and
3 such a scholarship may not exceed \$10,000 per academic
4 year for an individual (notwithstanding any other provi-
5 sion of law regarding the amount of a scholarship).

6 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2021 through 2025.

10 **“SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH**
11 **FELLOWSHIP PROGRAM.**

12 “(a) IN GENERAL.—The Director of the Centers for
13 Disease Control and Prevention, in collaboration with the
14 Deputy Assistant Secretary for Minority Health, the As-
15 sistant Secretary for Mental Health and Substance Use,
16 and the Director of the Indian Health Services, shall
17 award research fellowships to eligible individuals under
18 subsection (b) to conduct research that will examine gen-
19 der and health disparities and to pursue a career in the
20 health professions.

21 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
22 ship under subsection (a), an individual shall—

23 “(1) have experience in health research or pub-
24 lic health practice;

1 “(2) reside in a health professional shortage
2 area as designated by the Secretary under section
3 332;

4 “(3) have expressed an interest in the health
5 professions;

6 “(4) demonstrate promise for becoming a leader
7 in the field of women’s health;

8 “(5) secure admission to a health professions
9 school or graduate program with an emphasis in
10 gender studies; and

11 “(6) submit to the Secretary an application at
12 such time, in such manner, and containing such in-
13 formation as the Secretary may require.

14 “(c) USE OF FUNDS.—A fellowship awarded under
15 subsection (a) to an eligible individual shall be used to
16 support an opportunity for the individual to become a re-
17 searcher and advance the research base on the intersection
18 between gender and health.

19 “(d) PRIORITY.—In awarding fellowships under sub-
20 section (a), the Director of the Centers for Disease Con-
21 trol and Prevention shall give priority to those applicants
22 that—

23 “(1) are from disadvantaged backgrounds; and

24 “(2) have identified a mentor and academic ad-
25 visor who will assist in the completion of their grad-

1 uate or professional degree and have secured a re-
2 search assistant position with a researcher working
3 in the area of gender and health.

4 “(e) FELLOWSHIPS.—The Director of the Centers for
5 Disease Control and Prevention may approve fellowships
6 for individuals under this section for any period of edu-
7 cation in the student’s graduate or health profession ten-
8 ure, except that such a fellowship may not be provided
9 to an individual for more than 3 years, and such a fellow-
10 ship may not exceed \$18,000 per academic year for an
11 individual (notwithstanding any other provision of law re-
12 garding the amount of a fellowship).

13 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
14 is authorized to be appropriated to carry out this section
15 such sums as may be necessary for each of fiscal years
16 2021 through 2025.

17 **“SEC. 3421. PAUL DAVID WELLSTONE INTERNATIONAL**
18 **HEALTH FELLOWSHIP PROGRAM.**

19 “(a) IN GENERAL.—The Director of the Agency for
20 Healthcare Research and Quality, in collaboration with
21 the Deputy Assistant Secretary for Minority Health, shall
22 award research fellowships to eligible individuals under
23 subsection (b) to advance their understanding of inter-
24 national health.

1 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
2 ship under subsection (a), an individual shall—

3 “(1) have educational experience in the field of
4 international health;

5 “(2) reside in a health professional shortage
6 area as determined by the Secretary;

7 “(3) demonstrate promise for becoming a leader
8 in the field of international health;

9 “(4) be a college senior or recent graduate of
10 a 4-year institution of higher education; and

11 “(5) submit to the Secretary an application at
12 such time, in such manner, and containing such in-
13 formation as the Secretary may require.

14 “(c) USE OF FUNDS.—A fellowship awarded under
15 subsection (a) to an eligible individual shall be used to
16 support an opportunity for the individual to become a
17 health professional and to advance the knowledge of the
18 individual about international issues relating to health
19 care access and quality.

20 “(d) PRIORITY.—In awarding fellowships under sub-
21 section (a), the Director shall give priority to eligible indi-
22 viduals that—

23 “(1) are from a disadvantaged background; and

24 “(2) have identified a mentor at a health pro-
25 fessions school or institution, an academic advisor to

1 assist in the completion of their graduate or profes-
2 sional degree, and an advisor from an international
3 health non-governmental organization, private volun-
4 teer organization, or other international institution
5 or program that focuses on increasing health care
6 access and quality for residents in developing coun-
7 tries.

8 “(e) FELLOWSHIPS.—A fellowship awarded under
9 this section may not—

10 “(1) be provided to an eligible individual for
11 more than a period of 6 months;

12 “(2) be awarded to a graduate of a 4-year insti-
13 tution of higher education that has not been enrolled
14 in such institution for more than 1 year; and

15 “(3) exceed \$4,000 per academic year (notwith-
16 standing any other provision of law regarding the
17 amount of a fellowship).

18 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to carry out this section
20 such sums as may be necessary for each of fiscal years
21 2021 through 2025.

22 **“SEC. 3422. EDWARD R. ROYBAL HEALTH SCHOLAR PRO-**
23 **GRAM.**

24 “(a) IN GENERAL.—The Director of the Agency for
25 Healthcare Research and Quality, the Director of the Cen-

1 ters for Medicare & Medicaid Services, and the Adminis-
2 trator of the Health Resources and Services Administra-
3 tion, in collaboration with the Deputy Assistant Secretary
4 for Minority Health, shall award grants to eligible entities
5 to expose entering graduate students to the health profes-
6 sions.

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

9 “(1) be a clinical, public health, or health serv-
10 ices organization, community-based, academic, or
11 nonprofit entity, or other entity determined appro-
12 priate by the Director of the Agency for Healthcare
13 Research and Quality;

14 “(2) serve in a health professional shortage
15 area as designated by the Secretary under section
16 332;

17 “(3) work with students obtaining a degree in
18 the health professions; and

19 “(4) submit to the Secretary an application at
20 such time, in such manner, and containing such in-
21 formation as the Secretary may require.

22 “(c) USE OF FUNDS.—Amounts received under a
23 grant awarded under subsection (a) shall be used to sup-
24 port opportunities that expose students to non-research-
25 based health professions, including—

1 “(1) public health policy;

2 “(2) health care and pharmaceutical policy;

3 “(3) health care administration and manage-
4 ment;

5 “(4) health economics; and

6 “(5) other professions determined appropriate
7 by the Director of the Agency for Healthcare Re-
8 search and Quality, the Director of the Centers for
9 Medicare & Medicaid Services, or the Administrator
10 of the Health Resources and Services Administra-
11 tion.

12 “(d) PRIORITY.—In awarding grants under sub-
13 section (a), the Director of the Agency for Healthcare Re-
14 search and Quality, the Director of the Centers for Medi-
15 care & Medicaid Services, and the Administrator of the
16 Health Resources and Services Administration, in collabo-
17 ration with the Deputy Assistant for Secretary for Minor-
18 ity Health, shall give priority to those entities that—

19 “(1) have experience with health disparity elimi-
20 nation programs;

21 “(2) facilitate training in the fields described in
22 subsection (c); and

23 “(3) provide counseling or other services de-
24 signed to assist students in successfully completing
25 their education at the postsecondary level.

1 “(e) STIPENDS.—

2 “(1) IN GENERAL.—Subject to paragraph (2),
3 an entity receiving a grant under this section may
4 use the funds made available through such grant to
5 award stipends for educational and living expenses
6 to students participating in the opportunities sup-
7 ported by the grant.

8 “(2) LIMITATIONS.—A stipend awarded under
9 paragraph (1) to an individual—

10 “(A) may not be provided for a period that
11 exceeds 2 months; and

12 “(B) may not exceed \$100 per day (not-
13 withstanding any other provision of law regard-
14 ing the amount of a stipend).

15 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section
17 such sums as may be necessary for each of fiscal years
18 2021 through 2025.

19 **“SEC. 3423. LEADERSHIP FELLOWSHIP PROGRAMS.**

20 “(a) IN GENERAL.—The Secretary shall award
21 grants to national minority medical or health professional
22 associations to develop leadership fellowship programs for
23 underrepresented health professionals in order to—

1 “(1) assist such professionals in becoming fu-
2 ture leaders in public health and health care delivery
3 institutions; and

4 “(2) increase diversity in decision-making posi-
5 tions that can improve the health of underserved
6 communities.

7 “(b) USE OF FUNDS.—A leadership fellowship pro-
8 gram supported under this section shall—

9 “(1) focus on training mid-career physicians
10 and health care executives who have documented
11 leadership experience and a commitment to public
12 health services in underserved communities; and

13 “(2) support Federal public health policy and
14 budget programs, and priorities that impact health
15 equity, through activities such as didactic lectures
16 and leader site visits.

17 “(c) PERIOD OF GRANTS.—The period during which
18 payments are made under a grant awarded under sub-
19 section (a) may not exceed 3 years.

20 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2021 through 2026.”.

1 **SEC. 307. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
2 **PROGRAM.**

3 Section 402E of the Higher Education Act of 1965
4 (20 U.S.C. 1070a–15) is amended by striking subsection
5 (g) and inserting the following:

6 “(g) **COLLABORATION IN HEALTH PROFESSION DI-**
7 **VERSITY TRAINING PROGRAMS.**—The Secretary shall co-
8 ordinate with the Secretary of Health and Human Serv-
9 ices to ensure that there is collaboration between the goals
10 of the program under this section and programs of the
11 Health Resources and Services Administration that pro-
12 mote health workforce diversity. The Secretary of Edu-
13 cation shall take such measures as may be necessary to
14 encourage students participating in projects assisted
15 under this section to consider health profession careers.

16 “(h) **FUNDING.**—From amounts appropriated pursu-
17 ant to the authority of section 402A(g), the Secretary
18 shall, to the extent practicable, allocate funds for projects
19 authorized by this section in an amount which is not less
20 than \$31,000,000 for each of the fiscal years 2021
21 through 2026.”.

1 **SEC. 308. RULES FOR DETERMINATION OF FULL-TIME**
2 **EQUIVALENT RESIDENTS FOR COST-REPORT-**
3 **ING PERIODS.**

4 (a) DGME DETERMINATIONS.—Section 1886(h)(4)
5 of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as
6 amended by section 204(a), is amended—

7 (1) in subparagraph (E), by striking “Subject
8 to subparagraphs (J) and (K), such rules” and in-
9 serting “Subject to subparagraphs (J), (K), and
10 (M), such rules”;

11 (2) in subparagraph (J), by striking “Such
12 rules” and inserting “Subject to subparagraph (M),
13 such rules”;

14 (3) in subparagraph (K), by striking “In deter-
15 mining” and inserting “Subject to subparagraph
16 (M), in determining”; and

17 (4) by adding at the end the following new sub-
18 paragraph:

19 “(M) TREATMENT OF CERTAIN RESIDENTS
20 AND INTERNS.—For purposes of cost-reporting
21 periods beginning on or after October 1, 2021,
22 in determining the hospital’s number of full-
23 time equivalent residents for purposes of this
24 paragraph, all the time spent by an intern or
25 resident in an approved medical residency train-
26 ing program shall be counted toward the deter-

1 mination of full-time equivalency if the hos-
2 pital—

3 “(i) is recognized as a subsection (d)
4 hospital;

5 “(ii) is recognized as a subsection (d)
6 Puerto Rico hospital;

7 “(iii) is reimbursed under a reim-
8 bursement system authorized under section
9 1814(b)(3); or

10 “(iv) is a provider-based hospital out-
11 patient department.”.

12 (b) IME DETERMINATIONS.—Section
13 1886(d)(5)(B)(xi) of the Social Security Act (42 U.S.C.
14 1395ww(d)(5)(B)(xi)), as redesignated by section 204(b),
15 is amended—

16 (1) in subclause (II), by striking “In deter-
17 mining” and inserting “Subject to subclause (IV), in
18 determining”;

19 (2) in subclause (III), by striking “In deter-
20 mining” and inserting “Subject to subclause (IV), in
21 determining”; and

22 (3) by inserting after subclause (III) the fol-
23 lowing new subclause:

24 “(IV) For purposes of cost-reporting peri-
25 ods beginning on or after October 1, 2021, the

1 provisions of subparagraph (M) of subsection
2 (h)(4) shall apply under this subparagraph in
3 the same manner as they apply under such sub-
4 section.”.

5 **SEC. 309. DEVELOPING AND IMPLEMENTING STRATEGIES**
6 **FOR LOCAL HEALTH EQUITY.**

7 (a) GRANTS.—The Secretary of Health and Human
8 Services, acting jointly with the Secretary of Education
9 and the Secretary of Labor, shall make grants to institu-
10 tions of higher education for the purposes of—

11 (1) in accordance with subsection (b), devel-
12 oping capacity—

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

15 (B) to serve as national models of driving
16 local health equity;

17 (2) in accordance with subsection (c), devel-
18 oping a strategic partnership with the community in
19 which the institution is located; and

20 (3) collecting data on, and periodically evalu-
21 ating, the effectiveness of the institution’s programs
22 funded through this section to enable the institution
23 to adapt accordingly for maximum efficiency and
24 success.

1 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
2 HEALTH EQUITY.—As a condition on receipt of a grant
3 under subsection (a), an institution of higher education
4 shall agree to use the grant to build an evidence base for
5 successful strategies for increasing local health equity, and
6 to serve as a national model of driving local health equity,
7 by supporting—

8 (1) resources to strengthen institutional metrics
9 and capacity to execute institution-wide health work-
10 force goals that can serve as models for increasing
11 health equity in communities across the United
12 States;

13 (2) collaborations among a cohort of institu-
14 tions in implementing systemic change, partnership
15 development, and programmatic efforts supportive of
16 health equity goals across disciplines and popu-
17 lations; and

18 (3) enhanced or newly developed data systems
19 and research infrastructure capable of informing
20 current and future workforce efforts and building a
21 foundation for a broader research agenda targeting
22 urban health disparities.

23 (c) STRATEGIC PARTNERSHIPS.—As a condition on
24 receipt of a grant under subsection (a), an institution of
25 higher education shall agree to use the grant to develop

1 a strategic partnership with the community in which the
2 institution is located for the purposes of—

3 (1) strengthening connections between the insti-
4 tution and the community—

5 (A) to improve evaluation of and address
6 the community's health and health workforce
7 needs; and

8 (B) to engage the community in health
9 workforce development;

10 (2) developing, enhancing, or accelerating inno-
11 vative undergraduate and graduate programs in the
12 biomedical sciences and health professions; and

13 (3) strengthening pipeline programs in the bio-
14 medical sciences and health professions, including by
15 developing partnerships between institutions of high-
16 er education and elementary schools and secondary
17 schools to recruit the next generation of health pro-
18 fessionals earlier in the pipeline to a health care ca-
19 reer.

20 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
21 authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2021 through 2026.

1 **SEC. 310. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**
2 **IORAL HEALTH SOCIAL WORKERS.**

3 Section 455 of the Higher Education Act of 1965 (20
4 U.S.C. 1087e) is amended by adding at the end the fol-
5 lowing:

6 “(r) REPAYMENT PLAN FOR MENTAL AND BEHAV-
7 IORAL HEALTH SOCIAL WORKERS.—

8 “(1) IN GENERAL.—The Secretary shall cancel
9 the balance of interest and principal due, in accord-
10 ance with paragraph (2), on any eligible Federal Di-
11 rect Loan not in default for a borrower who—

12 “(A) has made 120 monthly payments on
13 the eligible Federal Direct Loan after October
14 1, 2020, pursuant to any one or a combination
15 of the following—

16 “(i) payments under an income-based
17 repayment plan under section 493C;

18 “(ii) payments under a standard re-
19 payment plan under subsection (d)(1)(A),
20 based on a 10-year repayment period;

21 “(iii) monthly payments under a re-
22 payment plan under subsection (d)(1) or
23 (g) of not less than the monthly amount
24 calculated under subsection (d)(1)(A),
25 based on a 10-year repayment period; or

1 “(iv) payments under an income con-
2 tingent repayment plan under subsection
3 (d)(1)(D); and

4 “(B)(i) is employed as a mental health or
5 behavioral health social worker, as defined by
6 the Secretary by regulation, at the time of such
7 forgiveness; and

8 “(ii) has been employed as such a mental
9 health or behavioral health social worker during
10 the period in which the borrower makes each of
11 the 120 payments as described in subparagraph
12 (A).

13 “(2) LOAN CANCELLATION AMOUNT.—After the
14 conclusion of the employment period described in
15 paragraph (1), the Secretary shall cancel the obliga-
16 tion to repay the balance of principal and interest
17 due as of the time of such cancellation, on the eligi-
18 ble Federal Direct Loans made to the borrower
19 under this part.

20 “(3) INELIGIBILITY FOR DOUBLE BENEFITS.—
21 No borrower may, for the same employment as a
22 mental health or behavioral health social worker, re-
23 ceive a reduction of loan obligations under both this
24 subsection and subsection (m), 428J, 428K, 428L,
25 or 460.

1 “(4) DEFINITION OF ELIGIBLE FEDERAL DI-
2 RECT LOAN.—In this subsection, the term ‘eligible
3 Federal Direct Loan’ means a Federal Direct Staf-
4 ford Loan, Federal Direct PLUS Loan, Federal Di-
5 rect Unsubsidized Stafford Loan, or a Federal Di-
6 rect Consolidation Loan.”.

7 **SEC. 311. HEALTH PROFESSIONS WORKFORCE FUND.**

8 (a) ESTABLISHMENT.—There is established in the
9 Health Resources and Services Administration of the De-
10 partment of Health and Human Services a Health Profes-
11 sions Workforce Fund to provide for expanded and sus-
12 tained national investment in the health professions and
13 nursing workforce development programs under title VII
14 and title VIII of the Public Health Service Act (42 U.S.C.
15 292 et seq.; 42 U.S.C. 296 et seq.).

16 (b) FUNDING.—

17 (1) IN GENERAL.—There is authorized to be
18 appropriated, and there is appropriated, out of any
19 monies in the Treasury not otherwise appropriated,
20 to the Health Professions Workforce Fund—

21 (A) \$355,000,000 for fiscal year 2021;

22 (B) \$375,000,000 for fiscal year 2022;

23 (C) \$392,000,000 for fiscal year 2023;

24 (D) \$412,000,000 for fiscal year 2024;

25 (E) \$432,000,000 for fiscal year 2025;

- 1 (F) \$454,000,000 for fiscal year 2026;
2 (G) \$476,000,000 for fiscal year 2027;
3 (H) \$500,000,000 for fiscal year 2028;
4 (I) \$525,000,000 for fiscal year 2029; and
5 (J) \$552,000,000 for fiscal year 2030.

6 (2) HEALTH PROFESSIONS EDUCATION PRO-
7 GRAMS.—For the purpose of carrying out health
8 professions education programs authorized under
9 title VII of the Public Health Service Act, in addi-
10 tion to any other amounts authorized to be appro-
11 priated for such purpose, there is authorized to be
12 appropriated out of any monies in the Health Pro-
13 fessions Workforce Fund, the following:

- 14 (A) \$240,000,000 for fiscal year 2021.
15 (B) \$253,000,000 for fiscal year 2022.
16 (C) \$265,000,000 for fiscal year 2023.
17 (D) \$278,000,000 for fiscal year 2024.
18 (E) \$292,000,000 for fiscal year 2025.
19 (F) \$307,000,000 for fiscal year 2026.
20 (G) \$322,000,000 for fiscal year 2027.
21 (H) \$338,000,000 for fiscal year 2028.
22 (I) \$355,000,000 for fiscal year 2029.
23 (J) \$373,000,000 for fiscal year 2030.

24 (3) NURSING WORKFORCE DEVELOPMENT PRO-
25 GRAMS.—For the purpose of carrying out nursing

1 workforce development programs authorized under
2 Title VIII of the Public Health Service Act, in addi-
3 tion to any other amounts authorized to be appro-
4 priated for such purpose, there is authorized to be
5 appropriated out of any monies in the Health Pro-
6 fessions Workforce Fund, the following:

7 (A) \$115,000,000 for fiscal year 2021.

8 (B) \$122,000,000 for fiscal year 2022.

9 (C) \$127,000,000 for fiscal year 2023.

10 (D) \$134,000,000 for fiscal year 2024.

11 (E) \$140,000,000 for fiscal year 2025.

12 (F) \$147,000,000 for fiscal year 2026.

13 (G) \$154,000,000 for fiscal year 2027.

14 (H) \$162,000,000 for fiscal year 2028.

15 (I) \$170,000,000 for fiscal year 2029.

16 (J) \$179,000,000 for fiscal year 2030.

17 **SEC. 312. FINDINGS; SENSE OF CONGRESS RELATING TO**
18 **GRADUATE MEDICAL EDUCATION.**

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

20 (1) Projections by the Association of American
21 Medical Colleges and other expert entities, such as
22 the Health Resources and Services Administration,
23 have indicated a nationwide shortage of up to
24 121,900 physicians, split evenly between primary
25 care and specialists, by 2032.

1 (2) Primarily due to the growing and aging
2 population, over the next decade, physician demand
3 is expected to grow up to 17 percent.

4 (3) The United States Census Bureau estimates
5 that the United States population will grow from
6 321 million in 2015 to 347 million in 2025. Further,
7 the number of Medicare beneficiaries is estimated to
8 increase from 47,800,000 in 2015 to approximately
9 66,000,000 in 2025.

10 (4) Approximately 36 percent of practicing phy-
11 sicians are over the age of 55 and are likely to retire
12 within the next decade.

13 (5) A nationwide physician shortage will result
14 in many people in the United States waiting longer
15 and traveling farther for health care; seeking non-
16 emergent care in emergency departments; and delay-
17 ing treatment until their health care needs become
18 more serious, complex, and costly.

19 (6) Changing demographics (such as an aging
20 population), new health care delivery models (such
21 as medical homes), and other factors (such as dis-
22 aster preparedness) are contributing to a shortage of
23 both generalist and specialist physicians.

24 (7) These shortages will have the most severe
25 impact on vulnerable and underserved populations,

1 including racial and ethnic minorities and the ap-
2 proximately 20 percent of people in the United
3 States who live in rural or inner-city locations des-
4 ignated as health professional shortage areas.

5 (8) The health care utilization equity model of
6 the Association of American Medical Colleges esti-
7 mates that if racial and ethnic minorities and indi-
8 viduals from rural areas utilized health care in a
9 similar way to their Caucasian counterparts living in
10 metropolitan areas, the physician shortage would re-
11 quire an additional 96,000 physicians.

12 (9) To address the physician shortage in rural
13 and medically underserved areas, medical education
14 and training need to be accessible to underrep-
15 resented minorities (African American, Hispanic,
16 Native American, and Native Hawaiian), and need
17 to increase pathway programs for underrepresented
18 minorities who make up less than 12 percent as well
19 as for international medical graduates who make up
20 25 percent of graduate medical education. Immigra-
21 tion pathways like student, exchange-visitor, and em-
22 ployment visas, and programs like the National In-
23 terest Waiver and Conrad 30 J-1 Visa Waiver, help
24 improve health access across the United States.

1 (10) United States medical school enrollment
2 will grow by 30 percent from 2018 to 2019 to help
3 reduce the shortage of quality physicians in the
4 United States.

5 (11) An increase in United States medical
6 school graduates must be accompanied by an in-
7 crease of 4,000 graduate medical education training
8 positions each year.

9 (12) Graduate medical education programs and
10 teaching hospitals provide venues in which the next
11 generation of physicians learns to work collabo-
12 ratively with other physicians and health profes-
13 sionals, adopt more efficient care delivery models
14 (such as care coordination and medical homes), in-
15 corporate health information technology and elec-
16 tronic health records in every aspect of their work,
17 apply new methods of assuring quality and safety,
18 and participate in groundbreaking clinical and public
19 health research.

20 (13) The Medicare program under title XVIII
21 of the Social Security Act (42 U.S.C. 1395 et seq.)
22 (having more beneficiaries than any other health
23 care program), supports its “fair share” of the costs
24 associated with graduate medical education.

1 (14) In general, the level of support of graduate
2 medical education by the Medicare program has
3 been capped since 1997 and has not been increased
4 to support the expansion of graduate medical edu-
5 cation programs needed to avert the projected physi-
6 cian shortage or to accommodate the increase in
7 United States medical school graduates.

8 (b) SENSE OF CONGRESS.—It is the sense of Con-
9 gress that eliminating the limit of the number of residency
10 positions that receive some level of Medicare support
11 under section 1886(h) of the Social Security Act (42
12 U.S.C. 1395ww(h)), also referred to as the Medical grad-
13 uate medical education cap, is critical to—

14 (1) ensuring an appropriate supply of physi-
15 cians to meet the health care needs in the United
16 States;

17 (2) facilitating equitable access for all who seek
18 health care; and

19 (3) mitigating disparities in health and health
20 care.

21 **SEC. 313. CAREER SUPPORT FOR SKILLED, INTERNATION-**
22 **ALLY EDUCATED HEALTH PROFESSIONALS.**

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

24 (1) According to the Association of Schools and
25 Programs of Public Health, projections indicate a

1 nationwide shortage of up to 250,000 public health
2 workers needed by 2020.

3 (2) Similar trends are projected for other health
4 professions indicating shortages across disciplines,
5 including within the fields of nursing (500,000 by
6 2025), dentistry (15,000 by 2025), pharmacy
7 (38,000 by 2030), mental and behavioral health, pri-
8 mary care (46,000 by 2025), and community and al-
9 lied health.

10 (3) A nationwide health workforce shortage will
11 result in serious health threats and more severe and
12 costly health care needs, due to, in part, a delayed
13 response to food-borne outbreaks, emerging infec-
14 tious diseases, natural disasters, fewer cancer
15 screenings, and delayed treatment.

16 (4) Vulnerable and underserved populations and
17 health professional shortage areas will be most se-
18 verely impacted by the health workforce shortage.

19 (5) According to the Migration Policy Institute,
20 more than 2,000,000 college-educated immigrants in
21 the United States today are unemployed or under-
22 employed in low- or semi-skilled jobs that fail to
23 draw on their education and expertise.

1 (6) Approximately 2 out of every 5 internation-
2 ally educated immigrants are unemployed or under-
3 employed.

4 (7) According to the Drexel University Center
5 for Labor Markets and Policy, underemployment for
6 internationally educated immigrant women is 28 per-
7 cent higher than for their male counterparts.

8 (8) According to the Drexel University Center
9 for Labor Markets and Policy, the mean annual
10 earnings of underemployed immigrants were
11 \$32,000, or 43 percent less than United States born
12 college graduates employed in the college labor mar-
13 ket.

14 (9) According to Upwardly Global and the Wel-
15 come Back Initiative, with proper guidance and sup-
16 port, underemployed skilled immigrants typically in-
17 crease their income by 215 percent to 900 percent.

18 (10) According to the Brookings Institution and
19 the Partnership for a New American Economy, im-
20 migrants working in the health workforce are, on av-
21 erage, better educated than United States-born
22 workers in the health workforce.

23 (b) GRANTS TO ELIGIBLE ENTITIES.—

24 (1) AUTHORITY TO PROVIDE GRANTS.—The
25 Secretary of Health and Human Services, acting

1 through the Bureau of Health Workforce within the
2 Health Resources and Services Administration, the
3 National Institute on Minority Health and Health
4 Disparities, or the Office of Minority Health (in this
5 section referred to as the “Secretary”), may award
6 grants to eligible entities to carry out activities de-
7 scribed in subsection (c).

8 (2) ELIGIBILITY.—To be eligible to receive a
9 grant under this section, an entity shall—

10 (A) be a clinical, public health, or health
11 services organization, a community-based or
12 nonprofit entity, an academic institution, a
13 faith-based organization, a State, county, or
14 local government, an area health education cen-
15 ter, or another entity determined appropriate by
16 the Secretary; and

17 (B) submit to the Secretary an application
18 at such time, in such manner, and containing
19 such information as the Secretary may require.

20 (c) AUTHORIZED ACTIVITIES.—A grant awarded
21 under this section shall be used—

22 (1) to provide services to assist unemployed and
23 underemployed skilled immigrants, residing in the
24 United States, who have legal, permanent work au-
25 thorization and who are internationally educated

1 health professionals, enter into the health workforce
2 of the United States with employment matching
3 their health professional skills and education, and
4 advance in employment to positions that better
5 match their health professional education and exper-
6 tise;

7 (2) to provide training opportunities to reduce
8 barriers to entry and advancement in the health
9 workforce for skilled, internationally educated immi-
10 grants;

11 (3) to educate employers regarding the abilities
12 and capacities of internationally educated health
13 professionals;

14 (4) to assist in the evaluation of foreign creden-
15 tials;

16 (5) to support preceptorships for international
17 medical graduates in hospital primary care training;
18 and

19 (6) to facilitate access to contextualized and ac-
20 celerated courses on English as a second language.

21 **SEC. 314. STUDY AND REPORT ON STRATEGIES FOR IN-**
22 **CREASING DIVERSITY.**

23 (a) STUDY.—The Comptroller General of the United
24 States shall conduct a study on strategies for increasing
25 the diversity of the health professional workforce. Such

1 study shall include an analysis of strategies for increasing
2 the number of health professionals from rural, lower in-
3 come, and underrepresented minority communities, includ-
4 ing which strategies are most effective for achieving such
5 goal.

6 (b) REPORT.—Not later than 2 years after the date
7 of enactment of this Act, the Comptroller General shall
8 submit to Congress a report on the study conducted under
9 subsection (a), together with recommendations for such
10 legislation and administrative action as the Comptroller
11 General determines appropriate.

12 **SEC. 315. CONRAD STATE 30 AND PHYSICIAN RETENTION.**

13 (a) CONRAD STATE 30 PROGRAM EXTENSION.—Sec-
14 tion 220(c) of the Immigration and Nationality Technical
15 Corrections Act of 1994 (Public Law 103–416; 8 U.S.C.
16 1182 note) is amended by striking “September 30, 2015”
17 and inserting “September 30, 2021”.

18 (b) RETAINING PHYSICIANS WHO HAVE PRACTICED
19 IN MEDICALLY UNDERSERVED COMMUNITIES.—Section
20 201(b)(1) of the Immigration and Nationality Act (8
21 U.S.C. 1151(b)(1)) is amended by adding at the end the
22 following:

23 “(F)(i) Alien physicians who have com-
24 pleted service requirements of a waiver re-

1 quested under section 203(b)(2)(B)(ii), includ-
2 ing—

3 “(I) alien physicians who completed
4 such service before the date of the enact-
5 ment of the Conrad State 30 and Physi-
6 cian Access Act; and

7 “(II) the spouse or children of an
8 alien physician described in subclause (I).

9 “(ii) Nothing in this subparagraph may be
10 construed—

11 “(I) to prevent the filing of a petition
12 with the Secretary of Homeland Security
13 for classification under section 204(a) or
14 the filing of an application for adjustment
15 of status under section 245 by an alien
16 physician described in this subparagraph
17 before the date by which such alien physi-
18 cian has completed the service described in
19 section 214(l) or worked full-time as a
20 physician for an aggregate of 5 years at
21 the location identified in the section 214(l)
22 waiver or in an area or areas designated by
23 the Secretary of Health and Human Serv-
24 ices as having a shortage of health care
25 professionals; or

1 “(II) to permit the Secretary of
2 Homeland Security to grant a petition or
3 application described in subclause (I) until
4 the alien has satisfied all of the require-
5 ments of the waiver received under section
6 214(l).”.

7 (c) EMPLOYMENT PROTECTIONS FOR PHYSICIANS.—

8 (1) EXCEPTIONS TO 2-YEAR FOREIGN RESI-
9 DENCY REQUIREMENT.—Section 214(l)(1) of the
10 Immigration and Nationality Act (8 U.S.C.
11 1184(l)(1)) is amended—

12 (A) in the matter preceding subparagraph
13 (A), by striking “Attorney General” and insert-
14 ing “Secretary of Homeland Security”;

15 (B) in subparagraph (A), by striking “Di-
16 rector of the United States Information Agen-
17 cy” and inserting “Secretary of State”;

18 (C) in subparagraph (B), by inserting “,
19 except as provided in paragraphs (7) and (8)”
20 before the semicolon at the end;

21 (D) in subparagraph (C), by striking
22 clauses (i) and (ii) and inserting the following:

23 “(i) the alien demonstrates a bona
24 fide offer of full-time employment at a
25 health facility or health care organization,

1 which employment has been determined by
2 the Secretary of Homeland Security to be
3 in the public interest;

4 “(ii) the alien—

5 “(I) has accepted employment
6 with the health facility or health care
7 organization in a geographic area or
8 areas which are designated by the
9 Secretary of Health and Human Serv-
10 ices as having a shortage of health
11 care professionals;

12 “(II) begins employment by the
13 later of the date that is—

14 “(aa) 120 days after receiv-
15 ing such waiver;

16 “(bb) 120 days after com-
17 pleting graduate medical edu-
18 cation or training under a pro-
19 gram approved pursuant to sec-
20 tion 212(j)(1); or

21 “(cc) 120 days after receiv-
22 ing nonimmigrant status or em-
23 ployment authorization, if the
24 alien or the alien’s employer peti-
25 tions for such nonimmigrant sta-

1 tus or employment authorization
2 not later than 120 days after the
3 date on which the alien completes
4 his or her graduate medical edu-
5 cation or training under a pro-
6 gram approved pursuant to sec-
7 tion 212(j)(1); and

8 “(III) agrees to continue to work
9 for a total of not less than 3 years in
10 the status authorized for such employ-
11 ment under this subsection, except as
12 provided in paragraph (8).”; and

13 (E) in subparagraph (D), in the matter
14 preceding clause (i), by inserting “(except as
15 provided in paragraph (8)).

16 (2) ALLOWABLE VISA STATUS FOR PHYSICIANS
17 FULFILLING WAIVER REQUIREMENTS IN MEDICALLY
18 UNDERSERVED AREAS.—Section 214(l)(2)(A) of
19 such Act (8 U.S.C. 1184(l)(2)(A)) is amended to
20 read as follows:

21 “(A) Upon the request of an interested
22 Federal agency or an interested State agency
23 for recommendation of a waiver under this sec-
24 tion by a physician who is maintaining valid
25 nonimmigrant status under section

1 101(a)(15)(J) and a favorable recommendation
2 by the Secretary of State, the Secretary of
3 Homeland Security may change the status of
4 such physician to any status authorized for em-
5 ployment under this Act. The numerical limita-
6 tions contained in subsection (g)(1)(A) shall not
7 apply to any alien whose status is changed
8 under this subparagraph.”.

9 (3) VIOLATION OF AGREEMENTS.—Section
10 214(l)(3)(A) of such Act (8 U.S.C. 1184(l)(3)(A)) is
11 amended by inserting “substantial requirement of
12 an” before “agreement entered into”.

13 (4) PHYSICIAN EMPLOYMENT IN UNDERSERVED
14 AREAS.—Section 214(l) of such Act (8 U.S.C.
15 1184(l)), as amended by this section, is further
16 amended by adding at the end the following:

17 “(4)(A) If an interested State agency denies the
18 application for a waiver under paragraph (1)(B)
19 from a physician pursuing graduate medical edu-
20 cation or training pursuant to section 101(a)(15)(J)
21 because the State has requested the maximum num-
22 ber of waivers permitted for that fiscal year, the
23 physician’s nonimmigrant status shall be extended
24 for up to 6 months if the physician agrees to seek
25 a waiver under this subsection (except for paragraph

1 (1)(D)(ii) to work for an employer described in
2 paragraph (1)(C) in a State that has not yet re-
3 quested the maximum number of waivers.

4 “(B) Such physician shall be authorized to
5 work only for the employer referred to in subpara-
6 graph (A) from the date on which a new waiver ap-
7 plication is filed with such State until the earlier
8 of—

9 “(i) the date on which the Secretary of
10 Homeland Security denies such waiver; or

11 “(ii) the date on which the Secretary ap-
12 proves an application for change of status
13 under paragraph (2)(A) pursuant to the ap-
14 proval of such waiver.”.

15 (5) CONTRACT REQUIREMENTS.—Section 214(l)
16 of such Act, as amended by this section, is further
17 amended by adding at the end the following:

18 “(5) An alien granted a waiver under para-
19 graph (1)(C) shall enter into an employment agree-
20 ment with the contracting health facility or health
21 care organization that—

22 “(A) specifies the maximum number of on-
23 call hours per week (which may be a monthly
24 average) that the alien will be expected to be

1 available and the compensation the alien will re-
2 ceive for on-call time;

3 “(B) specifies—

4 “(i) whether the contracting facility or
5 organization will pay the alien’s mal-
6 practice insurance premiums;

7 “(ii) whether the employer will provide
8 malpractice insurance; and

9 “(iii) the amount of such insurance
10 that will be provided;

11 “(C) describes all of the work locations
12 that the alien will work and includes a state-
13 ment that the contracting facility or organiza-
14 tion will not add additional work locations with-
15 out the approval of the Federal agency or State
16 agency that requested the waiver; and

17 “(D) does not include a non-compete provi-
18 sion.

19 “(6) An alien granted a waiver under this sub-
20 section whose employment relationship with a health
21 facility or health care organization terminates under
22 paragraph (1)(C)(ii) during the 3-year service period
23 required under paragraph (1) shall be considered to
24 be maintaining lawful status in an authorized period
25 of stay during the 120-day period referred to in

1 items (aa) and (bb) of subclause (III) of paragraph
2 (1)(C)(ii) or the 45-day period referred to in sub-
3 clause (III)(cc) of such paragraph.”.

4 (6) RECAPTURING WAIVER SLOTS LOST TO
5 OTHER STATES.—Section 214(l) of such Act, as
6 amended by this section, is further amended by add-
7 ing at the end the following:

8 “(7) If a recipient of a waiver under this sub-
9 section terminates the recipient’s employment with a
10 health facility or health care organization pursuant
11 to paragraph (1)(C)(ii), including termination of em-
12 ployment because of circumstances described in
13 paragraph (1)(C)(ii)(III), and accepts new employ-
14 ment with such a facility or organization in a dif-
15 ferent State, the State from which the alien is de-
16 parting may be accorded an additional waiver by the
17 Secretary of State for use in the fiscal year in which
18 the alien’s employment was terminated.”.

19 (7) EXCEPTION TO 3-YEAR WORK REQUIRE-
20 MENT.—Section 214(l) of such Act, as amended by
21 this section, is further amended by adding at the
22 end the following:

23 “(8) The 3-year work requirement set forth in
24 subparagraphs (C) and (D) of paragraph (1) shall
25 not apply if—

1 “(A)(i) the Secretary of Homeland Secu-
2 rity determines that extenuating circumstances,
3 including violations by the employer of the em-
4 ployment agreement with the alien or of labor
5 and employment laws, exist that justify a lesser
6 period of employment at such facility or organi-
7 zation; and

8 “(ii) the alien demonstrates, not later than
9 120 days after the employment termination
10 date (unless the Secretary determines that ex-
11 tenuating circumstances would justify an exten-
12 sion), another bona fide offer of employment at
13 a health facility or health care organization in
14 a geographic area or areas which are designated
15 by the Secretary of Health and Human Services
16 as having a shortage of health care profes-
17 sionals, for the remainder of such 3-year period;

18 “(B)(i) the interested State agency that re-
19 quested the waiver attests that extenuating cir-
20 cumstances, including violations by the em-
21 ployer of the employment agreement with the
22 alien or of labor and employment laws, exist
23 that justify a lesser period of employment at
24 such facility or organization; and

1 “(ii) the alien demonstrates, not later than
2 120 days after the employment termination
3 date (unless the Secretary determines that ex-
4 tenuating circumstances would justify an exten-
5 sion), another bona fide offer of employment at
6 a health facility or health care organization in
7 a geographic area or areas which are designated
8 by the Secretary of Health and Human Services
9 as having a shortage of health care profes-
10 sionals, for the remainder of such 3-year period;
11 or

12 “(C) the alien—

13 “(i) elects not to pursue a determina-
14 tion of extenuating circumstances pursuant
15 to subclause (A) or (B);

16 “(ii) terminates the alien’s employ-
17 ment relationship with the health facility
18 or health care organization at which the
19 alien was employed;

20 “(iii) demonstrates, not later than 45
21 days after the employment termination
22 date, another bona fide offer of employ-
23 ment at a health facility or health care or-
24 ganization in a geographic area or areas,
25 in the State that requested the alien’s

1 waiver, which are designated by the Sec-
2 retary of Health and Human Services as
3 having a shortage of health care profes-
4 sionals; and

5 “(iv) agrees to be employed for the re-
6 mainder of such 3-year period, and 1 addi-
7 tional year for each termination under
8 clause (ii).”.

9 (d) ALLOTMENT OF CONRAD 30 WAIVERS.—

10 (1) IN GENERAL.—Section 214(l) of the Immi-
11 gration and Nationality Act (8 U.S.C. 1184(l)), as
12 amended by subsection (d), is further amended by
13 adding at the end the following:

14 “(8)(A)(i) All States shall be allotted a total of 35
15 waivers under paragraph (1)(B) for a fiscal year if 90 per-
16 cent of the waivers available to the States receiving at
17 least 5 waivers were used in the previous fiscal year.

18 “(ii) When an allotment occurs under clause (i), all
19 States shall be allotted an additional 5 waivers under
20 paragraph (1)(B) for each subsequent fiscal year if 90
21 percent of the waivers available to the States receiving at
22 least 5 waivers were used in the previous fiscal year. If
23 the States are allotted 45 or more waivers for a fiscal year,
24 the States will only receive an additional increase of 5
25 waivers the following fiscal year if 95 percent of the waiv-

1 ers available to the States receiving at least 1 waiver were
2 used in the previous fiscal year.

3 “(B) Any increase in allotments under subparagraph
4 (A) shall be maintained indefinitely, unless in a fiscal year,
5 the total number of such waivers granted is 5 percent
6 lower than in the last year in which there was an increase
7 in the number of waivers allotted pursuant to this para-
8 graph, in which case—

9 “(i) the number of waivers allotted shall be de-
10 creased by five for all States beginning in the next
11 fiscal year; and

12 “(ii) each additional 5 percent decrease in such
13 waivers granted from the last year in which there
14 was an increase in the allotment, shall result in an
15 additional decrease of 5 waivers allotted for all
16 States, provided that the number of waivers allotted
17 for all States shall not drop below 30.”.

18 (2) ACADEMIC MEDICAL CENTERS.—Section
19 214(l)(1)(D) of such Act is amended—

20 (A) in clause (ii), by striking “and” at the
21 end;

22 (B) in clause (iii), by striking the period at
23 the end and inserting “; and”; and

24 (C) by adding at the end the following:

1 “(iv) in the case of a request by an inter-
2 ested State agency—

3 “(I) the head of such agency deter-
4 mines that the alien is to practice medicine
5 in, or be on the faculty of a residency pro-
6 gram at, an academic medical center (as
7 that term is defined in section
8 411.355(e)(2) of title 42, Code of Federal
9 Regulations, or similar successor regula-
10 tion), without regard to whether such facil-
11 ity is located within an area designated by
12 the Secretary of Health and Human Serv-
13 ices as having a shortage of health care
14 professionals; and

15 “(II) the head of such agency deter-
16 mines that—

17 “(aa) the alien physician’s work
18 is in the public interest; and

19 “(bb) the grant of such waiver
20 would not cause the number of the
21 waivers granted on behalf of aliens for
22 such State for a fiscal year (within
23 the limitation in subparagraph (B)
24 and subject to paragraph (6)) in ac-

1 cordance with the conditions of this
2 clause to exceed 3.”.

3 (e) AMENDMENTS TO THE PROCEDURES, DEFINI-
4 TIONS, AND OTHER PROVISIONS RELATED TO PHYSICIAN
5 IMMIGRATION.—

6 (1) DUAL INTENT FOR PHYSICIANS SEEKING
7 GRADUATE MEDICAL TRAINING.—Section 214(b) of
8 the Immigration and Nationality Act (8 U.S.C.
9 1184(b)) is amended by striking “(other than a non-
10 immigrant described in subparagraph (L) or (V) of
11 section 101(a)(15), and other than a nonimmigrant
12 described in any provision of section
13 101(a)(15)(H)(i) except subclause (b1) of such sec-
14 tion)” and inserting “(other than a nonimmigrant
15 described in subparagraph (L) or (V) of section
16 101(a)(15), a nonimmigrant described in any provi-
17 sion of section 101(a)(15)(H)(i) (except subclause
18 (b1) of such section), and an alien coming to the
19 United States to receive graduate medical education
20 or training as described in section 212(j) or to take
21 examinations required to receive graduate medical
22 education or training as described in section
23 212(j))”.

24 (2) PHYSICIAN NATIONAL INTEREST WAIVER
25 CLARIFICATIONS.—

1 (A) PRACTICE AND GEOGRAPHIC AREA.—
2 Section 203(b)(2)(B)(ii)(I) of the Immigration
3 and Nationality Act (8 U.S.C.
4 1153(b)(2)(B)(ii)(I)) is amended by striking
5 items (aa) and (bb) and inserting the following:

6 “(aa) the alien physician agrees to
7 work on a full-time basis practicing pri-
8 mary care, specialty medicine, or a com-
9 bination thereof, in an area or areas des-
10 ignated by the Secretary of Health and
11 Human Services as having a shortage of
12 health care professionals, or at a health
13 care facility under the jurisdiction of the
14 Secretary of Veterans Affairs; or

15 “(bb) the alien physician is pursuing
16 such waiver based upon service at a facility
17 or facilities that serve patients who reside
18 in a geographic area or areas designated
19 by the Secretary of Health and Human
20 Services as having a shortage of health
21 care professionals (without regard to
22 whether such facility or facilities are lo-
23 cated within such an area) and a Federal
24 agency, or a local, county, regional, or
25 State department of public health deter-

1 mines the alien physician’s work was or
2 will be in the public interest.”.

3 (B) FIVE-YEAR SERVICE REQUIREMENT.—
4 Section 203(b)(2)(B)(ii) of the Immigration
5 and Nationality Act (8 U.S.C. 1153(B)(ii)) is
6 amended—

7 (i) by moving subclauses (II), (III),
8 and (IV) 4 ems to the left; and

9 (ii) in subclause (II)—

10 (I) by inserting “(aa)” after
11 “(II)”; and

12 (II) by adding at the end the fol-
13 lowing:

14 “(bb) The 5-year service requirement
15 under item (aa) shall begin on the date on
16 which the alien physician begins work in
17 the shortage area in any legal status and
18 not on the date on which an immigrant
19 visa petition is filed or approved. Such
20 service shall be aggregated without regard
21 to when such service began and without re-
22 gard to whether such service began during
23 or in conjunction with a course of graduate
24 medical education.

1 “(cc) An alien physician shall not be
2 required to submit an employment contract
3 with a term exceeding the balance of the 5-
4 year commitment yet to be served or an
5 employment contract dated within a min-
6 imum time period before filing a visa peti-
7 tion under this subsection.

8 “(dd) An alien physician shall not be
9 required to file additional immigrant visa
10 petitions upon a change of work location
11 from the location approved in the original
12 national interest immigrant petition.”.

13 (3) TECHNICAL CLARIFICATION REGARDING AD-
14 VANCED DEGREE FOR PHYSICIANS.—Section
15 203(b)(2)(A) of the Immigration and Nationality
16 Act (8 U.S.C. 1153(b)(2)(A)) is amended by adding
17 at the end the following: “An alien physician holding
18 a foreign medical degree that has been deemed suffi-
19 cient for acceptance by an accredited United States
20 medical residency or fellowship program is a member
21 of the professions holding an advanced degree or its
22 equivalent.”.

23 (4) SHORT-TERM WORK AUTHORIZATION FOR
24 PHYSICIANS COMPLETING THEIR RESIDENCIES.—

1 (A) IN GENERAL.—A physician completing
2 graduate medical education or training de-
3 scribed in section 212(j) of the Immigration
4 and Nationality Act (8 U.S.C. 1182(j)) as a
5 nonimmigrant described in section
6 101(a)(15)(H)(i) of such Act (8 U.S.C.
7 1101(a)(15)(H)(i))—

8 (i) shall have such nonimmigrant sta-
9 tus automatically extended until October 1
10 of the fiscal year for which a petition for
11 a continuation of such nonimmigrant sta-
12 tus has been submitted in a timely manner
13 and the employment start date for the ben-
14 efiary of such petition is October 1 of
15 that fiscal year; and

16 (ii) shall be authorized to be employed
17 incident to status during the period be-
18 tween the filing of such petition and Octo-
19 ber 1 of such fiscal year.

20 (B) TERMINATION.—The physician's sta-
21 tus and employment authorization shall termi-
22 nate on the date that is 30 days after the date
23 on which a petition described in clause (i)(I) is
24 rejected, denied or revoked.

1 (C) AUTOMATIC EXTENSION.—A physi-
2 cian’s status and employment authorization will
3 automatically extend to October 1 of the next
4 fiscal year if all of the visas described in section
5 101(a)(15)(H)(i) of such Act that were author-
6 ized to be issued for the fiscal year have been
7 issued.

8 (5) APPLICABILITY OF SECTION 212(e) TO
9 SPOUSES AND CHILDREN OF J–1 EXCHANGE VISI-
10 TORS.—A spouse or child of an exchange visitor de-
11 scribed in section 101(a)(15)(J) of the Immigration
12 and Nationality Act (8 U.S.C. 1101(a)(15)(J)) shall
13 not be subject to the requirements under section
14 212(e) of such Act (8 U.S.C. 1182(e)).

15 **TITLE IV—IMPROVING HEALTH**
16 **CARE ACCESS AND QUALITY**
17 **Subtitle A—Improvement of**
18 **Coverage**

19 **SEC. 401. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
20 **TION EVIDENCING CITIZENSHIP OR NATION-**
21 **ALITY UNDER THE MEDICAID PROGRAM.**

22 (a) REPEAL.—Subsections (i)(22) and (x) of section
23 1903 of the Social Security Act (42 U.S.C. 1396b) are
24 each repealed.

25 (b) CONFORMING AMENDMENTS.—

1 (1) STATE PAYMENTS FOR MEDICAL ASSIST-
2 ANCE.—Section 1902 of the Social Security Act (42
3 U.S.C. 1396a) is amended—

4 (A) by amending paragraph (46) of sub-
5 section (a) to read as follows:

6 “(46) provide that information is requested and
7 exchanged for purposes of income and eligibility
8 verification in accordance with a State system which
9 meets the requirements of section 1137 of this
10 Act;”;

11 (B) in subsection (e)(13)(A)(i)—

12 (i) in the matter preceding subclause
13 (I), by striking “sections 1902(a)(46)(B)
14 and 1137(d)” and inserting “section
15 1137(d)”; and

16 (ii) in subclause (IV), by striking
17 “1902(a)(46)(B) or”; and

18 (C) by striking subsection (ee).

19 (2) PAYMENT TO STATES.—Section 1903 of the
20 Social Security Act (42 U.S.C. 1396b) is amended—

21 (A) in subsection (i), by redesignating
22 paragraphs (23) through (26) as paragraphs
23 (22) through (25), respectively; and

24 (B) by redesignating subsections (y) and
25 (z) as subsections (x) and (y), respectively.

1 (3) REPEAL.—Subsection (c) of section 6036 of
2 the Deficit Reduction Act of 2005 (42 U.S.C. 1396b
3 note) is repealed.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall take effect as if included in the enact-
6 ment of the Deficit Reduction Act of 2005.

7 **SEC. 402. REMOVING CITIZENSHIP AND IMMIGRATION BAR-**
8 **RIERS TO ACCESS TO AFFORDABLE HEALTH**
9 **CARE UNDER ACA.**

10 (a) IN GENERAL.—

11 (1) PREMIUM TAX CREDITS.—Section 36B of
12 the Internal Revenue Code of 1986 is amended—

13 (A) in subsection (c)(1)(B)—

14 (i) by amending the heading to read
15 as follows: “SPECIAL RULE FOR CERTAIN
16 INDIVIDUALS INELIGIBLE FOR MEDICAID
17 DUE TO STATUS”, and

18 (ii) in clause (ii), by striking “lawfully
19 present in the United States, but” and in-
20 serting “who”, and

21 (B) by striking subsection (e).

22 (2) COST-SHARING REDUCTIONS.—Section 1402
23 of the Patient Protection and Affordable Care Act
24 (42 U.S.C. 18071) is amended by striking sub-
25 section (e).

1 (3) BASIC HEALTH PROGRAM ELIGIBILITY.—
2 Section 1331(e)(1)(B) of the Patient Protection and
3 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
4 amended by striking “lawfully present in the United
5 States”.

6 (4) RESTRICTIONS ON FEDERAL PAYMENTS.—
7 Section 1412 of the Patient Protection and Afford-
8 able Care Act (42 U.S.C. 18082) is amended by
9 striking subsection (d).

10 (5) REQUIREMENT TO MAINTAIN MINIMUM ES-
11 SENTIAL COVERAGE.—Section 5000A(d) of the In-
12 ternal Revenue Code of 1986 is amended by striking
13 paragraph (3) and by redesignating paragraph (4)
14 as paragraph (3).

15 (b) CONFORMING AMENDMENTS.—

16 (1) Section 1411(a) of the Patient Protection
17 and Affordable Care Act (42 U.S.C. 18081(a)) is
18 amended by striking paragraph (1) and redesign-
19 ating paragraphs (2), (3), and (4) as paragraphs
20 (1), (2), and (3), respectively.

21 (2) Section 1312(f) of the Patient Protection
22 and Affordable Care Act (42 U.S.C. 18032(f)) is
23 amended—

1 (A) in the heading, by striking “; ACCESS
2 LIMITED TO CITIZENS AND LAWFUL RESI-
3 DENTS”; and

4 (B) by striking paragraph (3).

5 **SEC. 403. STUDY ON THE UNINSURED.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services (in this section referred to as the “Sec-
8 retary”) shall—

9 (1) conduct a study, in accordance with the
10 standards under section 3101 of the Public Health
11 Service Act (42 U.S.C. 300kk), on the demographic
12 characteristics of the population of individuals who
13 do not have health insurance coverage or oral health
14 coverage; and

15 (2) predict, based on such study, the demo-
16 graphic characteristics of the population of individ-
17 uals who would remain without health insurance cov-
18 erage after the end of any annual open enrollment
19 or any special enrollment period or upon enactment
20 and implementation of any legislative changes to the
21 Patient Protection and Affordable Care Act (Public
22 Law 111–148) that affect the number of persons eli-
23 gible for coverage.

24 (b) REPORTING REQUIREMENTS.—

1 (1) IN GENERAL.—Not later than 12 months
2 after the date of the enactment of this Act, the Sec-
3 retary shall submit to the Congress the results of
4 the study under subsection (a)(1) and the prediction
5 made under subsection (a)(2).

6 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
7 ISTICS.—The Secretary shall—

8 (A) report the demographic characteristics
9 under paragraphs (1) and (2) of subsection (a)
10 on the basis of racial and ethnic group, and
11 shall stratify the reporting on each racial and
12 ethnic group by other demographic characteris-
13 tics that can impact access to health insurance
14 coverage, such as sexual orientation, gender
15 identity, primary language, disability status,
16 sex, socioeconomic status, age group, and citi-
17 zenship and immigration status, in a manner
18 consistent with title I of this Act, including the
19 amendments made by such title; and

20 (B) not use such report to engage in or an-
21 ticipate any deportation or immigration related
22 enforcement action by any entity, including the
23 Department of Homeland Security.

1 **SEC. 404. MEDICAID IN THE TERRITORIES.**

2 (a) **ELIMINATION OF GENERAL MEDICAID FUNDING**
3 **LIMITATIONS (“CAP”) FOR TERRITORIES.—**

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

6 (A) in subsection (f), in the matter pre-
7 ceeding paragraph (1), by striking “subsection
8 (g)” and inserting “subsections (g) and (h)”;

9 (B) in subsection (g)(2), in the matter pre-
10 ceeding subparagraph (A), by inserting “and
11 subsection (h)” after “paragraphs (3) and (5)”;
12 and

13 (C) by adding at the end the following new
14 subsection:

15 “(h) **SUNSET OF MEDICAID FUNDING LIMITATIONS**
16 **FOR PUERTO RICO, THE VIRGIN ISLANDS OF THE**
17 **UNITED STATES, GUAM, THE NORTHERN MARIANA IS-**
18 **LANDS, AND AMERICAN SAMOA.—**Subsections (f) and (g)
19 shall not apply to Puerto Rico, the Virgin Islands of the
20 United States, Guam, the Northern Mariana Islands, and
21 American Samoa beginning with fiscal year 2020.”.

22 (2) **CONFORMING AMENDMENTS.—**

23 (A) Section 1902(j) of the Social Security
24 Act (42 U.S.C. 1396a(j)) is amended by strik-
25 ing “, the limitation in section 1108(f),”.

1 (B) Section 1903(u) of the Social Security
2 Act (42 U.S.C. 1396b(u)) is amended by strik-
3 ing paragraph (4).

4 (C) Section 1323(c)(1) of the Patient Pro-
5 tection and Affordable Care Act (42 U.S.C.
6 18043(c)(1)) is amended by striking “2019”
7 and inserting “2018”.

8 (3) EFFECTIVE DATE.—The amendments made
9 by this section shall apply beginning with fiscal year
10 2021.

11 (b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL
12 ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR
13 TERRITORIES.—Section 1905(b) of the Social Security
14 Act (42 U.S.C. 1396d(b)) is amended, in clause (2), by
15 inserting “for fiscal years before fiscal year 2020” after
16 “American Samoa”.

17 (c) APPLICATION OF MEDICAID WAIVER AUTHORITY
18 TO ALL OF THE TERRITORIES.—

19 (1) IN GENERAL.—Section 1902(j) of the Social
20 Security Act (42 U.S.C. 1396a(j)) is amended—

21 (A) by striking “American Samoa and the
22 Northern Mariana Islands” and inserting
23 “Puerto Rico, the Virgin Islands of the United
24 States, Guam, the Northern Mariana Islands,
25 and American Samoa”;

1 (B) by striking “American Samoa or the
2 Northern Mariana Islands” and inserting
3 “Puerto Rico, the Virgin Islands of the United
4 States, Guam, the Northern Mariana Islands,
5 or American Samoa”;

6 (C) by inserting “(1)” after “(j)”;

7 (D) by inserting “except as otherwise pro-
8 vided in this subsection,” after “Notwith-
9 standing any other requirement of this title”;
10 and

11 (E) by adding at the end the following:

12 “(2) The Secretary may not waive under this
13 subsection the requirement of subsection
14 (a)(10)(A)(i)(IX) (relating to coverage of adults for-
15 merly under foster care) with respect to any terri-
16 tory.”.

17 (2) EFFECTIVE DATE.—The amendments made
18 by this section shall apply beginning October 1,
19 2021.

20 (d) PERMITTING MEDICAID DSH ALLOTMENTS FOR
21 TERRITORIES.—Section 1923(f) of the Social Security Act
22 (42 U.S.C. 1396r–4) is amended—

23 (1) in paragraph (6), by adding at the end the
24 following new subparagraph:

25 “(C) TERRITORIES.—

1 “(i) FISCAL YEAR 2020.—For fiscal
2 year 2020, the DSH allotment for Puerto
3 Rico, the Virgin Islands of the United
4 States, Guam, the Northern Mariana Is-
5 lands, and American Samoa shall bear the
6 same ratio to \$300,000,000 as the ratio of
7 the number of individuals who are low-in-
8 come or uninsured and residing in such re-
9 spective territory (as estimated from time
10 to time by the Secretary) bears to the
11 sums of the number of such individuals re-
12 siding in all of the territories.

13 “(ii) SUBSEQUENT FISCAL YEAR.—
14 For each subsequent fiscal year, the DSH
15 allotment for each such territory is subject
16 to an increase in accordance with para-
17 graph (2).”; and

18 (2) in paragraph (9), by inserting before the pe-
19 riod at the end the following: “, and includes, begin-
20 ning with fiscal year 2021, Puerto Rico, the Virgin
21 Islands of the United States, Guam, the Northern
22 Mariana Islands, and American Samoa”.

1 **SEC. 405. 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, 2021” 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, 2021 (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.”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect on the date of enactment of
17 this Act. For purposes of determining an individual’s sta-
18 tus under section 1862(b)(1)(C) of the Social Security Act
19 (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection
20 (a), an individual who is within the coordinating period
21 as of the date of enactment of this Act shall have that
22 period extended to the full 42 months described in the last
23 sentence of such section, as added by the amendment
24 made by subsection (a)(2).

1 **SEC. 406. INDIAN DEFINED IN TITLE I OF THE PATIENT**
2 **PROTECTION AND AFFORDABLE CARE ACT.**

3 (a) DEFINITION OF INDIAN.—Section 1304 of the
4 Patient Protection and Affordable Care Act (42 U.S.C.
5 18024) is amended by adding at the end the following:

6 “(f) INDIAN.—

7 “(1) IN GENERAL.—In this title, the term ‘In-
8 dian’ means any individual—

9 “(A) described in paragraph (13) or (28)
10 of section 4 of the Indian Health Care Improve-
11 ment Act (25 U.S.C. 1603);

12 “(B) who is eligible for health services pro-
13 vided by the Indian Health Service under sec-
14 tion 809 of the Indian Health Care Improve-
15 ment Act (25 U.S.C. 1679);

16 “(C) who is of Indian descent and belongs
17 to the Indian community served by the local fa-
18 cilities and program of the Indian Health Serv-
19 ice; or

20 “(D) who is described in paragraph (2).

21 “(2) INCLUSIONS.—An individual is described
22 in this paragraph if the individual is any of the fol-
23 lowing:

24 “(A) A member of a federally recognized
25 Indian Tribe.

1 “(B) A resident of an urban center who
2 meets any of the following criteria:

3 “(i) Membership in a Tribe, band, or
4 other organized group of Indians, including
5 those Tribes, bands, or groups terminated
6 since 1940 and those recognized as of the
7 date of enactment of the Health Equity
8 and Accountability Act of 2018 or later by
9 the State in which they reside, or being a
10 descendant, in the first or second degree,
11 of any such member.

12 “(ii) Is an Eskimo or Aleut or other
13 Alaska Native.

14 “(iii) Is considered by the Secretary of
15 the Interior to be an Indian for any pur-
16 pose.

17 “(iv) Is determined to be an Indian
18 under regulations promulgated by the Sec-
19 retary.

20 “(C) An individual who is considered by
21 the Secretary of the Interior to be an Indian for
22 any purpose.

23 “(D) An individual who is considered by
24 the Secretary to be an Indian for purposes of
25 eligibility for Indian health care services, includ-

1 ing as a California Indian, Eskimo, Aleut, or
2 other Alaska Native.”.

3 (b) CONFORMING AMENDMENTS.—

4 (1) AFFORDABLE CHOICES HEALTH BENEFIT
5 PLANS.—Section 1311(c)(6)(D) of the Patient Pro-
6 tection and Affordable Care Act (42 U.S.C.
7 18031(c)(6)(D)) is amended by striking “(as defined
8 in section 4 of the Indian Health Care Improvement
9 Act)”.

10 (2) REDUCED COST-SHARING FOR INDIVIDUALS
11 ENROLLING IN QUALIFIED HEALTH PLANS.—Section
12 1402(d) of the Patient Protection and Affordable
13 Care Act (42 U.S.C. 18071(d)) is amended—

14 (A) in paragraph (1), in the matter pre-
15 ceding subparagraph (A), by striking “(as de-
16 fined in section 4(d) of the Indian Self-Deter-
17 mination and Education Assistance Act (25
18 U.S.C. 450b(d))”; and

19 (B) in paragraph (2), in the matter pre-
20 ceding subparagraph (A), by striking “(as so
21 defined)”.

22 (3) EXEMPTION FROM PENALTY FOR NOT
23 MAINTAINING MINIMUM ESSENTIAL COVERAGE.—
24 Section 5000A(e) of the Internal Revenue Code of

1 1986 is amended by striking paragraph (3) and in-
2 sserting the following:

3 “(3) INDIANS.—Any applicable individual who
4 is an Indian (as defined in section 1304(f) of the
5 Patient Protection and Affordable Care Act).”.

6 **SEC. 407. REMOVING MEDICARE BARRIER TO HEALTH**
7 **CARE.**

8 (a) PART A.—Section 1818(a)(3) of the Social Secu-
9 rity Act (42 U.S.C. 1395i-2(a)(3)) is amended by striking
10 “an alien” and all that follows through “under this sec-
11 tion” and inserting “an individual who is lawfully present
12 in the United States”.

13 (b) PART B.—Section 1836(2) of the Social Security
14 Act (42 U.S.C. 1395o(2)) is amended by striking “an
15 alien” and all that follows through “under this part” and
16 inserting “an individual who is lawfully present in the
17 United States”.

18 **SEC. 408. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
19 **PROVIDED BY URBAN INDIAN HEALTH CEN-**
20 **TERS.**

21 (a) IN GENERAL.—The third sentence of section
22 1905(b) of the Social Security Act (42 U.S.C. 1396(b))
23 is amended by inserting “or are received through a pro-
24 gram operated by an urban Indian organization through
25 a grant or contract under title V of such Act” after “(as

1 defined in section 4 of the Indian Health Care Improve-
2 ment Act)”.
3

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

7 **SEC. 409. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
8 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
9 **A FEDERALLY QUALIFIED HEALTH CENTER**
10 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
11 **TEM UNDER THE MEDICAID PROGRAM.**

12 (a) IN GENERAL.—The third sentence of section
13 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),
14 as amended by section 408(a), is amended by inserting
15 before the period the following: “, and with respect to
16 medical assistance provided to a Native Hawaiian (as de-
17 fined in section 12(2) of the Native Hawaiian Health Care
18 Improvement Act) through a federally qualified health
19 center or a Native Hawaiian health care system (as de-
20 fined in section 12(6) of such Act), whether directly, by
21 referral, or under contract or other arrangement between
22 such federally qualified health center or Native Hawaiian
23 health care system and another health care provider”.

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

1 **SEC. 410. MEDICAID COVERAGE 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 new subparagraph:

7 “(G) MEDICAID EXCEPTION FOR CITIZENS
8 OF FREELY ASSOCIATED STATES.—With respect
9 to eligibility for benefits for the designated Fed-
10 eral program described in paragraph (3)(C),
11 section 401(a) and paragraph (1) shall not
12 apply to any individual who lawfully resides in
13 1 of the 50 States or the District of Columbia
14 in accordance with the Compacts of Free Asso-
15 ciation between the Government of the United
16 States and the Governments of the Federated
17 States of Micronesia, the Republic of the Mar-
18 shall Islands, and the Republic of Palau and
19 shall not apply, at the option of the Governors
20 of Puerto Rico, the Virgin Islands, Guam, the
21 Northern Mariana Islands, or American Samoa,
22 respectively, as communicated to the Secretary
23 of Health and Human Services in writing, to
24 any individual who lawfully resides in the re-
25 spective territory in accordance with such Com-
26 pacts.”.

1 (b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—
2 Section 403(d) of the Personal Responsibility and Work
3 Opportunity Reconciliation Act of 1996 (8 U.S.C.
4 1613(d)) is amended—

5 (1) in paragraph (1), by striking “or” at the
6 end;

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

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

11 “(3) an individual described in section
12 402(b)(2)(G), but only with respect to the des-
13 ignated Federal program described in section
14 402(b)(3)(C).”.

15 (c) DEFINITION OF QUALIFIED ALIEN.—Section
16 431(b) of the Personal Responsibility and Work Oppor-
17 tunity Reconciliation Act of 1996 (8 U.S.C. 1641(b)) is
18 amended—

19 (1) in paragraph (6), by striking “; or” at the
20 end and inserting a comma;

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

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

1 “(8) an individual who lawfully resides in the
2 United States in accordance with a Compact of Free
3 Association referred to in section 402(b)(2)(G), but
4 only with respect to the designated Federal program
5 described in section 402(b)(3)(C) (relating to the
6 Medicaid program).”.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section take effect on October 1, 2021.

9 **SEC. 411. AT-RISK YOUTH MEDICAID PROTECTION.**

10 (a) IN GENERAL.—Section 1902 of the Social Secu-
11 rity Act (42 U.S.C. 1396a) is amended—

12 (1) in subsection (a)—

13 (A) by striking “and” at the end of para-
14 graph (83);

15 (B) by striking the period at the end of
16 paragraph (84) and inserting “; and”; and

17 (C) by inserting after paragraph (84) the
18 following new paragraph:

19 “(85) provide that—

20 “(A) the State shall not terminate eligi-
21 bility for medical assistance under a State plan
22 for an individual who is an eligible juvenile (as
23 defined in subsection (nn)(2)) because the juve-
24 nile is an inmate of a public institution (as de-
25 fined in subsection (nn)(3)), but may suspend

1 coverage during the period the juvenile is such
2 an inmate;

3 “(B) the State shall restore coverage for
4 such medical assistance to such an individual
5 upon the individual’s release from any such
6 public institution, without requiring a new ap-
7 plication from the individual, unless (and until
8 such date as) there is a determination that the
9 individual no longer meets the eligibility re-
10 quirements for such medical assistance; and

11 “(C) the State shall process any applica-
12 tion for medical assistance submitted by, or on
13 behalf of, a juvenile who is an inmate of a pub-
14 lic institution notwithstanding that the juvenile
15 is such an inmate.”; and

16 (2) by adding at the end the following new sub-
17 section:

18 “(m) JUVENILE; ELIGIBLE JUVENILE; PUBLIC IN-
19 STITUTION.—For purposes of subsection (a)(84) and this
20 subsection:

21 “(1) JUVENILE.—The term ‘juvenile’ means an
22 individual who is—

23 “(A) under 21 years of age; or

24 “(B) is described in subsection
25 (a)(10)(A)(i)(IX).

1 “(2) ELIGIBLE JUVENILE.—The term ‘eligible
2 juvenile’ means a juvenile who is an inmate of a
3 public institution and was eligible for medical assist-
4 ance under the State plan immediately before be-
5 coming an inmate of such a public institution or who
6 becomes eligible for such medical assistance while an
7 inmate of a public institution.

8 “(3) INMATE OF A PUBLIC INSTITUTION.—The
9 term ‘inmate of a public institution’ has the meaning
10 given such term for purposes of applying the sub-
11 division (A) following paragraph (30) of section
12 1905(a), taking into account the exception in such
13 subdivision for a patient of a medical institution.”.

14 (b) NO CHANGE IN EXCLUSION FROM MEDICAL AS-
15 SISTANCE FOR INMATES OF PUBLIC INSTITUTIONS.—
16 Nothing in this section shall be construed as changing the
17 exclusion from medical assistance under the subdivision
18 (A) following paragraph (30) of section 1905(a) of the So-
19 cial Security Act (42 U.S.C. 1396d(a)), including any ap-
20 plicable restrictions on a State submitting claims for Fed-
21 eral financial participation under title XIX of such Act
22 for such assistance.

23 (c) NO CHANGE IN CONTINUITY OF ELIGIBILITY BE-
24 FORE ADJUDICATION OR SENTENCING.—Nothing in this
25 section shall be construed to mandate, encourage, or sug-

1 gest that a State suspend or terminate coverage for indi-
2 viduals before they have been adjudicated or sentenced.

3 (d) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided in para-
5 graph (2), the amendments made by subsection (a)
6 shall apply to eligibility for medical assistance under
7 a State plan under title XIX of the Social Security
8 Act of juveniles who become inmates of public insti-
9 tutions on or after the date that is 1 year after the
10 date of the enactment of this Act.

11 (2) RULE FOR CHANGES REQUIRING STATE
12 LEGISLATION.—In the case of a State plan for med-
13 ical assistance under title XIX of the Social Security
14 Act which the Secretary of Health and Human Serv-
15 ices determines requires State legislation (other than
16 legislation appropriating funds) in order for the plan
17 to meet the additional requirements imposed by the
18 amendments made by subsection (a), the State plan
19 shall not be regarded as failing to comply with the
20 requirements of such title solely on the basis of its
21 failure to meet these additional requirements before
22 the first day of the first calendar quarter beginning
23 after the close of the first regular session of the
24 State legislature that begins after the date of the en-
25 actment of this Act. For purposes of the previous

1 sentence, in the case of a State that has a 2-year
2 legislative session, each year of such session shall be
3 deemed to be a separate regular session of the State
4 legislature.

5 **Subtitle B—Expansion of Access**

6 **SEC. 412. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

7 **ACT.**

8 Title XXXIV of the Public Health Service Act, as
9 amended by titles I, II, III, and IX of this Act, is further
10 amended by inserting after subtitle D the following:

11 **“Subtitle E—Reconstruction and**
12 **Improvement Grants for Public**
13 **Health Care Facilities Serving**
14 **Pacific Islanders and the Insu-**
15 **lar Areas**

16 **“SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
17 **INITIATIVES.**

18 “(a) IN GENERAL.—The Secretary, in collaboration
19 with the Administrator of the Health Resources and Serv-
20 ices Administration, the Director of the Agency for
21 Healthcare Research and Quality, and the Administrator
22 of the Centers for Medicare & Medicaid Services, shall
23 award grants to eligible entities for the conduct of dem-
24 onstration projects to improve the quality of and access
25 to health care.

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

3 “(1) be a health center, hospital, health plan,
4 health system, community clinic, or other health en-
5 tity determined appropriate by the Secretary—

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

9 “(B) that provides care or treatment for a
10 substantial number of patients who are unin-
11 sured, are receiving assistance under a State
12 plan under title XIX of the Social Security Act
13 (or under a waiver of such plan), or are mem-
14 bers of vulnerable populations, as determined
15 by the Secretary; and

16 “(C)(i) with respect to which, not less than
17 50 percent of the entity’s patient population is
18 made up of racial and ethnic minority groups;
19 or

20 “(ii) that—

21 “(I) serves a disproportionate percent-
22 age of local patients that are from a racial
23 and ethnic minority group, or that has a
24 patient population, at least 50 percent of

1 which is composed of individuals with lim-
2 ited English proficiency; and

3 “(II) provides an assurance that
4 amounts received under the grant will be
5 used only to support quality improvement
6 activities in the racial and ethnic minority
7 population served; and

8 “(2) prepare and submit to the Secretary an
9 application at such time, in such manner, and con-
10 taining such information as the Secretary may re-
11 quire.

12 “(c) PRIORITY.—In awarding grants under sub-
13 section (a), the Secretary shall give priority to applicants
14 under subsection (b)(2) that—

15 “(1) demonstrate an intent to operate as part
16 of a health care partnership, network, collaborative,
17 coalition, or alliance where each member entity con-
18 tributes to the design, implementation, and evalua-
19 tion of the proposed intervention; or

20 “(2) intend to use funds to carry out system-
21 wide changes with respect to health care quality im-
22 provement, including—

23 “(A) improved systems for data collection
24 and reporting;

1 “(B) innovative collaborative or similar
2 processes;

3 “(C) group programs with behavioral or
4 self-management interventions;

5 “(D) case management services;

6 “(E) physician or patient reminder sys-
7 tems;

8 “(F) educational interventions; or

9 “(G) other activities determined appro-
10 priate by the Secretary.

11 “(d) USE OF FUNDS.—An entity shall use amounts
12 received under a grant under subsection (a) to support
13 the implementation and evaluation of health care quality
14 improvement activities or minority health and health care
15 disparity reduction activities that include—

16 “(1) with respect to health care systems, activi-
17 ties relating to improving—

18 “(A) patient safety;

19 “(B) timeliness of care;

20 “(C) effectiveness of care;

21 “(D) efficiency of care;

22 “(E) patient centeredness; and

23 “(F) health information technology; and

24 “(2) with respect to patients, activities relating
25 to—

1 “(A) staying healthy;

2 “(B) getting well, mentally and physically;

3 “(C) living effectively with illness or dis-
4 ability;

5 “(D) coping with end-of-life issues; and

6 “(E) shared decisionmaking.

7 “(e) COMMON DATA SYSTEMS.—The Secretary shall
8 provide financial and other technical assistance to grant-
9 ees under this section for the development of common data
10 systems.

11 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section
13 such sums as may be necessary for each of fiscal years
14 2021 through 2026.

15 **“SEC. 3452. CENTERS OF EXCELLENCE.**

16 “(a) IN GENERAL.—The Secretary, acting through
17 the Administrator of the Health Resources and Services
18 Administration, shall designate centers of excellence at
19 public hospitals, and other health systems serving large
20 numbers of minority patients, that—

21 “(1) meet the requirements of section
22 3451(b)(1);

23 “(2) demonstrate excellence in providing care to
24 minority populations; and

1 “(3) demonstrate excellence in reducing dispari-
2 ties in health and health care.

3 “(b) REQUIREMENTS.—A hospital or health system
4 that serves as a center of excellence under subsection (a)
5 shall—

6 “(1) design, implement, and evaluate programs
7 and policies relating to the delivery of care in ra-
8 cially, ethnically, and linguistically diverse popu-
9 lations;

10 “(2) provide training and technical assistance
11 to other hospitals and health systems relating to the
12 provision of quality health care to minority popu-
13 lations; and

14 “(3) develop activities for graduate or con-
15 tinuing medical education that institutionalize a
16 focus on cultural competence training for health care
17 providers.

18 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section,
20 such sums as may be necessary for each of fiscal years
21 2021 through 2026.

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 in a culturally competent
12 and sustainable manner.

13 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
14 nancial assistance under subsection (a), an entity shall be
15 a public health facility or community health center located
16 in American Samoa, Guam, the Commonwealth of the
17 Northern Mariana Islands, the United States Virgin Is-
18 lands, Puerto Rico, or Hawaii that—

19 “(1) is owned or operated by—

20 “(A) the Government of American Samoa,
21 Guam, the Commonwealth of the Northern
22 Mariana Islands, the United States Virgin Is-
23 lands, Puerto Rico, or Hawaii or a unit of local
24 government; or

25 “(B) a nonprofit organization; and

1 “(2)(A) provides care or treatment for a sub-
2 stantial number of patients who are uninsured, re-
3 ceiving assistance under title XVIII of the Social Se-
4 curity Act, or a State plan under title XIX of such
5 Act (or under a waiver of such plan), or who are
6 members of a vulnerable population, as determined
7 by the Secretary; or

8 “(B) serves a disproportionate percentage of
9 local patients that are from a racial and ethnic mi-
10 nority group.

11 “(c) REPORT.—Not later than 180 days after the
12 date of enactment of this title and annually thereafter, the
13 Secretary shall submit to the Congress and the President
14 a report that includes an assessment of health resources
15 and facilities serving populations in American Samoa,
16 Guam, the Commonwealth of the Northern Mariana Is-
17 lands, the United States Virgin Islands, Puerto Rico, and
18 Hawaii. In preparing such report, the Secretary shall—

19 “(1) consult with and obtain information on all
20 health care facilities needs from the entities receiv-
21 ing direct financial assistance under subsection (a);

22 “(2) include all amounts of Federal assistance
23 received by each such entity in the preceding fiscal
24 year;

1 “(3) review the total unmet needs of health care
2 facilities serving American Samoa, Guam, the Com-
3 monwealth of the Northern Mariana Islands, the
4 United States Virgin Islands, Puerto Rico, and Ha-
5 waii, including needs for renovation and expansion
6 of existing facilities;

7 “(4) include a strategic plan for addressing the
8 needs of each such population identified in the re-
9 port; and

10 “(5) evaluate the effectiveness of the care pro-
11 vided by measuring patient outcomes and cost meas-
12 ures.

13 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated such sums as necessary
15 to carry out this section.”.

16 **SEC. 413. PROTECTING SENSITIVE LOCATIONS.**

17 Section 287 of the Immigration and Nationality Act
18 (8 U.S.C. 1357) is amended—

19 (1) by striking “Service” each place such term
20 appears and inserting “Department of Homeland
21 Security”;

22 (2) by striking “Attorney General” each place
23 such term appears and inserting “Secretary of
24 Homeland Security”;

1 (3) in subsection (f)(1), by striking “Commis-
2 sioner” and inserting “Director of U.S. Citizenship
3 and Immigration Services”;

4 (4) in subsection (h)—

5 (A) by striking “of the Immigration and
6 Nationality Act”; and

7 (B) by striking “of such Act”; and

8 (5) by adding at the end the following:

9 “(i)(1) In this subsection:

10 “(A) The term ‘appropriate committees of Con-
11 gress’ means—

12 “(i) the Committee on Homeland Security
13 and Governmental Affairs of the Senate;

14 “(ii) the Committee on the Judiciary of the
15 Senate;

16 “(iii) the Committee on Homeland Security
17 of the House of Representatives; and

18 “(iv) the Committee on the Judiciary of
19 the House of Representatives.

20 “(B) The term ‘enforcement action’—

21 “(i) means an apprehension, arrest, inter-
22 view, request for identification, search, or sur-
23 veillance for the purposes of immigration en-
24 forcement; and

1 “(ii) includes an enforcement action at, or
2 focused on, a sensitive location that is part of
3 a joint case led by another law enforcement
4 agency.

5 “(C) The term ‘exigent circumstances’ means a
6 situation involving—

7 “(i) the imminent risk of death, violence,
8 or physical harm to any person or property, in-
9 cluding a situation implicating terrorism or the
10 national security of the United States;

11 “(ii) the immediate arrest or pursuit of a
12 dangerous felon, terrorist suspect, or other indi-
13 vidual presenting an imminent danger; or

14 “(iii) the imminent risk of destruction of
15 evidence that is material to an ongoing criminal
16 case.

17 “(D) The term ‘prior approval’ means—

18 “(i) in the case of officers and agents of
19 U.S. Immigration and Customs Enforcement,
20 prior written approval to carry out an enforce-
21 ment action involving a specific individual or in-
22 dividuals authorized by—

23 “(I) the Assistant Director of Oper-
24 ations, Homeland Security Investigations;

1 “(II) the Executive Associate Direc-
2 tor, Homeland Security Investigations;

3 “(III) the Assistant Director for Field
4 Operations, Enforcement and Removal Op-
5 erations; or

6 “(IV) the Executive Associate Direc-
7 tor for Field Operations, Enforcement and
8 Removal Operations;

9 “(ii) in the case of officers and agents of
10 U.S. Customs and Border Protection, prior
11 written approval to carry out an enforcement
12 action involving a specific individual or individ-
13 uals authorized by—

14 “(I) a Chief Patrol Agent;

15 “(II) the Director of Field Operations;

16 “(III) the Director of Air and Marine
17 Operations; or

18 “(IV) the Internal Affairs Special
19 Agent in Charge; and

20 “(iii) in the case of other Federal, State,
21 or local law enforcement officers, to carry out
22 an enforcement action involving a specific indi-
23 vidual or individuals authorized by—

24 “(I) the head of the Federal agency
25 carrying out the enforcement action; or

1 “(II) the head of the State or local
2 law enforcement agency carrying out the
3 enforcement action.

4 “(E) The term ‘sensitive location’ includes all of
5 the physical space located within 1,000 feet of—

6 “(i) any medical treatment or health care
7 facility, including any hospital, doctor’s office,
8 accredited health clinic, alcohol or drug treat-
9 ment center, or emergent or urgent care facil-
10 ity;

11 “(ii) any public or private school, including
12 any known and licensed day care facility, pre-
13 school, other early learning program facility,
14 primary school, secondary school, postsecondary
15 school (including colleges and universities), or
16 other institution of learning (including voca-
17 tional or trade schools);

18 “(iii) any scholastic or education-related
19 activity or event, including field trips and inter-
20 scholastic events;

21 “(iv) any school bus or school bus stop
22 during periods when school children are present
23 on the bus or at the stop;

24 “(v) any organization or subdivision of
25 government that—

1 “(I) assists children, pregnant women,
2 victims of crime or abuse, or individuals
3 with significant mental or physical disabili-
4 ties; or

5 “(II) provides social services and as-
6 sistance, including emergency and disaster
7 services or assistance with food and nutri-
8 tion, housing affordability and income or
9 other services funded by State or local gov-
10 ernment, charitable giving, the Special
11 Supplemental Nutrition Program for
12 Women, Infants, and Children (WIC),
13 Supplemental Nutrition Assistance Pro-
14 gram (SNAP), Temporary Assistance for
15 Needy Families (TANF), or the United
16 States Housing Act;

17 “(vi) any church, synagogue, mosque, or
18 other place of worship, including buildings
19 rented for the purpose of religious services, re-
20 treats, counseling, workshops, instruction, and
21 education;

22 “(vii) any Federal, State, or local court-
23 house, including the office of an individual’s
24 legal counsel or representative, and a probation,
25 parole, or supervised release office;

1 “(viii) the site of a funeral, wedding, or
2 other religious ceremony or observance;

3 “(ix) any public demonstration, such as a
4 march, rally, or parade;

5 “(x) any domestic violence shelter, rape
6 crisis center, supervised visitation center, family
7 justice center, or victim services provider; or

8 “(xi) any other location specified by the
9 Secretary of Homeland Security for purposes of
10 this subsection.

11 “(2)(A) An enforcement action may not take place
12 at, or be focused on, a sensitive location unless—

13 “(i) the action involves exigent circumstances;
14 and

15 “(ii) prior approval for the enforcement action
16 was obtained from the appropriate official.

17 “(B) If an enforcement action is initiated pursuant
18 to subparagraph (A) and the exigent circumstances per-
19 mitting the enforcement action cease, the enforcement ac-
20 tion shall be discontinued until such exigent circumstances
21 reemerge.

22 “(C) If an enforcement action is carried out in viola-
23 tion of this subsection—

24 “(i) no information resulting from the enforce-
25 ment action may be entered into the record or re-

1 ceived into evidence in a removal proceeding result-
2 ing from the enforcement action; and

3 “(ii) the alien who is the subject of such re-
4 moval proceeding may file a motion for the imme-
5 diate termination of the removal proceeding.

6 “(3)(A) This subsection shall apply to any enforce-
7 ment action by officers or agents of the Department of
8 Homeland Security, including—

9 “(i) officers or agents of U.S. Immigration and
10 Customs Enforcement;

11 “(ii) officers or agents of U.S. Customs and
12 Border Protection; and

13 “(iii) any individual designated to perform im-
14 migration enforcement functions pursuant to sub-
15 section (g).

16 “(B) While carrying out an enforcement action at a
17 sensitive location, officers and agents referred to in sub-
18 paragraph (A) shall make every effort—

19 “(i) to limit the time spent at the sensitive loca-
20 tion;

21 “(ii) to limit the enforcement action at the sen-
22 sitive location to the person or persons for whom
23 prior approval was obtained; and

24 “(iii) to conduct themselves discreetly.

1 “(C) If, while carrying out an enforcement action
2 that is not initiated at or focused on a sensitive location,
3 officers or agents are led to a sensitive location, and no
4 exigent circumstance and prior approval with respect to
5 the sensitive location exists, such officers or agents shall—

6 “(i) cease before taking any further enforce-
7 ment action;

8 “(ii) conduct themselves in a discreet manner;

9 “(iii) maintain surveillance; and

10 “(iv) immediately consult their supervisor in
11 order to determine whether such enforcement action
12 should be discontinued.

13 “(D) The limitations under this paragraph shall not
14 apply to the transportation of an individual apprehended
15 at or near a land or sea border to a hospital or health
16 care provider for the purpose of providing medical care
17 to such individual.

18 “(4)(A) Each official specified in subparagraph (B)
19 shall ensure that the employees under his or her super-
20 vision receive annual training on compliance with—

21 “(i) the requirements under this subsection in
22 enforcement actions at or focused on sensitive loca-
23 tions and enforcement actions that lead officers or
24 agents to a sensitive location; and

1 “(ii) the requirements under section 239 of this
2 Act and section 384 of the Illegal Immigration Re-
3 form and Immigrant Responsibility Act of 1996 (8
4 U.S.C. 1367).

5 “(B) The officials specified in this subparagraph
6 are—

7 “(i) the Chief Counsel of U.S. Immigration and
8 Customs Enforcement;

9 “(ii) the Field Office Directors of U.S. Immi-
10 gration and Customs Enforcement;

11 “(iii) each Special Agent in Charge of U.S. Im-
12 migration and Customs Enforcement;

13 “(iv) each Chief Patrol Agent of U.S. Customs
14 and Border Protection;

15 “(v) the Director of Field Operations of U.S.
16 Customs and Border Protection;

17 “(vi) the Director of Air and Marine Operations
18 of U.S. Customs and Border Protection;

19 “(vii) the Internal Affairs Special Agent in
20 Charge of U.S. Customs and Border Protection; and

21 “(viii) the chief law enforcement officer of each
22 State or local law enforcement agency that enters
23 into a written agreement with the Department of
24 Homeland Security pursuant to subsection (g).

1 “(5) The Secretary of Homeland Security shall mod-
2 ify the Notice to Appear form (I-862)—

3 “(A) to provide the subjects of an enforcement
4 action with information, written in plain language,
5 summarizing the restrictions against enforcement
6 actions at sensitive locations set forth in this sub-
7 section and the remedies available to the alien if
8 such action violates such restrictions;

9 “(B) so that the information described in sub-
10 paragraph (A) is accessible to individuals with lim-
11 ited English proficiency; and

12 “(C) so that subjects of an enforcement action
13 are not permitted to verify that the officers or
14 agents that carried out such action complied with
15 the restrictions set forth in this subsection.

16 “(6)(A) The Director of U.S. Immigration and Cus-
17 toms Enforcement and the Commissioner of U.S. Customs
18 and Border Protection shall each submit an annual report
19 to the appropriate committees of Congress that includes
20 the information set forth in subparagraph (B) with respect
21 to the respective agency.

22 “(B) Each report submitted under subparagraph (A)
23 shall include, with respect to the submitting agency during
24 the reporting period—

1 “(i) the number of enforcement actions that
2 were carried out at, or focused on, a sensitive loca-
3 tion;

4 “(ii) the number of enforcement actions in
5 which officers or agents were subsequently led to a
6 sensitive location; and

7 “(iii) for each enforcement action described in
8 clause (i) or (ii)—

9 “(I) the date on which it occurred;

10 “(II) the specific site, city, county, and
11 State in which it occurred;

12 “(III) the components of the agency in-
13 volved in the enforcement action;

14 “(IV) a description of the enforcement ac-
15 tion, including the nature of the criminal activ-
16 ity of its intended target;

17 “(V) the number of individuals, if any, ar-
18 rested or taken into custody;

19 “(VI) the number of collateral arrests, if
20 any, and the reasons for each such arrest;

21 “(VII) a certification whether the location
22 administrator was contacted before, during, or
23 after the enforcement action; and

24 “(VIII) the percentage of all of the staff
25 members and supervisors reporting to the offi-

1 cials listed in paragraph (4)(B) who completed
2 the training required under paragraph (4)(A).

3 “(7) Nothing in the subsection may be construed—

4 “(A) to affect the authority of Federal, State,
5 or local law enforcement agencies—

6 “(i) to enforce generally applicable Federal
7 or State criminal laws unrelated to immigra-
8 tion; or

9 “(ii) to protect residents from imminent
10 threats to public safety; or

11 “(B) to limit or override the protections pro-
12 vided in—

13 “(i) section 239; or

14 “(ii) section 384 of the Illegal Immigration
15 Reform and Immigrant Responsibility Act of
16 1996 (8 U.S.C. 1367).”.

17 **SEC. 414. GRANTS FOR RACIAL AND ETHNIC APPROACHES**
18 **TO COMMUNITY HEALTH.**

19 (a) PURPOSE.—It is the purpose of this section to
20 award grants to assist communities in mobilizing and or-
21 ganizing resources in support of effective and sustainable
22 programs that will reduce or eliminate disparities in health
23 and health care experienced by racial and ethnic minority
24 individuals.

1 (b) AUTHORITY TO AWARD GRANTS.—The Secretary
2 of Health and Human Services, acting through the Ad-
3 ministrator of the Health Resources and Services Admin-
4 istration (referred to in this section as the “Secretary”),
5 shall award grants to eligible entities to assist in design-
6 ing, implementing, and evaluating culturally and linguis-
7 tically appropriate, science-based, and community-driven
8 sustainable strategies to eliminate racial and ethnic health
9 and health care disparities.

10 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
11 grant under this section, an entity shall—

12 (1) represent a coalition—

13 (A) whose principal purpose is to develop
14 and implement interventions to reduce or elimi-
15 nate a health or health care disparity in a tar-
16 geted racial or ethnic minority group in the
17 community served by the coalition; and

18 (B) that includes—

19 (i) members selected from among—

20 (I) public health departments;

21 (II) community-based organiza-
22 tions;

23 (III) university and research or-
24 ganizations;

1 (IV) Indian tribes or tribal orga-
2 nizations (as such terms are defined
3 in section 4 of the Indian Self-Deter-
4 mination and Education Assistance
5 Act (25 U.S.C. 5304)), the Indian
6 Health Service, or any other organiza-
7 tion that serves Alaska Natives; and

8 (V) interested public or private
9 health care providers or organizations
10 as determined appropriate by the Sec-
11 retary; and

12 (ii) at least 1 member from a commu-
13 nity-based organization that represents the
14 targeted racial or ethnic minority group;
15 and

16 (2) submit to the Secretary an application at
17 such time, in such manner, and containing such in-
18 formation as the Secretary may require, which shall
19 include—

20 (A) a description of the targeted racial or
21 ethnic populations in the community to be
22 served under the grant;

23 (B) a description of at least 1 health dis-
24 parity that exists in the racial or ethnic tar-
25 geted populations, including health issues such

1 as infant mortality, breast and cervical cancer
2 screening and management, musculoskeletal
3 diseases and obesity, prostate cancer screening
4 and management, cardiovascular disease, diabe-
5 tes, child and adult immunization levels, oral
6 disease, or other health priority areas as des-
7 ignated by the Secretary; and

8 (C) a demonstration of a proven record of
9 accomplishment of the coalition members in
10 serving and working with the targeted commu-
11 nity.

12 (d) SUSTAINABILITY.—The Secretary shall give pri-
13 ority to an eligible entity under this section if the entity
14 agrees that, with respect to the costs to be incurred by
15 the entity in carrying out the activities for which the grant
16 was awarded, the entity (and each of the participating
17 partners in the coalition represented by the entity) will
18 maintain its expenditures of non-Federal funds for such
19 activities at a level that is not less than the level of such
20 expenditures during the fiscal year immediately preceding
21 the first fiscal year for which the grant is awarded.

22 (e) NONDUPLICATION.—Any funds provided to an eli-
23 gible entity through a grant under this section shall—

1 (1) supplement, not supplant, any other Federal
2 funds made available to the entity for the purposes
3 of this section; and

4 (2) not be used to duplicate the activities of any
5 other health disparity grant program under this Act,
6 including an amendment made by this Act.

7 (f) TECHNICAL ASSISTANCE.—The Secretary may,
8 either directly or by grant or contract, provide any entity
9 that receives a grant under this section with technical and
10 other nonfinancial assistance necessary to meet the re-
11 quirements of this section.

12 (g) DISSEMINATION.—The Secretary shall encourage
13 and enable eligible entities receiving grants under this sec-
14 tion to share best practices, evaluation results, and reports
15 with communities not affiliated with such entities, by
16 using the internet, conferences, and other pertinent infor-
17 mation regarding the projects funded by this section, in-
18 cluding through using outreach efforts of the Office of Mi-
19 nority Health and the Centers for Disease Control and
20 Prevention.

21 (h) ADMINISTRATIVE BURDENS.—The Secretary
22 shall make every effort to minimize duplicative or unneces-
23 sary administrative burdens on eligible entities receiving
24 grants under this section.

1 (i) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out this section.

4 **SEC. 415. BORDER HEALTH GRANTS.**

5 (a) DEFINITIONS.—In this section:

6 (1) BORDER AREA.—The term “border area”
7 means the United States-Mexico Border Area, as de-
8 fined in section 8 of the United States-Mexico Bor-
9 der Health Commission Act (22 U.S.C. 290n–6).

10 (2) ELIGIBLE ENTITY.—The term “eligible enti-
11 ty” means an entity that is located in the border
12 area and is any of the following:

13 (A) A State, local government, or Tribal
14 government.

15 (B) A public institution of higher edu-
16 cation.

17 (C) A nonprofit health organization.

18 (D) A community health center.

19 (E) A community clinic that is a health
20 center receiving assistance under section 330 of
21 the Public Health Service Act (42 U.S.C.
22 254b).

23 (b) AUTHORIZATION.—From funds appropriated
24 under subsection (f), the Secretary of Health and Human
25 Services (in this section referred to as the “Secretary”),

1 acting through the United States members of the United
2 States-Mexico Border Health Commission, shall award
3 grants to eligible entities to address priorities and rec-
4 ommendations to improve the health of border area resi-
5 dents that are established by—

6 (1) the United States members of the United
7 States-Mexico Border Health Commission;

8 (2) the State border health offices; and

9 (3) the Secretary.

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

14 (d) USE OF FUNDS.—An eligible entity that receives
15 a grant under subsection (b) shall use the grant funds
16 for—

17 (1) programs relating to—

18 (A) maternal and child health;

19 (B) primary care and preventative health;

20 (C) public health and public health infra-
21 structure;

22 (D) musculoskeletal health and obesity;

23 (E) health education and promotion;

24 (F) oral health;

25 (G) mental and behavioral health;

1 (H) substance use disorders;

2 (I) health conditions that have a high prev-
3 alence in the border area;

4 (J) medical and health services research;

5 (K) workforce training and development;

6 (L) community health workers, patient
7 navigators, and promotores;

8 (M) health care infrastructure problems in
9 the border area (including planning and con-
10 struction grants);

11 (N) health disparities in the border area;

12 (O) environmental health; and

13 (P) outreach and enrollment services with
14 respect to Federal programs (including pro-
15 grams authorized under titles XIX and XXI of
16 the Social Security Act (42 U.S.C. 1396 et seq.;
17 42 U.S.C. 1397aa et seq.)); and

18 (2) other programs determined appropriate by
19 the Secretary.

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

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$200,000,000 for fiscal year 2021 and such sums as may
4 be necessary for each succeeding fiscal year.

5 **SEC. 416. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

6 (a) ELIMINATION OF ISOLATION TEST FOR COST-
7 BASED AMBULANCE REIMBURSEMENT.—

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

11 (A) in subparagraph (B)—

12 (i) by striking “owned and”; and

13 (ii) by inserting “(including when
14 such services are provided by the entity
15 under an arrangement with the hospital)”
16 after “hospital”; and

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

20 (2) EFFECTIVE DATE.—The amendments made
21 by this subsection shall apply to services furnished
22 on or after January 1, 2021.

23 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
24 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
25 REQUIREMENT.—

1 (1) IN GENERAL.—Section 1820(c)(2) of the
2 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
3 amended—

4 (A) in subparagraph (B)(iii), by striking
5 “provides not more than” and inserting “sub-
6 ject to subparagraph (F), provides not more
7 than”; and

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

10 “(F) ALTERNATIVE TO 25 INPATIENT BED
11 LIMIT REQUIREMENT.—

12 “(i) IN GENERAL.—A State may elect
13 to treat a facility, with respect to the des-
14 ignation of the facility for a cost-reporting
15 period, as satisfying the requirement of
16 subparagraph (B)(iii) relating to a max-
17 imum number of acute care inpatient beds
18 if the facility elects, in accordance with a
19 method specified by the Secretary and be-
20 fore the beginning of the cost-reporting pe-
21 riod, to meet the requirement under clause
22 (ii).

23 “(ii) ALTERNATE REQUIREMENT.—
24 The requirement under this clause, with
25 respect to a facility and a cost-reporting

1 period, is that the total number of inpa-
2 tient bed days described in subparagraph
3 (B)(iii) during such period will not exceed
4 7,300. For purposes of this subparagraph,
5 an individual who is an inpatient in a bed
6 in the facility for a single day shall be
7 counted as one inpatient bed day.

8 “(iii) WITHDRAWAL OF ELECTION.—
9 The option described in clause (i) shall not
10 apply to a facility for a cost-reporting pe-
11 riod if the facility (for any two consecutive
12 cost-reporting periods during the previous
13 5 cost-reporting periods) was treated under
14 such option and had a total number of in-
15 patient bed days for each of such two cost-
16 reporting periods that exceeded the num-
17 ber specified in such clause.”.

18 (2) EFFECTIVE DATE.—The amendments made
19 by paragraph (1) shall apply to cost-reporting peri-
20 ods beginning on or after the date of the enactment
21 of this Act.

22 **SEC. 417. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
23 **PITAL (RCH) PROGRAM.**

24 (a) IN GENERAL.—Section 1861 of the Social Secu-
25 rity Act (42 U.S.C. 1395x), as amended by section

1 205(b)(1), is amended by adding at the end of the fol-
2 lowing new subsection:

3 “Rural Community Hospital; Rural Community Hospital
4 Services

5 “(kkk)(1) The term ‘rural community hospital’
6 means a hospital (as defined in subsection (e)) that—

7 “(A) is located in a rural area (as defined in
8 section 1886(d)(2)(D)) or treated as being so lo-
9 cated pursuant to section 1886(d)(8)(E);

10 “(B) subject to paragraph (2), has less than 51
11 acute care inpatient beds, as reported in its most re-
12 cent cost report;

13 “(C) makes available 24-hour emergency care
14 services;

15 “(D) subject to paragraph (3), has a provider
16 agreement in effect with the Secretary and is open
17 to the public as of January 1, 2010; and

18 “(E) applies to the Secretary for such designa-
19 tion.

20 “(2) For purposes of paragraph (1)(B), beds in a
21 psychiatric or rehabilitation unit of the hospital which is
22 a distinct part of the hospital shall not be counted.

23 “(3) Paragraph (1)(D) shall not be construed to pro-
24 hibit any of the following from qualifying as a rural com-
25 munity hospital:

1 “(A) A replacement facility (as defined by the
2 Secretary in regulations in effect on January 1,
3 2012) with the same service area (as defined by the
4 Secretary in regulations in effect on such date).

5 “(B) A facility obtaining a new provider num-
6 ber pursuant to a change of ownership.

7 “(C) A facility which has a binding written
8 agreement with an outside, unrelated party for the
9 construction, reconstruction, lease, rental, or financ-
10 ing of a building as of January 1, 2012.

11 “(4) Nothing in this subsection shall be construed as
12 prohibiting a critical access hospital from qualifying as a
13 rural community hospital if the critical access hospital
14 meets the conditions otherwise applicable to hospitals
15 under subsection (e) and section 1866.

16 “(5) Nothing in this subsection shall be construed as
17 prohibiting a rural community hospital participating in
18 the demonstration program under section 410A of the
19 Medicare Prescription Drug, Improvement, and Mod-
20 ernization Act of 2003 (Public Law 108–173; 117 Stat.
21 2313) from qualifying as a rural community hospital if
22 the rural community hospital meets the conditions other-
23 wise applicable to hospitals under subsection (e) and sec-
24 tion 1866.”.

25 (b) PAYMENT.—

1 of the hospital in the application referred to in section
2 1861(kkk)(1)(E)—

3 “(1) 101 percent of the reasonable costs of pro-
4 viding such services, without regard to the amount
5 of the customary or other charge and any limitation
6 under section 1861(v)(1)(U), or

7 “(2) the amount of payment provided for under
8 the prospective payment system for covered OPD
9 services under section 1833(t).”.

10 (3) EXEMPTION FROM 30-PERCENT REDUCTION
11 IN REIMBURSEMENT FOR BAD DEBT.—Section
12 1861(v)(1)(T) of such Act (42 U.S.C.
13 1395x(v)(1)(T)) is amended by inserting “(other
14 than for a rural community hospital)” after “In de-
15 termining such reasonable costs for hospitals”.

16 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
17 SERVICES.—Section 1834(j) of such Act (as added by sub-
18 section (b)(2)) is amended—

19 (1) by redesignating paragraphs (1) and (2) as
20 subparagraphs (A) and (B), respectively;

21 (2) by inserting “(1)” after “(j)”; and

22 (3) by adding at the end the following:

23 “(2) The amounts of beneficiary cost-sharing for out-
24 patient services furnished in a rural community hospital
25 under this part shall be as follows:

1 “(A) For items and services that would have
2 been paid under section 1833(t) if furnished by a
3 hospital, the amount of cost-sharing determined
4 under paragraph (8) of such section.

5 “(B) For items and services that would have
6 been paid under section 1833(h) if furnished by a
7 provider of services or supplier, no cost-sharing shall
8 apply.

9 “(C) For all other items and services, the
10 amount of cost-sharing that would apply to the item
11 or service under the methodology that would be used
12 to determine payment for such item or service if pro-
13 vided by a physician, provider of services, or sup-
14 plier, as the case may be.”.

15 (d) CONFORMING AMENDMENTS.—

16 (1) PART A PAYMENT.—Section 1814(b) of
17 such Act (42 U.S.C. 1395f(b)) is amended in the
18 matter preceding paragraph (1) by inserting “other
19 than inpatient hospital services furnished by a rural
20 community hospital,” after “critical access hospital
21 services,”.

22 (2) PART B PAYMENT.—Section 1833(a) of
23 such Act (42 U.S.C. 1395l(a)), as amended by sec-
24 tion 205(b)(3), is amended—

1 (A) in paragraph (2), in the matter before
2 subparagraph (A), by striking “and (I)” and in-
3 serting “(I), and (K)”;

4 (B) by striking “and” at the end of para-
5 graph (8);

6 (C) by striking the period at the end of
7 paragraph (9) and inserting “; and”; and

8 (D) by adding at the end the following:

9 “(10) in the case of outpatient services fur-
10 nished by a rural community hospital, the amounts
11 described in section 1834(j).”.

12 (3) TECHNICAL AMENDMENTS.—

13 (A) CONSULTATION WITH STATE AGEN-
14 CIES.—Section 1863 of such Act (42 U.S.C.
15 1395z) is amended by striking “and (dd)(2)”
16 and inserting “(dd)(2), and (kkk)(1)”.

17 (B) PROVIDER AGREEMENTS.—Section
18 1866(a)(2)(A) of such Act (42 U.S.C.
19 1395cc(a)(2)(A)) is amended by inserting “sec-
20 tion 1834(j)(2),” after “section 1833(b),”.

21 (e) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to items and services furnished on
23 or after October 1, 2021.

1 **SEC. 418. MEDICARE REMOTE MONITORING PILOT**
2 **PROJECTS.**

3 (a) PILOT PROJECTS.—

4 (1) IN GENERAL.—Not later than 9 months
5 after the date of enactment of this Act, the Sec-
6 retary of Health and Human Services (in this sec-
7 tion referred to as the “Secretary”) shall conduct
8 pilot projects under title XVIII of the Social Secu-
9 rity Act (42 U.S.C. 1395 et seq.) for the purpose of
10 providing incentives to home health agencies to uti-
11 lize home monitoring and communications tech-
12 nologies that—

13 (A) enhance health outcomes for Medicare
14 beneficiaries; and

15 (B) reduce expenditures under such title.

16 (2) SITE REQUIREMENTS.—

17 (A) URBAN AND RURAL.—The Secretary
18 shall conduct the pilot projects under this sec-
19 tion in both urban and rural areas.

20 (B) SITE IN A SMALL STATE.—The Sec-
21 retary shall conduct at least 3 of the pilot
22 projects in a State with a population of less
23 than 1,000,000.

24 (3) DEFINITION OF HOME HEALTH AGENCY.—

25 In this section, the term “home health agency” has

1 the meaning given that term in section 1861(o) of
2 the Social Security Act (42 U.S.C. 1395x(o)).

3 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
4 OF PROJECTS.—The Secretary shall specify the criteria
5 for identifying those Medicare beneficiaries who shall be
6 considered within the scope of the pilot projects under this
7 section for purposes of the application of subsection (c)
8 and for the assessment of the effectiveness of the home
9 health agency in achieving the objectives of this section.
10 Such criteria may provide for the inclusion in the projects
11 of Medicare beneficiaries who begin receiving home health
12 services under title XVIII of the Social Security Act (42
13 U.S.C. 1395 et seq.) after the date of the implementation
14 of the projects.

15 (c) INCENTIVES.—

16 (1) PERFORMANCE TARGETS.—The Secretary
17 shall establish for each home health agency partici-
18 pating in a pilot project under this section a per-
19 formance target using one of the following meth-
20 odologies, as determined appropriate by the Sec-
21 retary:

22 (A) ADJUSTED HISTORICAL PERFORMANCE
23 TARGET.—The Secretary shall establish for the
24 agency—

1 (i) a base expenditure amount equal
2 to the average total payments made to the
3 agency under parts A and B of title XVIII
4 of the Social Security Act (42 U.S.C. 1395
5 et seq.) for Medicare beneficiaries deter-
6 mined to be within the scope of the pilot
7 project in a base period determined by the
8 Secretary; and

9 (ii) an annual per capita expenditure
10 target for such beneficiaries, reflecting the
11 base expenditure amount adjusted for risk
12 and adjusted growth rates.

13 (B) COMPARATIVE PERFORMANCE TAR-
14 GET.—The Secretary shall establish for the
15 agency a comparative performance target equal
16 to the average total payments under such parts
17 A and B during the pilot project for comparable
18 individuals in the same geographic area that
19 are not determined to be within the scope of the
20 pilot project.

21 (2) INCENTIVE.—Subject to paragraph (3), the
22 Secretary shall pay to each participating home care
23 agency an incentive payment for each year under the
24 pilot project equal to a portion of the Medicare sav-

1 ings realized for such year relative to the perform-
2 ance target under paragraph (1).

3 (3) LIMITATION ON EXPENDITURES.—The Sec-
4 retary shall limit incentive payments under this sec-
5 tion in order to ensure that the aggregate expendi-
6 tures under title XVIII of the Social Security Act
7 (42 U.S.C. 1395 et seq.) (including incentive pay-
8 ments under this subsection) do not exceed the
9 amount that the Secretary estimates would have
10 been expended if the pilot projects under this section
11 had not been implemented.

12 (d) WAIVER AUTHORITY.—The Secretary may waive
13 such provisions of titles XI and XVIII of the Social Secu-
14 rity Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.)
15 as the Secretary determines to be appropriate for the con-
16 duct of the pilot projects under this section.

17 (e) REPORT TO CONGRESS.—Not later than 5 years
18 after the date that the first pilot project under this section
19 is implemented, the Secretary shall submit to Congress a
20 report on the pilot projects. Such report shall contain a
21 detailed description of issues related to the expansion of
22 the projects under subsection (f) and recommendations for
23 such legislation and administrative actions as the Sec-
24 retary considers appropriate.

1 (f) EXPANSION.—If the Secretary determines that
2 any of the pilot projects under this section enhance health
3 outcomes for Medicare beneficiaries and reduce expendi-
4 tures under title XVIII of the Social Security Act (42
5 U.S.C. 1395 et seq.), the Secretary may initiate com-
6 parable projects in additional areas.

7 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
8 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
9 tive payment under this section—

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

14 (2) shall have no effect on the amount of such
15 payments.

16 **SEC. 419. RURAL HEALTH QUALITY ADVISORY COMMISSION**
17 **AND DEMONSTRATION PROJECTS.**

18 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
19 SION.—

20 (1) ESTABLISHMENT.—Not later than 6
21 months after the date of the enactment of this sec-
22 tion, the Secretary of Health and Human Services
23 (in this section referred to as the “Secretary”) shall
24 establish a commission to be known as the Rural

1 Health Quality Advisory Commission (in this section
2 referred to as the “Commission”).

3 (2) DUTIES OF COMMISSION.—

4 (A) NATIONAL PLAN.—The Commission
5 shall develop, coordinate, and facilitate imple-
6 mentation of a national plan for rural health
7 quality improvement. The national plan shall—

8 (i) identify objectives for rural health
9 quality improvement;

10 (ii) identify strategies to eliminate
11 known gaps in rural health system capacity
12 and improve rural health quality; and

13 (iii) provide recommendations for
14 Federal programs to identify opportunities
15 for strengthening and aligning policies and
16 programs to improve rural health quality.

17 (B) DEMONSTRATION PROJECTS.—The
18 Commission shall design demonstration projects
19 to recommend to the Secretary to test alter-
20 native models for rural health quality improve-
21 ment, including with respect to both personal
22 and population health.

23 (C) MONITORING.—The Commission shall
24 monitor progress toward the objectives identi-
25 fied pursuant to paragraph (1)(A).

1 (3) MEMBERSHIP.—

2 (A) NUMBER.—The Commission shall be
3 composed of 11 members appointed by the Sec-
4 retary.

5 (B) SELECTION.—The Secretary shall se-
6 lect the members of the Commission from
7 among individuals with significant rural health
8 care and health care quality expertise, including
9 expertise in clinical health care, health care
10 quality research, population or public health, or
11 purchaser organizations.

12 (4) CONTRACTING AUTHORITY.—Subject to the
13 availability of funds, the Commission may enter into
14 contracts and make other arrangements, as may be
15 necessary to carry out the duties described in para-
16 graph (2).

17 (5) STAFF.—Upon the request of the Commis-
18 sion, the Secretary may detail, on a reimbursable
19 basis, any of the personnel of the Office of Rural
20 Health Policy of the Health Resources and Services
21 Administration, the Agency for Healthcare Research
22 and Quality, or the Centers for Medicare & Medicaid
23 Services to the Commission to assist in carrying out
24 this subsection.

1 (6) REPORTS TO CONGRESS.—Not later than 1
2 year after the establishment of the Commission, and
3 annually thereafter, the Commission shall submit a
4 report to the Congress on rural health quality. Each
5 such report shall include the following:

6 (A) An inventory of relevant programs and
7 recommendations for improved coordination and
8 integration of policy and programs.

9 (B) An assessment of achievement of the
10 objectives identified in the national plan devel-
11 oped under paragraph (2) and recommenda-
12 tions for realizing such objectives.

13 (C) Recommendations on Federal legisla-
14 tion, regulations, or administrative policies to
15 enhance rural health quality and outcomes.

16 (b) RURAL HEALTH QUALITY DEMONSTRATION
17 PROJECTS.—

18 (1) IN GENERAL.—Not later than 270 days
19 after the date of the enactment of this section, the
20 Secretary, in consultation with the Rural Health
21 Quality Advisory Commission, the Office of Rural
22 Health Policy of the Health Resources and Services
23 Administration, the Agency for Healthcare Research
24 and Quality, and the Centers for Medicare & Med-
25 icaid Services, shall make grants to eligible entities

1 for a total of 5 demonstration projects to implement
2 and evaluate methods for improving the quality of
3 health care in rural communities. Each such dem-
4 onstration project shall include—

5 (A) alternative community models that—

6 (i) will achieve greater integration of
7 personal and population health services;
8 and

9 (ii) address safety, effectiveness,
10 patient- or community-centeredness, timeli-
11 ness, efficiency, and equity (the 6 aims
12 identified by the Institute of Medicine of
13 the National Academy of Sciences in its re-
14 port entitled “Crossing the Quality Chasm:
15 A New Health System for the 21st Cen-
16 tury” released on March 1, 2001);

17 (B) innovative approaches to the financing
18 and delivery of health services to achieve rural
19 health quality goals; and

20 (C) development of quality improvement
21 support structures to assist rural health sys-
22 tems and professionals (such as workforce sup-
23 port structures, quality monitoring and report-
24 ing, clinical care protocols, and information
25 technology applications).

1 (2) ELIGIBLE ENTITIES.—In this subsection,
2 the term “eligible entity” means a consortium
3 that—

4 (A) shall include—

5 (i) at least one health care provider or
6 health care delivery system located in a
7 rural area; and

8 (ii) at least one organization rep-
9 resenting multiple community stakeholders;
10 and

11 (B) may include other partners such as
12 rural research centers.

13 (3) CONSULTATION.—In developing the pro-
14 gram for awarding grants under this subsection, the
15 Secretary shall consult with the Administrator of the
16 Agency for Healthcare Research and Quality, rural
17 health care providers, rural health care researchers,
18 and private and nonprofit groups (including national
19 associations) which are undertaking similar efforts.

20 (4) EXPEDITED WAIVERS.—The Secretary shall
21 expedite the processing of any waiver that—

22 (A) is authorized under title XVIII or XIX
23 of the Social Security Act (42 U.S.C. 1395 et
24 seq.; 42 U.S.C. 1396 et seq.); and

1 (B) is necessary to carry out a demonstra-
2 tion project under this subsection.

3 (5) DEMONSTRATION PROJECT SITES.—The
4 Secretary shall ensure that the 5 demonstration
5 projects funded under this subsection are conducted
6 at a variety of sites representing the diversity of
7 rural communities in the United States.

8 (6) DURATION.—Each demonstration project
9 under this subsection shall be for a period of 4
10 years.

11 (7) INDEPENDENT EVALUATION.—The Sec-
12 retary shall enter into an arrangement with an enti-
13 ty that has experience working directly with rural
14 health systems for the conduct of an independent
15 evaluation of the program carried out under this
16 subsection.

17 (8) REPORT.—Not later than 1 year after the
18 conclusion of all of the demonstration projects fund-
19 ed under this subsection, the Secretary shall submit
20 a report to the Congress on the results of such
21 projects. The report shall include—

22 (A) an evaluation of patient access to care,
23 patient outcomes, and an analysis of the cost
24 effectiveness of each such project; and

1 (B) recommendations on Federal legisla-
2 tion, regulations, or administrative policies to
3 enhance rural health quality and outcomes.

4 (c) APPROPRIATION.—

5 (1) IN GENERAL.—Out of funds in the Treas-
6 ury not otherwise appropriated, there are appro-
7 priated to the Secretary to carry out this section
8 \$30,000,000 for the period of fiscal years 2021
9 through 2025.

10 (2) AVAILABILITY.—

11 (A) IN GENERAL.—Funds appropriated
12 under paragraph (1) shall remain available for
13 expenditure through fiscal year 2025.

14 (B) REPORT.—For purposes of carrying
15 out subsection (b)(8), funds appropriated under
16 paragraph (1) shall remain available for ex-
17 penditure through fiscal year 2026.

18 (3) RESERVATION.—Of the amount appro-
19 priated under paragraph (1), the Secretary shall re-
20 serve—

21 (A) \$5,000,000 to carry out subsection (a);

22 and

23 (B) \$25,000,000 to carry out subsection
24 (b), of which—

1 (i) 2 percent shall be for the provision
2 of technical assistance to grant recipients;
3 and

4 (ii) 5 percent shall be for independent
5 evaluation under subsection (b)(7).

6 **SEC. 420. RURAL HEALTH CARE SERVICES.**

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

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

15 “(a) PURPOSE.—The purpose of this section is to
16 provide for grants—

17 “(1) under subsection (b), to promote rural
18 health care services outreach;

19 “(2) under subsection (c), to provide for the
20 planning and implementation of integrated health
21 care networks in rural areas;

22 “(3) under subsection (d), to assist rural com-
23 munities in the Delta Region to reduce health dis-
24 parities and to promote and enhance health system
25 development; and

1 “(4) under subsection (e), to provide for the
2 planning and implementation of small rural health
3 care provider quality improvement activities.

4 “(b) RURAL HEALTH CARE SERVICES OUTREACH
5 GRANTS.—

6 “(1) GRANTS.—The Director of the Office of
7 Rural Health Policy of the Health Resources and
8 Services Administration (referred to in this section
9 as the ‘Director’) may award grants to eligible enti-
10 ties to promote rural health care services outreach
11 by expanding the delivery of health care services to
12 include new and enhanced services in rural areas.
13 The Director may award the grants for periods of
14 not more than 3 years.

15 “(2) ELIGIBILITY.—To be eligible to receive a
16 grant under this subsection for a project, an enti-
17 ty—

18 “(A) shall be a rural public or rural non-
19 profit private entity, a facility that qualifies as
20 a rural health clinic under title XVIII of the
21 Social Security Act, a public or nonprofit entity
22 existing exclusively to provide services to mi-
23 grant and seasonal farm workers in rural areas,
24 or a Tribal government whose grant-funded ac-

1 activities 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, including tracking factors
10 such as the number and type of primary
11 care visits, identification of a medical
12 home, or other general measures of such
13 access;

14 “(D) a description of how the local com-
15 munity or region to be served will be involved
16 in the development and ongoing operations of
17 the project;

18 “(E) a plan for sustaining the project after
19 Federal support for the project has ended;

20 “(F) a description of how the project will
21 be evaluated;

22 “(G) the administrative capacity to submit
23 annual performance data electronically as speci-
24 fied by the Director; and

1 “(H) other such information as the Direc-
2 tor determines to be appropriate.

3 “(c) RURAL HEALTH NETWORK DEVELOPMENT
4 GRANTS.—

5 “(1) GRANTS.—

6 “(A) IN GENERAL.—The Director may
7 award rural health network development grants
8 to eligible entities to promote, through planning
9 and implementation, the development of inte-
10 grated health care networks that have combined
11 the functions of the entities participating in the
12 networks in order to—

13 “(i) achieve efficiencies and economies
14 of scale;

15 “(ii) expand access to, coordinate, and
16 improve the quality of the health care de-
17 livery system through development of orga-
18 nizational efficiencies;

19 “(iii) implement health information
20 technology to achieve efficiencies, reduce
21 medical errors, and improve quality;

22 “(iv) coordinate care and manage
23 chronic illness; and

24 “(v) strengthen the rural health care
25 system as a whole in such a manner as to

1 show a quantifiable return on investment
2 to the participants in the network.

3 “(B) GRANT PERIODS.—The Director may
4 award such a rural health network development
5 grant—

6 “(i) for a period of 3 years for imple-
7 mentation activities; or

8 “(ii) for a period of 1 year for plan-
9 ning activities to assist in the initial devel-
10 opment of an integrated health care net-
11 work, if the proposed participants in the
12 network do not have a history of collabo-
13 rative efforts and a 3-year grant would be
14 inappropriate.

15 “(2) ELIGIBILITY.—To be eligible to receive a
16 grant under this subsection, an entity—

17 “(A) shall be a rural public or rural non-
18 profit private entity, a facility that qualifies as
19 a rural health clinic under title XVIII of the
20 Social Security Act, a public or nonprofit entity
21 existing exclusively to provide services to mi-
22 grant and seasonal farm workers in rural areas,
23 or a Tribal government whose grant-funded ac-
24 tivities will be conducted within federally recog-
25 nized Tribal areas;

1 “(B) shall represent a network composed
2 of participants—

3 “(i) that include 3 or more independ-
4 ently owned health care entities; and

5 “(ii) that may be nonprofit or for-
6 profit entities; and

7 “(C) shall not previously have received a
8 grant under this subsection (other than a 1-
9 year grant for planning activities) for the same
10 or a similar project.

11 “(3) APPLICATIONS.—To be eligible to receive a
12 grant under this subsection, an eligible entity, in
13 consultation with the appropriate State office of
14 rural health or another appropriate State entity,
15 shall prepare and submit to the Director an applica-
16 tion at such time, in such manner, and containing
17 such information as the Director may require, in-
18 cluding—

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) an explanation of the reasons why
23 Federal assistance is required to carry out the
24 project;

25 “(C) a description of—

1 “(i) the history of collaborative activi-
2 ties carried out by the participants in the
3 network;

4 “(ii) the degree to which the partici-
5 pants are ready to integrate their func-
6 tions; and

7 “(iii) how the local community or re-
8 gion to be served will benefit from and be
9 involved in the activities carried out by the
10 network;

11 “(D) a description of how the local com-
12 munity or region to be served will experience in-
13 creased access to quality health care services
14 across the continuum of care as a result of the
15 integration activities carried out by the net-
16 work, including a description of—

17 “(i) return on investment for the com-
18 munity and the network members; and

19 “(ii) other quantifiable performance
20 measures that show the benefit of the net-
21 work activities;

22 “(E) a plan for sustaining the project after
23 Federal support for the project has ended;

24 “(F) a description of how the project will
25 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 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
7 TEMS DEVELOPMENT GRANTS.—

8 “(1) GRANTS.—The Director may award grants
9 to eligible entities to support reduction of health dis-
10 parities, improve access to health care, and enhance
11 rural health system development in the Delta Re-
12 gion.

13 “(2) ELIGIBILITY.—To be eligible to receive a
14 grant under this subsection, an entity shall be a
15 rural public or rural nonprofit private entity, a facil-
16 ity that qualifies as a rural health clinic under title
17 XVIII of the Social Security Act, a public or non-
18 profit entity existing exclusively to provide services
19 to migrant and seasonal farm workers in rural
20 areas, or a Tribal government whose grant-funded
21 activities will be conducted within federally recog-
22 nized Tribal areas.

23 “(3) APPLICATIONS.—To be eligible to receive a
24 grant under this subsection, an eligible entity shall
25 prepare and submit to the Director an application at

1 such time, in such manner, and containing such in-
2 formation as the Director may require, including—

3 “(A) a description of the project that the
4 eligible entity will carry out using the funds
5 provided under the grant;

6 “(B) an explanation of the reasons why
7 Federal assistance is required to carry out the
8 project;

9 “(C) a description of the manner in which
10 the project funded under the grant will meet
11 the health care needs of the Delta Region;

12 “(D) a description of how the local com-
13 munity or region to be served will experience in-
14 creased access to quality health care services as
15 a result of the activities carried out by the enti-
16 ty;

17 “(E) a description of how health dispari-
18 ties will be reduced or the health system will be
19 improved;

20 “(F) a plan for sustaining the project after
21 Federal support for the project has ended;

22 “(G) a description of how the project will
23 be evaluated including process and outcome
24 measures related to the quality of care provided

1 or how the health care system improves its per-
2 formance;

3 “(H) a description of how the grantee will
4 develop an advisory group made up of rep-
5 resentatives of the communities to be served to
6 provide guidance to the grantee to best meet
7 community need; and

8 “(I) other such information as the Director
9 determines to be appropriate.

10 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
11 ITY IMPROVEMENT GRANTS.—

12 “(1) GRANTS.—The Director may award grants
13 to provide for the planning and implementation of
14 small rural health care provider quality improvement
15 activities. The Director may award the grants for
16 periods of 1 to 3 years.

17 “(2) ELIGIBILITY.—To be eligible for a grant
18 under this subsection, an entity—

19 “(A) shall be—

20 “(i) a rural public or rural nonprofit
21 private health care provider or provider of
22 health care services, such as a rural health
23 clinic; or

24 “(ii) another rural provider or net-
25 work of small rural providers identified by

1 the Director as a key source of local care;
2 and

3 “(B) shall not previously have received a
4 grant under this subsection for the same or a
5 similar project.

6 “(3) PREFERENCE.—In awarding grants under
7 this subsection, the Director shall give preference to
8 facilities that qualify as rural health clinics under
9 title XVIII of the Social Security Act.

10 “(4) APPLICATIONS.—To be eligible to receive a
11 grant under this subsection, an eligible entity shall
12 prepare and submit to the Director an application at
13 such time, in such manner, and containing such in-
14 formation as the Director may require, including—

15 “(A) a description of the project that the
16 eligible entity will carry out using the funds
17 provided under the grant;

18 “(B) an explanation of the reasons why
19 Federal assistance is required to carry out the
20 project;

21 “(C) a description of the manner in which
22 the project funded under the grant will assure
23 continuous quality improvement in the provision
24 of services by the entity;

1 “(D) a description of how the local com-
2 munity or region to be served will experience in-
3 creased access to quality health care services as
4 a result of the activities carried out by the enti-
5 ty;

6 “(E) a plan for sustaining the project after
7 Federal support for the project has ended;

8 “(F) a description of how the project will
9 be evaluated including process and outcome
10 measures related to the quality of care pro-
11 vided; and

12 “(G) other such information as the Direc-
13 tor determines to be appropriate.

14 “(f) GENERAL REQUIREMENTS.—

15 “(1) PROHIBITED USES OF FUNDS.—An entity
16 that receives a grant under this section may not use
17 funds provided through the grant—

18 “(A) to build or acquire real property; or

19 “(B) for construction.

20 “(2) COORDINATION WITH OTHER AGENCIES.—

21 The Director shall coordinate activities carried out
22 under grant programs described in this section, to
23 the extent practicable, with Federal and State agen-
24 cies and nonprofit organizations that are operating

1 similar grant programs, to maximize the effect of
2 public dollars in funding meritorious proposals.

3 “(g) REPORT.—Not later than September 30, 2022,
4 the Secretary shall prepare and submit to the appropriate
5 committees of Congress a report on the progress and ac-
6 complishments of the grant programs described in sub-
7 sections (b), (c), (d), and (e).

8 “(h) DEFINITION OF DELTA REGION.—In this sec-
9 tion, the term ‘Delta Region’ has the meaning given to
10 the term ‘region’ in section 382A of the Consolidated
11 Farm and Rural Development Act (7 U.S.C. 2009aa).

12 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 \$40,000,000 for fiscal year 2021 and such sums as may
15 be necessary for each of fiscal years 2022 through 2025.”.

16 **SEC. 421. COMMUNITY HEALTH CENTER COLLABORATIVE**
17 **ACCESS EXPANSION.**

18 Section 330(r)(4) of the Public Health Service Act
19 (42 U.S.C. 254b(r)(4)) is amended—

20 (1) in subparagraph (A), by striking “primary
21 health care services” each place it appears and in-
22 serting “primary health care and other mental, den-
23 tal, and physical health services”; and

24 (2) in subparagraph (B)—

1 (A) in clause (i), by striking “and” at the
2 end;

3 (B) in clause (ii), by striking the period at
4 the end and inserting “; and”; and

5 (C) by adding at the end the following:

6 “(iii) in the case of a rural health
7 clinic described in such subparagraph—

8 (I) that such clinic provides, to
9 the extent possible, enabling services,
10 such as transportation and language
11 assistance (including translation and
12 interpretation); and

13 (II) that the primary health
14 care and other services described in
15 such subparagraph are subject to full
16 reimbursement according to the pro-
17 spective payment system for Federally
18 qualified health center services under
19 section 1834(o) of the Social Security
20 Act.”.

21 **SEC. 422. FACILITATING THE PROVISION OF TELEHEALTH**
22 **SERVICES ACROSS STATE LINES.**

23 (a) IN GENERAL.—For purposes of expediting the
24 provision of telehealth services, for which payment is made
25 under the Medicare Program, across State lines, the Sec-

1 retary of Health and Human Services shall, in consulta-
2 tion with representatives of States, physicians, health care
3 practitioners, and patient advocates, encourage and facili-
4 tate the adoption of provisions allowing for multistate
5 practitioner practice across State lines.

6 (b) DEFINITIONS.—In subsection (a):

7 (1) TELEHEALTH SERVICE.—The term “tele-
8 health service” has the meaning given that term in
9 subparagraph (F) of section 1834(m)(4) of the So-
10 cial Security Act (42 U.S.C. 1395m(m)(4)).

11 (2) PHYSICIAN, PRACTITIONER.—The terms
12 “physician” and “practitioner” have the meaning
13 given those terms in subparagraphs (D) and (E), re-
14 spectively, of such section.

15 (3) MEDICARE PROGRAM.—The term “Medicare
16 Program” means the program of health insurance
17 administered by the Secretary of Health and Human
18 Services under title XVIII of the Social Security Act
19 (42 U.S.C. 1395 et seq.).

20 **SEC. 423. SCORING OF PREVENTIVE HEALTH SAVINGS.**

21 Section 202 of the Congressional Budget and Im-
22 poundment Control Act of 1974 (2 U.S.C. 602) is amend-
23 ed by adding at the end the following:

24 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

1 “(1) DETERMINATION BY THE DIRECTOR.—
2 Upon a request by the chairman or ranking minority
3 member of the Committee on the Budget of the Sen-
4 ate, or by the chairman or ranking minority member
5 of the Committee on the Budget of the House of
6 Representatives, the Director shall determine if a
7 proposed measure would result in reductions in
8 budget outlays in budgetary outyears through the
9 use of preventive health and preventive health serv-
10 ices.

11 “(2) PROJECTIONS.—If the Director determines
12 that a measure would result in substantial reduc-
13 tions in budget outlays as described in paragraph
14 (1), the Director—

15 “(A) shall include, in any projection pre-
16 pared by the Director, a description and esti-
17 mate of the reductions in budget outlays in the
18 budgetary outyears and a description of the
19 basis for such conclusions; and

20 “(B) may prepare a budget projection that
21 includes some or all of the budgetary outyears,
22 notwithstanding the time periods for projections
23 described in subsection (e) and sections 308,
24 402, and 424.

1 “(3) DEFINITIONS.—As used in this sub-
2 section—

3 “(A) the term ‘budgetary outyears’ means
4 the 2 consecutive 10-year periods beginning
5 with the first fiscal year that is 10 years after
6 the budget year provided for in the most re-
7 cently agreed to concurrent resolution on the
8 budget; and

9 “(B) the term ‘preventive health’ means an
10 action that focuses on the health of the public,
11 individuals, and defined populations in order to
12 protect, promote, and maintain health, wellness,
13 and functional ability, and prevent disease, dis-
14 ability, and premature death that is dem-
15 onstrated by credible and publicly available epi-
16 demiological projection models, incorporating
17 clinical trials or observational studies in hu-
18 mans, to avoid future health care costs.”.

19 **SEC. 424. SENSE OF CONGRESS ON MAINTENANCE OF EF-**
20 **FORT PROVISIONS REGARDING CHILDREN’S**
21 **HEALTH.**

22 It is the sense of the Congress that—

23 (1) the maintenance of effort provisions added
24 to sections 1902 and 2105(d) of the Social Security
25 Act (42 U.S.C. 1396a; 42 U.S.C. 1397ee(d)) by sec-

1 tions 2001(b) and 2101(b) of the Patient Protection
2 and Affordable Care Act were intended to maintain
3 the eligibility standards for the Medicaid program
4 under title XIX of the Social Security Act (42
5 U.S.C. 1396 et seq.) and Children’s Health Insur-
6 ance Program under title XXI of such Act (42
7 U.S.C. 1397aa et seq.) until the American Health
8 Benefit Exchanges in the States are fully oper-
9 ational;

10 (2) it is imperative that the maintenance of ef-
11 fort provisions are enforced to the strict standard in-
12 tended by the Congress through September 30,
13 2027;

14 (3) waiving the maintenance of effort provisions
15 should not be permitted;

16 (4) the maintenance of effort provisions ensure
17 the continued success of the Medicaid program and
18 Children’s Health Insurance Program and were in-
19 tended to specifically protect vulnerable and disabled
20 adults, children, and senior citizens, many of whom
21 are also members of communities of color; and

22 (5) the maintenance of effort provisions must
23 be strictly enforced and proposals to weaken the
24 maintenance of effort provisions must not be consid-
25 ered.

1 **SEC. 425. PROTECTION OF THE HHS OFFICES OF MINORITY**
2 **HEALTH.**

3 (a) IN GENERAL.—Pursuant to section 1707A of the
4 Public Health Service Act (42 U.S.C. 300u–6a), the Of-
5 fices of Minority Health established within the Centers for
6 Disease Control and Prevention, the Health Resources
7 and Services Administration, the Substance Abuse and
8 Mental Health Services Administration, the Agency for
9 Healthcare Research and Quality, the Food and Drug Ad-
10 ministration, and the Centers for Medicare & Medicaid
11 Services, are offices that, regardless of change in the
12 structure of the Department of Health and Human Serv-
13 ices, shall report to the Secretary of Health and Human
14 Services.

15 (b) SENSE OF CONGRESS.—It is the sense of the
16 Congress that any effort to eliminate or consolidate such
17 Offices of Minority Health undermines the progress
18 achieved so far.

19 **SEC. 426. 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 **“§ 7310. 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 for 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 for 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 any of 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 (b) CLERICAL AMENDMENT.—The table of sections
21 at the beginning of such chapter is amended by inserting
22 after the item relating to section 7309A the following new
23 item:

“7310. Office of Minority Health.”.

1 **SEC. 427. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
2 **ACCESS FOR LOW-INCOME PATIENTS.**

3 (a) IN GENERAL.—Not later than January 1, 2021,
4 the Comptroller General of the United States shall con-
5 duct a study on how amendments made by the Patient
6 Protection and Affordable Care Act (Public Law 111–
7 148) and the Health Care and Education Reconciliation
8 Act of 2010 (Public Law 111–152) to titles XVIII and
9 XIX of the Social Security Act (42 U.S.C. 1395 et seq.;
10 42 U.S.C. 1396 et seq.) relating to disproportionate share
11 hospital adjustment payments under Medicare and Med-
12 icaid (and subsequent amendments made with respect to
13 such payments) affect the timely access to health care
14 services for low-income patients. Such study shall—

15 (1) evaluate and examine whether States elect-
16 ing to make medical assistance available under sec-
17 tion 1902(a)(10)(A)(i)(VIII) of the Social Security
18 Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including
19 States making such an election through a waiver of
20 the State plan) to individuals described in such sec-
21 tion mitigate the need for payments to dispropor-
22 tionate share hospitals under section 1886(d)(5)(F)
23 of the Social Security Act (42 U.S.C.
24 1395ww(d)(5)(F)) and section 1923 of such Act (42
25 U.S.C. 1396r–4), including the impact of such

1 States electing to make medical assistance available
2 to such individuals on—

3 (A) the number of individuals in the
4 United States who are without health insurance
5 and the distribution of such individuals in rela-
6 tion to areas primarily served by dispropor-
7 tionate share hospitals; and

8 (B) the low-income utilization rate of such
9 hospitals and the resulting fiscal sustainability
10 of such hospitals;

11 (2) evaluate the appropriate level and distribu-
12 tion of such payments among such disproportionate
13 share hospitals for purposes of—

14 (A) sufficiently accounting for the level of
15 uncompensated care provided by such hospitals
16 to low-income patients; and

17 (B) providing timely access to health serv-
18 ices for individuals in medically underserved
19 areas; and

20 (3) assess, with respect to such disproportionate
21 share hospitals—

22 (A) the role played by such hospitals in
23 providing critical access to emergency, inpa-
24 tient, and outpatient health services, as well as

1 the location of such hospitals in relation to
2 medically underserved areas; and

3 (B) the extent to which such hospitals sat-
4 isfy the requirements established for charitable
5 hospital organizations under section 501(r) of
6 the Internal Revenue Code of 1986 with respect
7 to community health needs assessments, finan-
8 cial assistance policy requirements, limitations
9 on charges, and billing and collection require-
10 ments.

11 (b) REPORTS.—

12 (1) REPORT TO CONGRESS.—Not later than
13 180 days after the date on which the study under
14 subsection (a) is completed, the Comptroller General
15 of the United States shall submit to the Committee
16 on Energy and Commerce of the House of Rep-
17 resentatives and the Committee on Finance of the
18 Senate a report that contains—

19 (A) the results of the study;

20 (B) recommendations to Congress for any
21 legislative changes to the payments to dis-
22 proportionate share hospitals under section
23 1886(d)(5)(F) of the Social Security Act (42
24 U.S.C. 1395ww(d)(5)(F)) and section 1923 of
25 such Act (42 U.S.C. 1396r-4) that are needed

1 to ensure access to health services for low-in-
2 come patients that—

3 (i) are based on the number of indi-
4 viduals without health insurance, the
5 amount of uncompensated care provided by
6 such hospitals, and the impact of reduced
7 payment levels on low-income communities;
8 and

9 (ii) takes into account any reports
10 submitted by the Secretary of the Treas-
11 ury, in consultation with the Secretary of
12 Health and Human Services, to Congres-
13 sional committees regarding the costs in-
14 curred by charitable hospital organizations
15 for charity care, bad debt, nonreimbursed
16 expenses for services provided to individ-
17 uals under the Medicare program under
18 title XVIII of the Social Security Act and
19 the Medicaid program under title XIX of
20 such Act, and any community benefit ac-
21 tivities provided by such organizations.

22 (2) REPORT TO THE SECRETARY OF HEALTH
23 AND HUMAN SERVICES.—Not later than 180 days
24 after the date on which the study under subsection
25 (a) is completed, the Comptroller General of the

1 United States shall submit to the Secretary of
2 Health and Human Services a report that con-
3 tains—

4 (A) the results of the study; and

5 (B) any recommendations for purposes of
6 assisting in the development of the methodology
7 for the adjustment of payments to dispropor-
8 tionate share hospitals, as required under sec-
9 tion 1886(r) of the Social Security Act (42
10 U.S.C. 1395ww(r)) and the reduction of such
11 payments under section 1923(f)(7) of such Act
12 (42 U.S.C. 1396r-4(f)(7)), taking into account
13 the reports referred to in paragraph (1)(B)(ii).

14 **SEC. 428. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
15 **SERVICE.**

16 (a) REFERENCES.—Any reference in a law, regula-
17 tion, document, paper, or other record of the United
18 States to the Director of the Indian Health Service shall
19 be deemed to be a reference to the Assistant Secretary
20 of the Indian Health Service.

21 (b) EXECUTIVE SCHEDULE.—Section 5315 of title 5,
22 United States Code, is amended in the matter relating to
23 the Assistant Secretaries of Health and Human Services
24 by striking “(6)” and inserting “(7), 1 of whom shall be
25 the Assistant Secretary of the Indian Health Service”.

1 (c) CONFORMING AMENDMENT.—Section 5316 of
2 title 5, United States Code, is amended by striking “Direc-
3 tor, Indian Health Service, Department of Health and
4 Human Services.”.

5 **SEC. 429. REAUTHORIZATION OF THE NATIVE HAWAIIAN**
6 **HEALTH CARE IMPROVEMENT ACT.**

7 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
8 Section 6(h)(1) of the Native Hawaiian Health Care Im-
9 provement Act (42 U.S.C. 11705(h)(1)) is amended by
10 striking “may be necessary for fiscal years 1993 through
11 2019” and inserting “are necessary”.

12 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
13 LOKAHI.—Section 7(b) of the Native Hawaiian Health
14 Care Improvement Act (42 U.S.C. 11706(b)) is amended
15 by striking “may be necessary for fiscal years 1993
16 through 2019” and inserting “are necessary”.

17 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
18 Section 10(c) of the Native Hawaiian Health Care Im-
19 provement Act (42 U.S.C. 11709(c)) is amended by strik-
20 ing “may be necessary for fiscal years 1993 through
21 2019” and inserting “are necessary”.

22 **SEC. 430. AVAILABILITY OF NON-ENGLISH LANGUAGE**
23 **SPEAKING PROVIDERS.**

24 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
25 tient Protection and Affordable Care Act (42 U.S.C.

1 18031(c)(1)(B)) is amended by inserting before the semi-
2 colon the following: “and the ability of such provider to
3 provide care in a language other than English either
4 through the provider speaking such language or by the
5 provider having a qualified interpreter for an individual
6 with limited English proficiency (as defined in section
7 3400 of such Act) who speaks such language available
8 during office hours”.

9 (b) EFFECTIVE DATE.—The amendment made by
10 subsection (a) shall not apply to any plan beginning on
11 or prior to the date that is 1 year after the date of the
12 enactment of this Act.

13 **SEC. 431. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.**

14 (a) ESSENTIAL COMMUNITY PROVIDERS.—Section
15 1311(c)(1)(C) of the Patient Protection and Affordable
16 Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

17 (1) by inserting “(i)” after “(C)”; and

18 (2) by adding at the end the following new
19 clauses:

20 “(ii) not later than January 1, 2020, in-
21 crease the percentage of essential community
22 providers as described in clause (i) included in
23 its network by 10 percent annually (based on
24 the level in the plan for 2016) until 90 percent
25 of all federally-qualified health centers and 75

1 percent of all other such essential community
2 providers in the contract service area are in-net-
3 work; and

4 “(iii) include at least one essential commu-
5 nity provider in each of the essential community
6 provider categories described in section
7 156.235(a)(2)(ii)(B) of title 45, Code of Fed-
8 eral Regulations (as in effect on the date of en-
9 actment of the Health Equity and Account-
10 ability Act of 2020) in each county in the serv-
11 ice area, where available;”.

12 (b) REPORTING REQUIREMENTS.—Section
13 1311(e)(3) of the Patient Protection and Affordable Care
14 Act (42 U.S.C. 18031(e)(3)) is amended by adding at the
15 end the following new subparagraph:

16 “(E) DATA ON ESSENTIAL COMMUNITY
17 PROVIDERS.—The Secretary shall require quali-
18 fied health plans to submit annually to the Sec-
19 retary data on the percentage of essential com-
20 munity providers as described in clause (ii) of
21 subsection (c)(1)(C), by county, that contract
22 with each qualified health plan offered in that
23 county and the percentage of such essential
24 community providers, by category as described
25 in clause (iii) of such subsection, that contract

1 with each qualified health plan offered in that
2 county. Such data shall be made available to
3 the general public.”.

4 (c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS
5 APPLIED UNDER MEDICARE AND MEDICAID.—

6 (1) MEDICARE.—Section 1852(d)(1) of the So-
7 cial Security Act (42 U.S.C. 1395w–22(d)(1)) is
8 amended—

9 (A) by striking “and” at the end of sub-
10 paragraph (D);

11 (B) by striking the period at the end of
12 subparagraph (E) and inserting “; and”; and

13 (C) by adding at the end the following new
14 subparagraph:

15 “(F) the plan meets the requirements of
16 clauses (ii) and (iii) of section 1311(c)(1)(C) of
17 the Patient Protection and Affordable Care Act
18 (relating to inclusion in networks of essential
19 community providers).”.

20 (2) MEDICAID.—Section 1932(b)(5) of the So-
21 cial Security Act (42 U.S.C. 1396u–2(b)(5)) is
22 amended—

23 (A) by striking “and” at the end of sub-
24 paragraph (A);

1 (B) by striking the period at the end of
2 subparagraph (B) and inserting “; and”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(C) meets the requirements of clauses (ii)
6 and (iii) of section 1311(c)(1)(C) of the Patient
7 Protection and Affordable Care Act (relating to
8 inclusion in networks of essential community
9 providers) with respect to services offered in the
10 service area involved.”.

11 **SEC. 432. PROVIDER NETWORK ADEQUACY IN COMMU-**
12 **NITIES OF COLOR.**

13 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
14 tient Protection and Affordable Care Act (42 U.S.C.
15 18031(c)(1)(B)), as amended by section 428(a), is further
16 amended—

17 (1) by inserting “(i)” after “(B)”; and

18 (2) by adding at the end the following new
19 clauses:

20 “(ii) meet such network adequacy
21 standards as the Secretary may establish
22 with regard to—

23 “(I) appointment wait time;

1 “(II) travel time and distance to
2 health care provider facilities and pro-
3 viders by public and private transit;

4 “(III) hours of operation to ac-
5 commodate individuals who cannot
6 come to provider appointments during
7 standard business hours; and

8 “(IV) other network adequacy
9 standards to ensure that care through
10 these plans is accessible to diverse
11 communities, including individuals
12 with limited English proficiency as de-
13 fined in section 3400 of such Act; and

14 “(iii) provide coverage for services for
15 enrollees through out-of-network providers
16 at no additional cost to the enrollees in
17 cases where in-network providers are un-
18 able to comply with the standards estab-
19 lished under subclause (III) or (IV) of
20 clause (ii) for such services and the out-of-
21 network providers can deliver such services
22 in compliance with such standards.

23 “(b) EFFECTIVE DATE.—The amendments made by
24 subsection (a) shall not apply to plans beginning on or
25 prior to the date that is 1 year after the date of the enact-

1 ment of the Health Equity and Accountability Act of
2 2020.”.

3 **SEC. 433. IMPROVING ACCESS TO DENTAL CARE.**

4 (a) REPORTS TO CONGRESS.—

5 (1) GAO REPORTS.—Not later than 1 year
6 after the date of the enactment of this Act, the
7 Comptroller General of the United States shall sub-
8 mit to Congress—

9 (A) a report on the Alaska Dental Health
10 Aide Therapists program and the Dental Ther-
11 apist and Advanced Dental Therapist programs
12 in Minnesota, to assess the effectiveness of den-
13 tal therapists in—

14 (i) improving access to timely dental
15 care among communities of color;

16 (ii) providing high-quality care; and

17 (iii) providing culturally competent
18 care; and

19 (iv) providing accessible care to people
20 with disabilities;

21 (B) a report on State variations in the use
22 of dental hygienists and the effectiveness of ex-
23 panding the scope of practice for dental hygien-
24 ists in—

1 (i) improving access to timely dental
2 care among communities of color;

3 (ii) providing high-quality care;

4 (iii) providing culturally competent
5 care; and

6 (iv) providing accessible care to people
7 with disabilities; and

8 (C) the reports shall also explain how tele-
9 health service is used to enhance services pro-
10 vided by dental hygienists and therapists and
11 shall recommend any modifications in Medicare
12 and Medicaid to better provide for telehealth
13 consultations in conjunction with therapists'
14 and hygienists' care.

15 (2) HRSA REPORT ON DENTAL SHORTAGE
16 AREAS.—Not later than 1 year after the date of the
17 enactment of this Act, the Secretary of Health and
18 Human Services, acting through the Administrator
19 of the Health Resources and Services Administra-
20 tion, shall submit to Congress a report which details
21 geographic dental access shortages and the pre-
22 paredness of dental providers to offer culturally and
23 linguistically appropriate, affordable, accessible, and
24 timely services.

1 (b) EXPANSION OF DENTAL HEALTH AID THERA-
2 PISTS IN TRIBAL COMMUNITIES.—Section 119(d) of the
3 Indian Health Care Improvement Act (25 U.S.C.
4 1616l(d)) is amended—

5 (1) in paragraph (2), by striking “Subject to”
6 and all that follows and inserting “Subject to para-
7 graph (3), in establishing a national program under
8 paragraph (1), the Secretary shall not reduce the
9 amounts provided for the Community Health Aide
10 Program described in subsections (a) and (b).”;

11 (2) by striking paragraph (3); and

12 (3) by redesignating paragraph (4) as para-
13 graph (3).

14 (c) COVERAGE OF DENTAL SERVICES UNDER THE
15 MEDICARE PROGRAM.—

16 (1) COVERAGE.—Section 1861(s)(2) of the So-
17 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
18 ed—

19 (A) in subparagraph (GG), by striking
20 “and” at the end;

21 (B) in subparagraph (HH), by adding
22 “and” after the semicolon at the end; and

23 (C) by adding at the end the following new
24 subparagraph:

1 “(II) oral health services (as defined in sub-
2 section (kkk));”.

3 (2) ORAL HEALTH SERVICES DEFINED.—Sec-
4 tion 1861 of the Social Security Act (42 U.S.C.
5 1395x), as amended by sections 205(b) and 413(a),
6 is amended by adding at the end the following new
7 subsection:

8 “Oral Health Services

9 “(kkk)(1) The term ‘oral health services’ means serv-
10 ices (as defined by the Secretary) that are necessary to
11 prevent disease and promote oral health, restore oral
12 structures to health and function, and treat emergency
13 conditions.

14 “(2) For purposes of paragraph (1), such term shall
15 include mobile and portable oral health services (as de-
16 fined by the Secretary) that—

17 “(A) are provided for the purpose of over-
18 coming mobility, transportation, and access barriers
19 for individuals; and

20 “(B) satisfy the standards and certification re-
21 quirements established under section 1902(a)(82)(B)
22 for the State in which the services are provided.”.

23 (3) PAYMENT AND COINSURANCE.—Section
24 1833(a)(1) of the Social Security Act (42 U.S.C.
25 1395l(a)(1)) is amended—

1 (A) by striking “and” before “(CC)”; and

2 (B) by inserting before the semicolon at
3 the end the following: “, and (DD) with respect
4 to oral health services (as defined in section
5 1861(kkk)), the amount paid shall be (i) in the
6 case of such services that are preventive, 100
7 percent of the lesser of the actual charge for
8 the services or the amount determined under
9 the payment basis determined under section
10 1848, and (ii) in the case of all other such serv-
11 ices, 80 percent of the lesser of the actual
12 charge for the services or the amount deter-
13 mined under the payment basis determined
14 under section 1848”.

15 (4) PAYMENT UNDER PHYSICIAN FEE SCHED-
16 ULE.—Section 1848(j)(3) of the Social Security Act
17 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
18 “(2)(II),” after “risk assessment),”.

19 (5) DENTURES.—Section 1861(s)(8) of the So-
20 cial Security Act (42 U.S.C. 1395x(s)(8)) is amend-
21 ed—

22 (A) by striking “(other than dental)” and
23 inserting “(including dentures)”; and

24 (B) by striking “internal body”.

1 (6) REPEAL OF GROUND FOR EXCLUSION.—
2 Section 1862(a) of the Social Security Act (42
3 U.S.C. 1395y) is amended by striking paragraph
4 (12).

5 (7) EFFECTIVE DATE.—The amendments made
6 by this section shall apply to services furnished on
7 or after January 1, 2021.

8 (d) COVERAGE OF DENTAL SERVICES UNDER THE
9 MEDICAID PROGRAM.—

10 (1) IN GENERAL.—Section 1905 of the Social
11 Security Act (42 U.S.C. 1396d) is amended—

12 (A) in subsection (a)(10), by striking “den-
13 tal services” and inserting “oral health services
14 (as defined in subsection (ff)(1))”; and

15 (B) by adding at the end the following new
16 subsection:

17 “(ff)(1) Subject to paragraphs (2) and (3), for pur-
18 poses of this title, the term ‘oral health services’ means
19 services (as defined by the Secretary) that are necessary
20 to prevent disease and promote oral health, restore oral
21 structures to health and function, and treat emergency
22 conditions. These services shall include, in the case of
23 pregnant or postpartum women, such services as are nec-
24 essary to address oral health conditions that exist or are
25 exacerbated by pregnancy or childbirth or which, if left

1 untreated, could adversely affect fetal or child develop-
2 ment.

3 “(2) For purposes of paragraph (1), such term shall
4 include—

5 “(A) dentures; and

6 “(B) mobile and portable oral health services
7 (as defined by the Secretary) that—

8 “(i) are provided for the purpose of over-
9 coming mobility, transportation, and access bar-
10 riers for individuals; and

11 “(ii) satisfy the standards and certification
12 requirements established under section
13 1902(a)(84)(C) for the State in which the serv-
14 ices are provided.

15 “(3) For purposes of paragraph (1), such term shall
16 not include dental care or services provided to individuals
17 under the age of 21 under subsection (r)(3).”.

18 (2) CONFORMING AMENDMENTS.—

19 (A) STATE PLAN REQUIREMENTS.—Section
20 1902(a) of the Social Security Act (42 U.S.C.
21 1396a(a)) is amended—

22 (i) in paragraph (10)(A), in the mat-
23 ter preceding clause (i), by inserting
24 “(10),” after “(5),”;

1 (ii) in paragraph (82), by striking
2 “and” at the end;

3 (iii) in paragraph (83), by striking the
4 period at the end and inserting “; and”;
5 and

6 (iv) by inserting after paragraph (83)
7 the following:

8 “(84) provide for—

9 “(A) informing, in writing, all individuals
10 who have been determined to be eligible for
11 medical assistance of the availability of oral
12 health services (as defined in section 1905(ff));

13 “(B) conducting targeted outreach to preg-
14 nant women who have been determined to be el-
15 igible for medical assistance about the avail-
16 ability of medical assistance for such dental
17 services and the importance of receiving dental
18 care while pregnant; and

19 “(C) establishing and maintaining stand-
20 ards for and certification of mobile and portable
21 oral health services (as described in subsections
22 (r)(3)(C) and (ff)(2)(B) of section 1905).”.

23 (B) DEFINITION OF MEDICAL ASSIST-
24 ANCE.—Section 1905(a)(12) of the Social Secu-

1 rity Act (42 U.S.C. 1396d(a)(12)) is amended
2 by striking “, dentures,”.

3 (3) MOBILE AND PORTABLE ORAL HEALTH
4 SERVICES UNDER EPSDT.—Section 1905(r)(3) of the
5 Social Security Act (42 U.S.C. 1396d(r)(3)) is
6 amended—

7 (A) in subparagraph (A)(ii), by striking “;
8 and” and inserting a semicolon;

9 (B) in subparagraph (B), by striking the
10 period at the end and inserting “; and”; and

11 (C) by adding at the end the following new
12 subparagraph:

13 “(C) which shall include mobile and port-
14 able oral health services (as defined by the Sec-
15 retary) that—

16 “(i) are provided for the purpose of
17 overcoming mobility, transportation, or ac-
18 cess barriers for children; and

19 “(ii) satisfy the standards and certifi-
20 cation requirements established under sec-
21 tion 1902(a)(82)(C) for the State in which
22 the services are provided.”.

23 (e) ORAL HEALTH SERVICES AS AN ESSENTIAL
24 HEALTH BENEFIT.—Section 1302(b) of the Patient Pro-

1 tection and Affordable Care Act (42 U.S.C. 18022(b)) is
2 amended—

3 (1) in paragraph (1)—

4 (A) in subparagraph (J), by striking “oral
5 and”; and

6 (B) by adding at the end the following:

7 “(K) Oral health services for children and
8 adults.”; and

9 (2) by adding at the end the following:

10 “(6) ORAL HEALTH SERVICES.—For purposes
11 of paragraph (1)(K), the term ‘oral health services’
12 means services (as defined by the Secretary), that
13 are necessary to prevent any oral disease and pro-
14 mote oral health, restore oral structures to health
15 and function, and treat emergency oral conditions.”.

16 (f) DEMONSTRATION PROGRAM ON TRAINING AND
17 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
18 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
19 VETERANS IN RURAL AND OTHER UNDERSERVED COM-
20 MUNITIES.—

21 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

22 The Secretary of Veterans Affairs may carry out a
23 demonstration program to establish programs to
24 train and employ alternative dental health care pro-
25 viders in order to increase access to dental health

1 care services for veterans who are entitled to such
2 services from the Department of Veterans Affairs
3 and reside in rural and other underserved commu-
4 nities.

5 (2) TELEHEALTH.—For purposes of alternative
6 dental health care providers and other dental care
7 providers who are licensed to provide clinical care,
8 dental services provided under the demonstration
9 program under this subsection may be administered
10 by such providers through telehealth-enabled collabo-
11 ration and supervision when appropriate and fea-
12 sible.

13 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
14 VIDERS DEFINED.—In this subsection, the term “al-
15 ternative dental health care providers” has the
16 meaning given that term in section 340G–1(a)(2) of
17 the Public Health Service Act (42 U.S.C. 256g–
18 1(a)(2)).

19 (4) AUTHORIZATION OF APPROPRIATIONS.—
20 There are authorized to be appropriated such sums
21 as are necessary to carry out the demonstration pro-
22 gram under this subsection.

23 (g) DEMONSTRATION PROGRAM ON TRAINING AND
24 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
25 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR

1 MEMBERS OF THE ARMED FORCES AND DEPENDENTS
2 LACKING READY ACCESS TO SUCH SERVICES.—

3 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

4 The Secretary of Defense may carry out a dem-
5 onstration program to establish programs to train
6 and employ alternative dental health care providers
7 in order to increase access to dental health care
8 services for members of the Armed Forces and their
9 dependents who lack ready access to such services,
10 including the following:

11 (A) Members and dependents who reside in
12 rural areas or areas otherwise underserved by
13 dental health care providers.

14 (B) Members of the National Guard and
15 Reserves in active status who are potentially
16 deployable.

17 (2) TELEHEALTH.—For purposes of alternative
18 dental health care providers and other dental care
19 providers who are licensed to provide clinical care,
20 dental services provided under the demonstration
21 program under this subsection may be administered
22 by such providers through telehealth-enabled collabo-
23 ration and supervision when appropriate and fea-
24 sible.

1 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
2 VIDERS DEFINED.—In this subsection, the term “al-
3 ternative dental health care providers” has the
4 meaning given that term in section 340G–1(a)(2) of
5 the Public Health Service Act (42 U.S.C. 256g–
6 1(a)(2)).

7 (4) AUTHORIZATION OF APPROPRIATIONS.—
8 There are authorized to be appropriated such sums
9 as are necessary to carry out the demonstration pro-
10 gram under this subsection.

11 (h) DEMONSTRATION PROGRAM ON TRAINING AND
12 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
13 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
14 PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF
15 PRISONS.—

16 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
17 The Attorney General, acting through the Director
18 of the Bureau of Prisons, may carry out a dem-
19 onstration program to establish programs to train
20 and employ alternative dental health care providers
21 in order to increase access to dental health services
22 for prisoners within the custody of the Bureau of
23 Prisons.

24 (2) TELEHEALTH.—For purposes of alternative
25 dental health care providers and other dental care

1 providers who are licensed to provide clinical care,
2 dental services provided under the demonstration
3 program under this subsection may be administered
4 by such providers through telehealth-enabled collabo-
5 ration and supervision when appropriate and fea-
6 sible.

7 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
8 VIDERS DEFINED.—In this subsection and sub-
9 section (i), the term “alternative dental health care
10 providers” has the meaning given that term in sec-
11 tion 340G–1(a)(2) of the Public Health Service Act
12 (42 U.S.C. 256g–1(a)(2)).

13 (4) AUTHORIZATION OF APPROPRIATIONS.—
14 There are authorized to be appropriated such sums
15 as are necessary to carry out the demonstration pro-
16 gram under this subsection.

17 (i) DEMONSTRATION PROGRAM ON TRAINING AND
18 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
19 PROVIDERS FOR DENTAL HEALTH CARE SERVICES
20 UNDER THE INDIAN HEALTH SERVICE.—

21 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
22 The Secretary of Health and Human Services, act-
23 ing through the Indian Health Service, may carry
24 out a demonstration program to establish programs
25 to train and employ alternative dental health care

1 providers in order to help eliminate oral health dis-
2 parities and increase access to dental services
3 through health programs operated by the Indian
4 Health Service, Indian tribes, tribal organizations,
5 and urban Indian organizations (as the preceding 3
6 terms are defined in section 4 of the Indian Health
7 Care Improvement Act (25 U.S.C. 1603)).

8 (2) TELEHEALTH.—For purposes of alternative
9 dental health care providers and other dental care
10 providers who are licensed to provide clinical care,
11 dental services provided under the demonstration
12 program under this subsection may be administered
13 by such providers through telehealth-enabled collabo-
14 ration and supervision when appropriate and fea-
15 sible.

16 (3) AUTHORIZATION OF APPROPRIATIONS.—
17 There are authorized to be appropriated such sums
18 as are necessary to carry out the demonstration pro-
19 gram under this subsection.

20 **SEC. 434. PROVIDING FOR A SPECIAL ENROLLMENT PE-**
21 **RIOD FOR PREGNANT INDIVIDUALS.**

22 (a) PUBLIC HEALTH SERVICE ACT.—Section
23 2702(b)(2) of the Public Health Service Act (42 U.S.C.
24 300gg–1(b)(2)) is amended by inserting “including a spe-
25 cial enrollment period for pregnant individuals, beginning

1 on the date on which the pregnancy is reported to the
2 health insurance issuer” before the period at the end.

3 (b) PATIENT PROTECTION AND AFFORDABLE CARE
4 ACT.—Section 1311(c)(6) of the Patient Protection and
5 Affordable Care Act (42 U.S.C. 18031(c)(6)) is amend-
6 ed—

7 (1) in subparagraph (C), by striking “and” at
8 the end;

9 (2) by redesignating subparagraph (D) as sub-
10 paragraph (E); and

11 (3) by inserting after subparagraph (C) the fol-
12 lowing new subparagraph:

13 “(D) a special enrollment period for preg-
14 nant individuals, beginning on the date on
15 which the pregnancy is reported to the Ex-
16 change; and”.

17 (c) SPECIAL ENROLLMENT PERIODS.—

18 (1) INTERNAL REVENUE CODE.—Section
19 9801(f) of the Internal Revenue Code of 1986 (26
20 U.S.C. 9801(f)) is amended by adding at the end
21 the following new paragraph:

22 “(4) FOR PREGNANT INDIVIDUALS.—

23 “(A) A group health plan shall permit an
24 employee who is eligible, but not enrolled, for
25 coverage under the terms of the plan (or a de-

1 pendent of such an employee if the dependent
2 is eligible, but not enrolled, for coverage under
3 such terms) to enroll for coverage under the
4 terms of the plan upon pregnancy, with the spe-
5 cial enrollment period beginning on the date on
6 which the pregnancy is reported to the group
7 health plan or the pregnancy is confirmed by a
8 health care provider.

9 “(B) The Secretary shall promulgate regu-
10 lations with respect to the special enrollment
11 period under subparagraph (A), including es-
12 tablishing a time period for pregnant individ-
13 uals to enroll in coverage and effective date of
14 such coverage.”.

15 (2) ERISA.—Section 701(f) of the Employee
16 Retirement Income Security Act of 1974 (29 U.S.C.
17 1181(f)) is amended by adding at the end the fol-
18 lowing:

19 “(4) FOR PREGNANT INDIVIDUALS.—

20 “(A) A group health plan or health insur-
21 ance issuer in connection with a group health
22 plan shall permit an employee who is eligible,
23 but not enrolled, for coverage under the terms
24 of the plan (or a dependent of such an employee
25 if the dependent is eligible, but not enrolled, for

1 coverage under such terms) to enroll for cov-
2 erage under the terms of the plan upon preg-
3 nancy, with the special enrollment period begin-
4 ning on the date on which the pregnancy is re-
5 ported to the group health plan or health insur-
6 ance issuer or the pregnancy is confirmed by a
7 health care provider.

8 “(B) The Secretary shall promulgate regu-
9 lations with respect to the special enrollment
10 period under subparagraph (A), including es-
11 tablishing a time period for pregnant individ-
12 uals to enroll in coverage and effective date of
13 such coverage.”.

14 (d) **EFFECTIVE DATE.**—The amendments made by
15 this section shall apply with respect to plan years begin-
16 ning after the 2021 plan year.

17 **SEC. 435. COVERAGE OF MATERNITY CARE FOR DEPEND-**
18 **ENT CHILDREN.**

19 Section 2719A of the Public Health Service Act (42
20 U.S.C. 300gg–19a) is amended by adding at the end the
21 following:

22 “(e) **COVERAGE OF MATERNITY CARE.**—A group
23 health plan, or health insurance issuer offering group or
24 individual health insurance coverage, that provides cov-
25 erage for dependants shall ensure that such plan or cov-

1 erage includes coverage for maternity care associated with
2 pregnancy, childbirth, and postpartum care for all partici-
3 pants, beneficiaries, or enrollees, including dependants, in-
4 cluding coverage of labor and delivery. Such coverage shall
5 be provided to all pregnant dependents regardless of age.”.

6 **SEC. 436. FEDERAL EMPLOYEE HEALTH BENEFIT PLANS.**

7 (a) **COVERAGE OF PREGNANCY.—**

8 (1) **IN GENERAL.—**The Director of the Office of
9 Personnel Management shall issue such regulations
10 as are necessary to ensure that pregnancy is consid-
11 ered a change in family status and a qualifying life
12 event for an individual who is eligible to enroll, but
13 is not enrolled, in a health benefit plan under chap-
14 ter 89 title 5, United States Code.

15 (2) **EFFECTIVE DATE.—**The requirement in
16 paragraph (1) shall apply with respect to any con-
17 tract entered into under section 8902 of such title
18 beginning 12 months after the date of enactment of
19 this Act.

20 (b) **DESIGNATING CERTAIN FEHBP-RELATED**
21 **SERVICES AS EXCEPTED SERVICES UNDER THE ANTI-**
22 **DEFICIENCY ACT.—**

23 (1) **IN GENERAL.—**Section 8905 of title 5,
24 United States Code, is amended by adding at the
25 end the following:

1 “(i) Any services by an officer or em-
2 ployee under this chapter relating to en-
3 rolling individuals in a health benefits plan
4 under this chapter, or changing the enroll-
5 ment of an individual already so enrolled
6 due to an event described in section
7 5(a)(1) of the Healthy MOM Act, shall be
8 deemed, for purposes of section 1342 of
9 title 31, services for emergencies involving
10 the safety of human life or the protection
11 of property.”.

12 (2) APPLICATION.—The amendment made by
13 paragraph (1) shall apply to any lapse in appropria-
14 tions beginning on or after the date of enactment of
15 this Act.

16 **SEC. 437. CONTINUATION OF MEDICAID INCOME ELIGI-**
17 **BILITY STANDARD FOR PREGNANT INDIVID-**
18 **UALS AND INFANTS.**

19 Section 1902(l)(2)(A) of the Social Security Act (42
20 U.S.C. 1396a(l)(2)(A)) is amended—

21 (1) in clause (i), by striking “and not more
22 than 185 percent”;

23 (2) in clause (ii)—

24 (A) in subclause (I), by striking “and”
25 after the comma;

1 (B) in subclause (II), by striking the pe-
2 riod at the end and inserting “, and”; and

3 (C) by adding at the end the following:

4 “(III) January 1, 2020, is the
5 percentage provided under clause
6 (v).”; and

7 (3) by adding at the end the following new
8 clause:

9 “(v) The percentage provided under
10 clause (ii) for medical assistance provided
11 on or after January 1, 2020, with respect
12 to individuals described in subparagraph
13 (A) or (B) of paragraph (1) shall not be
14 less than—

15 “(I) the percentage specified for
16 such individuals by the State in an
17 amendment to its State plan (whether
18 approved or not) as of January 1,
19 2014; or

20 “(II) if no such percentage is
21 specified as of January 1, 2014, the
22 percentage established for such indi-
23 viduals under the State’s authorizing
24 legislation or provided for under the

1 State’s appropriations as of that
2 date.”.

3 **Subtitle C—Advancing Health Eq-**
4 **uity Through Payment and De-**
5 **livery Reform**

6 **SEC. 441. SENSE OF CONGRESS.**

7 It is the sense of Congress that—

8 (1) the sustainability of the health care system
9 in the United States hinges on restructuring how
10 health care is paid for, shifting away from paying
11 for the volume of services provided to the value the
12 services provide;

13 (2) high-value care is care that provides higher-
14 quality care more efficiently, achieving greater
15 health improvement and better health outcomes at
16 lower cost (per patient and overall);

17 (3) a high-value health care system must deliver
18 timely, accessible, well-coordinated, high-quality, cul-
19 turally centered, and language-appropriate care to
20 everyone;

21 (4) eliminating health disparities and achieving
22 health equity must be central to efforts to achieve a
23 high-value health care system;

24 (5) eliminating such disparities and achieving
25 such equity will require tailored interventions and

1 targeted investments to address inequities in health
2 and health care to make sure that health care deliv-
3 ery and payment efforts are responsive to and inclu-
4 sive of the needs of communities of color and other
5 communities experiencing disparities; and

6 (6) new models of value-based payment and
7 care delivery should consider the holistic needs of
8 the patient population and behavioral health, oral
9 health, their history of adverse childhood experiences
10 and adverse community environments, social deter-
11 minants of health, social risk factors, unmet social
12 needs, and the burden of intergenerational racial
13 and other inequities.

14 **SEC. 442. CENTERS FOR MEDICARE & MEDICAID SERVICES**
15 **REPORTING AND VALUE-BASED PROGRAMS.**

16 (a) **ADVANCING HEALTH EQUITY IN REPORTING AND**
17 **VALUE-BASED PAYMENT PROGRAMS.—**

18 (1) **IN GENERAL.**—The Administrator shall re-
19 quire that a clinician or other professional partici-
20 pating in any pay-for-reporting or value-based pay-
21 ment program stratify clinical quality measures by
22 disparity variables, including race, ethnicity, sex, pri-
23 mary language, disability status, sexual orientation,
24 gender identity, and socioeconomic status. A clini-
25 cian or other professional may use existing demo-

1 graphic data collection fields in certified electronic
2 health record technology (as defined in section
3 1848(o)(4) of the Social Security Act (42 U.S.C.
4 1395w-4(o)(4)) to carry out such data stratification
5 under the preceding sentence. Such stratified data
6 will assist clinicians and other professionals in the
7 identification of disparities obscured in aggregated
8 data and assist with the provision of interventions
9 that target reducing those disparities.

10 (2) CLINICIAN.—In assessing performance in
11 any value-based payment program, the Adminis-
12 trator shall incorporate a clinician or other profes-
13 sional's performance in reducing disparities across
14 race, ethnicity, sex, primary language, disability sta-
15 tus, sexual orientation, gender identity, and socio-
16 economic status. Linking performance payments to
17 the reduction of health care disparities across such
18 variables will assist in holding clinicians and other
19 professionals accountable for providing quality care
20 that can lead to decreased health inequities.

21 (3) REQUIREMENT OF ADOPTION OF CERT.—All
22 entities, clinicians, or other professionals partici-
23 pating in the Quality Payment Program shall be re-
24 quired to adopt 2015 certified electronic health

1 record technology (as so defined) as a condition of
2 participating in the Quality Payment Program.

3 (b) QUALITY IMPROVEMENT ACTIVITIES.—The Ad-
4 ministrator, upon yearly review of the Quality Payment
5 Program, shall add quality improvement activities that im-
6 plement the Culturally and Linguistically Accessible
7 Standards (CLAS) standards as Improvement Activities
8 under the Quality Payment Program.

9 **SEC. 443. DEVELOPMENT AND TESTING OF DISPARITY RE-**
10 **DUCING DELIVERY AND PAYMENT MODELS.**

11 (a) IN GENERAL.—The Center for Medicare and
12 Medicaid Innovation established under section 1115A of
13 the Social Security Act (42 U.S.C. 1315a) (in this section
14 referred to as the “CMI”) shall establish a dedicated fund
15 to identify, test, evaluate, and scale delivery and payment
16 models under the applicable titles (as defined in subsection
17 (a)(4)(B) of such section) that target health disparities
18 among racial and ethnic minorities, including models that
19 support high-value non-medical services that address so-
20 cially determined barriers to health, including English pro-
21 ficiency status, low health literacy, case management,
22 transportation, enrollment assistance needs, stable and af-
23 fordable housing, utility assistance, employment and ca-
24 reer development, and nutrition and food security which

1 will help to reduce disparities and impact the overall cost
2 of care.

3 (b) AMENDMENT TO SOCIAL SECURITY ACT.—Sec-
4 tion 1115A(a)(1) of the Social Security Act (42 U.S.C.
5 1315a(a)(1)) is amended as follows:

6 “(1) The purpose of the CMI is to test innova-
7 tive payment and service delivery models to reduce
8 program expenditures and improve health equity
9 under the applicable titles while preserving or en-
10 hancing the quality of care furnished to individuals
11 under such titles.”.

12 (c) PILOT PROGRAMS.—The CMI shall prioritize the
13 testing of models under such section 1115A that include
14 partnerships with entities, including community-based or-
15 ganizations or other nonprofit entities, to help address so-
16 cially determined barriers to health and health care.

17 (d) ALTERNATIVES.—Any model tested by the CMI
18 under such 1115A shall include measures to assess and
19 track the impact of the model on health disparities, using
20 existing measures such as the Healthcare Disparities and
21 Cultural Competency Measures endorsed by the entity
22 with a contract under section 1890(a) of the Social Secu-
23 rity Act (42 U.S.C. 1395aaa(a)), and stratified by race,
24 ethnicity, English proficiency, gender identity, sexual ori-
25 entation, and disability status.

1 **SEC. 444. DIVERSITY IN CENTERS FOR MEDICARE & MED-**
2 **ICAID CONSULTATION.**

3 (a) IN GENERAL.—In carrying out the duties under
4 this section, the CMI shall consult representatives of rel-
5 evant Federal agencies, and clinical and analytical experts
6 with expertise in medicine and health care management,
7 specifically such experts with expertise in—

8 (1) the health care needs of minority, rural, and
9 underserved populations; and

10 (2) the financial needs of safety net, commu-
11 nity-based, rural, and critical access providers, in-
12 cluding federally qualified health centers.

13 (b) OPEN DOOR FORUMS.—The CMI shall use open
14 door forums or other mechanisms to seek external feed-
15 back from interested parties and incorporate that feedback
16 into the development of models.

17 **SEC. 445. SUPPORTING SAFETY NET AND COMMUNITY-**
18 **BASED PROVIDERS TO COMPETE IN VALUE-**
19 **BASED PAYMENT SYSTEMS.**

20 (a) IN GENERAL.—Any pay-for-performance or alter-
21 native payment model that is developed and tested by the
22 Center for Medicare and Medicaid Innovation established
23 under section 1115A of the Social Security Act (42 U.S.C.
24 1315a), or any other agency of the Department of Health
25 and Human Services with respect to the programs under
26 titles XVIII, XIX, or XXI of such Act, shall be assessed

1 for potential impact on safety net, community-based, and
2 critical access providers, including federally qualified
3 health centers.

4 (b) NEW MODELS.—The rollout of any such models
5 shall include training and additional up front resources for
6 community-based and safety net providers to enable those
7 providers to participate in the model.

8 **Subtitle D—Health Empowerment** 9 **Zones**

10 **SEC. 451. SHORT TITLE.**

11 This subtitle may be cited as the “Health Empower-
12 ment Zone Act of 2020”.

13 **SEC. 452. FINDINGS.**

14 Congress finds the following:

15 (1) Numerous studies and reports, including
16 the 2015 National Healthcare Quality and Dispari-
17 ties Report of the Agency for Healthcare Research
18 and Quality and the 2002 report of the Institute of
19 Medicine entitled “Unequal Treatment: Confronting
20 Racial and Ethnic Disparities in Health Care”, doc-
21 ument the extensiveness to which health disparities
22 exist across the country.

23 (2) These studies have found that, on average,
24 racial and ethnic minorities are disproportionately
25 afflicted with chronic and acute conditions—such as

1 cancer, diabetes, musculoskeletal disease, obesity,
2 and hypertension—and suffer worse health out-
3 comes, worse health status, and higher mortality
4 rates than their White counterparts.

5 (3) Several recent studies also show that health
6 disparities are a function of not only access to health
7 care, but also the social determinants of health—in-
8 cluding the environment, the physical structure of
9 communities, nutrition and food options, educational
10 attainment and health literacy, employment, race,
11 ethnicity, immigration status, geography, and lan-
12 guage preference—that directly and indirectly affect
13 the health, health care, and wellness of individuals
14 and communities.

15 (4) Integrally involving and fully supporting the
16 communities most affected by health inequities in
17 the assessment, planning, launch, and evaluation of
18 health disparity elimination efforts are among the
19 leading recommendations made to adequately ad-
20 dress and ultimately reduce health disparities.

21 (5) Recommendations also include supporting
22 the efforts of community stakeholders from a broad
23 cross section—including local businesses, local de-
24 partments of commerce, education, labor, urban
25 planning, and transportation, and community-based

1 and other nonprofit organizations, including national
2 and regional intermediaries with demonstrated ca-
3 pacity to serve low-income urban communities—to
4 find areas of common ground around health dis-
5 parity elimination and collaborate to improve the
6 overall health and wellness of a community and its
7 residents.

8 **SEC. 453. DESIGNATION OF HEALTH EMPOWERMENT**
9 **ZONES.**

10 (a) IN GENERAL.—The Secretary may, at the request
11 of an eligible community partnership described in sub-
12 section (b)(1), designate an eligible area described in sub-
13 section (b)(2) as a health empowerment zone for the pur-
14 pose of eligibility for a grant under section 455.

15 (b) ELIGIBILITY CRITERIA.—

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

19 (A) demonstrates widespread public sup-
20 port from key individuals and entities in the eli-
21 gible area, including members of the target
22 community, State and local governments, non-
23 profit organizations including national and re-
24 gional intermediaries with demonstrated capac-
25 ity to serve low-income urban communities, and

1 community and industry leaders, for designa-
2 tion of the eligible area as a health empower-
3 ment zone; and

4 (B) includes representatives of—

5 (i) a broad cross section of stake-
6 holders and residents from communities in
7 the eligible area experiencing dispropor-
8 tionate disparities in health status and
9 health care; and

10 (ii) organizations, facilities, and insti-
11 tutions that have a history of working
12 within and serving such communities.

13 (2) ELIGIBLE AREA.—An area is eligible to be
14 designated as a health empowerment zone under this
15 section if one or more communities in the area expe-
16 rience disproportionate disparities in health status
17 and health care. In determining whether a commu-
18 nity experiences such disparities, the Secretary shall
19 consider data collected by the Department of Health
20 and Human Services focusing on the following areas:

21 (A) Access to affordable, high-quality
22 health services.

23 (B) The prevalence of disproportionate
24 rates of certain illnesses or diseases including
25 the following:

- 1 (i) Arthritis, osteoporosis, chronic
2 back conditions, and other musculoskeletal
3 diseases.
- 4 (ii) Cancer.
- 5 (iii) Chronic kidney disease.
- 6 (iv) Diabetes.
- 7 (v) Injury (intentional and uninten-
8 tional).
- 9 (vi) Violence (intimate and non-
10 intimate).
- 11 (vii) Maternal and paternal illnesses
12 and diseases.
- 13 (viii) Infant mortality.
- 14 (ix) Mental illness and other disabil-
15 ities.
- 16 (x) Substance use disorder treatment
17 and prevention, including underage drink-
18 ing.
- 19 (xi) Nutrition, obesity, and overweight
20 conditions.
- 21 (xii) Heart disease.
- 22 (xiii) Hypertension.
- 23 (xiv) Cerebrovascular disease or
24 stroke.
- 25 (xv) Tuberculosis.

1 (xvi) HIV/AIDS and other sexually
2 transmitted infections.

3 (xvii) Viral hepatitis.

4 (xviii) Asthma.

5 (xix) Tooth decay and other oral
6 health issues.

7 (C) Within the community, the historical
8 and persistent presence of conditions that have
9 been found to contribute to health disparities
10 including any such conditions respecting any of
11 the following:

12 (i) Poverty.

13 (ii) Educational status and the quality
14 of community schools.

15 (iii) Income.

16 (iv) Access to high-quality affordable
17 health care.

18 (v) Work and work environment.

19 (vi) Environmental conditions in the
20 community, including with respect to clean
21 water, clean air, and the presence or ab-
22 sence of pollutants.

23 (vii) Language and English pro-
24 ficiency.

1 (viii) Access to affordable healthy
2 food.

3 (ix) Access to ethnically and culturally
4 diverse health and human service providers
5 and practitioners.

6 (x) Access to culturally and linguis-
7 tically competent health and human serv-
8 ices and health and human service pro-
9 viders.

10 (xi) Health-supporting infrastructure.

11 (xii) Health insurance that is ade-
12 quate and affordable.

13 (xiii) Race, racism, and bigotry (con-
14 scious and unconscious).

15 (xiv) Sexual orientation.

16 (xv) Health literacy.

17 (xvi) Place of residence (such as
18 urban areas, rural areas, and reservations
19 of Indian tribes).

20 (xvii) Stress.

21 (c) PROCEDURE.—

22 (1) REQUEST.—A request under subsection (a)
23 shall—

1 (A) describe the bounds of the area to be
2 designated as a health empowerment zone and
3 the process used to select those bounds;

4 (B) demonstrate that the partnership sub-
5 mitting the request is an eligible community
6 partnership described in subsection (b)(1);

7 (C) demonstrate that the area is an eligible
8 area described in subsection (b)(2);

9 (D) include a comprehensive assessment of
10 disparities in health status and health care ex-
11 perience by one or more communities in the
12 area;

13 (E) set forth—

14 (i) a vision and a set of values for the
15 area; and

16 (ii) a comprehensive and holistic set of
17 goals to be achieved in the area through
18 designation as a health empowerment zone;
19 and

20 (F) include a strategic plan and an action
21 plan for achieving the goals described in sub-
22 paragraph (E)(ii).

23 (2) APPROVAL.—Not later than 60 days after
24 the receipt of a request for designation of an area
25 as a health empowerment zone under this section,

1 the Secretary shall approve or disapprove the re-
2 quest.

3 (d) **MINIMUM NUMBER.**—The Secretary—

4 (1) shall designate not more than 110 health
5 empowerment zones under this section; and

6 (2) shall designate at least one health empower-
7 ment zone in each of the several States, the District
8 of Columbia, and each territory or possession of the
9 United States.

10 **SEC. 454. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

11 At the request of any organization or entity seeking
12 to submit a request under section 453(a), the Secretary
13 shall provide technical assistance, and may award a grant,
14 to assist such organization or entity—

15 (1) to form an eligible community partnership
16 described in section 453(b)(1);

17 (2) to complete a health assessment, including
18 an assessment of health disparities under section
19 453(c)(1)(D); or

20 (3) to prepare and submit a request, including
21 a strategic plan, in accordance with section 453.

22 **SEC. 455. BENEFITS OF DESIGNATION.**

23 (a) **PRIORITY.**—In awarding a grant under sub-
24 section (b), a Federal official shall give priority to any ap-
25 plicant that—

- 1 (1) meets the eligibility criteria for the grant;
- 2 (2) proposes to use the grant for activities in a
- 3 health empowerment zone; and
- 4 (3) demonstrates that such activities will di-
- 5 rectly and significantly further the goals of the stra-
- 6 tegic plan approved for such zone under section 453.

7 (b) GRANTS FOR INITIAL IMPLEMENTATION OF

8 STRATEGIC PLAN.—

9 (1) IN GENERAL.—Upon designating an eligible

10 area as a health empowerment zone at the request

11 of an eligible community partnership, the Secretary

12 shall, subject to the availability of appropriations,

13 make a grant to the community partnership for im-

14 plementation of the strategic plan for such zone.

15 (2) GRANT PERIOD.—A grant under paragraph

16 (1) for a health empowerment zone shall be for a pe-

17 riod of 2 years and may be renewed, except that the

18 total period of grants under paragraph (1) for such

19 zone may not exceed 10 years.

20 (3) LIMITATION.—In awarding grants under

21 this subsection, the Secretary shall not give less pri-

22 ority to an applicant or reduce the amount of a

23 grant because the Secretary rendered technical as-

24 sistance or made a grant to the same applicant

25 under section 454.

1 (4) REPORTING.—The Secretary shall establish
2 metrics for measuring the progress of grantees
3 under this subsection and, based on such metrics,
4 require each such grantee to report to the Secretary
5 not less than every 6 months on the progress in im-
6 plementing the strategic plan for the health em-
7 powerment zone.

8 **SEC. 456. DEFINITION OF SECRETARY.**

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

17 **SEC. 457. AUTHORIZATION OF APPROPRIATIONS.**

18 To carry out this subtitle, there is authorized to be
19 appropriated \$100,000,000 for fiscal year 2021.

1 **TITLE V—IMPROVING HEALTH**
2 **OUTCOMES FOR WOMEN,**
3 **CHILDREN, AND FAMILIES**

4 **Subtitle A—In General**

5 **SEC. 501. GRANTS TO PROMOTE HEALTH FOR UNDER-**
6 **SERVED COMMUNITIES.**

7 Part Q of title III of the Public Health Service Act
8 (42 U.S.C. 280g et seq.) is amended by adding at the end
9 the following:

10 **“SEC. 399Z-3. GRANTS TO PROMOTE HEALTH FOR UNDER-**
11 **SERVED COMMUNITIES.**

12 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
13 laboration with the Administrator of the Health Resources
14 and Services Administration and other Federal officials
15 determined appropriate by the Secretary, is authorized to
16 award grants to eligible entities—

17 “(1) to promote health for underserved commu-
18 nities, with preference given to projects that benefit
19 racial and ethnic minority women, racial and ethnic
20 minority children, adolescents, and lesbian, gay, bi-
21 sexual, transgender, queer, or questioning commu-
22 nities; and

23 “(2) to strengthen health outreach initiatives in
24 medically underserved communities, including lin-
25 guistically isolated populations.

1 “(b) USE OF FUNDS.—Grants awarded pursuant to
2 subsection (a) may be used to support the activities of
3 community health workers, including such activities—

4 “(1) to educate and provide outreach regarding
5 enrollment in health insurance including the State
6 Children’s Health Insurance Program under title
7 XXI of the Social Security Act, Medicare under title
8 XVIII of such Act, and Medicaid under title XIX of
9 such Act;

10 “(2) to educate and provide outreach in a com-
11 munity setting regarding health problems prevalent
12 among underserved communities, and especially
13 among racial and ethnic minority women, racial and
14 ethnic minority children, adolescents, and lesbian,
15 gay, bisexual, transgender, queer, or questioning
16 communities;

17 “(3) to educate and provide experiential learn-
18 ing opportunities and target risk factors and healthy
19 behaviors that impede or contribute to achieving
20 positive health outcomes, including—

21 “(A) healthy nutrition;

22 “(B) physical activity;

23 “(C) overweight or obesity;

24 “(D) tobacco use, including the use of e-
25 cigarettes and vaping;

1 “(E) alcohol and substance use;

2 “(F) injury and violence;

3 “(G) sexual health;

4 “(H) mental health;

5 “(I) musculoskeletal health and arthritis;

6 “(J) prenatal and postnatal care;

7 “(K) dental and oral health;

8 “(L) understanding informed consent;

9 “(M) stigma; and

10 “(N) environmental hazards;

11 “(4) to promote community wellness and aware-
12 ness; and

13 “(5) to educate and refer target populations to
14 appropriate health care agencies and community-
15 based programs and organizations in order to in-
16 crease access to quality health care services, includ-
17 ing preventive health services.

18 “(c) APPLICATION.—

19 “(1) IN GENERAL.—Each eligible entity that
20 desires to receive a grant under subsection (a) shall
21 submit an application to the Secretary, at such time,
22 in such manner, and accompanied by such additional
23 information as the Secretary may require.

24 “(2) CONTENTS.—Each application submitted
25 pursuant to paragraph (1) shall—

1 “(A) describe the activities for which as-
2 sistance under this section is sought;

3 “(B) contain an assurance that, with re-
4 spect to each community health worker pro-
5 gram receiving funds under the grant awarded,
6 such program provides in-language training and
7 supervision to community health workers to en-
8 able such workers to provide authorized pro-
9 gram activities in (at least) the most commonly
10 used languages within a particular geographic
11 region;

12 “(C) contain an assurance that the appli-
13 cant will evaluate the effectiveness of commu-
14 nity health worker programs receiving funds
15 under the grant;

16 “(D) contain an assurance that each com-
17 munity health worker program receiving funds
18 under the grant will provide culturally com-
19 petent services in the linguistic context most
20 appropriate for the individuals served by the
21 program;

22 “(E) contain a plan to document and dis-
23 seminate project descriptions and results to
24 other States and organizations as identified by
25 the Secretary; and

1 “(F) describe plans to enhance the capac-
2 ity of individuals to utilize health services and
3 health-related social services under Federal,
4 State, and local programs by—

5 “(i) assisting individuals in estab-
6 lishing eligibility under the programs and
7 in receiving the services or other benefits
8 of the programs; and

9 “(ii) providing other services, as the
10 Secretary determines to be appropriate,
11 which may include transportation and
12 translation services.

13 “(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Secretary shall give priority to those appli-
15 cants—

16 “(1) who propose to target geographic areas
17 that—

18 “(A)(i) have a high percentage of residents
19 who are uninsured or underinsured (if the tar-
20 geted geographic area is located in a State that
21 has elected to make medical assistance available
22 under section 1902(a)(10)(A)(i)(VIII) of the
23 Social Security Act to individuals described in
24 such section);

1 “(ii) have a high percentage of under-
2 insured residents in a particular geographic
3 area (if the targeted geographic area is located
4 in a State that has not so elected); or

5 “(iii) have a high number of households ex-
6 perienceing extreme poverty; and

7 “(B) have a high percentage of families for
8 whom English is not their primary language or
9 including smaller limited English proficient
10 communities within the region that are not oth-
11 erwise reached by linguistically appropriate
12 health services;

13 “(2) with experience in providing health or
14 health-related social services to individuals who are
15 underserved with respect to such services; and

16 “(3) with documented community activity and
17 experience with community health workers.

18 “(e) COLLABORATION WITH ACADEMIC INSTITU-
19 TIONS.—The Secretary shall encourage community health
20 worker programs receiving funds under this section to col-
21 laborate with academic institutions, including minority-
22 serving institutions. Nothing in this section shall be con-
23 strued to require such collaboration.

24 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
25 NESS.—The Secretary shall establish guidelines for ensur-

1 ing the quality of the training and supervision of commu-
2 nity health workers under the programs funded under this
3 section and for ensuring the cost effectiveness of such pro-
4 grams.

5 “(g) MONITORING.—The Secretary shall monitor
6 community health worker programs identified in approved
7 applications and shall determine whether such programs
8 are in compliance with the guidelines established under
9 subsection (f).

10 “(h) TECHNICAL ASSISTANCE.—The Secretary may
11 provide technical assistance to community health worker
12 programs identified in approved applications with respect
13 to planning, developing, and operating programs under the
14 grant.

15 “(i) REPORT TO CONGRESS.—

16 “(1) IN GENERAL.—Not later than 4 years
17 after the date on which the Secretary first awards
18 grants under subsection (a), the Secretary shall sub-
19 mit to Congress a report regarding the grant
20 project.

21 “(2) CONTENTS.—The report required under
22 paragraph (1) shall include the following:

23 “(A) A description of the programs for
24 which grant funds were used.

25 “(B) The number of individuals served.

1 “(C) An evaluation of—

2 “(i) the effectiveness of these pro-
3 grams;

4 “(ii) the cost of these programs; and

5 “(iii) the impact of these programs on
6 the health outcomes of the community resi-
7 dents.

8 “(D) Recommendations for sustaining the
9 community health worker programs developed
10 or assisted under this section.

11 “(E) Recommendations regarding training
12 to enhance career opportunities for community
13 health workers.

14 “(j) DEFINITIONS.—In this section:

15 “(1) COMMUNITY HEALTH WORKER.—The term
16 ‘community health worker’ means an individual who
17 promotes health or nutrition within the community
18 in which the individual resides—

19 “(A) by serving as a liaison between com-
20 munities and health care agencies;

21 “(B) by providing guidance and social as-
22 sistance to community residents;

23 “(C) by enhancing community residents’
24 ability to effectively communicate with health
25 care providers;

1 “(D) by providing culturally and linguis-
2 tically appropriate health or nutrition edu-
3 cation;

4 “(E) by advocating for individual and com-
5 munity health, including dental, oral, mental,
6 and environmental health, or nutrition needs;

7 “(F) by taking into consideration the
8 needs of the communities served, including the
9 prevalence rates of risk factors that impede
10 achieving positive healthy outcomes among
11 women and children, especially among racial
12 and ethnic minority women and children; and

13 “(G) by providing referral and followup
14 services.

15 “(2) COMMUNITY SETTING.—The term ‘commu-
16 nity setting’ means a home or a community organi-
17 zation that serves a population.

18 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
19 tity’ means—

20 “(A) a unit of State, territorial, local, or
21 Tribal government (including a federally recog-
22 nized Tribe or Alaska Native village); or

23 “(B) a community-based organization.

1 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
2 The term ‘medically underserved community’ means
3 a community—

4 “(A) that has a substantial number of in-
5 dividuals who are members of a medically un-
6 derserved population, as defined by section
7 330(b)(3);

8 “(B) a significant portion of which is a
9 health professional shortage area as designated
10 under section 332; and

11 “(C) that includes populations that are lin-
12 guistically isolated, such as geographic areas
13 with a shortage of health professionals able to
14 provide linguistically appropriate services.

15 “(5) SUPPORT.—The term ‘support’ means the
16 provision of training, supervision, and materials
17 needed to effectively deliver the services described in
18 subsection (b), reimbursement for services, and
19 other benefits.

20 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 \$15,000,000 for each of fiscal years 2021 through 2025.”.

1 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
2 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
3 **NANT PERSONS, AND LAWFULLY PRESENT IN-**
4 **DIVIDUALS.**

5 (a) MEDICAID.—Section 1903(v) of the Social Secu-
6 rity Act (42 U.S.C. 1396b(v)) is amended by striking
7 paragraph (4) and inserting the following new paragraph:
8 “(4)(A) Notwithstanding sections 401(a), 402(b),
9 403, and 421 of the Personal Responsibility and Work Op-
10 portunity Reconciliation Act of 1996 and paragraph (1),
11 payment shall be made to a State under this section for
12 medical assistance furnished to an alien under this title
13 (including an alien described in such paragraph) who
14 meets any of the following conditions:

15 “(i) The alien is otherwise eligible for such as-
16 sistance under the State plan approved under this
17 title (other than the requirement of the receipt of
18 aid or assistance under title IV, supplemental secu-
19 rity income benefits under title XVI, or a State sup-
20 plementary payment) within either or both of the
21 following eligibility categories:

22 “(I) Children under 21 years of age, in-
23 cluding any optional targeted low-income child
24 (as such term is defined in section
25 1905(u)(2)(B)).

1 “(II) Pregnant persons during pregnancy
2 and during the 12-month period beginning on
3 the last day of the pregnancy.

4 “(ii) The alien is lawfully present in the United
5 States.

6 “(B) No debt shall accrue under an affidavit of sup-
7 port against any sponsor of an alien who meets the condi-
8 tions specified in subparagraph (A) on the basis of the
9 provision of medical assistance to such alien under this
10 paragraph and the cost of such assistance shall not be con-
11 sidered as an unreimbursed cost.”.

12 (b) SCHIP.—Subparagraph (N) of section
13 2107(e)(1) of the Social Security Act (42 U.S.C.
14 1397gg(e)(1)) is amended to read as follows:

15 “(N) Paragraph (4) of section 1903(v) (re-
16 lating to coverage of categories of children,
17 pregnant persons, and other lawfully present in-
18 dividuals).”.

19 (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-
20 withstanding sections 401(a), 402(a), and 403(a) of the
21 Personal Responsibility and Work Opportunity Reconcili-
22 ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))
23 and section 6(f) of the Food and Nutrition Act of 2008
24 (7 U.S.C. 2015(f)), persons who are lawfully present in
25 the United States shall be not be ineligible for benefits

1 under the supplemental nutrition assistance program on
2 the basis of their immigration status or date of entry into
3 the United States.

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

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

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

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

18 “(vi) shall provide a method for imple-
19 menting section 421 of the Personal Re-
20 sponsibility and Work Opportunity Rec-
21 onciliation Act of 1996 (8 U.S.C. 1631)
22 that does not require any unnecessary in-
23 formation from persons who may be ex-
24 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 “for—” and
6 all that follows and inserting “for assistance under
7 any State program funded under part A of title IV
8 of the Social Security Act (42 U.S.C. 601 et seq.)”;

9 (2) in subsection (b)—

10 (A) by striking “(1) PROGRAM OF TEM-
11 PORARY ASSISTANCE FOR NEEDY FAMILIES.—”;

12 and

13 (B) by striking paragraph (2); and

14 (3) in subsection (e), by striking “it—” and all
15 that follows and inserting “the term in section
16 419(5) of the Social Security Act (42 U.S.C.
17 619(5)) when referring to assistance provided under
18 a State program funded under paragraph A of title
19 IV of the Social Security Act (42 U.S.C. 601 et
20 seq.)”.

21 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
22 **AND AWARENESS.**

23 (a) IN GENERAL.—The Secretary shall establish and
24 implement a birth defects prevention and public awareness
25 program, consisting of the activities described in sub-
26 sections (c) and (d).

1 (b) DEFINITIONS.—In this section:

2 (1) MATERNAL.—The term “maternal” refers
3 to persons who are pregnant or breastfeeding of all
4 gender identities.

5 (2) PREGNANCY AND BREASTFEEDING INFOR-
6 MATION SERVICES.—The term “pregnancy and
7 breastfeeding information services” includes only—

8 (A) information services to provide accu-
9 rate, evidence-based, clinical information re-
10 garding maternal exposures during pregnancy
11 that may be associated with birth defects or
12 other health risks, such as exposures to medica-
13 tions, chemicals, infections, foodborne patho-
14 gens, illnesses, nutrition, or lifestyle factors;

15 (B) information services to provide accu-
16 rate, evidence-based, clinical information re-
17 garding maternal exposures during breast-
18 feeding that may be associated with health risks
19 to a breast-fed infant, such as exposures to
20 medications, chemicals, infections, foodborne
21 pathogens, illnesses, nutrition, lifestyle, or cli-
22 mate and weather-related factors;

23 (C) the provision of accurate, evidence-
24 based information weighing risks of exposures

1 during breastfeeding against the benefits of
2 breastfeeding; and

3 (D) the provision of information described
4 in subparagraph (A), (B), or (C) through coun-
5 selors, websites, fact sheets, telephonic or elec-
6 tronic communication, community outreach ef-
7 forts, or other appropriate means.

8 (3) SECRETARY.—The term “Secretary” means
9 the Secretary of Health and Human Services, acting
10 through the Director of the Centers for Disease
11 Control and Prevention.

12 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
13 subsection (a), the Secretary shall conduct or support a
14 nationwide media campaign to increase awareness among
15 health care providers and at-risk populations about preg-
16 nancy and breastfeeding information services.

17 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
18 INFORMATION SERVICES.—

19 (1) IN GENERAL.—In carrying out subsection
20 (a), the Secretary shall award grants to State or re-
21 gional agencies or organizations for any of the fol-
22 lowing:

23 (A) INFORMATION SERVICES.—The provi-
24 sion of, or campaigns to increase awareness

1 about, pregnancy and breastfeeding information
2 services.

3 (B) SURVEILLANCE AND RESEARCH.—The
4 conduct or support of—

5 (i) surveillance of or research on—

6 (I) maternal exposures and ma-
7 ternal health conditions that may in-
8 fluence the risk of birth defects, pre-
9 maturity, or other adverse pregnancy
10 outcomes; and

11 (II) maternal exposures that may
12 influence health risks to a breastfed
13 infant; or

14 (ii) networking to facilitate surveil-
15 lance or research described in this sub-
16 paragraph.

17 (2) PREFERENCE FOR CERTAIN STATES.—The
18 Secretary, in making any grant under this sub-
19 section, shall give preference to States, otherwise
20 equally qualified, that have a pregnancy and
21 breastfeeding information service in place.

22 (3) MATCHING FUNDS.—The Secretary may
23 only award a grant under this subsection to a State
24 or regional agency or organization that agrees, with
25 respect to the costs to be incurred in carrying out

1 the grant activities, to make available (directly or
2 through donations from public or private entities)
3 non-Federal funds toward such costs in an amount
4 equal to not less than 25 percent of the amount of
5 the grant.

6 (4) COORDINATION.—The Secretary shall en-
7 sure that activities funded through a grant under
8 this subsection are coordinated, to the maximum ex-
9 tent practicable, with other birth defects prevention
10 and environmental health activities of the Federal
11 Government, including with respect to pediatric envi-
12 ronmental health specialty units and children’s envi-
13 ronmental health centers.

14 (e) EVALUATION.—In furtherance of the program
15 under subsection (a), the Secretary shall provide for an
16 evaluation of pregnancy and breastfeeding information
17 services to identify efficient and effective models of—

18 (1) providing information;

19 (2) raising awareness and increasing knowledge
20 about birth defects prevention measures and tar-
21 geting education to at-risk groups;

22 (3) modifying risk behaviors; or

23 (4) other outcome measures as determined ap-
24 propriate by the Secretary.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 \$5,000,000 for fiscal year 2021, \$6,000,000 for fiscal year
4 2022, \$7,000,000 for fiscal year 2023, \$8,000,000 for fis-
5 cal year 2024, and \$9,000,000 for fiscal year 2025.

6 **SEC. 505. MOMMA’S ACT.**

7 (a) SHORT TITLE.—This section may be cited as the
8 “Mothers and Offspring Mortality and Morbidity Aware-
9 ness Act” or the “MOMMA’s Act”.

10 (b) FINDINGS.—Congress finds the following:

11 (1) Every year, across the United States,
12 4,000,000 women give birth, about 700 women suf-
13 fer fatal complications during pregnancy, while giv-
14 ing birth or during the postpartum period, and
15 70,000 women suffer near-fatal, partum-related
16 complications.

17 (2) The maternal mortality rate is often used as
18 a proxy to measure the overall health of a popu-
19 lation. While the infant mortality rate in the United
20 States has reached its lowest point, the risk of death
21 for women in the United States during pregnancy,
22 childbirth, or the postpartum period is higher than
23 such risk in many other developed nations. The esti-
24 mated maternal mortality rate (per 100,000 live
25 births) for the 48 contiguous States and Wash-

1 ington, DC, increased from 18.8 percent in 2000 to
2 23.8 percent in 2014 to 26.6 percent in 2018. This
3 estimated rate is on par with such rate for under-
4 developed nations such as Iraq and Afghanistan.

5 (3) International studies estimate the 2015 ma-
6 ternal mortality rate in the United States as 26.4
7 per 100,000 live births, which is almost twice the
8 2015 World Health Organization estimation of 14
9 per 100,000 live births.

10 (4) It is estimated that more than 60 percent
11 of maternal deaths in the United States are prevent-
12 able.

13 (5) According to the Centers for Disease Con-
14 trol and Prevention, the maternal mortality rate var-
15 ies drastically for women by race and ethnicity.
16 There are 12.7 deaths per 100,000 live births for
17 White women, 43.5 deaths per 100,000 live births
18 for African-American women, and 14.4 deaths per
19 100,000 live births for women of other ethnicities.
20 While maternal mortality disparately impacts Afri-
21 can-American women, this urgent public health crisis
22 traverses race, ethnicity, socioeconomic status, edu-
23 cational background, and geography.

24 (6) African-American women are 3 to 4 times
25 more likely to die from causes related to pregnancy

1 and childbirth compared to non-Hispanic White
2 women.

3 (7) The findings described in paragraphs (1)
4 through (6) are of major concern to researchers,
5 academics, members of the business community, and
6 providers across the obstetrical continuum rep-
7 resented by organizations such as March of Dimes;
8 the Preeclampsia Foundation; the American College
9 of Obstetricians and Gynecologists; the Society for
10 Maternal-Fetal Medicine; the Association of Wom-
11 en's Health, Obstetric, and Neonatal Nurses; the
12 California Maternal Quality Care Collaborative;
13 Black Women's Health Imperative; the National
14 Birth Equity Collaborative; Black Mamas Matter Al-
15 liance; EverThrive Illinois; the National Association
16 of Certified Professional Midwives; PCOS Challenge:
17 The National Polycystic Ovary Syndrome Associa-
18 tion; and the American College of Nurse Midwives.

19 (8) Hemorrhage, cardiovascular and coronary
20 conditions, cardiomyopathy, infection, embolism,
21 mental health conditions, preeclampsia and eclamp-
22 sia, polycystic ovary syndrome, infection and sepsis,
23 and anesthesia complications are the predominant
24 medical causes of maternal-related deaths and com-

1 plications. Most of these conditions are largely pre-
2 ventable or manageable.

3 (9) Oral health is an important part of
4 perinatal health. Reducing bacteria in a woman's
5 mouth during pregnancy can significantly reduce her
6 risk of developing oral diseases and spreading decay-
7 causing bacteria to her baby. Moreover, some evi-
8 dence suggests that women with periodontal disease
9 during pregnancy could be at greater risk for poor
10 birth outcomes, such as preeclampsia, pre-term
11 birth, and low-birth weight. Furthermore, a woman's
12 oral health during pregnancy is a good predictor of
13 her newborn's oral health, and since mothers can
14 unintentionally spread oral bacteria to their babies,
15 putting their children at higher risk for tooth decay,
16 prevention efforts should happen even before chil-
17 dren are born, as a matter of pre-pregnancy health
18 and prenatal care during pregnancy.

19 (10) The United States has not been able to
20 submit a formal maternal mortality rate to inter-
21 national data repositories since 2007. Thus, no offi-
22 cial maternal mortality rate exists for the United
23 States. There can be no maternal mortality rate
24 without streamlining maternal mortality-related data

1 from the State level and extrapolating such data to
2 the Federal level.

3 (11) In the United States, death reporting and
4 analysis is a State function rather than a Federal
5 process. States report all deaths—including mater-
6 nal deaths—on a semi-voluntary basis, without
7 standardization across States. While the Centers for
8 Disease Control and Prevention has the capacity and
9 system for collecting death-related data based on
10 death certificates, these data are not sufficiently re-
11 ported by States in an organized and standard for-
12 mat across States such that the Centers for Disease
13 Control and Prevention is able to identify causes of
14 maternal death and best practices for the prevention
15 of such death.

16 (12) Vital statistics systems often underesti-
17 mate maternal mortality and are insufficient data
18 sources from which to derive a full scope of medical
19 and social determinant factors contributing to ma-
20 ternal deaths. While the addition of pregnancy
21 checkboxes on death certificates since 2003 have
22 likely improved States' abilities to identify preg-
23 nancy-related deaths, they are not generally com-
24 pleted by obstetrical providers or persons trained to
25 recognize pregnancy-related mortality. Thus, these

1 vital forms may be missing information or may cap-
2 ture inconsistent data. Due to varying maternal
3 mortality-related analyses, lack of reliability, and
4 granularity in data, current maternal mortality
5 informatics do not fully encapsulate the myriad med-
6 ical and socially determinant factors that contribute
7 to such high maternal mortality rates within the
8 United States compared to other developed nations.
9 Lack of standardization of data and data sharing
10 across States and between Federal entities, health
11 networks, and research institutions keep the Nation
12 in the dark about ways to prevent maternal deaths.

13 (13) Having reliable and valid State data ag-
14 gregated at the Federal level is critical to the Na-
15 tion's ability to quell surges in maternal death and
16 imperative for researchers to identify long-lasting
17 interventions.

18 (14) Leaders in maternal wellness highly rec-
19 ommend that maternal deaths be investigated at the
20 State level first, and that standardized, streamlined,
21 de-identified data regarding maternal deaths be sent
22 annually to the Centers for Disease Control and Pre-
23 vention. Such data standardization and collection
24 would be similar in operation and effect to the Na-
25 tional Program of Cancer Registries of the Centers

1 for Disease Control and Prevention and akin to the
2 Confidential Enquiry in Maternal Deaths Pro-
3 gramme in the United Kingdom. Such a maternal
4 mortalities and morbidities registry and surveillance
5 system would help providers, academicians, law-
6 makers, and the public to address questions con-
7 cerning the types of, causes of, and best practices to
8 thwart, pregnancy-related or pregnancy-associated
9 mortality and morbidity.

10 (15) The United Nations Millennium Develop-
11 ment Goal 5a aimed to reduce by 75 percent, be-
12 tween 1990 and 2015, the maternal mortality rate,
13 yet this metric has not been achieved. In fact, the
14 maternal mortality rate in the United States has
15 been estimated to have more than doubled between
16 2000 and 2014. Yet, because national data are not
17 fully available, the United States does not have an
18 official maternal mortality rate.

19 (16) Many States have struggled to establish or
20 maintain Maternal Mortality Review Committees
21 (referred to in this section as “MMRC”). On the
22 State level, MMRCs have lagged because States have
23 not had the resources to mount local reviews. State-
24 level reviews are necessary as only the State depart-
25 ments of health have the authority to request med-

1 ical records, autopsy reports, and police reports crit-
2 ical to the function of the MMRC.

3 (17) The United Kingdom regards maternal
4 deaths as a health systems failure and a national
5 committee of obstetrics experts review each maternal
6 death or near-fatal childbirth complication. Such
7 committee also establishes the predominant course of
8 maternal-related deaths from conditions such as
9 preeclampsia. Consequently, the United Kingdom
10 has been able to reduce its incidence of preeclampsia
11 to less than one in 10,000 women—its lowest rate
12 since 1952.

13 (18) The United States has no comparable, co-
14 ordinated Federal process by which to review cases
15 of maternal mortality, systems failures, or best prac-
16 tices. Many States have active MMRCs and leverage
17 their work to impact maternal wellness. For exam-
18 ple, the State of California has worked extensively
19 with their State health departments, health and hos-
20 pital systems, and research collaborative organiza-
21 tions, including the California Maternal Quality Care
22 Collaborative and the Alliance for Innovation on Ma-
23 ternal Health, to establish MMRCs, wherein such
24 State has determined the most prevalent causes of
25 maternal mortality and recorded and shared data

1 with providers and researchers, who have developed
2 and implemented safety bundles and care protocols
3 related to preeclampsia, maternal hemorrhage, and
4 the like. In this way, the State of California has
5 been able to leverage its maternal mortality review
6 board system, generate data, and apply those data
7 to effect changes in maternal care-related protocol.
8 To date, the State of California has reduced its ma-
9 ternal mortality rate, which is now comparable to
10 the low rates of the United Kingdom.

11 (19) Hospitals and health systems across the
12 United States lack standardization of emergency ob-
13 stetrical protocols before, during, and after delivery.
14 Consequently, many providers are delayed in recog-
15 nizing critical signs indicating maternal distress that
16 quickly escalate into fatal or near-fatal incidences.
17 Moreover, any attempt to address an obstetrical
18 emergency that does not consider both clinical and
19 public health approaches falls woefully under the
20 mark of excellent care delivery. State-based maternal
21 quality collaborative organizations, such as the Cali-
22 fornia Maternal Quality Care Collaborative or enti-
23 ties participating in the Alliance for Innovation on
24 Maternal Health (AIM), have formed obstetrical pro-
25 tocols, tool kits, and other resources to improve sys-

1 tem care and response as they relate to maternal
2 complications and warning signs for such conditions
3 as maternal hemorrhage, hypertension, and
4 preeclampsia.

5 (20) The Centers for Disease Control and Pre-
6 vention reports that nearly half of all maternal
7 deaths occur in the immediate postpartum period—
8 the 42 days following a pregnancy—whereas more
9 than one-third of pregnancy-related or pregnancy-as-
10 sociated deaths occur while a person is still preg-
11 nant. Yet, for women eligible for the Medicaid pro-
12 gram on the basis of pregnancy, such Medicaid cov-
13 erage lapses at the end of the month on which the
14 60th postpartum day lands.

15 (21) The experience of serious traumatic
16 events, such as being exposed to domestic violence,
17 substance use disorder, or pervasive racism, can
18 over-activate the body's stress-response system.
19 Known as toxic stress, the repetition of high doses
20 of cortisol to the brain can harm healthy neuro-
21 logical development, which can have cascading phys-
22 ical and mental health consequences, as documented
23 in the Adverse Childhood Experiences study of the
24 Centers for Disease Control and Prevention.

1 (22) A growing body of evidence-based research
2 has shown the correlation between the stress associ-
3 ated with one's race—the stress of racism—and
4 one's birthing outcomes. The stress of sex and race
5 discrimination and institutional racism has been
6 demonstrated to contribute to a higher risk of ma-
7 ternal mortality, irrespective of one's gestational
8 age, maternal age, socioeconomic status, or indi-
9 vidual-level health risk factors, including poverty,
10 limited access to prenatal care, and poor physical
11 and mental health (although these are not nominal
12 factors). African-American women remain the most
13 at risk for pregnancy-associated or pregnancy-re-
14 lated causes of death. When it comes to
15 preeclampsia, for example, which is related to obe-
16 sity, African-American women of normal weight re-
17 main the most at risk of dying during the perinatal
18 period compared to non-African-American obese
19 women.

20 (23) The rising maternal mortality rate in the
21 United States is driven predominantly by the dis-
22 proportionately high rates of African-American ma-
23 ternal mortality.

24 (24) African-American women are 3 to 4 times
25 more likely to die from pregnancy or maternal-re-

1 lated distress than are White women, yielding one of
2 the greatest and most disconcerting racial disparities
3 in public health.

4 (25) Compared to women from other racial and
5 ethnic demographics, African-American women
6 across the socioeconomic spectrum experience pro-
7 longed, unrelenting stress related to racial and gen-
8 der discrimination, contributing to higher rates of
9 maternal mortality, giving birth to low-weight ba-
10 bies, and experiencing pre-term birth. Racism is a
11 risk factor for these aforementioned experiences.
12 This cumulative stress often extends across the life
13 course and is situated in everyday spaces where Afri-
14 can-American women establish livelihood. Structural
15 barriers, lack of access to care, and genetic pre-
16 dispositions to health vulnerabilities exacerbate Afri-
17 can-American women’s likelihood to experience poor
18 or fatal birthing outcomes, but do not fully account
19 for the great disparity.

20 (26) African-American women are twice as like-
21 ly to experience postpartum depression, and dis-
22 proportionately higher rates of preeclampsia com-
23 pared to White women.

24 (27) Racism is deeply ingrained in United
25 States systems, including in health care delivery sys-

1 tems between patients and providers, often resulting
2 in disparate treatment for pain, irreverence for cul-
3 tural norms with respect to health, and
4 dismissiveness. Research has demonstrated that pa-
5 tients respond more warmly and adhere to medical
6 treatment plans at a higher degree with providers of
7 the same race or ethnicity or with providers with
8 great ability to exercise empathy. However, the pro-
9 vider pool is not primed with many people of color,
10 nor are providers (whether student-doctors in train-
11 ing or licensed practitioners) consistently required to
12 undergo implicit bias, cultural competency, or empa-
13 thy training on a consistent, on-going basis.

14 (c) IMPROVING FEDERAL EFFORTS WITH RESPECT
15 TO PREVENTION OF MATERNAL MORTALITY.—

16 (1) TECHNICAL ASSISTANCE FOR STATES WITH
17 RESPECT TO REPORTING MATERNAL MORTALITY.—

18 Not later than one year after the date of enactment
19 of this Act, the Director of the Centers for Disease
20 Control and Prevention (referred to in this section
21 as the “Director”), in consultation with the Admin-
22 istrator of the Health Resources and Services Ad-
23 ministration, shall provide technical assistance to
24 States that elect to report comprehensive data on
25 maternal mortality, including oral, mental, and

1 breastfeeding health information, for the purpose of
2 encouraging uniformity in the reporting of such data
3 and to encourage the sharing of such data among
4 the respective States.

5 (2) BEST PRACTICES RELATING TO PREVEN-
6 TION OF MATERNAL MORTALITY.—

7 (A) IN GENERAL.—Not later than one year
8 after the date of enactment of this Act—

9 (i) the Director, in consultation with
10 relevant patient and provider groups, shall
11 issue best practices to State maternal mor-
12 tality review committees on how best to
13 identify and review maternal mortality
14 cases, taking into account any data made
15 available by States relating to maternal
16 mortality, including data on oral, mental,
17 and breastfeeding health, and utilization of
18 any emergency services; and

19 (ii) the Director, working in collabora-
20 tion with the Health Resources and Serv-
21 ices Administration, shall issue best prac-
22 tices to hospitals, State professional society
23 groups, and perinatal quality collaboratives
24 on how best to prevent maternal mortality.

1 (B) AUTHORIZATION OF APPROPRIA-
2 TIONS.—For purposes of carrying out this sub-
3 section, there is authorized to be appropriated
4 \$5,000,000 for each of fiscal years 2021
5 through 2025.

6 (3) ALLIANCE FOR INNOVATION ON MATERNAL
7 HEALTH GRANT PROGRAM.—

8 (A) IN GENERAL.—Not later than one year
9 after the date of enactment of this Act, the Sec-
10 retary of Health and Human Services (referred
11 to in this subsection as the “Secretary”), acting
12 through the Associate Administrator of the Ma-
13 ternal and Child Health Bureau of the Health
14 Resources and Services Administration, shall
15 establish a grant program to be known as the
16 Alliance for Innovation on Maternal Health
17 Grant Program (referred to in this subsection
18 as “AIM”) under which the Secretary shall
19 award grants to eligible entities for the purpose
20 of—

21 (i) directing widespread adoption and
22 implementation of maternal safety bundles
23 through collaborative State-based teams;
24 and

1 (ii) collecting and analyzing process,
2 structure, and outcome data to drive con-
3 tinuous improvement in the implementa-
4 tion of such safety bundles by such State-
5 based teams with the ultimate goal of
6 eliminating preventable maternal mortality
7 and severe maternal morbidity in the
8 United States.

9 (B) ELIGIBLE ENTITIES.—In order to be
10 eligible for a grant under paragraph (1), an en-
11 tity shall—

12 (i) submit to the Secretary an applica-
13 tion at such time, in such manner, and
14 containing such information as the Sec-
15 retary may require; and

16 (ii) demonstrate in such application
17 that the entity is an interdisciplinary,
18 multi-stakeholder, national organization
19 with a national data-driven maternal safety
20 and quality improvement initiative based
21 on implementation approaches that have
22 been proven to improve maternal safety
23 and outcomes in the United States.

1 (C) USE OF FUNDS.—An eligible entity
2 that receives a grant under paragraph (1) shall
3 use such grant funds—

4 (i) to develop and implement, through
5 a robust, multi-stakeholder process, mater-
6 nal safety bundles to assist States and
7 health care systems in aligning national,
8 State, and hospital-level quality improve-
9 ment efforts to improve maternal health
10 outcomes, specifically the reduction of ma-
11 ternal mortality and severe maternal mor-
12 bidity;

13 (ii) to ensure, in developing and im-
14 plementing maternal safety bundles under
15 subparagraph (A), that such maternal
16 safety bundles—

17 (I) satisfy the quality improve-
18 ment needs of a State or health care
19 system by factoring in the results and
20 findings of relevant data reviews, such
21 as reviews conducted by a State ma-
22 ternal mortality review committee;
23 and

24 (II) address topics such as—

25 (aa) obstetric hemorrhage;

- 1 (bb) maternal mental health;
- 2 (cc) the maternal venous
- 3 system;
- 4 (dd) obstetric care for
- 5 women with substance use dis-
- 6 orders, including opioid use dis-
- 7 order;
- 8 (ee) postpartum care basics
- 9 for maternal safety;
- 10 (ff) reduction of peripartum
- 11 racial and ethnic disparities;
- 12 (gg) reduction of primary
- 13 caesarean birth;
- 14 (hh) severe hypertension in
- 15 pregnancy;
- 16 (ii) severe maternal mor-
- 17 bidity reviews;
- 18 (jj) support after a severe
- 19 maternal morbidity event;
- 20 (kk) thromboembolism;
- 21 (ll) optimization of support
- 22 for breastfeeding; and
- 23 (mm) maternal oral health;
- 24 and

1 (iii) to provide ongoing technical as-
2 sistance at the national and State levels to
3 support implementation of maternal safety
4 bundles under subparagraph (A).

5 (D) MATERNAL SAFETY BUNDLE DE-
6 FINED.—For purposes of this subsection, the
7 term “maternal safety bundle” means standard-
8 ized, evidence-informed processes for maternal
9 health care.

10 (E) AUTHORIZATION OF APPROPRIA-
11 TIONS.—For purposes of carrying out this sub-
12 section, there is authorized to be appropriated
13 \$10,000,000 for each of fiscal years 2021
14 through 2025.

15 (4) FUNDING FOR STATE-BASED PERINATAL
16 QUALITY COLLABORATIVES DEVELOPMENT AND SUS-
17 TAINABILITY.—

18 (A) IN GENERAL.—Not later than one year
19 after the date of enactment of this Act, the Sec-
20 retary of Health and Human Services (referred
21 to in this subsection as the “Secretary”), acting
22 through the Division of Reproductive Health of
23 the Centers for Disease Control and Prevention,
24 shall establish a grant program to be known as
25 the State-Based Perinatal Quality Collaborative

1 grant program under which the Secretary
2 awards grants to eligible entities for the pur-
3 pose of development and sustainability of
4 perinatal quality collaboratives in every State,
5 the District of Columbia, and eligible terri-
6 tories, in order to measurably improve perinatal
7 care and perinatal health outcomes for preg-
8 nant and postpartum women and their infants.

9 (B) GRANT AMOUNTS.—Grants awarded
10 under this subsection shall be in amounts not to
11 exceed \$250,000 per year, for the duration of
12 the grant period.

13 (C) STATE-BASED PERINATAL QUALITY
14 COLLABORATIVE DEFINED.—For purposes of
15 this subsection, the term “State-based perinatal
16 quality collaborative” means a network of mul-
17 tidisciplinary teams that—

18 (i) work to improve measurable out-
19 comes for maternal and infant health by
20 advancing evidence-informed clinical prac-
21 tices using quality improvement principles;

22 (ii) work with hospital-based or out-
23 patient facility-based clinical teams, ex-
24 perts, and stakeholders, including patients
25 and families, to spread best practices and

1 optimize resources to improve perinatal
2 care and outcomes;

3 (iii) employ strategies that include the
4 use of the collaborative learning model to
5 provide opportunities for hospitals and
6 clinical teams to collaborate on improve-
7 ment strategies, rapid-response data to
8 provide timely feedback to hospital and
9 other clinical teams to track progress, and
10 quality improvement science to provide
11 support and coaching to hospital and clin-
12 ical teams; and

13 (iv) have the goal of improving popu-
14 lation-level outcomes in maternal and in-
15 fant health.

16 (D) AUTHORIZATION OF APPROPRIA-
17 TIONS.—For purposes of carrying out this sub-
18 section, there is authorized to be appropriated
19 \$14,000,000 per year for each of fiscal years
20 2021 through 2025.

21 (5) EXPANSION OF MEDICAID AND CHIP COV-
22 ERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

23 (A) REQUIRING COVERAGE OF ORAL
24 HEALTH SERVICES FOR PREGNANT AND
25 POSTPARTUM WOMEN.—

1 (i) MEDICAID.—Section 1905 of the
2 Social Security Act (42 U.S.C. 1396d) is
3 amended—

4 (I) in subsection (a)(4)—

5 (aa) by striking “; and (D)”

6 and inserting “; (D)”; and

7 (bb) by inserting “; and (E)

8 oral health services for pregnant

9 and postpartum women (as de-

10 fined in subsection (ee))” after

11 “subsection (bb)”; and

12 (II) by adding at the end the fol-

13 lowing new subsection:

14 “(ee) ORAL HEALTH SERVICES FOR PREGNANT AND
15 POSTPARTUM WOMEN.—

16 “(1) IN GENERAL.—For purposes of this title,
17 the term ‘oral health services for pregnant and
18 postpartum women’ means dental services necessary
19 to prevent disease and promote oral health, restore
20 oral structures to health and function, and treat
21 emergency conditions that are furnished to a woman
22 during pregnancy (or during the 1-year period be-
23 ginning on the last day of the pregnancy).

24 “(2) COVERAGE REQUIREMENTS.—To satisfy
25 the requirement to provide oral health services for

1 pregnant and postpartum women, a State shall, at
2 a minimum, provide coverage for preventive, diag-
3 nostic, periodontal, and restorative care consistent
4 with recommendations for perinatal oral health care
5 and dental care during pregnancy from the Amer-
6 ican Academy of Pediatric Dentistry and the Amer-
7 ican College of Obstetricians and Gynecologists.”.

8 (ii) CHIP.—Section 2103(c)(5)(A) of
9 the Social Security Act (42 U.S.C.
10 1397cc(c)(5)(A)) is amended by inserting
11 “or a targeted low-income pregnant
12 woman” after “targeted low-income child”.

13 (B) EXTENDING MEDICAID COVERAGE FOR
14 PREGNANT AND POSTPARTUM WOMEN.—Section
15 1902 of the Social Security Act (42 U.S.C.
16 1396a) is amended—

17 (i) in subsection (e)—

18 (I) in paragraph (5)—

19 (aa) by inserting “(including
20 oral health services for pregnant
21 and postpartum women (as de-
22 fined in section 1905(ee))” after
23 “postpartum medical assistance
24 under the plan”; and

1 (bb) by striking “60-day”
2 and inserting “1-year”; and
3 (II) in paragraph (6), by striking
4 “60-day” and inserting “1-year”; and
5 (ii) in subsection (l)(1)(A), by striking
6 “60-day” and inserting “1-year”.

7 (C) EXTENDING MEDICAID COVERAGE FOR
8 LAWFUL RESIDENTS.—Section 1903(v)(4)(A) of
9 the Social Security Act (42 U.S.C.
10 1396b(v)(4)(A)) is amended by striking “60-
11 day” and inserting “1-year”.

12 (D) EXTENDING CHIP COVERAGE FOR
13 PREGNANT AND POSTPARTUM WOMEN.—Section
14 2112(d)(2)(A) of the Social Security Act (42
15 U.S.C. 1397ll(d)(2)(A)) is amended by striking
16 “60-day” and inserting “1-year”.

17 (E) MAINTENANCE OF EFFORT.—

18 (i) MEDICAID.—Section 1902(l) of the
19 Social Security Act (42 U.S.C. 1396a(l)) is
20 amended by adding at the end the fol-
21 lowing new paragraph:

22 “(5) During the period that begins on the date of
23 enactment of this paragraph and ends on the date that
24 is five years after such date of enactment, as a condition
25 for receiving any Federal payments under section 1903(a)

1 for calendar quarters occurring during such period, a
2 State shall not have in effect, with respect to women who
3 are eligible for medical assistance under the State plan
4 or under a waiver of such plan on the basis of being preg-
5 nant or having been pregnant, eligibility standards, meth-
6 odologies, or procedures under the State plan or waiver
7 that are more restrictive than the eligibility standards,
8 methodologies, or procedures, respectively, under such
9 plan or waiver that are in effect on the date of enactment
10 of this paragraph.”.

11 (ii) CHIP.—Section 2105(d) of the
12 Social Security Act (42 U.S.C. 1397ee(d))
13 is amended by adding at the end the fol-
14 lowing new paragraph:

15 “(4) IN ELIGIBILITY STANDARDS FOR TAR-
16 GETED LOW-INCOME PREGNANT WOMEN.—During
17 the period that begins on the date of enactment of
18 this paragraph and ends on the date that is five
19 years after such date of enactment, as a condition
20 of receiving payments under subsection (a) and sec-
21 tion 1903(a), a State that elects to provide assist-
22 ance to women on the basis of being pregnant (in-
23 cluding pregnancy-related assistance provided to tar-
24 geted low-income pregnant women (as defined in
25 section 2112(d)), pregnancy-related assistance pro-

1 vided to women who are eligible for such assistance
2 through application of section 1902(v)(4)(A)(i)
3 under section 2107(e)(1), or any other assistance
4 under the State child health plan (or a waiver of
5 such plan) which is provided to women on the basis
6 of being pregnant) shall not have in effect, with re-
7 spect to such women, eligibility standards, meth-
8 odologies, or procedures under such plan (or waiver)
9 that are more restrictive than the eligibility stand-
10 ards, methodologies, or procedures, respectively,
11 under such plan (or waiver) that are in effect on the
12 date of enactment of this paragraph.”.

13 (F) INFORMATION ON BENEFITS.—The
14 Secretary of Health and Human Services shall
15 make publicly available on the internet website
16 of the Department of Health and Human Serv-
17 ices, information regarding benefits available to
18 pregnant and postpartum women and under the
19 Medicaid program and the Children’s Health
20 Insurance Program, including information on—

21 (i) benefits that States are required to
22 provide to pregnant and postpartum
23 women under such programs;

1 (ii) optional benefits that States may
2 provide to pregnant and postpartum
3 women under such programs; and

4 (iii) the availability of different kinds
5 of benefits for pregnant and postpartum
6 women, including oral health and mental
7 health benefits, under such programs.

8 (G) FEDERAL FUNDING FOR COST OF EX-
9 TENDED MEDICAID AND CHIP COVERAGE FOR
10 POSTPARTUM WOMEN.—

11 (i) MEDICAID.—Section 1905 of the
12 Social Security Act (42 U.S.C. 1396d), as
13 amended by paragraph (1), is further
14 amended—

15 (I) in subsection (b), by striking
16 “and (aa)” and inserting “(aa), and
17 (ff)”;

18 (II) by adding at the end the fol-
19 lowing:

20 “(ff) INCREASED FMAP FOR EXTENDED MEDICAL
21 ASSISTANCE FOR POSTPARTUM WOMEN.—Notwith-
22 standing subsection (b), the Federal medical assistance
23 percentage for a State, with respect to amounts expended
24 by such State for medical assistance for a woman who is
25 eligible for such assistance on the basis of being pregnant

1 or having been pregnant that is provided during the 305-
2 day period that begins on the 60th day after the last day
3 of her pregnancy (including any such assistance provided
4 during the month in which such period ends), shall be
5 equal to—

6 “(1) 100 percent for the first 20 calendar quar-
7 ters during which this subsection is in effect; and

8 “(2) 90 percent for calendar quarters there-
9 after.”.

10 (ii) CHIP.—Section 2105(c) of the
11 Social Security Act (42 U.S.C. 1397ee(c))
12 is amended by adding at the end the fol-
13 lowing new paragraph:

14 “(12) ENHANCED PAYMENT FOR EXTENDED
15 ASSISTANCE PROVIDED TO PREGNANT WOMEN.—
16 Notwithstanding subsection (b), the enhanced
17 FMAP, with respect to payments under subsection
18 (a) for expenditures under the State child health
19 plan (or a waiver of such plan) for assistance pro-
20 vided under the plan (or waiver) to a woman who is
21 eligible for such assistance on the basis of being
22 pregnant (including pregnancy-related assistance
23 provided to a targeted low-income pregnant woman
24 (as defined in section 2112(d)), pregnancy-related
25 assistance provided to a woman who is eligible for

1 such assistance through application of section
2 1902(v)(4)(A)(i) under section 2107(e)(1), or any
3 other assistance under the plan (or waiver) provided
4 to a woman who is eligible for such assistance on the
5 basis of being pregnant) during the 305-day period
6 that begins on the 60th day after the last day of her
7 pregnancy (including any such assistance provided
8 during the month in which such period ends), shall
9 be equal to—

10 “(A) 100 percent for the first 20 calendar
11 quarters during which this paragraph is in ef-
12 fect; and

13 “(B) 90 percent for calendar quarters
14 thereafter.”.

15 (H) EFFECTIVE DATE.—

16 (i) IN GENERAL.—Subject to subpara-
17 graph (B), the amendments made by this
18 subsection shall take effect on the first day
19 of the first calendar quarter that begins on
20 or after the date that is one year after the
21 date of enactment of this Act.

22 (ii) EXCEPTION FOR STATE LEGISLA-
23 TION.—In the case of a State plan under
24 title XIX of the Social Security Act or a
25 State child health plan under title XXI of

1 such Act that the Secretary of Health and
2 Human Services determines requires State
3 legislation in order for the respective plan
4 to meet any requirement imposed by
5 amendments made by this subsection, the
6 respective plan shall not be regarded as
7 failing to comply with the requirements of
8 such title solely on the basis of its failure
9 to meet such an additional requirement be-
10 fore the first day of the first calendar
11 quarter beginning after the close of the
12 first regular session of the State legislature
13 that begins after the date of enactment of
14 this Act. For purposes of the previous sen-
15 tence, in the case of a State that has a 2-
16 year legislative session, each year of the
17 session shall be considered to be a separate
18 regular session of the State legislature.

19 (6) REGIONAL CENTERS OF EXCELLENCE.—
20 Part P of title III of the Public Health Service Act
21 is amended by adding at the end the following new
22 section:

1 **“SEC. 399V-7. REGIONAL CENTERS OF EXCELLENCE AD-**
2 **DRESSING IMPLICIT BIAS AND CULTURAL**
3 **COMPETENCY IN PATIENT-PROVIDER INTER-**
4 **ACTIONS EDUCATION.**

5 “(a) IN GENERAL.—Not later than one year after the
6 date of enactment of this section, the Secretary, in con-
7 sultation with such other agency heads as the Secretary
8 determines appropriate, shall award cooperative agree-
9 ments for the establishment or support of regional centers
10 of excellence addressing implicit bias and cultural com-
11 petency in patient-provider interactions education for the
12 purpose of enhancing and improving how health care pro-
13 fessionals are educated in implicit bias and delivering cul-
14 turally competent health care.

15 “(b) ELIGIBILITY.—To be eligible to receive a cooper-
16 ative agreement under subsection (a), an entity shall—

17 “(1) be a public or other nonprofit entity speci-
18 fied by the Secretary that provides educational and
19 training opportunities for students and health care
20 professionals, which may be a health system, teach-
21 ing hospital, community health center, medical
22 school, school of public health, dental school, social
23 work school, school of professional psychology, or
24 any other health professional school or program at
25 an institution of higher education (as defined in sec-
26 tion 101 of the Higher Education Act of 1965) fo-

1 cused on the prevention, treatment, or recovery of
2 health conditions that contribute to maternal mor-
3 tality and the prevention of maternal mortality and
4 severe maternal morbidity;

5 “(2) demonstrate community engagement and
6 participation, such as through partnerships with
7 home visiting and case management programs; and

8 “(3) provide to the Secretary such information,
9 at such time and in such manner, as the Secretary
10 may require.

11 “(c) DIVERSITY.—In awarding a cooperative agree-
12 ment under subsection (a), the Secretary shall take into
13 account any regional differences among eligible entities
14 and make an effort to ensure geographic diversity among
15 award recipients.

16 “(d) DISSEMINATION OF INFORMATION.—

17 “(1) PUBLIC AVAILABILITY.—The Secretary
18 shall make publicly available on the internet website
19 of the Department of Health and Human Services
20 information submitted to the Secretary under sub-
21 section (b)(3).

22 “(2) EVALUATION.—The Secretary shall evalu-
23 ate each regional center of excellence established or
24 supported pursuant to subsection (a) and dissemi-

1 nate the findings resulting from each such evalua-
2 tion to the appropriate public and private entities.

3 “(3) DISTRIBUTION.—The Secretary shall share
4 evaluations and overall findings with State depart-
5 ments of health and other relevant State level offices
6 to inform State and local best practices.

7 “(e) MATERNAL MORTALITY DEFINED.—In this sec-
8 tion, the term ‘maternal mortality’ means death of a
9 woman that occurs during pregnancy or within the one-
10 year period following the end of such pregnancy.

11 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
12 purposes of carrying out this section, there is authorized
13 to be appropriated \$5,000,000 for each of fiscal years
14 2021 through 2025.”.

15 (7) SPECIAL SUPPLEMENTAL NUTRITION PRO-
16 GRAM FOR WOMEN, INFANTS, AND CHILDREN.—Sec-
17 tion 17(d)(3)(A)(ii) of the Child Nutrition Act of
18 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

19 (A) by striking the clause designation and
20 heading and all that follows through “A State”
21 and inserting the following:

22 “(ii) WOMEN.—

23 “(I) BREASTFEEDING WOMEN.—
24 A State”;

1 (B) in subclause (I) (as so designated), by
 2 striking “1 year” and all that follows through
 3 “earlier” and inserting “2 years postpartum”;
 4 and

5 (C) by adding at the end the following:

6 “(II) POSTPARTUM WOMEN.—A

7 State may elect to certify a
 8 postpartum woman for a period of 2
 9 years.”.

10 (8) DEFINITIONS.—In this section:

11 (A) MATERNAL MORTALITY.—The term
 12 “maternal mortality” means death of a woman
 13 that occurs during pregnancy or within the one-
 14 year period following the end of such preg-
 15 nancy.

16 (B) SEVERE MATERNAL MORBIDITY.—The
 17 term “severe maternal morbidity” includes un-
 18 expected outcomes of labor and delivery that re-
 19 sult in significant short-term or long-term con-
 20 sequences to a woman’s health.

21 (d) INCREASING EXCISE TAXES ON CIGARETTES AND
 22 ESTABLISHING EXCISE TAX EQUITY AMONG ALL TO-
 23 BACCO PRODUCT TAX RATES.—

24 (1) TAX PARITY FOR ROLL-YOUR-OWN TO-
 25 BACCO.—Section 5701(g) of the Internal Revenue

1 Code of 1986 is amended by striking “\$24.78” and
2 inserting “\$49.56”.

3 (2) TAX PARITY FOR PIPE TOBACCO.—Section
4 5701(f) of the Internal Revenue Code of 1986 is
5 amended by striking “\$2.8311 cents” and inserting
6 “\$49.56”.

7 (3) TAX PARITY FOR SMOKELESS TOBACCO.—

8 (A) Section 5701(e) of the Internal Rev-
9 enue Code of 1986 is amended—

10 (i) in paragraph (1), by striking
11 “\$1.51” and inserting “\$26.84”;

12 (ii) in paragraph (2), by striking
13 “50.33 cents” and inserting “\$10.74”; and

14 (iii) by adding at the end the fol-
15 lowing:

16 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
17 SINGLE-USE UNITS.—On discrete single-use units,
18 \$100.66 per thousand.”.

19 (B) Section 5702(m) of such Code is
20 amended—

21 (i) in paragraph (1), by striking “or
22 chewing tobacco” and inserting “, chewing
23 tobacco, or discrete single-use unit”;

24 (ii) in paragraphs (2) and (3), by in-
25 serting “that is not a discrete single-use

1 unit” before the period in each such para-
2 graph; and

3 (iii) by adding at the end the fol-
4 lowing:

5 “(4) DISCRETE SINGLE-USE UNIT.—The term
6 ‘discrete single-use unit’ means any product con-
7 taining tobacco that—

8 “(A) is not intended to be smoked; and

9 “(B) is in the form of a lozenge, tablet,
10 pill, pouch, dissolvable strip, or other discrete
11 single-use or single-dose unit.”.

12 (4) TAX PARITY FOR SMALL CIGARS.—Para-
13 graph (1) of section 5701(a) of the Internal Revenue
14 Code of 1986 is amended by striking “\$50.33” and
15 inserting “\$100.66”.

16 (5) TAX PARITY FOR LARGE CIGARS.—

17 (A) IN GENERAL.—Paragraph (2) of sec-
18 tion 5701(a) of the Internal Revenue Code of
19 1986 is amended by striking “52.75 percent”
20 and all that follows through the period and in-
21 serting the following: “\$49.56 per pound and a
22 proportionate tax at the like rate on all frac-
23 tional parts of a pound but not less than
24 10.066 cents per cigar.”.

1 (B) GUIDANCE.—The Secretary of the
2 Treasury, or the Secretary’s delegate, may issue
3 guidance regarding the appropriate method for
4 determining the weight of large cigars for pur-
5 poses of calculating the applicable tax under
6 section 5701(a)(2) of the Internal Revenue
7 Code of 1986.

8 (6) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO
9 AND CERTAIN PROCESSED TOBACCO.—Subsection (o)
10 of section 5702 of the Internal Revenue Code of
11 1986 is amended by inserting “, and includes proc-
12 essed tobacco that is removed for delivery or deliv-
13 ered to a person other than a person with a permit
14 provided under section 5713, but does not include
15 removals of processed tobacco for exportation” after
16 “wrappers thereof”.

17 (7) CLARIFYING TAX RATE FOR OTHER TO-
18 BACCO PRODUCTS.—

19 (A) IN GENERAL.—Section 5701 of the In-
20 ternal Revenue Code of 1986 is amended by
21 adding at the end the following new subsection:

22 “(i) OTHER TOBACCO PRODUCTS.—Any product not
23 otherwise described under this section that has been deter-
24 mined to be a tobacco product by the Food and Drug Ad-
25 ministration through its authorities under the Family

1 Smoking Prevention and Tobacco Control Act shall be
2 taxed at a level of tax equivalent to the tax rate for ciga-
3 rettes on an estimated per use basis as determined by the
4 Secretary.”.

5 (B) ESTABLISHING PER USE BASIS.—For
6 purposes of section 5701(i) of the Internal Rev-
7 enue Code of 1986, not later than 12 months
8 after the later of the date of the enactment of
9 this Act or the date that a product has been de-
10 termined to be a tobacco product by the Food
11 and Drug Administration, the Secretary of the
12 Treasury (or the Secretary of the Treasury’s
13 delegate) shall issue final regulations estab-
14 lishing the level of tax for such product that is
15 equivalent to the tax rate for cigarettes on an
16 estimated per use basis.

17 (8) CLARIFYING DEFINITION OF TOBACCO
18 PRODUCTS.—

19 (A) IN GENERAL.—Subsection (c) of sec-
20 tion 5702 of the Internal Revenue Code of 1986
21 is amended to read as follows:

22 “(c) TOBACCO PRODUCTS.—The term ‘tobacco prod-
23 ucts’ means—

24 “(1) cigars, cigarettes, smokeless tobacco, pipe
25 tobacco, and roll-your-own tobacco, and

1 “(2) any other product subject to tax pursuant
2 to section 5701(i).”.

3 (B) CONFORMING AMENDMENTS.—Sub-
4 section (d) of section 5702 of such Code is
5 amended by striking “cigars, cigarettes, smoke-
6 less tobacco, pipe tobacco, or roll-your-own to-
7 bacco” each place it appears and inserting “to-
8 bacco products”.

9 (9) INCREASING TAX ON CIGARETTES.—

10 (A) SMALL CIGARETTES.—Section
11 5701(b)(1) of such Code is amended by striking
12 “\$50.33” and inserting “\$100.66”.

13 (B) LARGE CIGARETTES.—Section
14 5701(b)(2) of such Code is amended by striking
15 “\$105.69” and inserting “\$211.38”.

16 (10) TAX RATES ADJUSTED FOR INFLATION.—

17 Section 5701 of such Code, as amended by sub-
18 section (g), is amended by adding at the end the fol-
19 lowing new subsection:

20 “(j) INFLATION ADJUSTMENT.—

21 “(1) IN GENERAL.—In the case of any calendar
22 year beginning after 2021, the dollar amounts pro-
23 vided under this chapter shall each be increased by
24 an amount equal to—

25 “(A) such dollar amount, multiplied by

1 “(B) the cost-of-living adjustment deter-
2 mined under section 1(f)(3) for the calendar
3 year, determined by substituting ‘calendar year
4 2017’ for ‘calendar year 2016’ in subparagraph
5 (A)(ii) thereof.

6 “(2) ROUNDING.—If any amount as adjusted
7 under paragraph (1) is not a multiple of \$0.01, such
8 amount shall be rounded to the next highest multiple
9 of \$0.01.”.

10 (11) FLOOR STOCKS TAXES.—

11 (A) IMPOSITION OF TAX.—On tobacco
12 products manufactured in or imported into the
13 United States which are removed before any tax
14 increase date and held on such date for sale by
15 any person, there is hereby imposed a tax in an
16 amount equal to the excess of—

17 (i) the tax which would be imposed
18 under section 5701 of the Internal Rev-
19 enue Code of 1986 on the article if the ar-
20 ticle had been removed on such date, over

21 (ii) the prior tax (if any) imposed
22 under section 5701 of such Code on such
23 article.

24 (B) CREDIT AGAINST TAX.—Each person
25 shall be allowed as a credit against the taxes

1 imposed by paragraph (1) an amount equal to
2 \$500. Such credit shall not exceed the amount
3 of taxes imposed by paragraph (1) on such date
4 for which such person is liable.

5 (C) LIABILITY FOR TAX AND METHOD OF
6 PAYMENT.—

7 (i) LIABILITY FOR TAX.—A person
8 holding tobacco products on any tax in-
9 crease date to which any tax imposed by
10 paragraph (1) applies shall be liable for
11 such tax.

12 (ii) METHOD OF PAYMENT.—The tax
13 imposed by paragraph (1) shall be paid in
14 such manner as the Secretary shall pre-
15 scribe by regulations.

16 (iii) TIME FOR PAYMENT.—The tax
17 imposed by paragraph (1) shall be paid on
18 or before the date that is 120 days after
19 the effective date of the tax rate increase.

20 (D) ARTICLES IN FOREIGN TRADE
21 ZONES.—Notwithstanding the Act of June 18,
22 1934 (commonly known as the Foreign Trade
23 Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.),
24 or any other provision of law, any article which
25 is located in a foreign trade zone on any tax in-

1 crease date shall be subject to the tax imposed
2 by paragraph (1) if—

3 (i) internal revenue taxes have been
4 determined, or customs duties liquidated,
5 with respect to such article before such
6 date pursuant to a request made under the
7 1st proviso of section 3(a) of such Act; or

8 (ii) such article is held on such date
9 under the supervision of an officer of the
10 United States Customs and Border Protec-
11 tion of the Department of Homeland Secu-
12 rity pursuant to the 2d proviso of such sec-
13 tion 3(a).

14 (E) DEFINITIONS.—For purposes of this
15 subsection—

16 (i) IN GENERAL.—Any term used in
17 this subsection which is also used in sec-
18 tion 5702 of such Code shall have the
19 same meaning as such term has in such
20 section.

21 (ii) TAX INCREASE DATE.—The term
22 “tax increase date” means the effective
23 date of any increase in any tobacco prod-
24 uct excise tax rate pursuant to the amend-

1 ments made by this section (other than
2 subsection (j) thereof).

3 (iii) SECRETARY.—The term “Sec-
4 retary” means the Secretary of the Treas-
5 ury or the Secretary’s delegate.

6 (F) CONTROLLED GROUPS.—Rules similar
7 to the rules of section 5061(e)(3) of such Code
8 shall apply for purposes of this subsection.

9 (G) OTHER LAWS APPLICABLE.—All provi-
10 sions of law, including penalties, applicable with
11 respect to the taxes imposed by section 5701 of
12 such Code shall, insofar as applicable and not
13 inconsistent with the provisions of this sub-
14 section, apply to the floor stocks taxes imposed
15 by paragraph (1), to the same extent as if such
16 taxes were imposed by such section 5701. The
17 Secretary may treat any person who bore the
18 ultimate burden of the tax imposed by para-
19 graph (1) as the person to whom a credit or re-
20 fund under such provisions may be allowed or
21 made.

22 (12) EFFECTIVE DATES.—

23 (A) IN GENERAL.—Except as provided in
24 paragraphs (2) through (4), the amendments
25 made by this section shall apply to articles re-

1 moved (as defined in section 5702(j) of the In-
2 ternal Revenue Code of 1986) after the last day
3 of the month which includes the date of the en-
4 actment of this Act.

5 (B) DISCRETE SINGLE-USE UNITS AND
6 PROCESSED TOBACCO.—The amendments made
7 by subsections (c)(1)(C), (c)(2), and (f) shall
8 apply to articles removed (as defined in section
9 5702(j) of the Internal Revenue Code of 1986)
10 after the date that is 6 months after the date
11 of the enactment of this Act.

12 (C) LARGE CIGARS.—The amendments
13 made by subsection (e) shall apply to articles
14 removed after December 31, 2021.

15 (D) OTHER TOBACCO PRODUCTS.—The
16 amendments made by subsection (g)(1) shall
17 apply to products removed after the last day of
18 the month which includes the date that the Sec-
19 retary of the Treasury (or the Secretary of the
20 Treasury's delegate) issues final regulations es-
21 tablishing the level of tax for such product.

1 **SEC. 506. RURAL MATERNAL AND OBSTETRIC MODERNIZA-**
2 **TION OF SERVICES.**

3 (a) SHORT TITLE.—This section may be cited as the
4 “Rural Maternal and Obstetric Modernization of Services
5 Act” or the “Rural MOMS Act”.

6 (b) IMPROVING RURAL MATERNAL AND OBSTETRIC
7 CARE DATA.—

8 (1) MATERNAL MORTALITY AND MORBIDITY AC-
9 TIVITIES.—Section 301 of the Public Health Service
10 Act (42 U.S.C. 241) is amended—

11 (A) by redesignating subsections (e)
12 through (h) as subsections (f) through (i), re-
13 spectively; and

14 (B) by inserting after subsection (d), the
15 following:

16 “(e) The Secretary, acting through the Director of
17 the Centers for Disease Control and Prevention, shall ex-
18 pand, intensify, and coordinate the activities of the Cen-
19 ters for Disease Control and Prevention with respect to
20 maternal mortality and morbidity.”.

21 (2) OFFICE OF WOMEN’S HEALTH.—Section
22 310A(b)(1) of the Public Health Service Act (42
23 U.S.C. 242s(b)(1)) is amended by inserting
24 “sociocultural (race, ethnicity, language, class, in-
25 come), including among American Indians and Alas-
26 ka Natives, as such terms are defined in section 4

1 of the Indian Health Care Improvement Act, and ge-
2 ographic contexts,” after “biological,”.

3 (3) SAFE MOTHERHOOD.—Section 317K(b)(2)
4 of the Public Health Service Act (42 U.S.C. 247b-
5 12(b)(2)) is amended—

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

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

10 (C) by inserting after subparagraph (L),
11 the following:

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

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

19 (A) in subsection (b)—

20 (i) by redesignating paragraphs (4)
21 through (9) as paragraphs (5) through
22 (10), respectively;

23 (ii) by inserting after paragraph (3)
24 the following:

1 “(4) carry out paragraphs (1) and (2) with re-
2 spect to pregnancy, with priority given to deaths re-
3 lated to pregnancy;”; and

4 (iii) in paragraph (5) (as so redesign-
5 ated), by striking “through (3)” and in-
6 serting “through (4)”; and

7 (B) in subsection (d)(4)(A)(iv), by insert-
8 ing “, including maternal mortality and other
9 maternal morbidity outcomes” before the semi-
10 colon.

11 (c) RURAL OBSTETRIC NETWORK GRANTS.—The
12 Public Health Service Act is amended by inserting after
13 section 317L–1 (42 U.S.C. 247b–13a) the following:

14 **“SEC. 317L–2. RURAL OBSTETRIC NETWORK GRANTS.**

15 “(a) IN GENERAL.—For the purpose of enabling the
16 Secretary (through grants, contracts, or otherwise), acting
17 through the Administrator of the Health Resources and
18 Services Administration, to establish collaborative im-
19 provement and innovation networks (referred to in this
20 section as ‘rural obstetric networks’) to improve outcomes
21 in birth and maternal morbidity and mortality, there is
22 appropriated to the Secretary, out of any money in the
23 Treasury not otherwise appropriated, \$3,000,000 for each
24 of fiscal years 2020 through 2024. Such amounts shall
25 remain available until expended.

1 “(b) USE OF FUNDS.—Amount appropriated under
2 subsection (a) shall be used for the establishment of col-
3 laborative improvement and innovation networks to im-
4 prove maternal health in rural areas by improving out-
5 comes in birth and maternal morbidity and mortality.
6 Rural obstetric networks established in accordance with
7 this section shall—

8 “(1) assist pregnant women and individuals in
9 rural areas connect with prenatal, labor and birth,
10 and postpartum care to improve outcomes in birth
11 and maternal mortality and morbidity;

12 “(2) identify successful prenatal, labor and
13 birth, and postpartum health delivery models for in-
14 dividuals in rural areas, including evidence-based
15 home visiting programs and successful, culturally
16 competent models with positive maternal health out-
17 comes that advance health equity;

18 “(3) develop a model for collaboration between
19 health facilities that have an obstetric health unit
20 and health facilities that do not have an obstetric
21 health unit;

22 “(4) provide training and guidance for health
23 facilities that do not have obstetric health units;

24 “(5) collaborate with academic institutions that
25 can provide regional expertise and research on ac-

1 cess, outcomes, needs assessments, and other identi-
2 fied data; and

3 “(6) measure and address inequities in birth
4 outcomes among rural residents, with an emphasis
5 on Black and American Indians and Alaska Native
6 residents, as such terms are defined in section 4 of
7 the Indian Health Care Improvement Act.

8 “(c) REQUIREMENTS.—

9 “(1) ESTABLISHMENT.—Not later than October
10 1, 2020, the Secretary shall establish rural obstetric
11 health networks in at least 5 regions.

12 “(2) DEFINITIONS.—In this section:

13 “(A) FRONTIER AREA.—The term ‘frontier
14 area’ means a frontier county, as defined in sec-
15 tion 1886(d)(3)(E)(iii)(III) of the Social Secu-
16 rity Act.

17 “(B) INDIAN TRIBE.—The term ‘Indian
18 tribe’ has the meaning given such term in sec-
19 tion 4 of the Indian Health Care Improvement
20 Act.

21 “(C) NATIVE HAWAIIAN HEALTH CARE
22 SYSTEM.—The term ‘Native Hawaiian Health
23 Care System’ has the meaning given such term
24 in section 12 of the Native Hawaiian Health
25 Care Improvement Act.

1 “(D) REGION.—The term ‘region’ means a
2 State, Indian tribe, rural area, or frontier area.

3 “(E) RURAL AREA.—The term ‘rural area’
4 has the meaning given that term in section
5 1886(d)(2)(D) of the Social Security Act.

6 “(F) TRIBAL ORGANIZATION.—The term
7 ‘tribal organization’ has the meaning given such
8 term in the Indian Self-Determination Act.

9 “(G) STATE.—The term ‘State’ has the
10 meaning given that term for purposes of title V
11 of the Social Security Act.”.

12 (d) TELEHEALTH NETWORK AND TELEHEALTH RE-
13 SOURCE CENTERS GRANT PROGRAMS.—Section 330I of
14 the Public Health Service Act (42 U.S.C. 254c-14) is
15 amended—

16 (1) in subsection (f)(1)(B)(iii), by adding at the
17 end the following:

18 “(XIII) Providers of maternal,
19 including prenatal, labor and birth,
20 and postpartum care services and en-
21 tities operation obstetric care units.”;

22 (2) in subsection (i)(1)(B), by inserting “labor
23 and birth, postpartum,” before “or prenatal”; and

24 (3) in subsection (k)(1)(B), by inserting “equip-
25 ment useful for caring for pregnant women and indi-

1 “(3) establishing, maintaining, or improving
2 academic units or programs that—

3 “(A) provide training for students or fac-
4 ulty, including through clinical experiences and
5 research, to improve maternal care in rural
6 areas; or

7 “(B) develop evidence-based practices or
8 recommendations for the design of the units or
9 programs described in subparagraph (A), in-
10 cluding curriculum content standards.

11 “(b) ACTIVITIES.—

12 “(1) TRAINING FOR MEDICAL RESIDENTS AND
13 FELLOWS.—A recipient of a grant under subsection
14 (a)(1)—

15 “(A) shall use the grant funds—

16 “(i) to plan, develop, and operate a
17 training program to provide obstetric care
18 in rural areas for family practice or obstet-
19 rics and gynecology residents and fellows;
20 or

21 “(ii) to train new family practice or
22 obstetrics and gynecology residents and fel-
23 lows in maternal and obstetric health care
24 to provide and expand access to maternal

1 and obstetric health care in rural areas;
2 and

3 “(B) may use the grant funds to provide
4 additional support for the administration of the
5 program or to meet the costs of projects to es-
6 tablish, maintain, or improve faculty develop-
7 ment, or departments, divisions, or other units
8 necessary to implement such training.

9 “(2) TRAINING FOR OTHER PROVIDERS.—A re-
10 cipient of a grant under subsection (a)(2)—

11 “(A) shall use the grant funds to plan, de-
12 velop, or operate a training program to provide
13 maternal health care services in rural, commu-
14 nity-based settings; and

15 “(B) may use the grant funds to provide
16 additional support for the administration of the
17 program or to meet the costs of projects to es-
18 tablish, maintain, or improve faculty develop-
19 ment, or departments, divisions, or other units
20 necessary to implement such program.

21 “(3) ACADEMIC UNITS OR PROGRAMS.—A re-
22 cipient of a grant under subsection (a)(3) shall enter
23 into a partnership with organizations such as an
24 education accrediting organization (such as the Liai-
25 son Committee on Medical Education, the Accredita-

1 tion Council for Graduate Medical Education, the
2 Commission on Osteopathic College Accreditation,
3 the Accreditation Commission for Education in
4 Nursing, the Commission on Collegiate Nursing
5 Education, the Accreditation Commission for Mid-
6 wifery Education, or the Accreditation Review Com-
7 mission on Education for the Physician Assistant) to
8 carry out activities under subsection (a)(3).

9 “(4) TRAINING PROGRAM REQUIREMENTS.—

10 The recipient of a grant under subsection (a)(1) or
11 (a)(2) shall ensure that training programs carried
12 out under the grant include instruction on—

13 “(A) maternal mental health, including
14 perinatal depression and anxiety and
15 postpartum depression;

16 “(B) maternal substance use disorder;

17 “(C) social determinants of health that im-
18 pact individuals living in rural communities, in-
19 cluding poverty, social isolation, access to nutri-
20 tion, education, transportation, and housing;
21 and

22 “(D) implicit bias.

23 “(c) ELIGIBLE ENTITIES.—

1 “(1) TRAINING FOR MEDICAL RESIDENTS AND
2 FELLOWS.—To be eligible to receive a grant under
3 subsection (a)(1), an entity shall—

4 “(A) be a consortium consisting of—

5 “(i) at least one teaching health cen-
6 ter; or

7 “(ii) the sponsoring institution (or
8 parent institution of the sponsoring insti-
9 tution) of—

10 “(I) an obstetrics and gynecology
11 or family medicine residency program
12 that is accredited by the Accreditation
13 Council of Graduate Medical Edu-
14 cation (or the parent institution of
15 such a program); or

16 “(II) a fellowship in maternal or
17 obstetric medicine, as determined ap-
18 propriate by the Secretary; or

19 “(B) be an entity described in subpara-
20 graph (A)(ii) that provides opportunities for
21 medical residents or fellows to train in rural
22 community-based settings.

23 “(2) TRAINING FOR OTHER PROVIDERS.—To be
24 eligible to receive a grant under subsection (a)(2),
25 an entity shall be—

1 “(A) a teaching health center (as defined
2 in section 749A(f));

3 “(B) a federally qualified health center (as
4 defined in section 1905(l)(2)(B) of the Social
5 Security Act);

6 “(C) a community mental health center (as
7 defined in section 1861(ff)(3)(B) of the Social
8 Security Act);

9 “(D) a rural health clinic (as defined in
10 section 1861(aa) of the Social Security Act);

11 “(E) a freestanding birth center (as de-
12 fined in section 1905(l)(3) of the Social Secu-
13 rity Act);

14 “(F) a health center operated by the In-
15 dian Health Service, an Indian tribe, a tribal
16 organization, or a Native Hawaiian Health Care
17 System (as such terms are defined in section 4
18 of the Indian Health Care Improvement Act
19 and section 12 of the Native Hawaiian Health
20 Care Improvement Act); or

21 “(G) an entity with a demonstrated record
22 of success in providing academic training for
23 nurse practitioners, physician assistants, cer-
24 tified nurse-midwives, certified midwives, cer-
25 tified professional midwives, home visiting

1 nurses, or non-clinical professionals, such as
2 doulas and community health workers.

3 “(3) ACADEMIC UNITS OR PROGRAMS.—To be
4 eligible to receive a grant under subsection (a)(3),
5 an entity shall be a school of medicine or osteopathic
6 medicine, a nursing school, a physician assistant
7 training program, an accredited public or nonprofit
8 private hospital, an accredited medical residency pro-
9 gram, a school accredited by the Midwifery Edu-
10 cation and Accreditation Council, or a public or pri-
11 vate nonprofit entity which the Secretary has deter-
12 mined is capable of carrying out such grant.

13 “(4) APPLICATION.—To be eligible to receive a
14 grant under subsection (a), an entity shall submit to
15 the Secretary an application at such time, in such
16 manner, and containing such information as the Sec-
17 retary may require, including an estimate of the
18 amount to be expended to conduct training activities
19 under the grant (including ancillary and administra-
20 tive costs).

21 “(d) DURATION.—Grants awarded under this section
22 shall be for a minimum of 5 years.

23 “(e) STUDY AND REPORT.—

24 “(1) STUDY.—

1 “(A) IN GENERAL.—The Secretary, acting
2 through the Administrator of the Health Re-
3 sources and Services Administration, shall con-
4 duct a study on the results of the demonstra-
5 tion program under this section.

6 “(B) DATA SUBMISSION.—Not later than
7 90 days after the completion of the first year
8 of the training program, and each subsequent
9 year for the duration of the grant, that the pro-
10 gram is in effect, each recipient of a grant
11 under subsection (a) shall submit to the Sec-
12 retary such data as the Secretary may require
13 for analysis for the report described in para-
14 graph (2).

15 “(2) REPORT TO CONGRESS.—Not later than 1
16 year after receipt of the data described in paragraph
17 (1)(B), the Secretary shall submit to Congress a re-
18 port that includes—

19 “(A) an analysis of the effect of the dem-
20 onstration program under this section on the
21 quality, quantity, and distribution of maternal,
22 including prenatal, labor and birth, and
23 postpartum care services and the demographics
24 of the recipients of those services;

1 “(B) an analysis of maternal and infant
2 health outcomes (including quality of care, mor-
3 bidity, and mortality) before and after imple-
4 mentation of the program in the communities
5 served by entities participating in the dem-
6 onstration; and

7 “(C) recommendations on whether the
8 demonstration program should be expanded.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section
11 \$5,000,000 for each of fiscal years 2020 through 2024.”.

12 (f) GAO REPORT.—Not later than 1 year after the
13 date of enactment of this Act, the Comptroller General
14 of the United States shall submit to the appropriate com-
15 mittees of Congress a report on the maternal, including
16 prenatal, labor and birth, and postpartum care in rural
17 areas. Such report shall include the following:

18 (1) The location of gaps in maternal and ob-
19 stetric clinicians and health professionals, including
20 non-clinical professionals such as doulas and com-
21 munity health workers.

22 (2) The location of gaps in facilities able to pro-
23 vide maternal, including prenatal, labor and birth,
24 and postpartum care in rural areas, including care
25 for high-risk pregnancies.

1 (3) The gaps in data on maternal mortality and
2 recommendations to standardize the format on col-
3 lecting data related to maternal mortality and mor-
4 bidity.

5 (4) The gaps in maternal health by race and
6 ethnicity in rural communities, with a focus on ra-
7 cial inequities for Black residents and among Indian
8 Tribes and American Indian/Alaska Native rural
9 residents (as such terms are defined in section 4 of
10 the Indian Health Care Improvement Act).

11 (5) A list of specific activities that the Sec-
12 retary of Health and Human Services plans to con-
13 duct on maternal, including prenatal, labor and
14 birth, and postpartum care.

15 (6) A plan for completing such activities.

16 (7) An explanation of Federal agency involve-
17 ment and coordination needed to conduct such ac-
18 tivities.

19 (8) A budget for conducting such activities.

20 (9) Other information that the Comptroller
21 General determines appropriate.

1 **SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN**
2 **UNEXPECTED INFANT DEATH AND SUDDEN**
3 **UNEXPLAINED DEATH IN CHILDHOOD.**

4 (a) ESTABLISHMENT.—The Secretary of Health and
5 Human Services, acting through the Administrator of the
6 Health Resources and Services Administration and in con-
7 sultation with the Director of the Centers for Disease Con-
8 trol and Prevention and the Director of the National Insti-
9 tutes of Health (in this section referred to as the “Sec-
10 retary”), shall establish and implement a culturally and
11 linguistically competent public health awareness and edu-
12 cation campaign to provide information that is focused on
13 decreasing the risk factors for sudden unexpected infant
14 death and sudden unexplained death in childhood, includ-
15 ing educating individuals about safe sleep environments,
16 sleep positions, and reducing exposure to smoking during
17 pregnancy and after birth.

18 (b) TARGETED POPULATIONS.—The campaign under
19 subsection (a) shall be designed to reduce health dispari-
20 ties through the targeting of populations with high rates
21 of sudden unexpected infant death and sudden unex-
22 plained death in childhood.

23 (c) CONSULTATION.—In establishing and imple-
24 menting the campaign under subsection (a), the Secretary
25 shall consult with national organizations representing
26 health care providers, including nurses and physicians,

1 parents, child care providers, children’s advocacy and safe-
2 ty organizations, maternal and child health programs, nu-
3 trition professionals focusing on women, infants, and chil-
4 dren, and other individuals and groups determined nec-
5 essary by the Secretary for such establishment and imple-
6 mentation.

7 (d) GRANTS.—

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

16 (2) APPLICATION.—To be eligible to receive a
17 grant under paragraph (1), an entity shall submit to
18 the Secretary an application at such time, in such
19 manner, and containing such information as the Sec-
20 retary may require.

21 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated to carry out this section
23 such sums as may be necessary for each of fiscal years
24 2021 through 2025.

1 **SEC. 508. REDUCING UNINTENDED TEENAGE PREG-**
2 **NANCIES.**

3 Title III of the Public Health Service Act (42 U.S.C.
4 241 et seq.) is amended by adding at the end the fol-
5 lowing:

6 **“PART W—YOUTH ACCESS TO SEXUAL HEALTH**
7 **SERVICES**

8 **“SEC. 3990O. AUTHORIZATION OF GRANTS TO SUPPORT**
9 **THE ACCESS OF MARGINALIZED YOUTH TO**
10 **SEXUAL HEALTH SERVICES.**

11 “(a) GRANTS.—The Secretary may award grants on
12 a competitive basis to eligible entities to support the access
13 of marginalized youth to sexual health services.

14 “(b) USE OF FUNDS.—An eligible entity that is
15 awarded a grant under subsection (a) may use the funds
16 to—

17 “(1) provide medically accurate and complete
18 and age-, developmentally, and culturally appro-
19 priate sexual health information to marginalized
20 youth, including information on how to access sexual
21 health services;

22 “(2) promote effective communication regarding
23 sexual health among marginalized youth;

24 “(3) promote and support better health, edu-
25 cation, and economic opportunities for school-age
26 parents; and

1 “(4) train individuals who work with
2 marginalized youth to promote—

3 “(A) the prevention of unintended preg-
4 nancy;

5 “(B) the prevention of sexually transmitted
6 infections, including the human immuno-
7 deficiency virus (HIV);

8 “(C) healthy relationships; and

9 “(D) the development of safe and sup-
10 portive environments.

11 “(c) APPLICATION.—To be awarded a grant under
12 subsection (a), an eligible entity shall submit an applica-
13 tion to the Secretary at such time, in such manner, and
14 containing such information as the Secretary may require.

15 “(d) PRIORITY.—In awarding grants under sub-
16 section (a), the Secretary shall give priority to eligible enti-
17 ties—

18 “(1) with a history of supporting the access of
19 marginalized youth to sexuality education or sexual
20 health services; and

21 “(2) that plan to serve marginalized youth that
22 are not served by Federal adolescent programs for
23 the prevention of pregnancy, HIV, and other sexu-
24 ally transmitted infections.

1 “(e) REQUIREMENTS.—The Secretary may not award
2 a grant under subsection (a) to an eligible entity unless—

3 “(1) such eligible entity has formed a partner-
4 ship with a community organization; and

5 “(2) such eligible entity agrees—

6 “(A) to employ a scientifically effective
7 strategy;

8 “(B) that all information provided to
9 marginalized youth will be—

10 “(i) age- and developmentally appro-
11 priate;

12 “(ii) medically accurate and complete;

13 “(iii) scientifically based; and

14 “(iv) provided in the language and
15 cultural context that is most appropriate
16 for the individuals served by the eligible
17 entity; and

18 “(C) that for each year the eligible entity
19 receives grant funds under subsection (a), the
20 eligible entity will submit to the Secretary an
21 annual report that includes—

22 “(i) the use of grant funds by the eli-
23 gible entity;

1 “(ii) how the use of grant funds has
2 increased the access of marginalized youth
3 to sexual health services; and

4 “(iii) such other information as the
5 Secretary may require.

6 “(f) PUBLICATION AND EVALUATIONS.—

7 “(1) EVALUATIONS.—Not less than once every
8 two years after the date of the enactment of this
9 part, the Secretary shall evaluate the effectiveness of
10 whichever of the following is greater:

11 “(A) Eight grants awarded under sub-
12 section (a).

13 “(B) Ten percent of the grants awarded
14 under subsection (a).

15 “(2) PUBLICATION.—The Secretary shall make
16 available to the public—

17 “(A) the evaluations required under para-
18 graph (1); and

19 “(B) the reports required under subsection
20 (e)(2)(C).

21 “(g) LIMITATIONS.—No funds made available to an
22 eligible entity under this section may be used by such enti-
23 ty to provide access to sexual health services that—

24 “(1) withhold sexual health-promoting or life-
25 saving information;

1 “(2) are medically inaccurate or have been sci-
2 entifically shown to be ineffective;

3 “(3) promote gender stereotypes;

4 “(4) are insensitive or unresponsive to the
5 needs of young people, including—

6 “(A) youth with varying gender identities,
7 gender expressions, and sexual orientations;

8 “(B) sexually active youth;

9 “(C) pregnant or parenting youth;

10 “(D) survivors of sexual abuse or assault;

11 and

12 “(E) youth of all physical, developmental,
13 and mental abilities; or

14 “(5) are inconsistent with the ethical impera-
15 tives of medicine and public health.

16 “(h) TRANSFER OF FUNDS.—Any unobligated bal-
17 ance of funds made available under section 510(d) of the
18 Social Security Act (42 U.S.C. 710(d)) (as in effect on
19 the day before the date of the enactment of this part) are
20 hereby transferred and made available to the Secretary to
21 carry out this section. The amounts transferred and made
22 available to carry out this section shall remain available
23 until expended.

24 “(i) DEFINITIONS.—In this section:

1 “(1) COMMUNITY ORGANIZATION.—The term
2 ‘community organization’ includes a State or local
3 health or education agency, public school, youth-fo-
4 cused organization that is faith-based and commu-
5 nity-based, juvenile justice entity, or other organiza-
6 tion that provides confidential and appropriate sexu-
7 ality education or sexual health services to
8 marginalized youth.

9 “(2) ELIGIBLE ENTITY.—The term ‘eligible en-
10 tity’ includes a State or local health or education
11 agency, public school, nonprofit organization, hos-
12 pital, or an Indian Tribe or Tribal organization (as
13 such terms are defined in section 4 of the Indian
14 Self-Determination and Education Assistance Act
15 (25 U.S.C. 5304)).

16 “(3) MARGINALIZED YOUTH.—The term
17 ‘marginalized youth’ means a person under the age
18 of 26 that is disadvantaged by underlying structural
19 barriers and social inequity.

20 “(4) MEDICALLY ACCURATE AND COMPLETE.—
21 The term ‘medically accurate and complete’, when
22 used with respect to information, means information
23 that—

24 “(A) is supported by research and recog-
25 nized as accurate, objective, and complete by

1 leading medical, psychological, psychiatric, or
2 public health organizations and agencies; and

3 “(B) does not withhold any information re-
4 lating to the effectiveness and benefits of cor-
5 rect and consistent use of condoms or other
6 contraceptives and pregnancy prevention meth-
7 ods.

8 “(5) SCIENTIFICALLY EFFECTIVE STRATEGY.—
9 The term ‘scientifically effective strategy’ means a
10 strategy that—

11 “(A) is widely recognized by leading med-
12 ical and public health agencies as effective in
13 promoting sexual health awareness and healthy
14 behavior; and

15 “(B) either—

16 “(i) has been demonstrated to be ef-
17 fective on the basis of rigorous scientific
18 research; or

19 “(ii) incorporates characteristics of ef-
20 fective programs.

21 “(6) SEXUAL HEALTH SERVICES.—The term
22 ‘sexual health services’ includes—

23 “(A) sexual health information, education,
24 and counseling;

25 “(B) contraception;

1 “(C) emergency contraception;

2 “(D) condoms and other barrier methods
3 to prevent pregnancy or sexually transmitted in-
4 fections;

5 “(E) routine gynecological care, including
6 human papillomavirus (HPV) vaccines and can-
7 cer screenings;

8 “(F) pre-exposure prophylaxis or post-ex-
9 posure prophylaxis;

10 “(G) mental health services;

11 “(H) sexual assault survivor services; and

12 “(I) other prevention, care, or treatment.”.

13 **SEC. 509. GESTATIONAL DIABETES.**

14 Part B of title III of the Public Health Service Act
15 (42 U.S.C. 243 et seq.) is amended by adding after section
16 317H the following:

17 **“SEC. 317H-1. GESTATIONAL DIABETES.**

18 “(a) UNDERSTANDING AND MONITORING GESTA-
19 TIONAL DIABETES.—

20 “(1) IN GENERAL.—The Secretary, acting
21 through the Director of the Centers for Disease
22 Control and Prevention, in consultation with the Di-
23 abetes Mellitus Interagency Coordinating Committee
24 established under section 429 and representatives of
25 appropriate national health organizations, shall de-

1 velop a multisite gestational diabetes research
2 project within the diabetes program of the Centers
3 for Disease Control and Prevention to expand and
4 enhance surveillance data and public health research
5 on gestational diabetes.

6 “(2) AREAS TO BE ADDRESSED.—The research
7 project developed under paragraph (1) shall ad-
8 dress—

9 “(A) procedures to establish accurate and
10 efficient systems for the collection of gestational
11 diabetes data within each State and common-
12 wealth, territory, or possession of the United
13 States;

14 “(B) the progress of collaborative activities
15 with the National Vital Statistics System, the
16 National Center for Health Statistics, and
17 State health departments with respect to the
18 standard birth certificate, in order to improve
19 surveillance of gestational diabetes;

20 “(C) postpartum methods of tracking indi-
21 viduals with gestational diabetes after delivery
22 as well as targeted interventions proven to
23 lower the incidence of type 2 diabetes in that
24 population;

1 “(D) variations in the distribution of diag-
2 nosed and undiagnosed gestational diabetes,
3 and of impaired fasting glucose tolerance and
4 impaired fasting glucose, within and among
5 groups of pregnant individuals; and

6 “(E) factors and culturally sensitive inter-
7 ventions that influence risks and reduce the in-
8 cidence of gestational diabetes and related com-
9 plications during childbirth, including cultural,
10 behavioral, racial, ethnic, geographic, demo-
11 graphic, socioeconomic, and genetic factors.

12 “(3) REPORT.—Not later than 2 years after the
13 date of the enactment of this section, and annually
14 thereafter, the Secretary shall generate a report on
15 the findings and recommendations of the research
16 project including prevalence of gestational diabetes
17 in the multisite area and disseminate the report to
18 the appropriate Federal and non-Federal agencies.

19 “(b) EXPANSION OF GESTATIONAL DIABETES RE-
20 SEARCH.—

21 “(1) IN GENERAL.—The Secretary shall expand
22 and intensify public health research regarding gesta-
23 tional diabetes. Such research may include—

24 “(A) developing and testing novel ap-
25 proaches for improving postpartum diabetes

1 testing or screening and for preventing type 2
2 diabetes in individuals who can become preg-
3 nant with a history of gestational diabetes; and

4 “(B) conducting public health research to
5 further understanding of the epidemiologic,
6 socioenvironmental, behavioral, translation, and
7 biomedical factors and health systems that in-
8 fluence the risk of gestational diabetes and the
9 development of type 2 diabetes in individuals
10 who can become pregnant with a history of ges-
11 tational diabetes.

12 “(2) AUTHORIZATION OF APPROPRIATIONS.—

13 There is authorized to be appropriated to carry out
14 this subsection \$5,000,000 for each of fiscal years
15 2021 through 2025.

16 “(c) DEMONSTRATION GRANTS TO LOWER THE
17 RATE OF GESTATIONAL DIABETES.—

18 “(1) IN GENERAL.—The Secretary, acting
19 through the Director of the Centers for Disease
20 Control and Prevention, shall award grants, on a
21 competitive basis, to eligible entities for demonstra-
22 tion projects that implement evidence-based inter-
23 ventions to reduce the incidence of gestational diabe-
24 tes, the recurrence of gestational diabetes in subse-
25 quent pregnancies, and the development of type 2 di-

1 abetes in individuals who can become pregnant with
2 a history of gestational diabetes.

3 “(2) PRIORITY.—In making grants under this
4 subsection, the Secretary shall give priority to
5 projects focusing on—

6 “(A) helping individuals who can become
7 pregnant who have 1 or more risk factors for
8 developing gestational diabetes;

9 “(B) working with individuals who can be-
10 come pregnant with a history of gestational dia-
11 betes during a previous pregnancy;

12 “(C) providing postpartum care for indi-
13 viduals who can become pregnant with gesta-
14 tional diabetes;

15 “(D) tracking cases where individuals who
16 can become pregnant with a history of gesta-
17 tional diabetes developed type 2 diabetes;

18 “(E) educating mothers with a history of
19 gestational diabetes about the increased risk of
20 their child developing diabetes;

21 “(F) working to prevent gestational diabe-
22 tes and prevent or delay the development of
23 type 2 diabetes in individuals who can become
24 pregnant with a history of gestational diabetes;
25 and

1 “(G) achieving outcomes designed to assess
2 the efficacy and cost-effectiveness of interven-
3 tions that can inform decisions on long-term
4 sustainability, including third-party reimburse-
5 ment.

6 “(3) APPLICATION.—An eligible entity desiring
7 to receive a grant under this subsection shall submit
8 to the Secretary—

9 “(A) an application at such time, in such
10 manner, and containing such information as the
11 Secretary may require; and

12 “(B) a plan to—

13 “(i) lower the rate of gestational dia-
14 betes during pregnancy; or

15 “(ii) develop methods of tracking indi-
16 viduals who can become pregnant with a
17 history of gestational diabetes and develop
18 effective interventions to lower the inci-
19 dence of the recurrence of gestational dia-
20 betes in subsequent pregnancies and the
21 development of type 2 diabetes.

22 “(4) USES OF FUNDS.—An eligible entity re-
23 ceiving a grant under this subsection shall use the
24 grant funds to carry out demonstration projects de-
25 scribed in paragraph (1), including—

1 “(A) expanding community-based health
2 promotion education, activities, and incentives
3 focused on the prevention of gestational diabe-
4 tes and development of type 2 diabetes in indi-
5 viduals who can become pregnant with a history
6 of gestational diabetes;

7 “(B) aiding State- and Tribal-based diabe-
8 tes prevention and control programs to collect,
9 analyze, disseminate, and report surveillance
10 data on individuals who can become pregnant
11 with, and at risk for, gestational diabetes, the
12 recurrence of gestational diabetes in subsequent
13 pregnancies, and, for individuals who can be-
14 come pregnant with a history of gestational dia-
15 betes, the development of type 2 diabetes; and

16 “(C) training and encouraging health care
17 providers—

18 “(i) to promote risk assessment, high-
19 quality care, and self-management for ges-
20 tational diabetes and the recurrence of ges-
21 tational diabetes in subsequent preg-
22 nancies; and

23 “(ii) to prevent the development of
24 type 2 diabetes in individuals who can be-
25 come pregnant with a history of gesta-

1 tional diabetes, and its complications in the
2 practice settings of the health care pro-
3 viders.

4 “(5) REPORT.—Not later than 4 years after the
5 date of the enactment of this section, the Secretary
6 shall prepare and submit to the Congress a report
7 concerning the results of the demonstration projects
8 conducted through the grants awarded under this
9 subsection.

10 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
11 this subsection, the term ‘eligible entity’ means a
12 nonprofit organization (such as a nonprofit academic
13 center or community health center) or a State, Trib-
14 al, or local health agency.

15 “(7) AUTHORIZATION OF APPROPRIATIONS.—
16 There is authorized to be appropriated to carry out
17 this subsection \$5,000,000 for each of fiscal years
18 2021 through 2025.

19 “(d) POSTPARTUM FOLLOWUP 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 followup 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 individuals with a history
4 of gestational 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 medically accurate and complete
13 information on emergency contraceptives.

14 (2) DISSEMINATION.—The Secretary may dis-
15 seminate medically accurate and complete informa-
16 tion under paragraph (1) directly or through ar-
17 rangements with nonprofit organizations, community
18 health workers including promotores, consumer
19 groups, institutions of higher education, clinics, the
20 media, and Federal, State, and local agencies.

21 (3) INFORMATION.—The information dissemi-
22 nated under paragraph (1) shall—

23 (A) include, at a minimum, a description
24 of emergency contraceptives and an explanation
25 of the use, safety, efficacy, affordability, and

1 availability, including over-the-counter access,
2 of such contraceptives and options for access
3 without cost-sharing through insurance and
4 other programs;

5 (B) include emergency contraception to
6 health care providers, including pharmacists;
7 and

8 (C) be pilot tested for consumer com-
9 prehension, cultural and linguistic appropriate-
10 ness, and acceptance of the messages across
11 geographically, racially, ethnically, and linguis-
12 tically diverse populations.

13 (b) EMERGENCY CONTRACEPTION INFORMATION
14 PROGRAM FOR HEALTH CARE PROVIDERS.—

15 (1) IN GENERAL.—The Secretary, acting
16 through the Administrator of the Health Resources
17 and Services Administration and in consultation
18 with major medical and public health organizations,
19 shall develop and disseminate to health care pro-
20 viders, including pharmacists, information on emer-
21 gency contraceptives.

22 (2) INFORMATION.—The information dissemi-
23 nated under paragraph (1) shall include, at a min-
24 imum—

1 (A) information describing the use, safety,
2 efficacy, and availability of emergency contra-
3 ceptives, and options for access without cost-
4 sharing through insurance and other programs;

5 (B) a recommendation regarding the use of
6 such contraceptives; and

7 (C) information explaining how to obtain
8 copies of the information developed under sub-
9 section (a) for distribution to the patients of
10 the providers.

11 (c) DEFINITIONS.—In this section:

12 (1) HEALTH CARE PROVIDER.—The term
13 “health care provider” means an individual who is li-
14 censed or certified under State law to provide health
15 care services and who is operating within the scope
16 of such license. Such term shall include a phar-
17 macist.

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

22 (3) SECRETARY.—The term “Secretary” means
23 the Secretary of Health and Human Services.

24 (d) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of the fiscal years
2 2021 through 2025.

3 **SEC. 511. COMPREHENSIVE SEX EDUCATION PROGRAMS.**

4 (a) PURPOSES; FINDING; SENSE OF CONGRESS.—

5 (1) PURPOSES.—The purposes of this section
6 are to provide young people with comprehensive sex
7 education programs that—

8 (A) promote and uphold the rights of
9 young people to information in order to make
10 healthy decisions about their sexual health;

11 (B) provide the information and skills all
12 young people need to make informed, respon-
13 sible, and healthy decisions in order to become
14 sexually healthy adults and have healthy rela-
15 tionships;

16 (C) provide information about the preven-
17 tion of unintended pregnancy, sexually trans-
18 mitted infections, including HIV, dating vio-
19 lence, sexual assault, bullying, and harassment;
20 and

21 (D) provide resources and information on
22 topics ranging from gender stereotyping and
23 gender roles and stigma and socio-cultural in-
24 fluences surrounding sex and sexuality.

1 (2) FINDING ON REQUIRED RESOURCES.—In
2 order to provide the comprehensive sex education de-
3 scribed in paragraph (1), Congress finds that in-
4 creased resources are required for sex education pro-
5 grams that—

6 (A) substantially incorporate elements of
7 evidence-based programs or characteristics of
8 effective programs;

9 (B) cover a broad range of topics, includ-
10 ing medically accurate and complete informa-
11 tion that is age and developmentally appro-
12 priate about all the aspects of sex, sexual
13 health, and sexuality;

14 (C) are gender and gender identity-sen-
15 sitive, emphasizing the importance of equality
16 and the social environment for achieving sexual
17 and reproductive health and overall well-being;

18 (D) promote educational achievement, crit-
19 ical thinking, decisionmaking, self-esteem, and
20 self-efficacy;

21 (E) help develop healthy attitudes and in-
22 sights necessary for understanding relationships
23 between oneself and others and society;

24 (F) foster leadership skills and community
25 engagement by—

- 1 (i) promoting principles of fairness,
2 human dignity, and respect; and
3 (ii) engaging young people as partners
4 in their communities; and
5 (G) are culturally and linguistically appro-
6 priate, reflecting the diverse circumstances and
7 realities of young people.

8 (3) SENSE OF CONGRESS.—It is the sense of
9 Congress that—

10 (A) federally funded sex education pro-
11 grams should aim to—

12 (i) provide information about a range
13 of human sexuality topics, including—

14 (I) human development, healthy
15 relationships, personal skills;

16 (II) sexual behavior including ab-
17 stinence;

18 (III) sexual health including pre-
19 venting unintended pregnancy;

20 (IV) sexually transmitted infec-
21 tions including HIV; and

22 (V) society and culture;

23 (ii) promote safe and healthy relation-
24 ships;

25 (iii) promote gender equity;

1 (iv) use, and be informed by, the best
2 scientific information available;

3 (v) be culturally appropriate and in-
4 clusive of youth with varying gender identi-
5 ties, gender expressions, and sexual ori-
6 entations;

7 (vi) be built on characteristics of ef-
8 fective programs;

9 (vii) expand the existing body of re-
10 search on comprehensive sex education
11 programs through program evaluation;

12 (viii) expand training programs for
13 teachers of comprehensive sex education;

14 (ix) build on programs funded under
15 section 513 of the Social Security Act (42
16 U.S.C. 713) and the Office of Adolescent
17 Health's Teen Pregnancy Prevention Pro-
18 gram, funded under title II of the Consoli-
19 dated Appropriations Act, 2010 (Public
20 Law 111–117; 123 Stat. 3253), and on
21 programs supported through the Centers
22 for Disease Control and Prevention (CDC);
23 and

24 (x) promote and uphold the rights of
25 young people to information in order to

1 make healthy and autonomous decisions
2 about their sexual health; and

3 (B) no Federal funds should be used for
4 health education programs that—

5 (i) withhold health-promoting or life-
6 saving information about sexuality-related
7 topics, including HIV;

8 (ii) are medically inaccurate or have
9 been scientifically shown to be ineffective;

10 (iii) promote gender or racial stereo-
11 types;

12 (iv) are insensitive and unresponsive
13 to the needs of sexually active young peo-
14 ple;

15 (v) are insensitive and unresponsive to
16 the needs of survivors of sexual violence;

17 (vi) are insensitive and unresponsive
18 to the needs of youth of all physical, devel-
19 opmental, and mental abilities;

20 (vii) are insensitive and unresponsive
21 to the needs of youth with varying gender
22 identities, gender expressions, and sexual
23 orientations; or

24 (viii) are inconsistent with the ethical
25 imperatives of medicine and public health.

1 (b) GRANTS FOR COMPREHENSIVE SEX EDUCATION
2 FOR ADOLESCENTS.—

3 (1) PROGRAM AUTHORIZED.—The Secretary of
4 Health and Human Services, in coordination with
5 the Associate Commissioner of the Family and
6 Youth Services Bureau of the Administration on
7 Children, Youth, and Families of the Department of
8 Health and Human Services, the Director of the Of-
9 fice of Adolescent Health, the Director of the Divi-
10 sion of Adolescent and School Health within the
11 Centers for Disease Control and Prevention and the
12 Secretary of Education, shall award grants, on a
13 competitive basis, to eligible entities to enable such
14 eligible entities to carry out programs that provide
15 adolescents with comprehensive sex education, as de-
16 scribed in paragraph (6).

17 (2) DURATION.—Grants awarded under this
18 section shall be for a period of 5 years.

19 (3) ELIGIBLE ENTITY.—In this section, the
20 term “eligible entity” means a public or private enti-
21 ty that focuses on adolescent health and education
22 or has experience working with adolescents.

23 (4) APPLICATIONS.—An eligible entity desiring
24 a grant under this subsection shall submit an appli-
25 cation to the Secretary at such time, in such man-

1 ner, and containing such information as the Sec-
2 retary may require, including an assurance to par-
3 ticipate in the evaluation described in subsection (e).

4 (5) PRIORITY.—In awarding grants under this
5 section, the Secretary shall give priority to eligible
6 entities that—

7 (A) are State or local public entities;

8 (B) are entities not currently receiving
9 funds under—

10 (i) section 513 of the Social Security
11 Act (42 U.S.C. 713);

12 (ii) the Office of Adolescent Health’s
13 Teen Pregnancy Prevention Program,
14 funded under title II of the Consolidated
15 Appropriations Act, 2010 (Public Law
16 111–117; 123 Stat. 3253), or any substan-
17 tially similar successive program; or

18 (iii) the Centers for Disease Control
19 and Prevention’s Division of Adolescent
20 and School Health; and

21 (C) address health inequities among young
22 people that face systemic barriers resulting in
23 disproportionate rates of not less than one of
24 the following:

25 (i) Unintended pregnancies.

1 (ii) Sexually transmitted infections,
2 including HIV.

3 (iii) Dating violence and sexual vio-
4 lence.

5 (6) USE OF FUNDS.—

6 (A) IN GENERAL.—Each eligible entity
7 that receives a grant under this section shall
8 use the grant funds to carry out an education
9 program that provides adolescents with com-
10 prehensive sex education that—

11 (i) is age and developmentally appro-
12 priate;

13 (ii) is medically accurate and com-
14 plete;

15 (iii) substantially incorporates ele-
16 ments of evidence-based sex education in-
17 struction; or

18 (iv) creates a demonstration project
19 based on characteristics of effective pro-
20 grams.

21 (B) CONTENTS OF COMPREHENSIVE SEX
22 EDUCATION PROGRAMS.—The comprehensive
23 sex education programs funded under this sec-
24 tion shall include instruction and materials that
25 address—

1 (i) the physical, social, and emotional
2 changes of human development including,
3 human anatomy, reproduction, and sexual
4 development;

5 (ii) healthy relationships, including
6 friendships, within families, and society,
7 that are based on mutual respect, and the
8 ability to distinguish between healthy and
9 unhealthy relationships, including—

10 (I) effective communication, ne-
11 gotiation and refusal skills, including
12 the skills to recognize and report in-
13 appropriate or abusive sexual ad-
14 vances;

15 (II) bodily autonomy, setting and
16 respecting personal boundaries, prac-
17 ticing personal safety, and consent;
18 and

19 (III) the limitations and harm of
20 gender-role stereotypes, violence, coer-
21 cion, bullying, harassment, and intimi-
22 dation in relationships;

23 (iii) healthy decision-making skills
24 about sexuality and relationships that in-
25 clude—

- 1 (I) critical thinking, problem
2 solving, self-efficacy, stress-manage-
3 ment, self-care, and decisionmaking;
- 4 (II) individual values and atti-
5 tudes;
- 6 (III) the promotion of positive
7 body images;
- 8 (IV) developing an understanding
9 that there are a range of body types
10 and encouraging positive feeling about
11 students' own body types;
- 12 (V) information on how to re-
13 spect others and ensure safety on the
14 internet and when using other forms
15 of digital communication;
- 16 (VI) information on local services
17 and resources where students can ob-
18 tain additional information related to
19 bullying, harassment, dating violence
20 and sexual assault, suicide prevention,
21 and other related care;
- 22 (VII) encouragement for youth to
23 communicate with their parents or
24 guardians, health and social service
25 professionals, and other trusted adults

1 about sexuality and intimate relation-
2 ships;

3 (VIII) information on how to cre-
4 ate a safe environment for all stu-
5 dents and others in society;

6 (IX) examples of varying types of
7 relationships, couples, and family
8 structures; and

9 (X) affirmative representation of
10 varying gender identities, gender ex-
11 pressions, and sexual orientations, in-
12 cluding individuals and relationships
13 between same sex couples and their
14 families;

15 (iv) abstinence, delaying age of first
16 sexual activity, the use of condoms, preven-
17 tive medication, vaccination, birth control,
18 and other sexually transmitted infection
19 prevention measures, and the options for
20 pregnancy, including parenting, adoption,
21 and abortion, including—

22 (I) the importance of effectively
23 using condoms, preventive medication,
24 and applicable vaccinations to protect

1 against sexually transmitted infec-
2 tions, including HIV;

3 (II) the benefits of effective con-
4 traceptive and condom use in avoiding
5 unintended pregnancy;

6 (III) the relationship between
7 substance use and sexual health and
8 behaviors; and

9 (IV) information about local
10 health services where students can ob-
11 tain additional information and serv-
12 ices related to sexual and reproductive
13 health and other related care;

14 (v) through affirmative recognition,
15 the roles that traditions, values, religion,
16 norms, gender roles, acculturation, family
17 structure, health beliefs, and political
18 power play in how students make decisions
19 that affect their sexual health, using exam-
20 ples of various types of races, ethnicities,
21 cultures, and families, including single-par-
22 ent households and young families;

23 (vi) information about gender identity,
24 gender expression, and sexual orientation
25 for all students, including—

1 (I) affirmative recognition that
2 people have different gender identi-
3 ties, gender expressions, and sexual
4 orientations; and

5 (II) community resources that
6 can provide additional support for in-
7 dividuals with varying gender identi-
8 ties, gender expressions, and sexual
9 orientations; and

10 (vii) opportunities to explore the roles
11 that race, ethnicity, immigration status,
12 disability status, economic status, home-
13 lessness, foster care status, and language
14 within different communities affect sexual
15 attitudes in society and culture and how
16 this may impact student sexual health.

17 (c) GRANTS FOR COMPREHENSIVE SEX EDUCATION
18 AT INSTITUTIONS OF HIGHER EDUCATION.—

19 (1) PROGRAM AUTHORIZED.—The Secretary, in
20 coordination with the Secretary of Education, shall
21 award grants, on a competitive basis, to institutions
22 of higher education or consortia of such institutions
23 to enable such institutions to provide young people
24 with comprehensive sex education, as described in
25 paragraph (5)(B).

1 (2) DURATION.—Grants awarded under this
2 subsection shall be for a period of 5 years.

3 (3) APPLICATIONS.—An institution of higher
4 education or consortium of such institutions desiring
5 a grant under this subsection shall submit an appli-
6 cation to the Secretary at such time, in such man-
7 ner, and containing such information as the Sec-
8 retary may require, including an assurance to par-
9 ticipate in the evaluation described in subsection (e).

10 (4) PRIORITY.—In awarding grants under this
11 subsection, the Secretary shall give priority to an in-
12 stitution of higher education that—

13 (A) has an enrollment of needy students,
14 as defined in section 318(b) of the Higher Edu-
15 cation Act of 1965 (20 U.S.C. 1059e(b));

16 (B) is a Hispanic-serving institution, as
17 defined in section 502(a) of such Act (20
18 U.S.C. 1101a(a));

19 (C) is a Tribal College or University, as
20 defined in section 316(b) of such Act (20
21 U.S.C. 1059c(b));

22 (D) is an Alaska Native-serving institution,
23 as defined in section 317(b) of such Act (20
24 U.S.C. 1059d(b));

1 (E) is a Native Hawaiian-serving institu-
2 tion, as defined in section 317(b) of such Act
3 (20 U.S.C. 1059d(b));

4 (F) is a Predominately Black Institution,
5 as defined in section 318(b) of such Act (20
6 U.S.C. 1059e(b));

7 (G) is a Native American-serving, non-
8 tribal institution, as defined in section 319(b)
9 of such Act (20 U.S.C. 1059f(b));

10 (H) is an Asian American and Native
11 American Pacific Islander-serving institution, as
12 defined in section 320(b) of such Act (20
13 U.S.C. 1059g(b)); or

14 (I) is a minority institution, as defined in
15 section 365 of such Act (20 U.S.C. 1067k),
16 with an enrollment of needy students, as de-
17 fined in section 312 of such Act (20 U.S.C.
18 1058).

19 (5) USES OF FUNDS.—

20 (A) IN GENERAL.—An institution of higher
21 education, or a consortium, receiving a grant
22 under this subsection shall use grant funds to
23 integrate issues relating to comprehensive sex
24 education into the institution of higher edu-
25 cation, or consortium, in order to reach a large

1 number of students, by carrying out 1 or more
2 of the following activities:

3 (i) Developing or adopting educational
4 content for issues relating to comprehen-
5 sive sex education that will be incorporated
6 into student orientation, general education,
7 or core courses.

8 (ii) Developing or adopting, and im-
9 plementing schoolwide educational pro-
10 gramming outside of class that delivers ele-
11 ments of comprehensive sex education pro-
12 grams to students, faculty, and staff.

13 (iii) Developing or adopting innovative
14 technology-based approaches to deliver sex
15 education to students, faculty, and staff.

16 (iv) Developing or adopting, and im-
17 plementing peer-outreach and education
18 programs to generate discussion, educate,
19 and raise awareness among students about
20 issues relating to comprehensive sex edu-
21 cation.

22 (B) CONTENTS OF SEX EDUCATION PRO-
23 GRAMS.—Each institution of higher education’s
24 program of comprehensive sex education funded
25 under this section shall include instruction and

1 materials that address the contents required
2 under subsection (b)(6).

3 (d) GRANTS FOR PRE-SERVICE AND IN-SERVICE
4 TEACHER TRAINING.—

5 (1) PROGRAM AUTHORIZED.—The Secretary, in
6 coordination with the Director of the Centers for
7 Disease Control and Prevention and the Secretary of
8 Education, shall award grants, on a competitive
9 basis, to eligible entities to enable such eligible enti-
10 ties to carry out the activities described in para-
11 graph (5).

12 (2) DURATION.—Grants awarded under this
13 section shall be for a period of 5 years.

14 (3) ELIGIBLE ENTITY.—In this section, the
15 term “eligible entity” means—

16 (A) a State educational agency, as defined
17 in section 8101 of the Elementary and Sec-
18 ondary Education of 1965 (20 U.S.C. 7801);

19 (B) a local educational agency, as defined
20 in section 8101 of the Elementary and Sec-
21 ondary Education of 1965 (20 U.S.C. 7801);

22 (C) a Tribe or Tribal organization, as de-
23 fined in section 4 of the Indian Self-Determina-
24 tion and Education Assistance Act (25 U.S.C.
25 5304);

1 (D) a State or local department of health;

2 (E) a State or local department of edu-
3 cation;

4 (F) an educational service agency, as de-
5 fined in section 8101 of the Elementary and
6 Secondary Education of 1965 (20 U.S.C.
7 7801);

8 (G) a nonprofit institution of higher edu-
9 cation, as defined in section 101 of the Higher
10 Education Act of 1965 (20 U.S.C. 1001);

11 (H) a national or statewide nonprofit orga-
12 nization that has as its primary purpose the im-
13 provement of provision of comprehensive sex
14 education through training and effective teach-
15 ing of comprehensive sex education; or

16 (I) a consortium of nonprofit organizations
17 that has as its primary purpose the improve-
18 ment of provision of comprehensive sex edu-
19 cation through training and effective teaching
20 of comprehensive sex education.

21 (4) APPLICATION.—An eligible entity desiring a
22 grant under this subsection shall submit an applica-
23 tion to the Secretary at such time, in such manner,
24 and containing such information as the Secretary

1 may require, including an assurance to participate in
2 the evaluation described in subsection (e).

3 (5) AUTHORIZED ACTIVITIES.—

4 (A) REQUIRED ACTIVITY.—Each eligible
5 entity receiving a grant under this section shall
6 use grant funds for professional development
7 and training of relevant faculty, school adminis-
8 trators, teachers, and staff, in order to increase
9 effective teaching of comprehensive sex edu-
10 cation students.

11 (B) PERMISSIBLE ACTIVITIES.—Each eligi-
12 ble entity receiving a grant under this section
13 may use grant funds to—

14 (i) provide research-based training of
15 teachers for comprehensive sex education
16 for adolescents as a means of broadening
17 student knowledge about issues related to
18 human development, healthy relationships,
19 personal skills, and sexual behavior, includ-
20 ing abstinence, sexual health, and society
21 and culture;

22 (ii) support the dissemination of infor-
23 mation on effective practices and research
24 findings concerning the teaching of com-
25 prehensive sex education;

1 (iii) support research on—

2 (I) effective comprehensive sex
3 education teaching practices; and

4 (II) the development of assess-
5 ment instruments and strategies to
6 document—

7 (aa) student understanding
8 of comprehensive sex education;
9 and

10 (bb) the effects of com-
11 prehensive sex education;

12 (iv) convene national conferences on
13 comprehensive sex education, in order to
14 effectively train teachers in the provision of
15 comprehensive sex education; and

16 (v) develop and disseminate appro-
17 priate research-based materials to foster
18 comprehensive sex education.

19 (C) SUBGRANTS.—Each eligible entity re-
20 ceiving a grant under this subsection may
21 award subgrants to nonprofit organizations that
22 possess a demonstrated record of providing
23 training to faculty, school administrators,
24 teachers, and staff on comprehensive sex edu-
25 cation to—

1 (i) train teachers in comprehensive
2 sex education;

3 (ii) support internet or distance learn-
4 ing related to comprehensive sex education;

5 (iii) promote rigorous academic stand-
6 ards and assessment techniques to guide
7 and measure student performance in com-
8 prehensive sex education;

9 (iv) encourage replication of best
10 practices and model programs to promote
11 comprehensive sex education;

12 (v) develop and disseminate effective,
13 research-based comprehensive sex edu-
14 cation learning materials;

15 (vi) develop academic courses on the
16 pedagogy of sex education at institutions
17 of higher education; or

18 (vii) convene State-based conferences
19 to train teachers in comprehensive sex edu-
20 cation and to identify strategies for im-
21 provement.

22 (e) IMPACT EVALUATION AND REPORTING.—

23 (1) MULTI-YEAR EVALUATION.—

24 (A) IN GENERAL.—Not later than 6
25 months after the date of the enactment of this

1 Act, the Secretary shall enter into a contract
2 with a nonprofit organization with experience in
3 conducting impact evaluations, to conduct a
4 multi-year evaluation on the impact of the
5 grants under subsections (b), (c), and (d), and
6 to report to Congress and the Secretary on the
7 findings of such evaluation.

8 (B) EVALUATION.—The evaluation con-
9 ducted under this subsection shall—

10 (i) be conducted in a manner con-
11 sistent with relevant, nationally recognized
12 professional and technical evaluation
13 standards;

14 (ii) use sound statistical methods and
15 techniques relating to the behavioral
16 sciences, including quasi-experimental de-
17 signs, inferential statistics, and other
18 methodologies and techniques that allow
19 for conclusions to be reached;

20 (iii) be carried out by an independent
21 organization that has not received a grant
22 under subsection (b), (c), or (d); and

23 (iv) be designed to provide informa-
24 tion on—

1 (I) output measures, such as the
2 number of individuals served under
3 the grant and the number of hours of
4 instruction;

5 (II) outcome measures, including
6 measures relating to—

7 (aa) the knowledge that in-
8 dividuals participating in the
9 grant program have gained in
10 each of the following age and de-
11 velopmentally appropriate
12 areas—

13 (AA) growth and devel-
14 opment;

15 (BB) relationship dy-
16 namics;

17 (CC) ways to prevent
18 unintended pregnancy and
19 sexually transmitted infec-
20 tions, including HIV; and

21 (DD) sexual health;

22 (bb) the age and develop-
23 mentally appropriate skills that
24 individuals participating in the

1 grant program have gained re-
2 garding—

3 (AA) negotiation and
4 communication;

5 (BB) decisionmaking
6 and goal-setting;

7 (CC) interpersonal
8 skills and healthy relation-
9 ships; and

10 (DD) condom use; and

11 (cc) the behaviors of adoles-
12 cents participating in the grant
13 program, including data about—

14 (AA) age of first inter-
15 course;

16 (BB) condom and con-
17 traceptive use at first inter-
18 course;

19 (CC) recent condom
20 and contraceptive use;

21 (DD) substance use;

22 (EE) dating abuse and
23 lifetime history of sexual as-
24 sult, dating violence, bul-

1 lying, harassment, stalking;
2 and
3 (F) academic per-
4 formance; and
5 (III) other measures necessary to
6 evaluate the impact of the grant pro-
7 gram.

8 (C) REPORT.—Not later than 6 years after
9 the date of enactment of this Act, the organiza-
10 tion conducting the evaluation under this sub-
11 section shall prepare and submit to the appro-
12 priate committees of Congress and the Sec-
13 retary an evaluation report. Such report shall
14 be made publicly available, including on the
15 website of the Department of Health and
16 Human Services.

17 (2) SECRETARY'S REPORT TO CONGRESS.—Not
18 later than 1 year after the date of the enactment of
19 this Act, and annually thereafter for a period of 5
20 years, the Secretary shall prepare and submit to the
21 appropriate committees of Congress a report on the
22 activities to provide adolescents and young people
23 with comprehensive sex education and pre-service
24 and in-service teacher training funded under this

1 section. The Secretary's report to Congress shall in-
2 clude—

3 (A) a statement of how grants awarded by
4 the Secretary meet the purposes described in
5 subsection (a)(1); and

6 (B) information about—

7 (i) the number of eligible entities and
8 institutions of higher education that are
9 receiving grant funds under subsections
10 (b), (c), and (d);

11 (ii) the specific activities supported by
12 grant funds awarded under subsections
13 (b), (c), and (d);

14 (iii) the number of adolescents served
15 by grant programs funded under sub-
16 section (b);

17 (iv) the number of young people
18 served by grant programs funded under
19 subsection (c);

20 (v) the number of faculty, school ad-
21 ministrators, teachers, and staff trained
22 under subsection (d); and

23 (vi) the status of the evaluation re-
24 quired under paragraph (1).

1 (f) NONDISCRIMINATION.—Programs funded under
2 this section shall not discriminate on the basis of actual
3 or perceived sex, race, color, ethnicity, national origin, dis-
4 ability, sexual orientation, gender identity, or religion.
5 Nothing in this section shall be construed to invalidate or
6 limit rights, remedies, procedures, or legal standards avail-
7 able under any other Federal law or any law of a State
8 or a political subdivision of a State, including the Civil
9 Rights Act of 1964 (42 U.S.C. 2000a et seq.), title IX
10 of the Education Amendments of 1972 (20 U.S.C. 1681
11 et seq.), section 504 of the Rehabilitation Act of 1973 (29
12 U.S.C. 794), the Americans with Disabilities Act of 1990
13 (42 U.S.C. 12101 et seq.), and section 1557 of the Patient
14 Protection and Affordable Care Act (42 U.S.C. 18116).

15 (g) LIMITATION.—No Federal funds provided under
16 this section may be used for health education programs
17 that—

18 (1) withhold health-promoting or life-saving in-
19 formation about sexuality-related topics, including
20 HIV;

21 (2) are medically inaccurate or have been sci-
22 entifically shown to be ineffective;

23 (3) promote gender or racial stereotypes;

24 (4) are insensitive and unresponsive to the
25 needs of sexually active young people;

1 (5) are insensitive and unresponsive to the
2 needs of pregnant or parenting young people;

3 (6) are insensitive and unresponsive to the
4 needs of survivors of sexual abuse or assault;

5 (7) are insensitive and unresponsive to the
6 needs of youth of all physical, developmental, or
7 mental abilities;

8 (8) are insensitive and unresponsive to individ-
9 uals with varying gender identities, gender expres-
10 sions, and sexual orientations; or

11 (9) are inconsistent with the ethical imperatives
12 of medicine and public health.

13 (h) AMENDMENTS TO OTHER LAWS.—

14 (1) AMENDMENT TO THE PUBLIC HEALTH
15 SERVICE ACT.—Section 2500 of the Public Health
16 Service Act (42 U.S.C. 300ee) is amended by strik-
17 ing subsections (b) through (d) and inserting the fol-
18 lowing:

19 “(b) CONTENTS OF PROGRAMS.—All programs of
20 education and information receiving funds under this sub-
21 chapter shall include information about the potential ef-
22 fects of intravenous substance abuse.”.

23 (2) AMENDMENTS TO THE ELEMENTARY AND
24 SECONDARY EDUCATION ACT OF 1965.—Section 8526

1 of the Elementary and Secondary Education Act of
2 1965 (20 U.S.C. 7906) is amended—

3 (A) by striking paragraph (3);

4 (B) by redesignating paragraphs (4) and
5 (5) as paragraphs (3) and (4), respectively;

6 (C) in paragraph (4), by inserting “or”
7 after the semicolon;

8 (D) in paragraph (5), by striking “; or”
9 and inserting a period; and

10 (E) by striking paragraph (6).

11 (i) DEFINITIONS.—In this section:

12 (1) ADOLESCENTS.—The term “adolescents”
13 means individuals who are ages 10 through 19 at
14 the time of commencement of participation in a pro-
15 gram supported under this section.

16 (2) AGE AND DEVELOPMENTALLY APPRO-
17 PRIATE.—The term “age and developmentally appro-
18 priate” means topics, messages, and teaching meth-
19 ods suitable to particular age, age group of children
20 and adolescents, or developmental levels, based on
21 cognitive, emotional, social, and behavioral capacity
22 of most students at that age level.

23 (3) APPROPRIATE COMMITTEES OF CON-
24 GRESS.—The term “appropriate committees of Con-
25 gress” means the Committee on Health, Education,

1 Labor, and Pensions of the Senate, the Committee
2 on Appropriations of the Senate, the Committee on
3 Energy and Commerce of the House of Representa-
4 tives, the Committee on Education and the Work-
5 force of the House of Representatives, and the Com-
6 mittee on Appropriations of the House of Represent-
7 atives.

8 (4) CHARACTERISTICS OF EFFECTIVE PRO-
9 GRAMS.—The term “characteristics of effective pro-
10 grams” means the aspects of evidence-based pro-
11 grams, including development, content, and imple-
12 mentation of such programs, that—

13 (A) have been shown to be effective in
14 terms of increasing knowledge, clarifying values
15 and attitudes, increasing skills, and impacting
16 upon behavior; and

17 (B) are widely recognized by leading med-
18 ical and public health agencies to be effective in
19 changing sexual behaviors that lead to sexually
20 transmitted infections, including HIV, unin-
21 tended pregnancy, and dating violence and sex-
22 ual assault among young people.

23 (5) COMPREHENSIVE SEX EDUCATION.—The
24 term “comprehensive sex education” means instruc-
25 tional part of a comprehensive school health edu-

1 cation approach which addresses the physical, men-
2 tal, emotional, and social dimensions of human sexu-
3 ality; designed to motivate and assist students to
4 maintain and improve their sexual health, prevent
5 disease and reduce sexual health-related risk behav-
6 iors; and enable and empower students to develop
7 and demonstrate age and developmentally appro-
8 priate sexuality and sexual health-related knowledge,
9 attitudes, skills, and practices.

10 (6) CONSENT.—The term “consent” means af-
11 firmative, conscious, and voluntary agreement to en-
12 gage in interpersonal, physical, or sexual activity.

13 (7) CULTURALLY APPROPRIATE.—The term
14 “culturally appropriate” means materials and in-
15 struction that respond to culturally diverse individ-
16 uals, families and communities in an inclusive, re-
17 spectful and effective manner; including materials
18 and instruction that are inclusive of race, ethnicity,
19 languages, cultural background, religion, sex, gender
20 identity, sexual orientation, and different abilities.

21 (8) EVIDENCE-BASED.—The term “evidence-
22 based”, when used with respect to sex education in-
23 struction, means a sex education program that has
24 been proven through rigorous evaluation to be effec-
25 tive in changing sexual behavior or incorporates ele-

1 ments of other programs that have been proven to
2 be effective in changing sexual behavior.

3 (9) GENDER EXPRESSION.—The term “gender
4 expression”, when used with respect to a sex edu-
5 cation program, means the expression of one’s gen-
6 der, such as through behavior, clothing, haircut, or
7 voice, and which may or may not conform to socially
8 defined behaviors and characteristics typically asso-
9 ciated with being either masculine or feminine.

10 (10) GENDER IDENTITY.—Except with respect
11 to subsection (f), the term “gender identity”, when
12 used with respect to a sex education program, means
13 the gender-related identity, appearance, mannerisms,
14 or other gender-related characteristics of an indi-
15 vidual, regardless of the individual’s designated sex
16 at birth including a person’s deeply held sense or
17 knowledge of their own gender; such as male, fe-
18 male, both or neither.

19 (11) INCLUSIVE.—The term “inclusive”, when
20 used with respect to a sex education program, means
21 curriculum that ensures that students from histori-
22 cally marginalized communities are reflected in
23 classroom materials and lessons.

24 (12) INSTITUTION OF HIGHER EDUCATION.—
25 The term “institution of higher education” has the

1 meaning given the term in section 101 of the Higher
2 Education Act of 1965 (20 U.S.C. 1001).

3 (13) MEDICALLY ACCURATE AND COMPLETE.—

4 The term “medically accurate and complete”, when
5 used with respect to a sex education program, means
6 that—

7 (A) the information provided through the
8 program is verified or supported by the weight
9 of research conducted in compliance with ac-
10 cepted scientific methods and is published in
11 peer-reviewed journals, where applicable; or

12 (B)(i) the program contains information
13 that leading professional organizations and
14 agencies with relevant expertise in the field rec-
15 ognize as accurate, objective, and complete; and

16 (ii) the program does not withhold infor-
17 mation about the effectiveness and benefits of
18 correct and consistent use of condoms and
19 other contraceptives.

20 (14) SECRETARY.—The term “Secretary”
21 means the Secretary of Health and Human Services.

22 (15) SEXUAL DEVELOPMENT.—The term “sex-
23 ual development” means the lifelong process of phys-
24 ical, behavioral, cognitive, and emotional growth and
25 change as it relates to an individual’s sexuality and

1 sexual maturation, including puberty, identity devel-
2 opment, socio-cultural influences, and sexual behav-
3 iors.

4 (16) SEXUAL ORIENTATION.—Except with re-
5 spect to subsection (f), the term “sexual orienta-
6 tion”, when used with respect to a sex education
7 program, means an individual’s attraction, including
8 physical or emotional, to the same or different gen-
9 der.

10 (17) YOUNG PEOPLE.—The term “young peo-
11 ple” means individuals who are ages 10 through 24
12 at the time of commencement of participation in a
13 program supported under this section.

14 (j) FUNDING.—

15 (1) APPROPRIATION.—For the purpose of car-
16 rying out this section, there is appropriated
17 \$75,000,000 for each of fiscal years 2021 through
18 2026. Amounts appropriated under this subsection
19 shall remain available until expended.

20 (2) RESERVATIONS OF FUNDS.—

21 (A) The Secretary shall reserve 50 percent
22 of the amount appropriated under paragraph
23 (1) for the purposes of awarding grants for
24 comprehensive sex education for adolescents
25 under subsection (c).

1 (B) The Secretary shall reserve 25 percent
2 of the amount appropriated under paragraph
3 (1) for the purposes of awarding grants for
4 comprehensive sex education at institutes of
5 higher education under subsection (d).

6 (C) The Secretary shall reserve 20 percent
7 of the amount appropriated under paragraph
8 (1) for the purposes of awarding grants for pre-
9 service and in-service teacher training under
10 subsection (e).

11 (D) The Secretary shall reserve 2 percent
12 of the amount appropriated under paragraph
13 (1) for the purpose of carrying out the impact
14 evaluation and reporting required under sub-
15 section (a).

16 (3) SECRETARIAL RESPONSIBILITIES.—The
17 Secretary shall reserve 3 percent of the amount ap-
18 propriated under paragraph (1) for each fiscal year
19 for expenditures by the Secretary to provide, directly
20 or through a competitive grant process, research,
21 training, and technical assistance, including dissemi-
22 nation of research and information regarding effec-
23 tive and promising practices, providing consultation
24 and resources, and developing resources and mate-
25 rials to support the activities of recipients of grants.

1 In carrying out such functions, the Secretary shall
2 collaborate with a variety of entities that have exper-
3 tise in adolescent sexual health development, edu-
4 cation, and promotion.

5 (4) REPROGRAMMING OF ABSTINENCE ONLY
6 UNTIL MARRIAGE PROGRAM FUNDING.—The unobli-
7 gated balance of funds made available to carry out
8 section 510 of the Social Security Act (42 U.S.C.
9 710) (as in effect on the day before the date of en-
10 actment of this Act) are hereby transferred and shall
11 be used by the Secretary to carry out this section.
12 The amounts transferred and made available to
13 carry out this section shall remain available until ex-
14 pended.

15 (5) REPEAL OF ABSTINENCE ONLY UNTIL MAR-
16 RIAGE PROGRAM.—Section 510 of the Social Secu-
17 rity Act (42 U.S.C. 710) is repealed.

18 **SEC. 512. COMPASSIONATE ASSISTANCE FOR RAPE EMER-**
19 **GENCIES.**

20 (a) MEDICARE.—

21 (1) LIMITATION ON PAYMENT.—Section
22 1866(a)(1) of the Social Security Act (42 U.S.C.
23 1395cc(a)(1)) is amended—

24 (A) by moving the indentation of subpara-
25 graph (W) 2 ems to the left;

1 (B) in subparagraph (X)—

2 (i) by moving the indentation 2 ems
3 to the left; and

4 (ii) by striking “and” at the end;

5 (C) in subparagraph (Y), by striking the
6 period at the end and inserting “; and”; and

7 (D) by inserting after subparagraph (Y)
8 the following new subparagraph:

9 “(Z) in the case of a hospital or critical access
10 hospital, to adopt and enforce a policy to ensure
11 compliance with the requirements of subsection (l)
12 and to meet the requirements of such subsection.”.

13 (2) ASSISTANCE TO VICTIMS.—Section 1866 of
14 the Social Security Act (42 U.S.C. 1395cc) is
15 amended by adding at the end the following new
16 subsection:

17 “(l) COMPASSIONATE ASSISTANCE FOR RAPE EMER-
18 GENCIES.—

19 “(1) IN GENERAL.—For purposes of section
20 1866(a)(1)(Z), a hospital meets the requirements of
21 this subsection if the hospital provides each of the
22 services described in paragraph (2) to each indi-
23 vidual, whether or not eligible for benefits under this
24 title or under any other form of health insurance,

1 who comes to the hospital on or after January 1,
2 2021, and—

3 “(A) who states to hospital personnel that
4 they are victims of sexual assault;

5 “(B) who is accompanied by an individual
6 who states to hospital personnel that the indi-
7 vidual is a victim of sexual assault; or

8 “(C) whom hospital personnel, during the
9 course of treatment and care for the individual,
10 have reason to believe is a victim of sexual as-
11 sault.

12 “(2) REQUIRED SERVICES DESCRIBED.—For
13 purposes of paragraph (1), the services described in
14 this subparagraph are the following:

15 “(A) Provision of medically and factually
16 accurate and unbiased written and oral infor-
17 mation about emergency contraception that—

18 “(i) is written in clear and concise
19 language;

20 “(ii) is readily comprehensible;

21 “(iii) includes an explanation that
22 emergency contraceptives—

23 “(I) has been approved by the
24 Food and Drug Administration for in-
25 dividuals and is a safe and effective

1 way to prevent pregnancy after unpro-
2 tected intercourse or contraceptive
3 failure if taken in a timely manner;

4 “(II) is more effective the sooner
5 it is taken; and

6 “(III) does not cause an abortion
7 and cannot interrupt an established
8 pregnancy;

9 “(iv) meets such conditions regarding
10 the provision of such information in lan-
11 guages other than English as the Secretary
12 may establish; and

13 “(v) is provided without regard to the
14 ability of the individual or their family to
15 pay costs associated with the provision of
16 such information to the individual.

17 “(B) Immediate offer to provide emergency
18 contraception to the individual at the hospital
19 and, in the case that the individual accepts such
20 offer, immediate provision to the individual of
21 such contraception on the same day it is re-
22 quested without regard to the inability of the
23 individual or their family to pay costs associ-
24 ated with the offer and provision of such con-
25 traception.

1 “(C) Development and implementation of a
2 written policy to ensure that an individual is
3 present at the hospital, or on-call, who—

4 “(i) has authority to dispense or pre-
5 scribe emergency contraception, independ-
6 ently, or under a protocol prepared by a
7 physician for the administration of emer-
8 gency contraception at the hospital to a
9 victim of sexual assault; and

10 “(ii) is trained to comply with the re-
11 quirements of this section.

12 “(D) Provision of medically and factually
13 accurate and unbiased written and oral infor-
14 mation and counseling about post-exposure pro-
15 phylaxis (PEP) protocol for the prevention of
16 HIV.

17 “(E) Immediately offer to begin PEP to
18 the individual at the hospital except in cases
19 where the medical professional’s best judgement
20 is that further evaluation is required or that
21 such a regimen will be substantially detrimental
22 to the individual’s health. Such provision shall
23 be offered regardless of the individual’s ability
24 to pay. Hospitals shall be responsible for ensur-

1 ing adequate supply of PEP medications to pro-
2 vide to patients.

3 “(3) HOSPITAL DEFINED.—For purposes of
4 this paragraph, the term ‘hospital’ includes a critical
5 access hospital, as defined in section
6 1861(mm)(1).”.

7 (b) LIMITATION ON PAYMENT UNDER MEDICAID.—
8 Section 1903(i) of the Social Security Act (42 U.S.C.
9 1396b(i)) is amended by inserting after paragraph (8) the
10 following new paragraph:

11 “(9) with respect to any amount expended for
12 care or services furnished under the plan by a hos-
13 pital on or after January 1, 2021, unless such hos-
14 pital meets the requirements specified in section
15 1866(l) for purposes of title XVIII.”.

16 **SEC. 513. ACCESS TO BIRTH CONTROL DUTIES OF PHAR-**
17 **MACIES TO ENSURE PROVISION OF FDA-AP-**
18 **PROVED CONTRACEPTION.**

19 Part B of title II of the Public Health Service Act
20 (42 U.S.C. 238 et seq.) is amended by adding at the end
21 the following:

22 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
23 **OF FDA-APPROVED CONTRACEPTION.**

24 “(a) IN GENERAL.—Subject to subsection (c), a
25 pharmacy that receives Food and Drug Administration-

1 approved drugs or devices in interstate commerce shall
2 maintain compliance with the following:

3 “(1) If a customer requests a contraceptive or
4 a medication related to a contraceptive, including
5 emergency contraception, that is in stock, the phar-
6 macy shall ensure that the contraceptive is provided
7 to the customer without delay.

8 “(2) If a customer requests a contraceptive or
9 a medication related to a contraceptive that is not
10 in stock and the pharmacy in the normal course of
11 business stocks contraception, the pharmacy shall
12 immediately inform the customer that the contracep-
13 tive is not in stock and without delay offer the cus-
14 tomer the following options:

15 “(A) If the customer prefers to obtain the
16 contraceptive or a medication related to a con-
17 traceptive through a referral or transfer, the
18 pharmacy shall—

19 “(i) locate a pharmacy of the cus-
20 tomer’s choice or the closest pharmacy
21 confirmed to have the contraceptive or a
22 medication related to a contraceptive in
23 stock; and

24 “(ii) refer the customer or transfer
25 the prescription to that pharmacy.

1 “(B) If the customer prefers for the phar-
2 macy to order the contraceptive or a medication
3 related to a contraceptive, the pharmacy shall
4 obtain the contraceptive or medication under
5 the pharmacy’s standard procedure for expe-
6 dited ordering of medication and notify the cus-
7 tomer when the contraceptive or medication ar-
8 rives.

9 “(3) The pharmacy shall ensure that—

10 “(A) the pharmacy does not operate an en-
11 vironment in which customers are intimidated,
12 threatened, or harassed in the delivery of serv-
13 ices relating to a request for contraception or a
14 medication related to a contraceptive;

15 “(B) the pharmacy’s employees do not
16 interfere with or obstruct the delivery of serv-
17 ices relating to a request for contraception or a
18 medication related to a contraceptive;

19 “(C) the pharmacy’s employees do not in-
20 tentionally misrepresent or deceive customers
21 about the availability of a contraceptive or a
22 medication related to a contraceptive, or the
23 mechanism of action of such contraceptive or
24 medication;

1 “(D) the pharmacy’s employees do not
2 breach medical confidentiality with respect to a
3 request for a contraceptive or a medication re-
4 lated to a contraceptive or threaten to breach
5 such confidentiality; or

6 “(E) the pharmacy’s employees do not
7 refuse to return a valid, lawful prescription for
8 a contraceptive or a medication related to a
9 contraceptive upon customer request.

10 “(b) CONTRACEPTIVES NOT ORDINARILY
11 STOCKED.—Nothing in subsection (a)(2) shall be con-
12 strued to require any pharmacy to comply with such sub-
13 section if the pharmacy does not ordinarily stock contra-
14 ceptives or a medication related to a contraceptive in the
15 normal course of business.

16 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
17 MACY PRACTICE.—This section does not prohibit a phar-
18 macy from refusing to provide a contraceptive or a medi-
19 cation related to a contraceptive to a customer in accord-
20 ance with any of the following:

21 “(1) If it is unlawful to dispense the contracep-
22 tive or a medication related to a contraceptive to the
23 customer without a valid, lawful prescription and no
24 such prescription is presented.

1 “(2) If the customer is unable to pay for the
2 contraceptive or the medication related to a contra-
3 ceptive.

4 “(3) If the employee of the pharmacy refuses to
5 provide the contraceptive or a medication related to
6 a contraceptive on the basis of a professional clinical
7 judgment.

8 “(d) RELATION TO OTHER LAW.—

9 “(1) RULE OF CONSTRUCTION.—Nothing in
10 this section shall be construed to invalidate or limit
11 rights, remedies, procedures, or legal standards
12 under title VII of the Civil Rights Act of 1964.

13 “(2) CERTAIN CLAIMS.—The Religious Free-
14 dom Restoration Act of 1993 shall not provide a
15 claim concerning, or a defense to a claim under this
16 section, or provide a basis for challenging the appli-
17 cation or enforcement of this section.

18 “(e) PREEMPTION.—This section does not preempt
19 any provision of State law or any professional obligation
20 made applicable by a State board or other entity respon-
21 sible for licensing or discipline of pharmacies or phar-
22 macists, to the extent that such State law or professional
23 obligation provides protections for customers that are
24 greater than the protections provided by this section.

25 “(f) ENFORCEMENT.—

1 “(1) CIVIL PENALTY.—A pharmacy that vio-
2 lates a requirement of subsection (a) is liable to the
3 United States for a civil penalty in an amount not
4 exceeding \$1,000 per day of violation, not to exceed
5 \$100,000 for all violations adjudicated in a single
6 proceeding.

7 “(2) PRIVATE CAUSE OF ACTION.—Any person
8 aggrieved as a result of a violation of a requirement
9 of subsection (a) may, in any court of competent ju-
10 risdiction, commence a civil action against the phar-
11 macy involved to obtain appropriate relief, including
12 actual and punitive damages, injunctive relief, and a
13 reasonable attorney’s fee and cost.

14 “(3) LIMITATIONS.—A civil action under para-
15 graph (1) or (2) may not be commenced against a
16 pharmacy after the expiration of the 5-year period
17 beginning on the date on which the pharmacy alleg-
18 edly engaged in the violation involved.

19 “(g) DEFINITIONS.—In this section:

20 “(1) CONTRACEPTION.—The term ‘contracep-
21 tion’ or ‘contraceptive’ means any drug or device ap-
22 proved by the Food and Drug Administration to pre-
23 vent pregnancy.

1 “(2) EMPLOYEE.—The term ‘employee’ means
2 a person hired, by contract or any other form of an
3 agreement, by a pharmacy.

4 “(3) MEDICATION RELATED TO A CONTRACEP-
5 TIVE.—The term ‘medication related to a contracep-
6 tive’ means any drug or device approved by the Food
7 and Drug Administration that a medical professional
8 determines necessary to use before or in conjunction
9 with a contraceptive.

10 “(4) PHARMACY.—The term ‘pharmacy’ means
11 an entity that—

12 “(A) is authorized by a State to engage in
13 the business of selling prescription drugs at re-
14 tail; and

15 “(B) employs one or more employees.

16 “(5) PRODUCT.—The term ‘product’ means a
17 Food and Drug Administration-approved drug or de-
18 vice.

19 “(6) PROFESSIONAL CLINICAL JUDGMENT.—
20 The term ‘professional clinical judgment’ means the
21 use of professional knowledge and skills to form a
22 clinical judgment, in accordance with prevailing
23 medical standards.

24 “(7) WITHOUT DELAY.—The term ‘without
25 delay’, with respect to a pharmacy providing, pro-

1 “(A) protecting, promoting, and supporting
2 the innate capacities of childbearing individuals
3 and their newborns for childbirth, breastfeed-
4 ing, and attachment;

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

16 “(C) reliably incorporating noninvasive,
17 evidence-based practices that have documented
18 correlation with considerable improvement in
19 outcomes with no detrimental side effects, such
20 as smoking cessation programs in pregnancy
21 and proven models of group prenatal care that
22 integrate health assessment, education, and
23 support into a unified program and supporting
24 evidence-based breastfeeding promotion efforts

1 with respect for a breastfeeding individual’s
2 personal decisionmaking;

3 “(D) a shared understanding of the quali-
4 fications of licensed providers of maternity care
5 and the best evidence about the safety, satisfac-
6 tion, outcomes, and costs of their care, and ap-
7 propriate deployment of such caregivers within
8 the maternity care workforce to address the
9 needs of childbearing individuals and newborns
10 and the growing shortage of maternity care-
11 givers;

12 “(E) a shared understanding of the results
13 of the best available research comparing hos-
14 pital, birth center, and planned home births, in-
15 cluding information about each setting’s safety,
16 satisfaction, outcomes, and costs;

17 “(F) high-quality, evidence-based child-
18 birth education that promotes a natural,
19 healthy, and safe approach to pregnancy, child-
20 birth, and early parenting; is taught by certified
21 educators, peer counselors, and health profes-
22 sionals; and promotes informed decisionmaking
23 by childbearing individuals; and

24 “(G) developing measures that enable a
25 more robust, balanced set of standardized ma-

1 ternity care measures, including performance
2 and quality measures;”.

3 **SEC. 515. INTERAGENCY COORDINATING COMMITTEE ON**
4 **THE PROMOTION OF OPTIMAL MATERNITY**
5 **OUTCOMES.**

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

9 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON**
10 **THE PROMOTION OF OPTIMAL MATERNITY**
11 **OUTCOMES.**

12 “(a) IN GENERAL.—The Secretary, acting through
13 the Deputy Assistant Secretary for Women’s Health under
14 section 229 and in collaboration with the Federal officials
15 specified in subsection (b), shall establish the Interagency
16 Coordinating Committee on the Promotion of Optimal Ma-
17 ternity Outcomes (referred to in this section as the
18 ‘ICCPOM’).

19 “(b) OTHER AGENCIES.—The officials specified in
20 this subsection are the Secretary of Labor, the Secretary
21 of Defense, the Secretary of Veterans Affairs, the Surgeon
22 General, the Director of the Centers for Disease Control
23 and Prevention, the Administrator of the Health Re-
24 sources and Services Administration, the Administrator of
25 the Centers for Medicare & Medicaid Services, the Direc-

1 tor of the Indian Health Service, the Administrator of the
2 Substance Abuse and Mental Health Services Administra-
3 tion, the Director of the National Institute on Child
4 Health and Development, the Director of the Agency for
5 Healthcare Research and Quality, the Assistant Secretary
6 for Children and Families, the Deputy Assistant Secretary
7 for Minority Health, the Director of the Office of Per-
8 sonnel Management, and such other Federal officials as
9 the Secretary of Health and Human Services determines
10 to be appropriate.

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

13 “(d) DUTIES.—The ICCPOM shall guide policy and
14 program development across the Federal Government with
15 respect to promotion of optimal maternity care, provided,
16 however, that nothing in this section shall be construed
17 as transferring regulatory or program authority from an
18 agency to the ICCPOM.

19 “(e) CONSULTATIONS.—The ICCPOM shall actively
20 seek the input of, and shall consult with, all appropriate
21 and interested stakeholders, including State health depart-
22 ments, public health research and interest groups, founda-
23 tions, childbearing individuals and their advocates, and
24 maternity care professional associations and organiza-

1 tions, reflecting racially, ethnically, demographically, and
2 geographically diverse communities.

3 “(f) ANNUAL REPORT.—

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

7 “(A) all programs and policies of Federal
8 agencies (including the Medicare Program
9 under title XVIII of the Social Security Act and
10 the Medicaid program under title XIX of such
11 Act) designed to promote optimal maternity
12 care, focusing particularly on programs and
13 policies that support the adoption of evidence
14 based maternity care, as defined by timely, sci-
15 entifically sound systematic reviews;

16 “(B) all programs and policies of Federal
17 agencies (including the Medicare Program
18 under title XVIII of the Social Security Act and
19 the Medicaid program under title XIX of such
20 Act) designed to address the problems of mater-
21 nal mortality and morbidity, infant mortality,
22 prematurity, and low birth weight, including
23 such programs and policies designed to address
24 racial and ethnic disparities with respect to
25 each of such problems;

1 “(C) the extent of progress in reducing
2 maternal mortality and infant mortality, low
3 birth weight, and prematurity at State and na-
4 tional levels; and

5 “(D) such other information regarding op-
6 timal maternity care (such as quality and per-
7 formance measures) as the Secretary deter-
8 mines to be appropriate.

9 The information specified in subparagraph (C) shall
10 be included in each such report in a manner that
11 disaggregates such information by race, ethnicity,
12 and indigenous status in order to determine the ex-
13 tent of progress in reducing racial and ethnic dis-
14 parities and disparities related to indigenous status.

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

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

22 “(B) The rate of vaginal births after cesar-
23 ean.

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

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

1 “(E) The rate of freestanding birth center
2 births.

3 “(F) The rate of planned and unplanned
4 home birth.

5 “(G) The rate of attended births by pro-
6 vider, including by an obstetrician-gynecologist,
7 family practice physician, obstetrician-gyne-
8 cologist physician assistant, certified nurse-mid-
9 wife, certified midwife, and certified profes-
10 sional midwife.

11 “(H) The cost of maternity care
12 disaggregated by place of birth and provider of
13 care, including—

14 “(i) uncomplicated vaginal birth;

15 “(ii) complicated vaginal birth;

16 “(iii) uncomplicated cesarean birth;

17 and

18 “(iv) complicated cesarean birth.

19 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated, in addition to amounts
21 authorized to be appropriated under section 229(e), to
22 carry out this section \$1,000,000 for each of the fiscal
23 years 2021 through 2025.”.

24 (b) CONFORMING AMENDMENTS.—

1 (1) INCLUSION AS DUTY OF HHS OFFICE ON
2 WOMEN’S HEALTH.—Section 229(b) of such Act (42
3 U.S.C. 237a(b)), as amended by section 514, is fur-
4 ther amended by adding at the end the following
5 new paragraph:

6 “(9) establish the Interagency Coordinating
7 Committee on the Promotion of Optimal Maternity
8 Outcomes in accordance with section 229A; and”.

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

13 **SEC. 516. CONSUMER EDUCATION CAMPAIGN.**

14 Section 229(b) of the Public Health Service Act (42
15 U.S.C. 237a(b)), as amended by sections 514 and 515,
16 is further amended by adding at the end the following:

17 “(10) not later than one year after the date of
18 the enactment of the Health Equity and Account-
19 ability Act of 2020, develop and implement a 4-year
20 culturally and linguistically appropriate multimedia
21 consumer education campaign that is designed to
22 promote understanding and acceptance of evidence-
23 based maternity practices and models of care for op-
24 timal maternity outcomes among individuals of

1 childbearing ages and families of such individuals
2 and that—

3 “(A) highlights the importance of pro-
4 tecting, promoting, and supporting the innate
5 capacities of childbearing individuals and their
6 newborns for childbirth, breastfeeding, and at-
7 tachment;

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

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

21 “(D) emphasizes the noninvasive maternity
22 practices that have strong proven correlation or
23 may be associated with considerable improve-
24 ment in outcomes with no detrimental side ef-
25 fects, and are significantly underused in the

1 United States, including smoking cessation pro-
2 grams in pregnancy, group model prenatal care,
3 continuous labor support, nonsupine positions
4 for birth, and external version to turn breech
5 babies at term;

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

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

15 “(G) fosters participation in high-quality,
16 evidence-based childbirth education that pro-
17 motes a natural, healthy, and safe approach to
18 pregnancy, childbirth, and early parenting; is
19 taught by certified educators, peer counselors,
20 and health professionals; and promotes in-
21 formed decisionmaking by childbearing individ-
22 uals; and

23 “(H) is pilot tested for consumer com-
24 prehension, cultural sensitivity, and acceptance
25 of the messages across geographically, racially,

1 ethnically, and linguistically diverse popu-
2 lations.”.

3 **SEC. 517. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
4 **VIEWS FOR CARE OF CHILDBEARING INDI-**
5 **VIDUALS AND NEWBORNS.**

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

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

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

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

21 (1) scientific peer-reviewed journals;

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

1 (3) Internet websites of agencies and organiza-
2 tions throughout the world that produce such sys-
3 tematic reviews.

4 (c) FEATURES.—The database shall—

5 (1) provide bibliographic citations for each
6 record within the database, and for each such cita-
7 tion include an explanation of the level and quality
8 of evidence;

9 (2) include abstracts, as available;

10 (3) provide reference to companion documents
11 as may exist for each review, such as evidence tables
12 and guidelines or consumer educational materials de-
13 veloped from the review;

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

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

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

21 (7) offer to users periodic electronic notification
22 of database updates relating to users' topics of inter-
23 est.

24 (d) OUTREACH.—Not later than the first date the
25 database is made publicly available and periodically there-

1 after, the Secretary of Health and Human Services shall
2 publicize the availability, features, and uses of the data-
3 base under this section to the stakeholders described in
4 subsection (e).

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

10 (1) Federal Medicaid administrators and State
11 agencies administering State plans under title XIX
12 of the Social Security Act pursuant to section
13 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

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

21 (3) maternal-fetal medicine specialists;

22 (4) neonatologists;

23 (5) childbearing individuals and advocates for
24 such individuals, including childbirth educators cer-
25 tified by a nationally accredited program, rep-

1 resenting communities that are diverse in terms of
2 race, ethnicity, indigenous status, and geographic
3 area;

4 (6) employers and purchasers;

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

7 (8) journalists; and

8 (9) bibliographic informatics specialists.

9 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
10 authorized to be appropriated \$2,500,000 for each of the
11 fiscal years 2021 through 2023 for the purpose of devel-
12 oping the database and such sums as may be necessary
13 for each subsequent fiscal year for updating the database
14 and providing outreach and notification to users, as de-
15 scribed in this section.

16 **SEC. 518. EXPANSION OF CDC PREVENTION RESEARCH**
17 **CENTERS PROGRAM TO INCLUDE CENTERS**
18 **ON OPTIMAL MATERNITY OUTCOMES.**

19 (a) IN GENERAL.—Not later than one year after the
20 date of the enactment of this Act, the Secretary of Health
21 and Human Services shall support the establishment of
22 additional Prevention Research Centers under the Preven-
23 tion Research Center Program administered by the Cen-
24 ters for Disease Control and Prevention. Such additional

1 centers shall each be known as a Center for Excellence
2 on Optimal Maternity Outcomes.

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

5 (1) conduct at least one focused program of re-
6 search to improve maternity outcomes, including the
7 reduction of cesarean birth rates, elective inductions,
8 prematurity rates, and low birth weight rates within
9 an underserved population that has a disproportion-
10 ately large burden of suboptimal maternity out-
11 comes, including maternal mortality and morbidity,
12 infant mortality, prematurity, or low birth weight,
13 and developing performance and quality measures
14 for accountability;

15 (2) work with partners on special interest
16 projects, as specified by the Centers for Disease
17 Control and Prevention and other relevant agencies
18 within the Department of Health and Human Serv-
19 ices, and on projects funded by other sources; and

20 (3) involve a minimum of two distinct birth set-
21 ting models, such as a hospital labor and delivery
22 model and freestanding birth center model; or a hos-
23 pital labor and delivery model and planned home
24 birth model.

1 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
2 for Excellence on Optimal Maternity Outcomes shall in-
3 clude the following interdisciplinary providers of maternity
4 care:

5 (1) Obstetrician-gynecologists.

6 (2) At least two of the following providers:

7 (A) Family practice physicians.

8 (B) Nurse practitioners.

9 (C) Physician assistants.

10 (D) Certified professional midwives.

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

15 (1) Mental health.

16 (2) Doula labor support.

17 (3) Nutrition education.

18 (4) Childbirth education.

19 (5) Social work.

20 (6) Physical therapy or occupation therapy.

21 (7) Substance abuse services.

22 (8) Home visiting.

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

1 nity Outcomes shall complement and not replicate the
2 work of the other.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section
5 \$2,000,000 for each of the fiscal years 2021 through
6 2025.

7 **SEC. 519. EXPANDING MODELS ALLOWED TO BE TESTED BY**
8 **CENTER FOR MEDICARE & MEDICAID INNO-**
9 **VATION TO INCLUDE MATERNITY CARE MOD-**
10 **ELS.**

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

14 “(xxviii) Promoting evidence-based
15 models of care that have been associated
16 with reductions in maternal and infant
17 health disparities, including incorporating
18 the use of doula and promotoras support
19 for pregnant and childbearing individuals
20 into evidence-based models of prenatal
21 care, labor and delivery, and postpartum
22 care, and supporting the appropriate use of
23 out-of-hospital birth models, including
24 births at home and in freestanding birth
25 centers.”.

1 **SEC. 520. DEVELOPMENT OF INTERPROFESSIONAL MATER-**
2 **NITY CARE EDUCATIONAL MODELS AND**
3 **TOOLS.**

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

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

20 (2) suggestions for multidisciplinary use of the
21 consensus physiologic curriculum;

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

1 (4) pilot demonstrations of interprofessional
2 educational models.

3 (b) PARTICIPANTS.—The Commission shall include
4 maternity care educators, curriculum developers, service
5 leaders, certification leaders, and accreditation leaders
6 from the various professions that provide maternity care
7 in the United States. Such professions shall include obste-
8 trician gynecologists, certified nurse midwives or certified
9 midwives, family practice physicians, nurse practitioners,
10 physician assistants, certified professional midwives, and
11 perinatal nurses. Additionally, the Commission shall in-
12 clude representation from maternity care consumer advo-
13 cates.

14 (c) CURRICULUM.—The consensus standard physio-
15 logic maternity care curriculum described in subsection
16 (a)(1) shall—

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

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

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

23 (4) incorporate recommendations to ensure re-
24 spectful, safe, and seamless consultation, referral,
25 transport, and transfer of care when necessary;

1 (5) include cultural sensitivity and strategies to
2 decrease disparities in maternity outcomes; and

3 (6) include implicit bias training.

4 (d) REPORT.—Not later than 6 months after the final
5 meeting of the Commission, the Secretary of Health and
6 Human Services shall—

7 (1) submit to Congress a report containing the
8 recommendations made by the Commission under
9 this section; and

10 (2) make such report publicly available.

11 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
12 authorized to be appropriated to carry out this section
13 \$1,000,000 for each of the fiscal years 2021 and 2022,
14 and such sums as are necessary for each of the fiscal years
15 2023 through 2025.

16 **SEC. 521. INCLUDING SERVICES FURNISHED BY CERTAIN**
17 **STUDENTS, INTERNS, AND RESIDENTS SU-**
18 **PERVISED BY CERTIFIED NURSE MIDWIVES**
19 **WITHIN INPATIENT HOSPITAL SERVICES**
20 **UNDER MEDICARE.**

21 (a) IN GENERAL.—Section 1861(b) of the Social Se-
22 curity Act (42 U.S.C. 1395x(b)) is amended—

23 (1) in paragraph (6), by striking “; or” at the
24 end and inserting “, or in the case of services in a
25 hospital or osteopathic hospital by a student midwife

1 or an intern or resident-in-training under a teaching
2 program previously described in this paragraph who
3 is in the field of obstetrics and gynecology, if such
4 student midwife, intern, or resident-in-training is su-
5 pervised by a certified nurse-midwife to the extent
6 permitted under applicable State law and as may be
7 authorized by the hospital;”;

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

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

12 “(8) a certified nurse-midwife where the hos-
13 pital has a teaching program approved as specified
14 in paragraph (6), if—

15 “(A) the hospital elects to receive any pay-
16 ment due under this title for reasonable costs of
17 such services; and

18 “(B) all certified nurse-midwives in such
19 hospital agree not to bill charges for profes-
20 sional services rendered in such hospital to indi-
21 viduals covered under the insurance program
22 established by this title.”.

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

1 **SEC. 522. GRANTS TO PROFESSIONAL ORGANIZATIONS TO**
2 **INCREASE DIVERSITY IN MATERNAL, REPRO-**
3 **DUCTIVE, AND SEXUAL HEALTH PROFES-**
4 **SIONALS.**

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

10 (1) for fiscal year 2021, planning grants de-
11 scribed in subsection (b); and

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

14 (b) PLANNING GRANTS.—

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

17 (A) To collect data and identify any work-
18 force disparities, with respect to a health pro-
19 fession, at each of the following areas along the
20 health professional continuum:

21 (i) Pipeline availability with respect to
22 students at the high school and college or
23 university levels considering and working
24 toward entrance in the profession, includ-
25 ing barriers triggered by criminal records.

1 (ii) Entrance into the training pro-
2 gram for the profession.

3 (iii) Graduation from such training
4 program.

5 (iv) Entrance into practice, including
6 barriers triggered by criminal records.

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

9 (B) To develop one or more strategies to
10 address the workforce disparities within the
11 health profession, as identified under (and in
12 response to the findings pursuant to) subpara-
13 graph (A).

14 (2) APPLICATION.—To be eligible to receive a
15 grant under this subsection, an eligible health pro-
16 fessional organization shall submit to the Secretary
17 of Health and Human Services an application in
18 such form and manner and containing such informa-
19 tion as specified by the Secretary.

20 (3) AMOUNT.—Each grant awarded under this
21 subsection shall be for an amount not to exceed
22 \$300,000.

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

1 (A) information on the extent and distribu-
2 tion of workforce disparities identified through
3 the grant; and

4 (B) reasonable objectives and strategies
5 developed to address such disparities within a
6 5-, 10-, and 25-year period.

7 (c) IMPLEMENTATION GRANTS.—

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

12 (2) APPLICATION.—To be eligible to receive a
13 grant under this subsection, an eligible health pro-
14 fessional organization shall submit to the Secretary
15 of Health and Human Services an application in
16 such form and manner as specified by the Secretary.
17 Each such application shall contain information on
18 the capability of the organization to carry out a
19 strategy described in paragraph (1), involvement of
20 partners or coalitions, plans for developing sustain-
21 ability of the efforts after the culmination of the
22 grant cycle, and any other information specified by
23 the Secretary.

24 (3) AMOUNT.—Each grant awarded under this
25 subsection shall be for an amount not to exceed

1 \$500,000 each year during the 4-year period of the
2 grant.

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

17 (d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZA-
18 TION DEFINED.—For purposes of this section, the term
19 “eligible health professional organization” means a profes-
20 sional organization representing obstetrician-gynecolo-
21 gists, certified nurse midwives, certified midwives, family
22 practice physicians, nurse practitioners whose scope of
23 practice includes maternity or sexual and reproductive
24 health care, physician assistants whose scope of practice
25 includes obstetrical or sexual and reproductive health care,

1 or certified professional midwives adolescent medicine spe-
2 cialists, and pediatricians who provide sexual and repro-
3 ductive health care.

4 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
5 authorized to be appropriated to carry out this section
6 \$2,000,000 for fiscal year 2021 and \$3,000,000 for each
7 of the fiscal years 2022 through 2025.

8 **SEC. 523. INTERAGENCY UPDATE TO THE QUALITY FAMILY**
9 **PLANNING GUIDELINES.**

10 (a) IN GENERAL.—Not later than six months after
11 the date of enactment of this Act, the Director of the Cen-
12 ters for Disease Control and Prevention and the Office
13 of Population Affairs shall review and expand the 2014
14 Quality Family Planning Guidelines to address—

15 (1) health disparities; and

16 (2) the importance of patient-directed contra-
17 ceptive decisionmaking.

18 (b) CONSULTATION.—In carrying out subsection (a),
19 the Director of the Centers for Disease Control and Pre-
20 vention and the Office of Population Affairs shall convene
21 a meeting, and solicit the views of, stakeholders including
22 experts on health disparities, experts on reproductive coer-
23 cion, representatives of provider organizations, patient ad-
24 vocates, reproductive justice organizations, organizations
25 that represent racial and ethnic minority communities, or-

1 ganizations that represent people with disabilities, organi-
2 zations that represent LGBTQ persons, and organizations
3 that represent people with limited English proficiency.

4 **SEC. 524. DISSEMINATION OF THE QUALITY FAMILY PLAN-**
5 **NING GUIDELINES.**

6 (a) **IN GENERAL.**—Not later than six months after
7 the date of enactment of this Act, the Secretary of Health
8 and Human Services and the Director of the Centers for
9 Disease Control and Prevention shall—

10 (1) develop a plan for outreach to publicly fund-
11 ed health care providers, including federally qualified
12 health centers and branches of the Indian Health
13 Service, about the quality family planning guidelines
14 referred to in section 524; and

15 (2) award grants to eligible entities to imple-
16 ment these guidelines for all patients seeking family
17 planning services.

18 (b) **DEFINITION.**—In this section, the term “eligible
19 entity” means a publicly funded health care provider that
20 serves persons of reproductive age.

1 **Subtitle B—Pregnancy Screening**

2 **SEC. 531. PREGNANCY INTENTION SCREENING INITIATIVE** 3 **DEMONSTRATION PROGRAM.**

4 Part P of title III of the Public Health Service Act
5 (42 U.S.C. 280g et seq.) is amended by adding at the end
6 the following:

7 **“SEC. 399V-7. PREGNANCY INTENTION SCREENING INITIA-** 8 **TIVE DEMONSTRATION PROGRAM.**

9 “(a) PROGRAM ESTABLISHMENT.—The Secretary,
10 acting through the Director of the Centers for Disease
11 Control and Prevention, shall establish a demonstration
12 program to facilitate the clinical adoption of pregnancy in-
13 tention screening initiatives by health care and social serv-
14 ices providers.

15 “(b) GRANTS.—The Secretary may carry out the
16 demonstration program through awarding grants to eligi-
17 ble entities to implement pregnancy intention screening
18 initiatives, collect data, and evaluate such initiatives.

19 “(c) ELIGIBLE ENTITIES.—

20 “(1) IN GENERAL.—An eligible entity under
21 this section is an entity described in paragraph (2)
22 that provides non-directive, comprehensive, medically
23 accurate information.

24 “(2) ENTITIES DESCRIBED.—For purposes of
25 paragraph (1), an entity described in this paragraph

1 is a community-based organization, voluntary health
2 organization, public health department, community
3 health center, or other interested public or private
4 primary, behavioral, or other health care or social
5 service provider or organization.

6 “(d) PREGNANCY INTENTION SCREENING INITIA-
7 TIVE.—For purposes of this section, the term ‘pregnancy
8 intention screening initiative’ means any initiative by an
9 eligible entity to routinely screen women with respect to
10 their pregnancy intentions and goals to either prevent un-
11 intended pregnancies or improve the likelihood of healthy
12 pregnancies, in order to better provide health care that
13 meets the contraceptive or pre-pregnancy needs and goals
14 of such women.

15 “(e) EVALUATION.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Director of the Centers for Disease
18 Control and Prevention, shall, by grant or contract,
19 and after consultation as described in paragraph (2),
20 conduct an evaluation of the demonstration pro-
21 gram, with respect to pregnancy intention screening
22 initiatives, conducted under this section. Such eval-
23 uation shall include:

24 “(A) Assessment of the implementation of
25 pregnancy intention screening protocols among

1 a diverse group of patients and providers, in-
2 cluding collecting data on the experiences and
3 outcomes for diverse patient populations in a
4 variety of clinical settings.

5 “(B) Analysis of outcome measures that
6 will facilitate effective and widespread adoption
7 of such protocols by health care providers for
8 inquiring about and responding to pregnancy
9 goals of women with both contraceptive and
10 pre-pregnancy care.

11 “(C) Consideration of health disparities
12 among the population served.

13 “(D) Assessment of the equitable and vol-
14 untary application of such initiatives to minor-
15 ity and medically underserved communities.

16 “(E) Assessment of the training, capacity,
17 and ongoing technical assistance needed for
18 providers to effectively implement such preg-
19 nancy intention screening protocols.

20 “(F) Assessment of whether referral sys-
21 tems for selected protocols follow evidence-based
22 standards that ensure access to comprehensive
23 health services and appropriate follow-up care.

1 “(G) Measuring through rigorous methods
2 the effect of such initiatives on key health out-
3 comes.

4 “(2) CONSULTATION WITH INDEPENDENT, EX-
5 PERT ADVISORY PANEL.—In conducting evaluation
6 under paragraph (1), the Director of the Centers for
7 Disease Control and Prevention shall consult with
8 physicians, physician assistants, advanced practice
9 registered nurses, nurse midwives, and other health
10 care providers who specialize in women’s health, and
11 other experts in public health, clinical practice, pro-
12 gram evaluation, and research.

13 “(3) REPORT.—Not later than one year after
14 the last day of the demonstration program under
15 this section, the Director of the Centers for Disease
16 Control and Prevention shall submit to Congress a
17 report on the results of the evaluation conducted
18 under paragraph (1) and shall make the report pub-
19 licly available.

20 “(f) FUNDING.—

21 “(1) AUTHORIZATION OF APPROPRIATIONS.—
22 To carry out this section, there is authorized to be
23 appropriated \$10,000,000 for each of fiscal years
24 2021 through 2025.

1 “(2) LIMITATION.—Not more than 20 percent
2 of funds appropriated to carry out this section pur-
3 suant to paragraph (1) for a fiscal year may be used
4 for purposes of the evaluation under subsection
5 (e).”.

6 **TITLE VI—MENTAL HEALTH**

7 **SEC. 601. MENTAL HEALTH FINDINGS.**

8 Congress finds the following:

9 (1) Despite the existence of effective treat-
10 ments, inequities lie in the availability, accessibility,
11 and quality of mental health services for racial and
12 ethnic minorities and people with disabilities.

13 (2) These inequities have powerful significance
14 for minority groups and for society as a whole.

15 (3) Racial and ethnic minorities and people
16 with disabilities bear a greater burden from unmet
17 mental health needs and thus suffer a greater loss
18 to their overall health and productivity.

19 (4) Improving community conditions and one’s
20 home environment, paired with high-quality, acces-
21 sible, and culturally tailored mental health services,
22 can reduce the likelihood, frequency, and intensity of
23 challenges to one’s mental health.

24 (5) The presence of strong social connections
25 and trust, opportunities to experience and share cul-

1 tural identity, safe gathering places, and economic
2 opportunity are community factors that benefit men-
3 tal health.

4 (6) The social, physical, and economic condi-
5 tions in communities can have tremendous influence
6 on daily stressors that shape mental health out-
7 comes.

8 (7) The foremost barriers include the cost of
9 care, societal stigma, and the fragmented organiza-
10 tion of services.

11 (8) People with disabilities who are racial or
12 ethnic minorities may have co-occurring mental
13 health conditions which, without proper accommoda-
14 tions and support, further stigmatize them and limit
15 their participation in society.

16 (9) African-American, Latinx, Asian-American,
17 Pacific Islander, Native, and other people of color
18 have attitudes toward mental health challenges that
19 are another barrier to seeking mental health care.

20 (10) Mental illness retains considerable stigma
21 in many communities of color, including those of
22 Asian Americans and Pacific Islanders, and seeking
23 treatment is not always encouraged.

24 (11) Addressing mental health stigma and in-
25 creasing culturally appropriate treatment modalities

1 in communities will help to increase utilization of
2 mental health services for people who have trouble
3 functioning because of mental health challenges.

4 (12) There is a link between mental health di-
5 agnosis and the likelihood of an individual commit-
6 ting suicide.

7 (13) A comprehensive public health approach to
8 behavioral health fosters protective factors in racial
9 and ethnic communities that support mental health.

10 (14) Approaches to mental health and address-
11 ing trauma must keep in mind the historical and
12 cultural trauma that has impacted many commu-
13 nities of color.

14 (15) Treatment modalities must keep individual
15 communities' approaches to mental health in mind,
16 for example—

17 (A) cultural healing practices; and

18 (B) the mental health professionals needed
19 to provide those services such as peer support
20 specialists.

21 (16) Approaches to mental health and address-
22 ing trauma must keep in mind the concept of
23 intersectionality of individuals; that individuals may
24 have many inequities that shape the way they proc-
25 ess and experience everyday life.

1 **SEC. 602. COVERAGE OF MARRIAGE AND FAMILY THERA-**
2 **PIST SERVICES, MENTAL HEALTH COUN-**
3 **SELOR SERVICES, AND SUBSTANCE ABUSE**
4 **COUNSELOR SERVICES UNDER PART B OF**
5 **THE MEDICARE PROGRAM.**

6 (a) COVERAGE OF SERVICES.—

7 (1) IN GENERAL.—Section 1861(s)(2) of the
8 Social Security Act (42 U.S.C. 1395x(s)(2)), as
9 amended by section 431(c), is amended—

10 (A) in subparagraph (GG), by striking
11 “and” at the end;

12 (B) in subparagraph (HH), by inserting
13 “and” at the end; and

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

16 “(II) marriage and family therapist services (as
17 defined in subsection (lll)(1)) and mental health
18 counselor services (as defined in subsection (lll)(3))
19 and substance abuse counselor services (as defined
20 in subsection (lll)(5));”.

21 (2) DEFINITIONS.—Section 1861 of the Social
22 Security Act (42 U.S.C. 1395x), as amended by sec-
23 tions 205(b)(a), 413(a), and 431(c), is amended by
24 adding at the end the following new subsection:

1 “Marriage and Family Therapist Services; Marriage and
2 Family Therapist; Mental Health Counselor Serv-
3 ices; Mental Health Counselor; Substance Abuse
4 Counselor Services; Substance Abuse Counselor;
5 Peer Support Specialist

6 “(lll)(1) The term ‘marriage and family therapist
7 services’ means services performed by a marriage and
8 family therapist (as defined in paragraph (2)) for the diag-
9 nosis and treatment of mental illnesses, which the mar-
10 riage and family therapist is legally authorized to perform
11 under State law (or the State regulatory mechanism pro-
12 vided by State law) of the State in which such services
13 are performed, as would otherwise be covered if furnished
14 by a physician or as an incident to a physician’s profes-
15 sional service, but only if no facility or other provider
16 charges or is paid any amounts with respect to the fur-
17 nishing of such services.

18 “(2) The term ‘marriage and family therapist’ means
19 an individual who—

20 “(A) possesses a master’s or doctoral degree
21 that qualifies for licensure or certification as a mar-
22 riage and family therapist pursuant to State law, in-
23 cluding but not limited to, clinical social workers and
24 occupational therapists;

1 “(B) after obtaining such degree has performed
2 at least 2 years of clinical supervised experience in
3 marriage and family therapy; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of marriage and family therapists, is li-
7 censed or certified as a marriage and family thera-
8 pist in such State.

9 “(3) The term ‘mental health counselor services’
10 means services performed by a mental health counselor (as
11 defined in paragraph (4)) for the diagnosis and treatment
12 of mental illnesses that the mental health counselor is le-
13 gally authorized to perform under State law (or the State
14 regulatory mechanism provided by the State law) of the
15 State in which such services are performed, as would oth-
16 erwise be covered if furnished by a physician or as incident
17 to a physician’s professional service, but only if no facility
18 or other provider charges or is paid any amounts with re-
19 spect to the furnishing of such services.

20 “(4) The term ‘mental health counselor’ means an
21 individual who—

22 “(A) possesses a master’s or doctor’s degree in
23 mental health counseling or a related field, including
24 clinical social workers and occupational therapists;

1 “(B) after obtaining such a degree has per-
2 formed at least 2 years of supervised mental health
3 counselor practice; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of mental health counselors or professional
7 counselors, is licensed or certified as a mental health
8 counselor or professional counselor in such State.

9 “(5) The term ‘substance abuse counselor services’
10 means services performed by a substance abuse counselor
11 (as defined in paragraph (6)) for the diagnosis and treat-
12 ment of substance abuse and addiction that the substance
13 abuse counselor is legally authorized to perform under
14 State law (or the State regulatory mechanism provided by
15 the State law) of the State in which such services are per-
16 formed, as would otherwise be covered if furnished by a
17 physician or as incident to a physician’s professional serv-
18 ice, but only if no facility or other provider charges or is
19 paid any amounts with respect to the furnishing of such
20 services.

21 “(6) The term ‘substance abuse counselor’ means an
22 individual who—

23 “(A) has performed at least 2 years of super-
24 vised substance abuse counselor practice;

1 “(B) in the case of an individual performing
2 services in a State that provides for licensure or cer-
3 tification of substance abuse counselors or profes-
4 sional counselors, is licensed or certified as a sub-
5 stance abuse counselor or professional counselor in
6 such State; or

7 “(C) is a drug and alcohol counselor as defined
8 in section 40.281 of title 49, Code of Federal Regu-
9 lations.

10 “(7) The term ‘peer support specialist’ means an in-
11 dividual who—

12 “(A) is an individual living in recovery with
13 mental illness, addiction, or systems involvement;

14 “(B) has skills learned in formal training; and

15 “(C) delivers services in behavioral health set-
16 tings to promote mind-body recovery and resil-
17 iency.”.

18 (3) PROVISION FOR PAYMENT UNDER PART
19 B.—Section 1832(a)(2)(B) of the Social Security
20 Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

21 (A) by striking “and” at the end of clause

22 (iv); and

23 (B) by adding at the end the following new
24 clause:

1 “(v) marriage and family therapist
2 services, mental health counselor services,
3 and substance abuse counselor services;
4 and”.

5 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
6 of the Social Security Act (42 U.S.C. 1395l(a)(1)),
7 as amended by section 431(c)(3), is amended—

8 (A) by striking “and” before “(DD)”; and
9 (B) by inserting before the semicolon at
10 the end the following: “, and (EE) with respect
11 to marriage and family therapist services, men-
12 tal health counselor services, and substance
13 abuse counselor services under section
14 1861(s)(2)(II), the amounts paid shall be 80
15 percent of the lesser of the actual charge for
16 the services or 75 percent of the amount deter-
17 mined for payment of a psychologist under sub-
18 paragraph (L)”.

19 (5) EXCLUSION OF MARRIAGE AND FAMILY
20 THERAPIST SERVICES, MENTAL HEALTH COUNSELOR
21 SERVICES, AND PEER SUPPORT SPECIALIST SERV-
22 ICES FROM SKILLED NURSING FACILITY PROSPEC-
23 TIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii)
24 of the Social Security Act (42 U.S.C.
25 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-

1 riage and family therapist services (as defined in
2 section 1861(III)(1)), mental health counselor serv-
3 ices (as defined in section 1861(III)(3)),” after
4 “qualified psychologist services,”.

5 (6) INCLUSION OF MARRIAGE AND FAMILY
6 THERAPISTS, MENTAL HEALTH COUNSELORS, AND
7 SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS
8 FOR ASSIGNMENT OF CLAIMS.—Section
9 1842(b)(18)(C) of the Social Security Act (42
10 U.S.C. 1395u(b)(18)(C)) is amended by adding at
11 the end the following new clauses:

12 “(vii) A marriage and family therapist (as de-
13 fined in section 1861(III)(2)).

14 “(viii) A mental health counselor (as defined in
15 section 1861(III)(4)).

16 “(ix) A substance abuse counselor (as defined
17 in section 1861(III)(6)).

18 “(x) A peer support specialist (as defined in
19 section 1861(III)(7)).”.

20 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
21 ICES PROVIDED IN CERTAIN SETTINGS.—

22 (1) RURAL HEALTH CLINICS AND FEDERALLY
23 QUALIFIED HEALTH CENTERS.—Section
24 1861(aa)(1)(B) of the Social Security Act (42
25 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or

1 by a clinical social worker (as defined in subsection
2 (hh)(1)),” and inserting “, by a clinical social worker
3 (as defined in subsection (hh)(1)), by a marriage
4 and family therapist (as defined in subsection
5 (lll)(2)), or by a mental health counselor (as defined
6 in subsection (lll)(4)), or by a substance abuse coun-
7 selor (as defined in section 1861 (lll)(6)).”.

8 (2) HOSPICE PROGRAMS.—Section
9 1861(dd)(2)(B)(i)(III) of the Social Security Act (42
10 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by in-
11 sserting “or one marriage and family therapist (as
12 defined in subsection (lll)(2))” after “social worker”.

13 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
14 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR
15 POSTHOSPITAL SERVICES.—Section 1861(ee)(2)(G) of
16 the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is
17 amended by inserting “marriage and family therapist (as
18 defined in subsection (lll)(2)),” after “social worker,”.

19 (d) EFFECTIVE DATE.—The amendments made by
20 this section shall apply with respect to services furnished
21 on or after January 1, 2021.

1 **SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION**
2 **PROGRAM.**

3 Part D of title V of the Public Health Service Act
4 (42 U.S.C. 290dd et seq.) is amended by adding at the
5 end the following:

6 **“SEC. 553. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
7 **PROVISION OF BEHAVIORAL HEALTH CARE**
8 **IN PRIMARY CARE SETTINGS.**

9 “(a) GRANTS.—The Secretary, acting through the
10 Assistant Secretary for Mental Health and Substance
11 Abuse, shall award grants to eligible entities for the pur-
12 pose of establishing interprofessional health care teams
13 that provide behavioral health care.

14 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
15 a grant under this section, an entity shall be a Federally
16 qualified health center (as defined in section 1861(aa) of
17 the Social Security Act), rural health clinic, or women’s
18 health clinics behavioral health program (including any
19 such program operated by a community-based organiza-
20 tion) serving a high proportion of individuals from racial
21 and ethnic minority groups (as defined in section
22 1707(g)).

23 “(c) LOAN FORGIVENESS.—To encourage qualified
24 allied health professionals to enter the mental health field,
25 an eligible entity receiving a grant under this section shall
26 agree to use at least \$10,000 of the grant on a loan for-

1 givenness program for practitioners who commit to working
2 in the mental health field for a period of two years.

3 “(d) **SCIENTIFICALLY AND CULTURALLY BASED.**—
4 Integrated health care funded through this section shall
5 be scientifically and culturally based, taking into consider-
6 ation the results of the most recent peer-reviewed research
7 available.

8 “(e) **AUTHORIZATION OF APPROPRIATIONS.**—To
9 carry out this section, there is authorized to be appro-
10 priated \$20,000,000 for each of fiscal years 2021 through
11 2025.”.

12 **SEC. 604. ADDRESSING RACIAL AND ETHNIC MENTAL**
13 **HEALTH DISPARITIES RESEARCH GAPS.**

14 (a) **IN GENERAL.**—Not later than 6 months after the
15 date of the enactment of this Act, the Director of the Na-
16 tional Institute on Minority Health and Health Disparities
17 shall enter into an arrangement with the National Acad-
18 emy of Sciences to carry out the activities under sub-
19 section (b), or, if the National Academy of Sciences de-
20 clines to enter into such an arrangement, the Director of
21 the National Institute on Minority Health and Health Dis-
22 parities, in cooperation with the Agency for Healthcare
23 Research and Quality, shall carry out the activities under
24 subsection (b).

1 (b) ACTIVITIES.—The applicable entity under sub-
2 section (a) shall—

3 (1) conduct a study with respect to mental
4 health disparities in racial and ethnic minority
5 groups (as defined in section 1707(g) of the Public
6 Health Service Act (42 U.S.C. 300u–6(g))); and

7 (2) submit to Congress a report on the results
8 of such study, including—

9 (A) a compilation of information on the dy-
10 namics of mental health outcomes in such racial
11 and ethnic minority groups; and

12 (B) the degree of the co-occurrence of
13 mental conditions with other disabilities in such
14 racial and ethnic groups, including physical dis-
15 abilities, mental disabilities, and mental dis-
16 orders or mental health conditions which co-
17 occur with one another;

18 (C) a compilation of information on the
19 impact of exposure to community violence, com-
20 munity trauma, adverse childhood experiences,
21 weather extremes worsened by climate change
22 (such as heat waves, hurricanes, and wildfires),
23 substance use, and other psychological traumas,
24 on mental disorders in such racial and minority
25 groups, stratified by household income level;

1 (D) a compilation of information on the
2 impact of the intersectionality of transgender
3 men in racial and ethnic minority groups; and

4 (E) a description of how protective factors
5 contrast and compare among different commu-
6 nities of color, identifying cultural strengths.

7 **SEC. 605. HEALTH PROFESSIONS COMPETENCIES TO AD-**
8 **DRESS RACIAL AND ETHNIC MENTAL HEALTH**
9 **DISPARITIES.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services, acting through the Assistant Secretary
12 for Mental Health and Substance Use, shall award grants
13 to qualified national organizations for the purposes of—

14 (1) developing, and disseminating to health pro-
15 fessional educational programs curricula or core
16 competencies addressing mental health inequities
17 among racial and ethnic minority groups for use in
18 the training of students in the professions of social
19 work, psychology, psychiatry, marriage and family
20 therapy, mental health counseling, peer support, and
21 substance abuse counseling; and

22 (2) certifying community health workers and
23 peer wellness specialists with respect to such cur-
24 ricula and core competencies and integrating and ex-
25 panding the use of such workers and specialists into

1 health care and community-based settings to address
2 mental health disparities among racial and ethnic
3 minority groups.

4 (b) CURRICULA; CORE COMPETENCIES.—Organiza-
5 tions receiving funds under subsection (a) may use the
6 funds to engage in the following activities related to the
7 development and dissemination of curricula or core com-
8 petencies described in subsection (a)(1):

9 (1) Formation of committees or working groups
10 comprised of experts from accredited health profes-
11 sions schools to identify core competencies relating
12 to mental health disparities among racial and ethnic
13 minority groups.

14 (2) Planning of workshops in national fora to
15 allow for public input, including input from commu-
16 nities of color with lived experience, into the edu-
17 cational needs associated with mental health dispari-
18 ties among racial and ethnic minority groups.

19 (3) Dissemination and promotion of the use of
20 curricula or core competencies in undergraduate and
21 graduate health professions training programs na-
22 tionwide.

23 (4) Establishing external stakeholder advisory
24 boards to provide meaningful input into policy and
25 program development and best practices to reduce

1 mental health inequities among racial and ethnic
2 groups, including participation from communities of
3 color with lived experience of the impacts of mental
4 health disparities.

5 (c) DEFINITIONS.—In this section:

6 (1) QUALIFIED NATIONAL ORGANIZATION.—The
7 term “qualified national organization” means a na-
8 tional organization that focuses on the education of
9 students in programs of social work, occupational
10 therapy, psychology, psychiatry, and marriage and
11 family therapy.

12 (2) RACIAL AND ETHNIC MINORITY GROUP.—
13 The term “racial and ethnic minority group” has the
14 meaning given to such term in section 1707(g) of
15 the Public Health Service Act (42 U.S.C. 300u-
16 6(g)).

17 (d) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section
19 such sums as may be necessary for each of fiscal years
20 2021 through 2025.

21 **SEC. 606. GEOACCESS STUDY.**

22 The Assistant Secretary for Mental Health and Sub-
23 stance Use shall—

24 (1) conduct a study to—

1 (A) determine which geographic areas of
2 the United States have shortages of specialty
3 mental health providers; and

4 (B) assess the preparedness of speciality
5 mental health providers to deliver culturally and
6 linguistically appropriate, affordable, and acces-
7 sible services; and

8 (2) submit a report to Congress on the results
9 of such study.

10 **SEC. 607. ASIAN AMERICAN, NATIVE HAWAIIAN, PACIFIC IS-**
11 **LANDER, AND HISPANIC AND LATINO BEHAV-**
12 **IORAL AND MENTAL HEALTH OUTREACH AND**
13 **EDUCATION STRATEGIES.**

14 Part D of title V of the Public Health Service Act
15 (42 U.S.C. 290dd et seq.), as amended by section 603,
16 is further amended by adding at the end the following new
17 section:

18 **“SEC. 554. BEHAVIORAL AND MENTAL HEALTH OUTREACH**
19 **AND EDUCATION STRATEGIES.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Assistant Secretary for Mental Health and Substance
22 Use, shall, in coordination with advocacy and behavioral
23 and mental health organizations serving populations of
24 Asian American, Native Hawaiian, Pacific Islander, and
25 Hispanic and Latino individuals or communities, develop

1 and implement an outreach and education strategy to pro-
2 mote behavioral and mental health, clarify that behavioral
3 and mental health conditions are treatable and that rea-
4 sonable accommodations are required under section 504
5 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and
6 titles II and III of the Americans with Disabilities Act
7 of 1990 (42 U.S.C. 12131 et seq.), and reduce stigma as-
8 sociated with mental health conditions and substance
9 abuse among the Asian American, Native Hawaiian, and
10 Pacific Islander and Hispanic and Latino populations.

11 Such strategy shall—

12 “(1) be designed to—

13 “(A) meet the diverse cultural and lan-
14 guage needs of the various Asian American,
15 Native Hawaiian, Pacific Islander, and His-
16 panic and Latino populations; and

17 “(B) ensure such strategies are develop-
18 mentally (with respect to the beneficiary’s rel-
19 ative age and experience) and age appropriate,
20 as well as cognitively accessible to persons with
21 cognitive disabilities;

22 “(2) increase awareness of symptoms of mental
23 illnesses common among such populations, taking
24 into account differences within subgroups (such as

1 gender, gender identity, age, sexual orientation, dis-
2 ability, and ethnicity) of such populations;

3 “(3) provide information on evidence-based, cul-
4 turally and linguistically appropriate and adapted
5 interventions and treatments;

6 “(4) ensure full participation of, and engage,
7 both consumers and community members in the de-
8 velopment and implementation of materials; and

9 “(5) seek to broaden the perspective among
10 both individuals in such communities and stake-
11 holders serving such communities to use a com-
12 prehensive public health approach to promoting be-
13 havioral health that addresses a holistic view of
14 health by focusing on the intersection between be-
15 havioral and physical health.

16 “(b) REPORTS.—Beginning not later than 1 year
17 after the date of the enactment of this section and annu-
18 ally thereafter, the Secretary, acting through the Assistant
19 Secretary, shall submit to Congress, and make publicly
20 available, a report on the extent to which the strategy de-
21 veloped and implemented under subsection (a) increased
22 behavioral and mental health outcomes associated with
23 mental health conditions and substance abuse among
24 Asian American, Native Hawaiian, Pacific Islander, and
25 Hispanic and Latino populations.

1 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section
3 \$300,000 for fiscal year 2021.”.

4 **SEC. 608. MENTAL HEALTH IN SCHOOLS.**

5 (a) PURPOSE.—It is the purpose of this section to—

6 (1) revise, increase funding for, and expand the
7 scope of the Project AWARE State Educational
8 Agency Grant Program carried out by the Secretary
9 of Health and Human Services, in order to provide
10 access to more comprehensive school-based mental
11 health services and supports;

12 (2) provide for comprehensive staff development
13 for school and community service personnel working
14 in the school;

15 (3) provide for comprehensive training to im-
16 prove health and academic outcomes for children
17 with, or at risk for, mental health conditions, for
18 parents or guardians, siblings, and other family
19 members of such children, and for concerned mem-
20 bers of the community;

21 (4) provide for comprehensive, universal, evi-
22 dence-based screening to identify children and ado-
23 lescents with potential mental health conditions or
24 unmet emotional health needs;

1 (5) recognize best practices for the delivery of
2 mental health care in school-based settings, includ-
3 ing school-based health centers;

4 (6) provide for comprehensive training for par-
5 ents or guardians, siblings, other family members,
6 and concerned members of the community on behalf
7 of children and adolescents experiencing mental
8 health trauma, disorder, or disability; and

9 (7) establish formal working relationships be-
10 tween health, human service, and educational enti-
11 ties that support the mental and emotional health of
12 children and adolescents in the school setting.

13 (b) TECHNICAL AMENDMENTS.—The second part G
14 (relating to services provided through religious organiza-
15 tions) of title V of the Public Health Service Act (42
16 U.S.C. 290kk et seq.) is amended—

17 (1) by redesignating such part as part J; and

18 (2) by redesignating sections 581 through 584
19 as sections 596 through 596C, respectively.

20 (c) SCHOOL-BASED MENTAL HEALTH AND CHIL-
21 DREN AND VIOLENCE.—Section 581 of the Public Health
22 Service Act (42 U.S.C. 290hh) is amended to read as fol-
23 lows:

1 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN**
2 **AND ADOLESCENTS AND TRAUMA.**

3 “(a) IN GENERAL.—The Secretary, in collaboration
4 with the Secretary of Education, shall, directly or through
5 grants, contracts, or cooperative agreements awarded to
6 eligible entities described in subsection (c), assist local
7 communities and schools (including schools funded by the
8 Bureau of Indian Education) in applying a public health
9 approach to mental health services both in schools and in
10 the community. Such approach should provide comprehen-
11 sive developmentally appropriate services and supports,
12 that are linguistically and culturally appropriate and trau-
13 ma-informed, and incorporate developmentally appropriate
14 strategies of positive behavioral interventions and sup-
15 ports. A comprehensive school mental health program
16 funded under this section shall assist children in dealing
17 with traumatic experiences, grief, bereavement, risk of sui-
18 cide, violence, and individual and community trauma that
19 children may experience, and shall be implemented with
20 a focus on positive youth development. Causes of trauma
21 for children may include but are not limited to exposure
22 to multiple forms of violence and abuse, structural racism
23 and discrimination, family housing instability, family job
24 loss, and climate-related disasters.

25 “(b) ACTIVITIES.—Under the program under sub-
26 section (a), the Secretary may—

1 “(1) provide financial support to enable local
2 communities to implement a comprehensive cul-
3 turally and linguistically appropriate, trauma-in-
4 formed, and developmentally appropriate, school-
5 based mental health program that—

6 “(A) builds awareness of multiple forms of
7 trauma, individual trauma, and intergenera-
8 tional, continuum of impacts of trauma, on pop-
9 ulations;

10 “(B) trains appropriate staff and edu-
11 cators to identify, and screen for, signs of trau-
12 ma exposure, mental health conditions, or risk
13 of suicide; and

14 “(C) incorporates positive behavioral inter-
15 ventions, family engagement, student treatment,
16 and multi-generational supports to foster the
17 health and development of children, prevent
18 mental health conditions, and ameliorate the
19 impacts of trauma;

20 “(2) provide technical assistance to local com-
21 munities with respect to the development of pro-
22 grams described in paragraph (1);

23 “(3) provide assistance to local communities in
24 the development of policies to address child and ado-
25 lescent trauma and mental health conditions;

1 “(4) facilitate community partnerships among
2 families, students, law enforcement agencies, edu-
3 cation agencies, mental health and substance use
4 disorder systems, family-based mental health service
5 systems, child welfare agencies, health care providers
6 (including primary care physicians, mental health
7 professionals, and other professionals who specialize
8 in children’s mental health such as child and adoles-
9 cent psychiatrists), institutions of higher education,
10 faith-based programs, trauma networks, public
11 health, youth development and recreation, youth em-
12 ployment organizations, and other community-based
13 systems; and

14 “(5) establish and promote trauma-informed,
15 culturally based, and supportive mechanisms for
16 children and adolescents to share their experiences
17 of individual and community trauma, including their
18 exposure to violence, with trusted adults.

19 “(c) REQUIREMENTS.—

20 “(1) IN GENERAL.—To be eligible for a grant,
21 contract, or cooperative agreement under subsection
22 (a), an entity shall—

23 “(A) be a partnership that includes—

24 “(i) a State educational agency (as
25 defined in section 8101 of the Elementary

1 and Secondary Education Act of 1965) in
2 coordination with one or more local edu-
3 cational agencies (as defined in section
4 8101 of such Act) or a consortium of enti-
5 ties described in subparagraph (B), (C),
6 (D), or (E) of the definition of a local edu-
7 cational agency in section 8101 of such
8 Act; and

9 “(ii) in accordance with paragraph
10 (2)(A)(i), appropriate public or private en-
11 tities that employ interventions that are
12 evidence-based (as defined in section 8101
13 of the Elementary and Secondary Edu-
14 cation Act of 1965); and

15 “(B) submit an application, endorsed by
16 all members of the partnership, that—

17 “(i) specifies which members will
18 serve as the lead partners; and

19 “(ii) contains the assurances described
20 in paragraph (2).

21 “(2) REQUIRED ASSURANCES.—An application
22 under paragraph (1) shall contain assurances as fol-
23 lows:

24 “(A) The eligible entity will ensure that, in
25 carrying out activities under this section, the el-

1 eligible entity will enter into a memorandum of
2 understanding—

3 “(i) with at least 2 entities from the
4 following categories: community-based,
5 public or private mental-health providers,
6 health care entities, public health entities,
7 law enforcement or juvenile justice entities,
8 child welfare agencies, family-based mental
9 health entities, trauma networks, commu-
10 nity-based entities, or other entities as de-
11 termined by the Secretary (which may in-
12 clude a human services agency or institu-
13 tion of higher education); and

14 “(ii) that clearly states—

15 “(I) the responsibilities of each
16 partner with respect to the activities
17 to be carried out, including how fam-
18 ily and community engagement will be
19 incorporated in the activities;

20 “(II) how school-employed and
21 school-based mental health profes-
22 sionals will be utilized for carrying out
23 such responsibilities;

1 “(III) how each such partner will
2 be accountable for carrying out such
3 responsibilities; and

4 “(IV) the amount of non-Federal
5 funding or in-kind contributions that
6 each such partner will contribute in
7 order to sustain the program.

8 “(B) The comprehensive school-based men-
9 tal health program carried out under this sec-
10 tion supports the flexible use of funds to ad-
11 dress—

12 “(i) universal prevention, through the
13 promotion of the social, emotional, mental,
14 and behavioral health of all students in an
15 environment that is conducive to learning;

16 “(ii) the reduction in the likelihood of
17 at-risk students developing social, emo-
18 tional, or behavioral health problems, or
19 substance use disorders;

20 “(iii) the screening for, and early
21 identification of, social, emotional, mental,
22 and behavioral problems, or substance use
23 disorders and the provision of early inter-
24 vention services;

1 “(iv) the treatment or referral for
2 treatment of students with existing social,
3 emotional, and mental behavioral health
4 problems, or substance use disorders;

5 “(v) the development and implementa-
6 tion of evidence-based programs (including
7 program curricula, school supports, and
8 after-school programs) to assist children
9 who are experiencing or have been exposed
10 to individual and community trauma or ex-
11 posed to multiple forms of violence; and

12 “(vi) the development and implemen-
13 tation of evidence-based programs to assist
14 children who are grieving, which may in-
15 clude training for school personnel on the
16 impact of trauma and bereavement on chil-
17 dren, and services to provide support to
18 grieving children.

19 “(C) The comprehensive school-based men-
20 tal health program carried out under this sec-
21 tion will provide for in-service training of all
22 school personnel, including ancillary staff and
23 volunteers, in—

24 “(i) the techniques and supports need-
25 ed to promote early identification of chil-

1 dren with trauma histories, children who
2 are grieving, and children with a mental
3 health condition or at risk of developing a
4 mental health condition, or who are at risk
5 of suicide;

6 “(ii) the use of referral mechanisms
7 that effectively link such children to appro-
8 priate prevention, treatment, and interven-
9 tion services in the school and in the com-
10 munity and to follow up when services are
11 not available;

12 “(iii) strategies that promote a school-
13 wide positive environment, including strat-
14 egies to prevent bullying, which includes
15 cyber-bullying;

16 “(iv) strategies for promoting the so-
17 cial, emotional, mental, and behavioral
18 health of all students;

19 “(v) strategies for promoting the so-
20 cial, emotional, mental, and behavioral
21 health of all students; and

22 “(vi) strategies to increase the knowl-
23 edge and skills of school and community
24 leaders about the impact of individual and
25 community trauma and exposure to mul-

1 multiple forms of violence on the application of
2 a public health approach to comprehensive
3 school-based mental health programs.

4 “(D) The comprehensive school-based men-
5 tal health program carried out under this sec-
6 tion will include comprehensive training for par-
7 ents or guardians, siblings, and other family
8 members of children with mental health condi-
9 tions, and for concerned members of the com-
10 munity, in—

11 “(i) the techniques and supports need-
12 ed to promote early identification of chil-
13 dren with trauma histories, children who
14 are grieving, children with a mental health
15 condition or at risk of developing a mental
16 health condition, and children who are at
17 risk of suicide;

18 “(ii) the use of referral mechanisms
19 that effectively link such children to appro-
20 priate prevention, treatment, and interven-
21 tion services in the school and in the com-
22 munity and followup when such services
23 are not available; and

24 “(iii) strategies that promote a school-
25 and community-wide positive environment,

1 including strategies to prevent bullying, in-
2 cluding cyber-bullying.

3 “(E) The comprehensive school-based men-
4 tal health program carried out under this sec-
5 tion will demonstrate the measures to be taken
6 to sustain the program (which may include
7 seeking funding for the program under a State
8 Medicaid plan under title XIX of the Social Se-
9 curity Act or a waiver of such a plan, or under
10 a State plan under subpart 1 of part B or part
11 E of title IV of the Social Security Act).

12 “(F) The eligible entity is supported by the
13 State agency with primary responsibility for be-
14 havioral health to ensure that comprehensive
15 school-based mental health program carried out
16 under this section will be sustainable after
17 funding under this section terminates.

18 “(G) The comprehensive school-based men-
19 tal health program carried out under this sec-
20 tion will be coordinated with early intervening
21 activities carried out under the Individuals with
22 Disabilities Education Act or activities funded
23 under part A of title IV of the Elementary and
24 Secondary Education Act of 1965.

1 “(H) The comprehensive school-based
2 mental health program carried out under this
3 section will be coordinated with early inter-
4 vening activities carried out under the Individ-
5 uals with Disabilities Education Act.

6 “(I) The comprehensive school-based men-
7 tal health program carried out under this sec-
8 tion will be trauma informed, evidence based,
9 and developmentally, culturally, and linguis-
10 tically appropriate.

11 “(J) The comprehensive school-based men-
12 tal health program carried out under this sec-
13 tion will include a broad needs assessment of
14 youth who drop out or are expelled from school
15 due to policies of ‘zero tolerance’ with respect
16 to drugs, alcohol, or weapons and an inability
17 to obtain appropriate services.

18 “(K) The mental health services provided
19 through the comprehensive school-based mental
20 health program carried out under this section
21 will be provided by qualified mental and behav-
22 ioral health professionals who are—

23 “(i) certified, credentialed, or licensed
24 by the State involved in compliance with
25 applicable Federal and State law; and

1 “(ii) practicing within their area of
2 expertise.

3 “(L) The comprehensive school-based men-
4 tal health program carried out under this sec-
5 tion will permit students to self-refer to the pro-
6 gram for mental health care and self-consent
7 for mental health crisis care to the extent per-
8 mitted by State or other applicable law.

9 “(3) COORDINATOR.—Any entity that is a
10 member of a partnership described in paragraph
11 (1)(A) may serve as the coordinator of funding and
12 activities under the grant if all members of the part-
13 nership agree.

14 “(4) COMPLIANCE WITH HIPAA.—A grantee
15 under this section shall be deemed to be a covered
16 entity for purposes of compliance with the regula-
17 tions promulgated under section 264(c) of the
18 Health Insurance Portability and Accountability Act
19 of 1996 with respect to any patient records devel-
20 oped through activities under the grant.

21 “(5) COMPLIANCE WITH FERPA.—Section 444
22 of the General Education Provisions Act (commonly
23 known as the ‘Family Educational Rights and Pri-
24 vacy Act of 1974’) shall apply to any entity that is
25 a member of the partnership in the same manner

1 that such section applies to an educational agency or
2 institution (as that term is defined in such section).

3 “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary
4 shall ensure that grants, contracts, or cooperative agree-
5 ments under subsection (a) will be distributed equitably
6 among the regions of the country and among urban and
7 rural areas.

8 “(e) DURATION OF AWARDS.—With respect to the
9 award of a grant, contract, or cooperative agreement
10 under subsection (a), the award shall be for a period of
11 5 years and may be renewed for subsequent 5-year peri-
12 ods.

13 “(f) EVALUATION AND MEASURES OF OUTCOMES.—

14 “(1) DEVELOPMENT OF PROCESS.—The Assist-
15 ant Secretary shall develop a fiscally appropriate
16 process for evaluating activities carried out under
17 this section. Such process shall include—

18 “(A) the development of guidelines for the
19 submission of program data by grant, contract,
20 or cooperative agreement recipients;

21 “(B) the development of measures of out-
22 comes (in accordance with paragraph (2)) to be
23 applied by such recipients in evaluating pro-
24 grams carried out under this section; and

1 “(C) the submission of annual reports by
2 such recipients concerning the effectiveness of
3 programs carried out under this section.

4 “(2) MEASURES OF OUTCOMES.—

5 “(A) IN GENERAL.—The Assistant Sec-
6 retary shall develop measures of outcomes to be
7 applied by recipients of assistance under this
8 section, and the Assistant Secretary, in evalu-
9 ating the effectiveness of programs carried out
10 under this section. Such measures shall include
11 student and family measures as provided for in
12 subparagraph (B) and local educational meas-
13 ures as provided for under subparagraph (C).

14 “(B) STUDENT AND FAMILY MEASURES OF
15 OUTCOMES.—The measures of outcomes devel-
16 oped under paragraph (1)(B) relating to stu-
17 dents and families shall, with respect to activi-
18 ties and interventions carried out under a pro-
19 gram under this section, at a minimum include
20 provisions to evaluate whether the program is
21 effective in—

22 “(i) enhancing the social skills and
23 emotional resilience of all students, as well
24 as providing support to students who expe-
25 rience peer-inflicted bullying and isolation;

1 “(ii) improving academic outcomes,
2 including as measured by proficiency on
3 the annual assessments under section
4 1111(b)(2) of the Elementary and Sec-
5 ondary Education Act of 1965;

6 “(iii) reducing the incidence of behav-
7 iors that harm the self or others, or other-
8 wise disrupt the learning environment of
9 other students, when such behavior cannot
10 be reduced by the presence of reasonable
11 accommodations;

12 “(iv) improving participation and en-
13 gagement in classroom activities in chil-
14 dren with mental health conditions;

15 “(v) reducing substance use disorders;

16 “(vi) reducing rates of suicide;

17 “(vii) reducing suspensions, truancy,
18 expulsions, and violence;

19 “(viii) increasing high school gradua-
20 tion rates, calculated using the four-year
21 adjusted cohort graduation rate or the ex-
22 tended-year adjusted cohort graduation
23 rate (as such terms are defined in section
24 8101 of the Elementary and Secondary
25 Education Act of 1965); and

1 “(ix) improving attendance rates and
2 rates of chronic absenteeism;

3 “(x) improving access to care for men-
4 tal health conditions, including access to
5 mental health services that are trauma-in-
6 formed, and developmentally, linguistically,
7 and culturally appropriate;

8 “(xi) improving health outcomes; and

9 “(xii) decreasing disparities among
10 vulnerable and protected populations in
11 outcomes described in clauses (i) through
12 (xi).

13 “(C) LOCAL EDUCATIONAL OUTCOMES.—

14 The outcome measures developed under para-
15 graph (1)(B) relating to local educational sys-
16 tems shall, with respect to activities carried out
17 under a program under this section, at a min-
18 imum include provisions to evaluate—

19 “(i) the effectiveness of comprehensive
20 school mental health programs established
21 under this section;

22 “(ii) the effectiveness of formal part-
23 nership linkages among child and family
24 serving institutions, community support
25 systems, and the educational system;

1 “(iii) the progress made in sustaining
2 the program once funding under the grant
3 has expired;

4 “(iv) the effectiveness of training and
5 professional development programs for all
6 school personnel that incorporate indica-
7 tors that measure cultural and linguistic
8 competencies under the program in a man-
9 ner that incorporates appropriate cultural
10 and linguistic training;

11 “(v) the improvement in perception of
12 a safe and supportive learning environment
13 among school staff, students, and parents;

14 “(vi) the improvement in case-finding
15 of students in need of more intensive serv-
16 ices and referral of identified students to
17 early intervention and clinical services;

18 “(vii) the improvement in the imme-
19 diate availability of clinical assessment and
20 treatment services within the context of
21 the local community to students posing a
22 danger to themselves or others;

23 “(viii) the increased successful matric-
24 ulation to postsecondary school;

25 “(ix) reduced suicide rates;

1 “(x) referrals to juvenile justice; and

2 “(xi) increased educational equity.

3 “(3) SUBMISSION OF ANNUAL DATA.—An eligi-
4 ble entity described in subsection (c) that receives a
5 grant, contract, or cooperative agreement under this
6 section shall annually submit to the Assistant Sec-
7 retary a report that includes data to evaluate the
8 success of the program carried out by the entity
9 based on whether such program is achieving the pur-
10 poses of the program. Such reports shall utilize the
11 measures of outcomes under paragraph (2) in a rea-
12 sonable manner to demonstrate the progress of the
13 program in achieving such purposes.

14 “(4) EVALUATION BY ASSISTANT SECRETARY.—
15 Based on the data submitted under paragraph (3),
16 the Assistant Secretary shall annually submit to
17 Congress a report concerning the results and effec-
18 tiveness of the programs carried out with assistance
19 received under this section.

20 “(5) LIMITATION.—An eligible entity shall use
21 not more than 20 percent of amounts received under
22 a grant under this section to carry out evaluation
23 activities under this subsection.

24 “(g) INFORMATION AND EDUCATION.—The Sec-
25 retary shall establish comprehensive information and edu-

1 cation programs to disseminate the findings of the knowl-
2 edge development and application under this section to the
3 general public and to health care professionals.

4 “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF
5 APPROPRIATIONS.—

6 “(1) AMOUNT OF GRANTS.—A grant under this
7 section shall be in an amount that is not more than
8 \$2,000,000 for each of the first 5 fiscal years fol-
9 lowing the date of enactment of the Mental Health
10 Services for Students Act of 2019. The Secretary
11 shall determine the amount of each such grant based
12 on the population of children up to age 21 of the
13 area to be served under the grant.

14 “(2) AUTHORIZATION OF APPROPRIATIONS.—
15 There is authorized to be appropriated to carry out
16 this section \$200,000,000 for each of the first 5 fis-
17 cal years following the date of enactment of the Im-
18 migrants’ Mental Health Act of 2020.”.

19 (d) CONFORMING AMENDMENT.—Part G of title V
20 of the Public Health Service Act (42 U.S.C. 290hh et
21 seq.), as amended by this section, is further amended by
22 striking the part heading and inserting the following:

1 **“PART G—SCHOOL-BASED MENTAL HEALTH”.**

2 **SEC. 609. BUILDING AN EFFECTIVE WORKFORCE IN MEN-**
3 **TAL HEALTH.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services, in coordination with the Assistant Sec-
6 retary for Mental Health and Substance Use, the Adminis-
7 trator of the Health Resources and Services Administra-
8 tion, and the Secretary of Labor, shall, in coordination
9 with advocacy and behavioral and mental health organiza-
10 tions serving people of color—

11 (1) develop, strengthen, and implement strate-
12 gies to bolster career pathways for mental health
13 professionals; and

14 (2) identify the breadth of settings where men-
15 tal and behavioral health care can take place.

16 (b) CONTENTS.—Strategies under subsection (a)
17 shall include—

18 (1) the variety of settings where mental health
19 professionals are needed, including community-based
20 organizations, women’s centers, shelters, organiza-
21 tions focused on youth development, workforce agen-
22 cies, job placement and development centers, emer-
23 gency rooms, the special supplemental nutrition pro-
24 gram for women, infants, and children under section
25 17 of the Child Nutrition Act of 1966 (42 U.S.C.
26 1786), food banks, legal aid, and benefit issuers as

1 defined in section 3 of the Food and Nutrition Act
2 of 2008 (7 U.S.C. 2012);

3 (2) defining career pathways in mental and be-
4 havioral health, to help communities understand the
5 variety of careers in mental health that are avail-
6 able;

7 (3) building career pathways in mental and be-
8 havioral health as part of the curriculum at the
9 postsecondary education level;

10 (4) providing accessible training and certifi-
11 cation pathways for lay health workers such as com-
12 munity health workers and other peer support indi-
13 viduals to ensure that careers pay a living wage;

14 (5) creating incentives for students in the fields
15 of occupational therapy, social work, medicine, and
16 nursing to learn more about mental health, and to
17 include a mental health rotation as a part of the
18 health professional curricula;

19 (6) including training and education for teach-
20 ers about the basics of section 504 of the Rehabilita-
21 tion Act of 1973 (29 U.S.C. 794) and individualized
22 education programs (as defined in section 614(d) of
23 the Individuals with Disabilities in Education Act
24 (20 U.S.C. 1414(d));

1 (7) researching, developing, and implementing
2 programs for mental and behavioral health profes-
3 sionals to prevent burnout;

4 (8) finding better and increased avenues to en-
5 sure equity by providing better loan forgiveness pro-
6 grams, including a focus area within the National
7 Health Service Corps focused on community trauma.

8 **SEC. 610. MENTAL HEALTH AT THE BORDER.**

9 (a) SHORT TITLE.—This section may be cited as the
10 “Immigrants’ Mental Health Act of 2020”.

11 (b) TRAINING FOR CERTAIN CBP PERSONNEL IN
12 MENTAL HEALTH ISSUES.—

13 (1) TRAINING TO IDENTIFY RISK FACTORS AND
14 WARNING SIGNS IN IMMIGRANTS AND REFUGEES.—

15 (A) IN GENERAL.—The Commissioner of
16 U.S. Customs and Border Protection, in con-
17 sultation with the Assistant Secretary for Men-
18 tal Health and Substance Use, the Adminis-
19 trator of the Health Resources and Services Ad-
20 ministration, and nongovernmental experts in
21 the delivery of health care in humanitarian cri-
22 ses and in the delivery of health care to chil-
23 dren, shall develop and implement a training
24 curriculum for U.S. Customs and Border Pro-
25 tection agents and officers assigned to U.S.

1 Customs and Border Protection facilities to en-
2 able such agents and officers to identify the
3 risk factors and warning signs in immigrants
4 and refugees of mental health issues relating to
5 trauma.

6 (B) REQUIREMENTS.—The training cur-
7 riculum described in subparagraph (A) shall—

8 (i) apply to all U.S. Customs and
9 Border Protection agents and officers
10 working at U.S. Customs and Border Pro-
11 tection facilities;

12 (ii) provide for crisis intervention
13 using a trauma-informed approach; and

14 (iii) provide for mental health
15 screenings for immigrants and refugees ar-
16 riving at the border in their preferred lan-
17 guage or with appropriate language assist-
18 ance.

19 (2) TRAINING TO ADDRESS MENTAL HEALTH
20 AND WELLNESS OF CBP AGENTS AND OFFICERS.—

21 (A) IN GENERAL.—The Commissioner of
22 U.S. Customs and Border Protection, in con-
23 sultation with the Assistant Secretary for Men-
24 tal Health and Substance Use, the Adminis-
25 trator of the Health Resources and Services Ad-

1 ministration, and nongovernmental experts in
2 the delivery of mental health care, shall develop
3 and implement a training curriculum for U.S.
4 Customs and Border Protection agents and offi-
5 cers assigned to U.S. Customs and Border Pro-
6 tection facilities to address the mental health
7 and wellness of individuals working at such fa-
8 cilities.

9 (B) REQUIREMENT.—The training cur-
10 riculum described in subparagraph (A) shall be
11 designed to help U.S. Customs and Border Pro-
12 tection agents and officers working at U.S.
13 Customs and Border Protection facilities to—

14 (i) better manage their own stress and
15 the stress of their coworkers; and

16 (ii) be more aware of the psychological
17 pressures experienced during their jobs.

18 (3) ANNUAL REVIEW OF TRAINING.—Beginning
19 with respect to fiscal year 2022, the Assistant Sec-
20 retary for Mental Health and Substance Use shall—

21 (A) conduct an annual review of the train-
22 ing implemented pursuant to paragraphs (1)
23 and (2); and

1 (B) submit the results of each such review,
2 including any recommendations for improve-
3 ment of such training, to—

4 (i) the Commissioner of U.S. Customs
5 and Border Protection; and

6 (ii) the Committees on Appropria-
7 tions, Energy and Commerce, Homeland
8 Security, and the Judiciary of the House
9 of Representatives and the Committees on
10 Appropriations, Health, Education, Labor,
11 and Pensions, and Homeland Security and
12 Governmental Affairs of the Senate.

13 (4) AUTHORIZATION OF APPROPRIATIONS.—To
14 carry out this subsection, there is authorized to be
15 appropriated—

16 (A) for fiscal year 2021, \$50,000 to de-
17 velop the training under paragraphs (1) and
18 (2); and

19 (B) for each of fiscal years 2022 through
20 2026—

21 (i) \$20,000 to implement such train-
22 ing pursuant to paragraphs (1) and (2);
23 and

1 (ii) such sums as may be necessary to
2 review and make recommendations for
3 such training pursuant to paragraph (3).

4 (c) STAFFING BORDER FACILITIES AND DETENTION
5 CENTERS.—

6 (1) IN GENERAL.—To adequately evaluate the
7 mental health needs of immigrants, refugees, border
8 patrol agents, and staff, the Commissioner of U.S.
9 Customs and Border Protection shall assign at least
10 one qualified mental or behavioral health expert to
11 each U.S. Customs and Border Protection facility.

12 (2) QUALIFICATIONS.—To be qualified for pur-
13 poses of paragraph (1), a mental or behavioral
14 health expert shall be—

15 (A) bilingual;

16 (B) well-versed in culturally appropriate
17 and trauma-informed interventions; and

18 (C) have particular expertise in child or
19 adolescent mental health or family mental
20 health.

21 (3) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this subsection, there is authorized to be
23 appropriated \$3,000,000 for each of fiscal years
24 2021 through 2025.

1 (d) NO SHARING OF DEPARTMENT OF HEALTH AND
2 HUMAN SERVICES MENTAL HEALTH INFORMATION FOR
3 ASYLUM DETERMINATIONS, IMMIGRATION HEARINGS, OR
4 DEPORTATION PROCEEDINGS.—The officers, employees,
5 and agents of the Department of Health and Human Serv-
6 ices, including the Office of Refugee Resettlement, may
7 not share with the Department of Homeland Security, and
8 the officers, employees, and agents of the Department of
9 Homeland Security may not request or receive from the
10 Department of Health and Human Services, for the pur-
11 poses of an asylum determination, immigration hearing,
12 or deportation proceeding, any information or record
13 that—

14 (1) concerns the mental health of an alien; and
15 (2) was obtained or produced by a mental or
16 behavioral health professional while the alien was in
17 a shelter or otherwise in the custody of the Federal
18 Government.

19 (e) DEFINITIONS.—In this section:

20 (1) The term “U.S. Customs and Border Pro-
21 tection facility” means any of the following facilities
22 that typically detain migrants on behalf of U.S. Cus-
23 toms and Border Protection:

24 (A) U.S. Border Patrol stations.

25 (B) Ports of entry.

1 (C) Checkpoints.

2 (D) Forward operating bases.

3 (E) Secondary inspection areas.

4 (F) Short-term custody facilities.

5 (2) The term “forward operating base” means
6 a permanent facility established by U.S. Customs
7 and Border Protection in forward or remote loca-
8 tions, and designated as such by U.S. Customs and
9 Border Protection.

10 **TITLE VII—ADDRESSING HIGH-**
11 **IMPACT MINORITY DISEASES**

12 **Subtitle A—Cancer**

13 **SEC. 701. LUNG CANCER MORTALITY REDUCTION.**

14 (a) SHORT TITLE.—This section may be cited as the
15 “Lung Cancer Mortality Reduction Act of 2020”.

16 (b) FINDINGS.—Congress makes the following find-
17 ings:

18 (1) Lung cancer is the leading cause of cancer
19 death for both men and women, accounting for 25
20 percent of all cancer deaths.

21 (2) Lung cancer kills more people annually
22 than breast cancer, prostate cancer, colon cancer,
23 liver cancer, melanoma, and kidney cancer combined.

24 (3) Since the National Cancer Act of 1971
25 (Public Law 92–218; 85 Stat. 778), coordinated and

1 comprehensive research has raised the 5-year sur-
2 vival rates for breast cancer to 90 percent, for pros-
3 tate cancer to 99 percent, and for colon cancer to
4 64 percent.

5 (4) The 5-year survival rate for lung cancer is
6 still only 18 percent, and a similar coordinated and
7 comprehensive research effort is required to achieve
8 increases in lung cancer survivability rates.

9 (5) Sixty percent of lung cancer cases are now
10 diagnosed in nonsmokers or former smokers.

11 (6) Two-thirds of nonsmokers diagnosed with
12 lung cancer are women.

13 (7) Certain minority populations, such as Afri-
14 can-American males, have disproportionately high
15 rates of lung cancer incidence and mortality, despite
16 their smoking rate being similar to other racial
17 groups.

18 (8) Members of the Baby Boomer Generation
19 are entering their 60s, the most common age at
20 which people develop lung cancer.

21 (9) Tobacco addiction and exposure to other
22 lung cancer carcinogens such as Agent Orange and
23 other herbicides and battlefield emissions are serious
24 problems among military personnel and war vet-
25 erans.

1 (10) Significant and rapid improvements in
2 lung cancer mortality can be expected through great-
3 er use and access to lung cancer screening tests for
4 at-risk individuals.

5 (11) Recent research has shown that screening
6 with low-dose computed tomography scan reduced
7 lung cancer death mortality by 20 percent for those
8 with a high risk of lung cancer through early detec-
9 tion. The Centers for Medicare & Medicaid Services
10 supports annual lung cancer screening for high-risk
11 patients with low-dose computed tomography.

12 (12) Additional strategies are necessary to fur-
13 ther enhance the existing tests and therapies avail-
14 able to diagnose and treat lung cancer in the future.

15 (13) The August 2001 Report of the Lung
16 Cancer Progress Review Group of the National Can-
17 cer Institute stated that funding for lung cancer re-
18 search was “far below the levels characterized for
19 other common malignancies and far out of propor-
20 tion to its massive health impact”.

21 (14) The Report of the Lung Cancer Progress
22 Review Group identified as its “highest priority” the
23 creation of integrated, multidisciplinary, multi-insti-
24 tutional research consortia organized around the

1 problem of lung cancer rather than around specific
2 research disciplines.

3 (15) The United States must enhance its re-
4 sponse to the issues raised in the Report of the
5 Lung Cancer Progress Review Group, and this can
6 be accomplished through the establishment of a co-
7 ordinated effort designed to reduce the lung cancer
8 mortality rate by 50 percent by 2020 and targeted
9 funding to support this coordinated effort.

10 (c) SENSE OF CONGRESS CONCERNING INVESTMENT
11 IN LUNG CANCER RESEARCH.—It is the sense of the Con-
12 gress that—

13 (1) lung cancer mortality reduction should be
14 made a national public health priority; and

15 (2) a comprehensive mortality reduction pro-
16 gram coordinated by the Secretary of Health and
17 Human Services is justified and necessary to ade-
18 quately address and reduce lung cancer mortality.

19 (d) LUNG CANCER MORTALITY REDUCTION PRO-
20 GRAM.—

21 (1) IN GENERAL.—Subpart 1 of part C of title
22 IV of the Public Health Service Act (42 U.S.C. 285
23 et seq.) is amended by adding at the end the fol-
24 lowing:

1 **“SEC. 417H. LUNG CANCER MORTALITY REDUCTION PRO-**
2 **GRAM.**

3 “(a) IN GENERAL.—Not later than 6 months after
4 the date of the enactment of the Health Equity and Ac-
5 countability Act of 2020, the Secretary, in consultation
6 with the Secretary of Defense, the Secretary of Veterans
7 Affairs, the Director of the National Institutes of Health,
8 the Director of the Centers for Disease Control and Pre-
9 vention, the Commissioner of Food and Drugs, the Admin-
10 istrator of the Centers for Medicare & Medicaid Services,
11 the Director of the National Institute on Minority Health
12 and Health Disparities, and other members of the Lung
13 Cancer Advisory Board established under section 701 of
14 the Health Equity and Accountability Act of 2020, shall
15 implement a comprehensive program, to be known as the
16 Lung Cancer Mortality Reduction Program, to achieve a
17 reduction of at least 25 percent in the mortality rate of
18 lung cancer by 2020.

19 “(b) REQUIREMENTS.—The Program shall include at
20 least the following:

21 “(1) With respect to the National Institutes of
22 Health—

23 “(A) a strategic review and prioritization
24 by the National Cancer Institute of research
25 grants to achieve the goal of the Lung Cancer

1 Mortality Reduction Program in reducing lung
2 cancer mortality;

3 “(B) the provision of funds to enable the
4 Airway Biology and Disease Branch of the Na-
5 tional Heart, Lung, and Blood Institute to ex-
6 pand its research programs to include pre-
7 dispositions to lung cancer, the interrelationship
8 between lung cancer and other pulmonary and
9 cardiac disease, and the diagnosis and treat-
10 ment of those interrelationships;

11 “(C) the provision of funds to enable the
12 National Institute of Biomedical Imaging and
13 Bioengineering to expedite the development of
14 computer-assisted diagnostic, surgical, treat-
15 ment, and drug-testing innovations to reduce
16 lung cancer mortality, such as through expan-
17 sion of the Institute’s Quantum Grant Program
18 and Image-Guided Interventions programs; and

19 “(D) the provision of funds to enable the
20 National Institute of Environmental Health
21 Sciences to implement research programs rel-
22 ative to the lung cancer incidence.

23 “(2) With respect to the Food and Drug Ad-
24 ministration—

1 “(A) activities under section 529B 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, and the issuance of updated guide-
16 lines.

17 “(5) The promotion (including education) of
18 lung cancer screening within minority and rural pop-
19 ulations and the study of the effectiveness of efforts
20 to increase such screening.

21 “(6) The cooperation and coordination of all
22 minority and health disparity programs within the
23 Department of Health and Human Services to en-
24 sure that all aspects of the Lung Cancer Mortality
25 Reduction Program under this section adequately

1 address the burden of lung cancer on minority and
2 rural populations.

3 “(7) The cooperation and coordination of all to-
4 bacco control and cessation programs within agen-
5 cies of the Department of Health and Human Serv-
6 ices to achieve the goals of the Lung Cancer Mor-
7 tality Reduction Program under this section with
8 particular emphasis on the coordination of drug and
9 other cessation treatments with early detection pro-
10 tocols.”.

11 (2) FEDERAL FOOD, DRUG, AND COSMETIC
12 ACT.—Subchapter B of chapter V of the Federal
13 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
14 seq.) is amended by adding at the end the following:

15 **“SEC. 529B. DRUGS RELATING TO LUNG CANCER.**

16 “(a) IN GENERAL.—The provisions of this sub-
17 chapter shall apply to a drug described in subsection (b)
18 to the same extent and in the same manner as such provi-
19 sions apply to a drug for a rare disease or condition.

20 “(b) QUALIFIED DRUGS.—A drug described in this
21 subsection is—

22 “(1) a chemoprevention drug for precancerous
23 conditions of the lung;

24 “(2) a drug for targeted therapeutic treat-
25 ments, including any vaccine, for lung cancer; or

1 at the high incidence and mortality rates of lung cancer
2 among minority and low-income populations.”.

3 (e) DEPARTMENT OF DEFENSE AND THE DEPART-
4 MENT OF VETERANS AFFAIRS.—The Secretary of Defense
5 and the Secretary of Veterans Affairs, each in coordina-
6 tion with the Secretary of Health and Human Services,
7 shall engage—

8 (1) in the implementation within the Depart-
9 ment of Defense and the Department of Veterans
10 Affairs of an early detection and disease manage-
11 ment research program for military personnel and
12 veterans whose smoking history and exposure to car-
13 cinogens during active duty service has increased
14 their risk for lung cancer; and

15 (2) in the implementation of coordinated care
16 programs for military personnel and veterans diag-
17 nosed with lung cancer.

18 (f) LUNG CANCER ADVISORY BOARD.—

19 (1) IN GENERAL.—The Secretary of Health and
20 Human Services shall convene a Lung Cancer Advi-
21 sory Board (referred to in this section as the
22 “Board”)—

23 (A) to monitor the programs established
24 under this section (and the amendments made
25 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 prised 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) 2 representatives each from the fields
12 of clinical medicine focused on lung cancer,
13 lung cancer research, imaging, drug develop-
14 ment, and lung cancer advocacy, to be ap-
15 pointed by the Secretary of Health and Human
16 Services.

17 (g) AUTHORIZATION OF APPROPRIATIONS.—

18 (1) IN GENERAL.—To carry out this section
19 (and the amendments made by this section), there
20 are authorized to be appropriated \$75,000,0000 for
21 fiscal year 2021 and such sums as may be necessary
22 for each of fiscal years 2022 through 2025.

23 (2) LUNG CANCER MORTALITY REDUCTION PRO-
24 GRAM.—The amounts appropriated under paragraph
25 (1) shall be allocated as follows:

1 (A) \$25,000,000 for fiscal year 2021, and
2 such sums as may be necessary for each of fis-
3 cal years 2022 through 2025, for the activities
4 described in section 417H(b)(1)(B) of the Pub-
5 lic Health Service Act, as added by subsection
6 (d);

7 (B) \$25,000,000 for fiscal year 2021, and
8 such sums as may be necessary for each of fis-
9 cal years 2022 through 2025, for the activities
10 described in section 417H(b)(1)(C) of the Pub-
11 lic Health Service Act;

12 (C) \$10,000,000 for fiscal year 2021, and
13 such sums as may be necessary for each of fis-
14 cal years 2022 through 2025, for the activities
15 described in section 417H(b)(1)(D) of the Pub-
16 lic Health Service Act; and

17 (D) \$15,000,000 for fiscal year 2021, and
18 such sums as may be necessary for each of fis-
19 cal years 2022 through 2025, for the activities
20 described in section 417H(b)(3) of the Public
21 Health Service Act.

1 **SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUT-**
2 **REACH, SCREENING, TESTING, ACCESS, AND**
3 **TREATMENT EFFECTIVENESS.**

4 (a) **SHORT TITLE.**—This section may be cited as the
5 “Prostate Research, Outreach, Screening, Testing, Access,
6 and Treatment Effectiveness Act of 2020” or the “PROS-
7 TATE Act”.

8 (b) **FINDINGS.**—Congress makes the following find-
9 ings:

10 (1) Prostate cancer is the second leading cause
11 of cancer death among men.

12 (2) In 2018, an estimated 164,690 men will be
13 diagnosed with prostate cancer and more than
14 29,000 will die from this disease.

15 (3) Roughly 2,000,000 to 3,000,000 people in
16 the United States are living with a diagnosis of pros-
17 tate cancer and its consequences.

18 (4) While prostate cancer generally affects older
19 individuals, younger men are also at risk for the dis-
20 ease, and when prostate cancer appears in early
21 middle age, it frequently takes on a more aggressive
22 form.

23 (5) There are significant racial and ethnic dis-
24 parities that demand attention; African Americans
25 have prostate cancer mortality rates that are more
26 than double those in the White population.

1 (6) Underserved rural populations have higher
2 rates of mortality compared to their urban counter-
3 parts, and innovative and cost-efficient methods to
4 improve rural access to high-quality care should take
5 advantage of advances in telehealth to diagnose and
6 treat prostate cancer when appropriate.

7 (7) Certain veterans populations may have
8 nearly twice the incidence of prostate cancer as the
9 general population of the United States.

10 (8) Urologists may constitute the specialists
11 who diagnose and treat the vast majority of prostate
12 cancer patients.

13 (9) Although much basic and translational re-
14 search has been completed and much is currently
15 known, there are still many unanswered questions,
16 such as the extent to which known disparities are at-
17 tributable to disease etiology, access to care, or edu-
18 cation and awareness in the community.

19 (10) Causes of prostate cancer are not known.
20 There is not good information regarding how to dif-
21 ferentiate accurately, early on, between aggressive
22 and indolent forms of the disease. As a result, there
23 is significant overtreatment in prostate cancer.
24 There are no treatments that can durably arrest

1 growth or cure prostate cancer once it has metasta-
2 sized.

3 (11) A significant proportion (about 23 to 54
4 percent) of cases may be clinically indolent and
5 “overdiagnosed”, resulting in significant overtreat-
6 ment. More accurate tests will allow men and their
7 families to face less physical, psychological, financial,
8 and emotional trauma, and billions of dollars could
9 be saved in private and public health care systems
10 in an area that has been identified by the Medicare
11 program under title XVIII of the Social Security Act
12 (42 U.S.C. 1395 et seq.) as one of 8 high-volume,
13 high-cost areas in the Resource Utilization Report
14 Program established under the Medicare Improve-
15 ments for Patients and Providers Act of 2008 (Pub-
16 lic Law 110–275).

17 (12) Prostate cancer research and health care
18 programs across Federal agencies should be coordi-
19 nated to improve accountability and actively encour-
20 age the translation of research into practice, to iden-
21 tify and implement best practices, in order to foster
22 an integrated and consistent focus on effective pre-
23 vention, diagnosis, and treatment of this disease.

24 (c) PROSTATE CANCER COORDINATION AND EDU-
25 CATION.—

1 (1) INTERAGENCY PROSTATE CANCER COORDI-
2 NATION AND EDUCATION TASK FORCE.—Not later
3 than 180 days after the date of the enactment of
4 this section, the Secretary of Veterans Affairs, in co-
5 operation with the Secretary of Defense and the Sec-
6 retary of Health and Human Services, shall estab-
7 lish an Interagency Prostate Cancer Coordination
8 and Education Task Force (in this section referred
9 to as the “Prostate Cancer Task Force”).

10 (2) DUTIES.—The Prostate Cancer Task Force
11 shall—

12 (A) develop a summary of advances in
13 prostate cancer research supported or con-
14 ducted by Federal agencies relevant to the diag-
15 nosis, prevention, and treatment of prostate
16 cancer, including psychosocial impairments re-
17 lated to prostate cancer treatment, and compile
18 a list of best practices that warrant broader
19 adoption in health care programs;

20 (B) consider establishing, and advocating
21 for, a guidance to enable physicians to allow
22 screening of men who are over age 74, on a
23 case-by-case basis, taking into account quality
24 of life and family history of prostate cancer;

1 (C) share and coordinate information on
2 Federal research and health care program ac-
3 tivities, including activities related to—

4 (i) determining how to improve re-
5 search and health care programs, including
6 psychosocial impairments related to pros-
7 tate cancer treatment;

8 (ii) identifying any gaps in the overall
9 research inventory and in health care pro-
10 grams;

11 (iii) identifying opportunities to pro-
12 mote translation of research into practice;
13 and

14 (iv) maximizing the effects of Federal
15 efforts by identifying opportunities for col-
16 laboration and leveraging of resources in
17 research and health care programs that
18 serve individuals who are susceptible to or
19 diagnosed with prostate cancer;

20 (D) develop a comprehensive interagency
21 strategy and advise relevant Federal agencies in
22 the solicitation of proposals for collaborative,
23 multidisciplinary research and health care pro-
24 grams, including proposals to evaluate factors

1 that may be related to the etiology of prostate
2 cancer, that would—

3 (i) result in innovative approaches to
4 study emerging scientific opportunities or
5 eliminate knowledge gaps in research to
6 improve the prostate cancer research port-
7 folio of the Federal Government;

8 (ii) outline key research questions,
9 methodologies, and knowledge gaps; and

10 (iii) ensure consistent action, as out-
11 lined by section 402(b) of the Public
12 Health Service Act;

13 (E) develop a coordinated message related
14 to screening and treatment for prostate cancer
15 to be reflected in educational and beneficiary
16 materials for Federal health programs as such
17 documents are updated; and

18 (F) not later than 2 years after the date
19 of the establishment of the Prostate Cancer
20 Task Force, submit to the Expert Advisory
21 Panel to be reviewed and returned within 30
22 days, and then within 90 days submitted to
23 Congress recommendations—

24 (i) regarding any appropriate changes
25 to research and health care programs, in-

1 cluding recommendations to improve the
2 research portfolio of the Department of
3 Veterans Affairs, the Department of De-
4 fense, National Institutes of Health, and
5 other Federal agencies to ensure that sci-
6 entifically based strategic planning is im-
7 plemented in support of research and
8 health care program priorities;

9 (ii) designed to ensure that the re-
10 search and health care programs and ac-
11 tivities of the Department of Veterans Af-
12 fairs, the Department of Defense, the De-
13 partment of Health and Human Services,
14 and other Federal agencies are free of un-
15 necessary duplication;

16 (iii) regarding public participation in
17 decisions relating to prostate cancer re-
18 search and health care programs to in-
19 crease the involvement of patient advo-
20 cates, community organizations, and med-
21 ical associations representing a broad geo-
22 graphical area;

23 (iv) on how to best disseminate infor-
24 mation on prostate cancer research and
25 progress achieved by health care programs;

1 (v) about how to expand partnerships
2 between public entities, including Federal
3 agencies, and private entities to encourage
4 collaborative, cross-cutting research and
5 health care delivery;

6 (vi) assessing any cost savings and ef-
7 ficiencies realized through the efforts iden-
8 tified and supported in this section and
9 recommending expansion of those efforts
10 that have proved most promising while also
11 ensuring against any conflicts in directives
12 from other congressional or statutory man-
13 dates or enabling statutes;

14 (vii) identifying key priority action
15 items from among the recommendations;
16 and

17 (viii) with respect to the level of fund-
18 ing needed by each agency to implement
19 the recommendations contained in the re-
20 port.

21 (3) MEMBERS OF THE PROSTATE CANCER TASK
22 FORCE.—The Prostate Cancer Task Force described
23 in this subsection shall be comprised of representa-
24 tives from such Federal agencies, as each head of
25 such applicable agencies determines necessary, to co-

1 ordinate a uniform message relating to prostate can-
2 cer screening and treatment where appropriate, in-
3 cluding representatives of the following:

4 (A) The Department of Veterans Affairs,
5 including representatives of each relevant pro-
6 gram area of the Department of Veterans Af-
7 fairs.

8 (B) The Prostate Cancer Research Pro-
9 gram of the Congressionally Directed Medical
10 Research program of the Department of De-
11 fense.

12 (C) The Department of Health and
13 Human Services, including at a minimum rep-
14 resentatives of each of the following:

15 (i) The National Institutes of Health.

16 (ii) National research institutes and
17 centers, including the National Cancer In-
18 stitute, the National Institute of Allergy
19 and Infectious Diseases, and the Office of
20 Minority Health.

21 (iii) The Centers for Medicare & Med-
22 icaid Services.

23 (iv) The Food and Drug Administra-
24 tion.

1 (v) The Centers for Disease Control
2 and Prevention.

3 (vi) The Agency for Healthcare Re-
4 search and Quality.

5 (vii) The Health Resources and Serv-
6 ices Administration.

7 (4) APPOINTING EXPERT ADVISORY PANELS.—
8 The Prostate Cancer Task Force shall appoint ex-
9 pert advisory panels, as such task force determines
10 appropriate, to provide input and concurrence from
11 individuals and organizations from the medical,
12 prostate cancer patient and advocate, research, and
13 delivery communities with expertise in prostate can-
14 cer diagnosis, treatment, and research, including
15 practicing urologists, primary care providers, and
16 others and individuals with expertise in education
17 and outreach to underserved populations affected by
18 prostate cancer.

19 (5) MEETINGS.—The Prostate Cancer Task
20 Force shall convene not less than twice a year, or
21 more frequently as the Secretary of Veterans Affairs
22 determines to be appropriate.

23 (6) FEDERAL ADVISORY COMMITTEE ACT.—

24 (A) IN GENERAL.—Except as provided in
25 subparagraph (B), the Federal Advisory Com-

1 mittee Act (5 U.S.C. App.) shall apply to the
2 Prostate Cancer Task Force.

3 (B) EXCEPTION.—Section 14(a)(2)(B) of
4 such Act (relating to the termination of advi-
5 sory committees) shall not apply to the Prostate
6 Cancer Task Force.

7 (7) SUNSET DATE.—The Prostate Cancer Task
8 Force shall terminate on September 30, 2025.

9 (d) PROSTATE CANCER RESEARCH.—

10 (1) RESEARCH COORDINATION.—The Secretary
11 of Veterans Affairs, in coordination with the Sec-
12 retary of Defense and the Secretary of Health and
13 Human Services, shall establish and carry out a pro-
14 gram to coordinate and intensify prostate cancer re-
15 search. Such research program shall—

16 (A) develop advances in diagnostic and
17 prognostic methods and tests, including bio-
18 markers and an improved prostate cancer
19 screening blood test, including improvements or
20 alternatives to the prostate specific antigen test
21 and additional tests to distinguish indolent from
22 aggressive disease;

23 (B) develop better understanding of the
24 etiology of the disease (including an analysis of
25 lifestyle factors proven to be involved in higher

1 rates of prostate cancer, such as obesity and
2 diet, and in different ethnic, racial, and socio-
3 economic groups, such as the African-American,
4 Latino or Hispanic, and American Indian popu-
5 lations and men with a family history of pros-
6 tate cancer) to improve prevention efforts;

7 (C) expand basic research into prostate
8 cancer, including studies of fundamental molec-
9 ular and cellular mechanisms;

10 (D) identify and provide clinical testing of
11 novel agents for the prevention and treatment
12 of prostate cancer;

13 (E) establish clinical registries for prostate
14 cancer;

15 (F) use the National Institute of Bio-
16 medical Imaging and Bioengineering and the
17 National Cancer Institute for assessment of ap-
18 propriate imaging modalities; and

19 (G) address such other matters relating to
20 prostate cancer research as may be identified by
21 the Federal agencies participating in the pro-
22 gram under this subsection.

23 (2) PROSTATE CANCER ADVISORY BOARD.—

24 There is established in the Office of the Chief Sci-
25 entist of the Food and Drug Administration a Pros-

1 tate Cancer Scientific Advisory Board. Such board
2 shall be responsible for accelerating real-time shar-
3 ing of the latest research data and accelerating
4 movement of new medicines to patients.

5 (3) UNDERSERVED MINORITY GRANT PRO-
6 GRAM.—In carrying out such program, the Secretary
7 shall—

8 (A) award grants to eligible entities to
9 carry out components of the research outlined
10 in paragraph (1);

11 (B) integrate and build upon existing
12 knowledge gained from comparative effective-
13 ness research; and

14 (C) recognize and address—

15 (i) the racial and ethnic disparities in
16 the incidence and mortality rates of pros-
17 tate cancer and men with a family history
18 of prostate cancer;

19 (ii) any barriers in access to care and
20 participation in clinical trials that are spe-
21 cific to racial, ethnic, and other under-
22 served minorities and men with a family
23 history of prostate cancer;

1 (iii) outreach and educational efforts
2 to raise awareness among the populations
3 described in clause (ii); and
4 (iv) appropriate access and utilization
5 of imaging modalities.

6 (e) TELEHEALTH AND RURAL ACCESS PILOT
7 PROJECTS.—

8 (1) IN GENERAL.—The Secretary of Veterans
9 Affairs, in cooperation with the Secretary of Defense
10 and the Secretary of Health and Human Services
11 (referred to in this section collectively as the “Secre-
12 taries”) shall establish 4-year telehealth pilot
13 projects for the purpose of analyzing the clinical out-
14 comes and cost-effectiveness associated with tele-
15 health services in a variety of geographic areas that
16 contain high proportions of medically underserved
17 populations, including African Americans, Latinos or
18 Hispanics, American Indians or Alaska Natives, and
19 those in rural areas. Such projects shall promote ef-
20 ficient use of specialist care through better coordina-
21 tion of primary care and physician extender teams
22 in underserved areas and more effectively employ
23 tumor boards to better counsel patients.

24 (2) ELIGIBLE ENTITIES.—

1 (A) IN GENERAL.—The Secretaries shall
2 select eligible entities to participate in the pilot
3 projects under this section.

4 (B) PRIORITY.—In selecting eligible enti-
5 ties to participate in the pilot projects under
6 this section, the Secretaries shall give priority
7 to such entities located in medically under-
8 served areas, particularly those that include Af-
9 rican Americans, Latinos and Hispanics, and
10 facilities of the Indian Health Service, including
11 Indian Health Service-operated facilities, trib-
12 ally operated facilities, and Urban Indian Clin-
13 ics, and those in rural areas.

14 (3) EVALUATION.—The Secretaries shall,
15 through the pilot projects, evaluate—

16 (A) the effective and economic delivery of
17 care in diagnosing and treating prostate cancer
18 with the use of telehealth services in medically
19 underserved and Tribal areas including collabo-
20 rative uses of health professionals and integra-
21 tion of the range of telehealth and other tech-
22 nologies;

23 (B) the effectiveness of improving the ca-
24 pacity of nonmedical providers and nonspecial-
25 ized medical providers to provide health services

1 for prostate cancer in medically underserved
2 and Tribal areas, including the exploration of
3 innovative medical home models with collabora-
4 tion between urologists, other relevant medical
5 specialists, including oncologists, radiologists,
6 and primary care teams and coordination of
7 care through the efficient use of primary care
8 teams and physician extenders; and

9 (C) the effectiveness of using telehealth
10 services to provide prostate cancer treatment in
11 medically underserved areas, including the use
12 of tumor boards to facilitate better patient
13 counseling.

14 (4) REPORT.—Not later than 1 year after the
15 completion of the pilot projects under this sub-
16 section, the Secretaries shall submit to Congress a
17 report describing the outcomes of such pilot projects,
18 including any cost savings and efficiencies realized,
19 and providing recommendations, if any, for expand-
20 ing the use of telehealth services.

21 (f) EDUCATION AND AWARENESS.—

22 (1) IN GENERAL.—The Secretary of Veterans
23 Affairs (referred to in this subsection as the “Sec-
24 retary”) shall develop a national education campaign
25 for prostate cancer. Such campaign shall involve the

1 use of written educational materials and public serv-
2 ice announcements consistent with the findings of
3 the Prostate Cancer Task Force under subsection
4 (c), that are intended to encourage men to seek
5 prostate cancer screening when appropriate.

6 (2) RACIAL DISPARITIES AND THE POPULATION
7 OF MEN WITH A FAMILY HISTORY OF PROSTATE
8 CANCER.—In developing the national campaign
9 under paragraph (1), the Secretary shall ensure that
10 such educational materials and public service an-
11 nouncements are more readily available in commu-
12 nities experiencing racial disparities in the incidence
13 and mortality rates of prostate cancer and by men
14 of any race classification with a family history of
15 prostate cancer.

16 (3) GRANTS.—In carrying out the national
17 campaign under this section, the Secretary shall
18 award grants to nonprofit private entities to enable
19 such entities to test alternative outreach and edu-
20 cation strategies.

21 (g) AUTHORIZATION OF APPROPRIATIONS.—

22 (1) IN GENERAL.—There is authorized to be
23 appropriated to carry out this section for the period
24 of fiscal years 2021 through 2025 an amount equal
25 to the savings described in paragraph (2).

1 (2) CORRESPONDING REDUCTION.—The savings
2 described in this paragraph is the amount author-
3 ized to be appropriated by provisions of law other
4 than this section for the period of fiscal years 2021
5 through 2025 for Federal research and health care
6 program activities related to prostate cancer, re-
7 duced by the amount of Federal savings projected to
8 be achieved over such period by implementation of
9 this section.

10 **SEC. 703. PROSTATE RESEARCH, IMAGING, AND MEN’S EDU-**
11 **CATION (PRIME).**

12 (a) SHORT TITLE.—This section may be cited as the
13 “Prostate Research, Imaging, and Men’s Education Act
14 of 2020” or the “PRIME Act of 2020”.

15 (b) FINDINGS.—Congress makes the following find-
16 ings:

17 (1) Prostate cancer has reached epidemic pro-
18 portions, particularly among African-American men,
19 and strikes and kills men in numbers comparable to
20 the number of women who lose their lives from
21 breast cancer.

22 (2) Life-saving breakthroughs in screening, di-
23 agnosis, and treatment of breast cancer resulted
24 from the development of advanced imaging tech-
25 nologies led by the Federal Government.

1 (3) Men should have accurate and affordable
2 prostate cancer screening exams and minimally
3 invasive treatment tools, similar to what women have
4 for breast cancer.

5 (4) While it is important for men to take ad-
6 vantage of current prostate cancer screening tech-
7 niques, a recent NCI-funded study demonstrated
8 that the most common available methods of detect-
9 ing prostate cancer (PSA blood test and physical
10 exams) are not foolproof, causing numerous false
11 alarms and false reassurances.

12 (5) The absence of advanced imaging tech-
13 nologies for prostate cancer causes the lack of accu-
14 rate information critical for clinical decisions, result-
15 ing in missed cancers and lost lives, as well as un-
16 necessary and costly medical procedures, with re-
17 lated complications.

18 (6) With prostate imaging tools, men and their
19 families would face less physical, psychological, fi-
20 nancial and emotional trauma and billions of dollars
21 could be saved in private and public health care sys-
22 tems.

23 (c) RESEARCH AND DEVELOPMENT OF PROSTATE
24 CANCER IMAGING TECHNOLOGIES.—

1 (1) EXPANSION OF RESEARCH.—The Secretary
2 of Health and Human Services (referred to in this
3 section as the “Secretary”), acting through the Di-
4 rector of the National Institutes of Health and the
5 Administrator of the Health Resources and Services
6 Administration, and in consultation with the Sec-
7 retary of Defense, shall carry out a program to ex-
8 pand and intensify research to develop innovative
9 advanced imaging technologies for prostate cancer
10 detection, diagnosis, and treatment comparable to
11 state-of-the-art mammography technologies.

12 (2) EARLY STAGE RESEARCH.—In imple-
13 menting the program under paragraph (1), the Sec-
14 retary, acting through the Administrator of the
15 Health Resources and Services Administration, shall
16 carry out a grant program to encourage the early
17 stages of research in prostate imaging to develop
18 and implement new ideas, proof of concepts, and
19 pilot studies for high-risk technologic innovation in
20 prostate cancer imaging that would have a high po-
21 tential impact for improving patient care, including
22 individualized care, quality of life, and cost-effective-
23 ness.

24 (3) LARGE-SCALE LATER STAGE RESEARCH.—
25 In implementing the program under paragraph (1),

1 the Secretary, acting through the Director of the
2 National Institutes of Health, shall utilize the Na-
3 tional Institute of Biomedical Imaging and Bio-
4 engineering and the National Cancer Institute for
5 advanced stages of research in prostate imaging, in-
6 cluding technology development and clinical trials for
7 projects determined by the Secretary to have dem-
8 onstrated promising preliminary results and proof of
9 concept.

10 (4) INTERDISCIPLINARY PRIVATE-PUBLIC PART-
11 NERSHIPS.—In developing the program under para-
12 graph (1), the Secretary, acting through the Admin-
13 istrator of the Health Resources and Services Ad-
14 ministration, shall establish interdisciplinary private-
15 public partnerships to develop and implement re-
16 search strategies for expedited innovation in imaging
17 and image-guided treatment and to conduct such re-
18 search.

19 (5) RACIAL DISPARITIES.—In developing the
20 program under paragraph (1), the Secretary shall
21 recognize and address—

22 (A) the racial disparities in the incidences
23 of prostate cancer and mortality rates with re-
24 spect to such disease; and

1 (B) any barriers in access to care and par-
2 ticipation in clinical trials that are specific to
3 racial minorities.

4 (6) AUTHORIZATION OF APPROPRIATIONS.—

5 (A) IN GENERAL.—Subject to subpara-
6 graph (B), there is authorized to be appro-
7 priated to carry out this section \$100,000,000
8 for each of the fiscal years 2021 through 2025.

9 (B) SPECIFIC ALLOCATIONS.—Of the
10 amount authorized to be appropriated under
11 subparagraph (A) for each of the fiscal years
12 described in such paragraph—

13 (i) no less than 10 percent may be ap-
14 propriated to carry out the grant program
15 under paragraph (2); and

16 (ii) no more than 1 percent may be
17 appropriated to carry out paragraph (4).

18 (d) PUBLIC AWARENESS AND EDUCATION CAM-
19 PAIGN.—

20 (1) NATIONAL CAMPAIGN.—The Secretary shall
21 carry out a national campaign to increase the aware-
22 ness and knowledge of Americans with respect to the
23 need for prostate cancer screening and for improved
24 detection technologies.

1 (2) REQUIREMENTS.—The national campaign
2 conducted shall include—

3 (A) roles for the Health Resources Services
4 Administration, the Office on Minority Health
5 of the Department of Health and Human Serv-
6 ices, the Centers for Disease Control and Pre-
7 vention, and the Office of Minority Health of
8 the Centers for Disease Control and Prevention;
9 and

10 (B) the development and distribution of
11 written educational materials, and the develop-
12 ment and placing of public service announce-
13 ments, that are intended to encourage men to
14 seek prostate cancer screening and to create
15 awareness of the need for improved imaging
16 technologies for prostate cancer screening and
17 diagnosis, including in-vitro blood testing and
18 imaging technologies.

19 (3) RACIAL DISPARITIES.—In developing the
20 national campaign under paragraph (1), the Sec-
21 retary shall recognize and address—

22 (A) the racial disparities in the incidences
23 of prostate cancer and mortality rates with re-
24 spect to such disease; and

1 (B) any barriers in access to care and par-
2 ticipation in clinical trials that are specific to
3 racial minorities.

4 (4) GRANTS.—The Secretary shall establish a
5 program to award grants to nonprofit private enti-
6 ties to enable such entities to test alternative out-
7 reach and education strategies to increase the
8 awareness and knowledge of Americans with respect
9 to the need for prostate cancer screening and im-
10 proved imaging technologies.

11 (5) AUTHORIZATION OF APPROPRIATIONS.—
12 There is authorized to be appropriated to carry out
13 this section \$10,000,000 for each of the fiscal years
14 2021 through 2025.

15 (e) IMPROVING PROSTATE CANCER SCREENING
16 BLOOD TESTS.—

17 (1) IN GENERAL.—The Secretary, in coordina-
18 tion with the Secretary of Defense, shall carry out
19 research to develop an improved prostate cancer
20 screening blood test using in-vitro detection.

21 (2) AUTHORIZATION OF APPROPRIATIONS.—
22 There is authorized to be appropriated to carry out
23 this section, \$20,000,000 for each of fiscal years
24 2021 through 2025.

25 (f) REPORTING AND COMPLIANCE.—

1 (1) REPORT AND STRATEGY.—Not later than
2 12 months after the date of the enactment of this
3 Act, the Secretary shall submit to Congress a report
4 that details the strategy of the Secretary for imple-
5 menting the requirements of this section and the
6 status of such efforts.

7 (2) FULL COMPLIANCE.—Not later than 36
8 months after the date of the enactment of this Act,
9 and annually thereafter, the Secretary shall submit
10 to Congress a report that—

11 (A) describes the research and development
12 and public awareness and education campaigns
13 funded under this section;

14 (B) provides evidence that projects involv-
15 ing high-risk, high-impact technologic innova-
16 tion, proof of concept, and pilot studies are
17 prioritized;

18 (C) provides evidence that the Secretary
19 recognizes and addresses any barriers in access
20 to care and participation in clinical trials that
21 are specific to racial minorities in the imple-
22 mentation of this section;

23 (D) contains assurances that all the other
24 provisions of this section are fully implemented;
25 and

1 (E) certifies compliance with the provisions
2 of this section, or in the case of a Federal agen-
3 cy that has not complied with any of such pro-
4 visions, an explanation as to such failure to
5 comply.

6 **SEC. 704. PROSTATE CANCER DETECTION RESEARCH AND**
7 **EDUCATION.**

8 (a) **SHORT TITLE.**—This section may be cited as the
9 “Prostate Cancer Detection Research and Education
10 Act”.

11 (b) **PLAN TO DEVELOP AND VALIDATE A TEST OR**
12 **TESTS FOR PROSTATE CANCER.**—

13 (1) **IN GENERAL.**—The Secretary of Health and
14 Human Services (referred to in this section as the
15 “Secretary”), acting through the Director of the Na-
16 tional Institutes of Health, shall establish an advi-
17 sory council on prostate cancer (referred to in this
18 section as the “advisory council”) to draft a plan for
19 the development and validation of an accurate test
20 or tests, such as biomarkers or imaging, to detect
21 and diagnose prostate cancer.

22 (2) **ADVISORY COUNCIL.**—

23 (A) **MEMBERSHIP.**—

1 (i) FEDERAL MEMBERS.—The advi-
2 sory council shall be comprised of the fol-
3 lowing experts:

4 (I) A designee of the Centers for
5 Disease Control and Prevention.

6 (II) A designee of the Centers for
7 Medicare & Medicaid Services.

8 (III) A designee of the Office of
9 the Director of the National Cancer
10 Institute.

11 (IV) A designee of the Director
12 of the Department of Defense Con-
13 gressionally Directed Medical Re-
14 search Program.

15 (V) A designee of the Director of
16 the National Institute of Biomedical
17 Imaging and Bioengineering.

18 (VI) A designee of the Director
19 of the National Institute of General
20 Medical Sciences.

21 (VII) A designee of the Director
22 of the National Institute on Minority
23 Health and Health Disparities.

1 (VIII) A designee of the Office of
2 the Director of the National Institutes
3 of Health.

4 (IX) A designee of the Food and
5 Drug Administration.

6 (X) A designee of the Agency for
7 Healthcare Research and Quality.

8 (XI) A designee of the Director
9 of the Telemedicine and Advanced
10 Technology Research Center of the
11 Department of Defense.

12 (ii) NON-FEDERAL MEMBERS.—In ad-
13 dition to the members described in clause
14 (i), the advisory council shall include 8 ex-
15 pert members from outside the Federal
16 Government to be appointed by the Sec-
17 retary, which shall include—

18 (I) 2 prostate cancer patient ad-
19 vocates;

20 (II) 2 health care providers with
21 a range of expertise and experience in
22 prostate cancer; and

23 (III) 4 leading researchers with
24 prostate cancer-related expertise in a
25 range of clinical disciplines.

1 (B) MEETINGS.—The advisory council
2 shall meet quarterly and such meetings shall be
3 open to the public.

4 (C) ADVICE.—The advisory council shall
5 advise the Secretary or the Secretary’s des-
6 ignee.

7 (D) ANNUAL REPORT.—Not later than 1
8 year after the date of enactment of this Act, the
9 advisory council shall provide to the Secretary,
10 or the Secretary’s designee, and Congress—

11 (i) an initial evaluation of all federally
12 funded efforts in prostate cancer research
13 relating to the development and validation
14 of an accurate test or tests to detect and
15 diagnose prostate cancer;

16 (ii) a plan for the development and
17 validation of a reliable test or tests for the
18 detection and accurate diagnosis of pros-
19 tate cancer; and

20 (iii) a set of standards for prostate
21 cancer screening, developed in coordination
22 with the United States Preventive Services
23 Task Force, to ensure that any tools for
24 screening, detection, and diagnosis devel-
25 oped in accordance with the plan under

1 clause (ii) will meet the requirements of
2 the Task Force for recommendation as a
3 proven preventive or diagnostic service.

4 (E) TERMINATION.—The advisory council
5 shall terminate on December 31, 2024.

6 (3) FUNDING.—The Secretary may make avail-
7 able \$1,000,000 from amounts appropriated to the
8 National Institutes of Health for each of fiscal years
9 2021 through 2025 to carry out this subsection.

10 (c) COORDINATION AND INTENSIFICATION OF PROS-
11 TATE CANCER RESEARCH.—

12 (1) IN GENERAL.—The Director of the National
13 Institutes of Health, in consultation with the Sec-
14 retary of Defense, shall coordinate and intensify re-
15 search in accordance with the plan, with particular
16 attention provided to leveraging existing research to
17 develop and validate a test or tests, such as bio-
18 markers or imaging, to detect and accurately diag-
19 nose prostate cancer in order to improve quality of
20 life for millions of Americans, and decrease health
21 care system costs.

22 (2) FUNDING.—The Secretary may make avail-
23 able \$30,000,000 from amounts appropriated to the
24 National Institutes of Health for each of fiscal years
25 2022 through 2026 to carry out this subsection.

1 (d) PUBLIC AWARENESS AND EDUCATION CAM-
2 PAIGN.—

3 (1) NATIONAL CAMPAIGN.—The Secretary, in
4 coordination with the Director of the National Insti-
5 tutes of Health and the Director of the Centers for
6 Disease Control and Prevention, shall carry out a
7 national campaign to increase the awareness and
8 knowledge of prostate cancer.

9 (2) REQUIREMENTS.—The national campaign
10 conducted under paragraph (1) shall include—

11 (A) roles for the National Cancer Institute,
12 the National Institute on Minority Health and
13 Health Disparities, the Office on Minority
14 Health of the Department of Health and
15 Human Services, and the Office of Minority
16 Health of the Centers for Disease Control and
17 Prevention; and

18 (B) the development and distribution of
19 written educational materials, and the develop-
20 ment and placing of public service announce-
21 ments, that are intended to encourage men to
22 seek prostate cancer screening when symptoms
23 are present, when they have a family history of
24 prostate cancer, or if they belong to a high-risk
25 population.

1 (3) RACIAL DISPARITIES.—In developing the
2 national campaign under paragraph (1), the Sec-
3 retary shall recognize and address—

4 (A) the racial disparities in the incidences
5 of prostate cancer and mortality rates with re-
6 spect to such disease; and

7 (B) any barriers in access to patient care
8 and participation in clinical trials that are spe-
9 cific to racial minorities.

10 (4) GRANTS.—The Secretary shall establish a
11 program to award grants to nonprofit private enti-
12 ties to enable such entities to test alternative out-
13 reach and education strategies to increase the
14 awareness and knowledge of Americans with respect
15 to prostate cancer.

16 (5) AUTHORIZATION OF APPROPRIATIONS.—
17 There is authorized to be appropriated to carry out
18 this subsection \$5,000,000 for each of fiscal years
19 2021 through 2025.

20 **SEC. 705. NATIONAL PROSTATE CANCER COUNCIL.**

21 (a) SHORT TITLE.—This section may be cited as the
22 “National Prostate Cancer Plan Act”.

23 (b) NATIONAL PROSTATE CANCER COUNCIL.—

24 (1) ESTABLISHMENT.—There is established in
25 the Office of the Secretary of Health and Human

1 Services (referred to in this section as the “Sec-
2 retary”) the National Prostate Cancer Council on
3 Screening, Early Detection, Assessment, and Moni-
4 toring of Prostate Cancer (referred to in this section
5 as the “Council”).

6 (2) PURPOSE OF THE COUNCIL.—The Council
7 shall—

8 (A) develop and implement a national stra-
9 tegic plan for the accelerated creation, advance-
10 ment, and testing of diagnostic tools to improve
11 screening, early detection, assessment, and
12 monitoring of prostate cancer, including—

13 (i) early detection of aggressive pros-
14 tate cancer to save lives;

15 (ii) monitoring of tumor response to
16 treatment, including recurrence and pro-
17 gression; and

18 (iii) accurate assessment and surveil-
19 lance of indolent disease to reduce unnec-
20 essary biopsies and treatment;

21 (B) provide information and coordination
22 of prostate cancer research and services across
23 all Federal agencies;

1 (C) review diagnostic tools and their over-
2 all effectiveness at screening, detecting, assess-
3 ing, and monitoring of prostate cancer;

4 (D) evaluate all programs in prostate can-
5 cer that are in existence on the date of enact-
6 ment of this Act, including Federal budget re-
7 quests and approvals and public-private part-
8 nerships;

9 (E) submit an annual report to the Sec-
10 retary and Congress on the creation and imple-
11 mentation of the national strategic plan under
12 subparagraph (A); and

13 (F) ensure the inclusion of men at high
14 risk for prostate cancer, including men from
15 ethnic and racial populations and men who are
16 least likely to receive care, in clinical, research,
17 and service efforts, with the purpose of decreas-
18 ing health disparities.

19 (3) MEMBERSHIP.—

20 (A) FEDERAL MEMBERS.—The Council
21 shall be led by the Secretary or designee and
22 comprised of the following experts:

23 (i) Two representatives of the Na-
24 tional Institutes of Health, including 1 rep-
25 resentative of the National Institute of

1 Biomedical Imaging and Bioengineering
2 and 1 representative of the National Can-
3 cer Institute.

4 (ii) A representative of the Centers
5 for Disease Control and Prevention.

6 (iii) A representative of the Centers
7 for Medicare & Medicaid Services.

8 (iv) A designee of the Director of the
9 Department of Defense Congressionally
10 Directed Medical Research Program.

11 (v) A designee of the Director of the
12 Office of Minority Health.

13 (vi) A representative of the Food and
14 Drug Administration.

15 (vii) A representative of the Agency
16 for Healthcare Research and Quality.

17 (B) NON-FEDERAL MEMBERS.—In addi-
18 tion to the members described in subparagraph
19 (A), the Council shall include 14 expert mem-
20 bers from outside the Federal Government,
21 which shall include—

22 (i) 6 prostate cancer patient advo-
23 cates, including—

24 (I) 2 patient-survivors;

1 (II) 2 caregivers of prostate can-
2 cer patients; and

3 (III) 2 representatives from na-
4 tional prostate cancer disease organi-
5 zations that fund research or have
6 demonstrated experience in providing
7 assistance to patients, families, and
8 medical professionals, including infor-
9 mation on health care options, edu-
10 cation, and referral; and

11 (ii) 8 health care stakeholders with
12 specific expertise in prostate cancer re-
13 search in the critical areas of clinical ex-
14 pertise, including medical oncology, radi-
15 ology, radiation oncology, urology, and pa-
16 thology.

17 (4) MEETINGS.—The Council shall meet quar-
18 terly and meetings shall be open to the public.

19 (5) ADVICE.—The Council shall advise the Sec-
20 retary, or the Secretary’s designee.

21 (6) ANNUAL REPORT.—The Council shall sub-
22 mit annual reports, beginning not later than 1 year
23 after the date of enactment of this Act, to the Sec-
24 retary or the Secretary’s designee and to Congress.

25 The annual report shall include—

1 (A) in the first year—

2 (i) an evaluation of all federally fund-
3 ed efforts in prostate cancer research and
4 gaps relating to the development and vali-
5 dation of diagnostic tools for prostate can-
6 cer; and

7 (ii) recommendations for priority ac-
8 tions to expand, eliminate, coordinate, or
9 condense programs based on the perform-
10 ance, mission, and purpose of the pro-
11 grams; and

12 (B) annually thereafter for 5 years—

13 (i) an outline for the development and
14 implementation of a national research plan
15 for creation and validation of accurate di-
16 agnostic tools to improve prostate cancer
17 care in accordance with paragraph (1);

18 (ii) roles for the National Cancer In-
19 stitute, National Institute on Minority
20 Health and Health Disparities, and the Of-
21 fice on Minority Health of the Department
22 of Health and Human Services;

23 (iii) an analysis of the disparities in
24 the incidence and mortality rates of pros-
25 tate cancer in men at high risk of the dis-

1 ease, including individuals with family his-
2 tory, increasing age, or African-American
3 heritage; and

4 (iv) a review of the progress towards
5 the realization of the proposed strategic
6 plan.

7 (7) TERMINATION.—The Council shall termi-
8 nate on December 31, 2025.

9 **SEC. 706. IMPROVED MEDICAID COVERAGE FOR CERTAIN**
10 **BREAST AND CERVICAL CANCER PATIENTS**
11 **IN THE TERRITORIES.**

12 (a) ELIMINATION OF FUNDING LIMITATIONS.—

13 (1) IN GENERAL.—Section 1108(g)(4) of the
14 Social Security Act (42 U.S.C. 1308(g)(4)) is
15 amended by adding at the end the following: “With
16 respect to fiscal years beginning with fiscal year
17 2021, payment for medical assistance for individuals
18 who are eligible for such assistance only on the basis
19 of section 1902(a)(10)(A)(ii)(XVIII) shall not be
20 taken into account in applying subsection (f) (as in-
21 creased in accordance with paragraphs (1), (2), (3),
22 and (5) of this subsection) to Puerto Rico, the Vir-
23 gin Islands, Guam, the Northern Mariana Islands,
24 or American Samoa for such fiscal year.”.

1 (2) TECHNICAL AMENDMENT.—Such section is
2 further amended by striking “(3), and (4)” and in-
3 serting “(3), and (5)”.

4 (b) APPLICATION OF ENHANCED FMAP FOR HIGH-
5 EST STATE.—Section 1905(b) of such Act (42 U.S.C.
6 1396d(b)) is amended by adding at the end the following:
7 “Notwithstanding the first sentence of this subsection,
8 with respect to medical assistance described in clause (4)
9 of such sentence that is furnished in Puerto Rico, the Vir-
10 gin Islands, Guam, the Northern Mariana Islands, or
11 American Samoa in a fiscal year, the Federal medical as-
12 sistance percentage is equal to the highest such percentage
13 applied under such clause for such fiscal year for any of
14 the 50 States or the District of Columbia that provides
15 such medical assistance for any portion of such fiscal
16 year.”

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to payment for medical assistance
19 for items and services furnished on or after October 1,
20 2021.

21 **SEC. 707. CANCER PREVENTION AND TREATMENT DEM-**
22 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
23 **NORITIES.**

24 (a) DEMONSTRATION.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (referred to in this section as the
3 “Secretary”) shall conduct demonstration projects
4 for the purpose of developing models and evaluating
5 methods that—

6 (A) improve the quality of items and serv-
7 ices provided to target individuals in order to
8 facilitate reduced disparities in early detection
9 and treatment of cancer;

10 (B) improve clinical outcomes, satisfaction,
11 quality of life, appropriate use of items and
12 services covered under the Medicare program
13 under title XVIII of the Social Security Act (42
14 U.S.C. 1395 et seq.), and referral patterns with
15 respect to target individuals with cancer;

16 (C) eliminate disparities in the rate of pre-
17 ventive cancer screening measures, such as Pap
18 smears, prostate cancer screenings, colon cancer
19 screenings, breast cancer screenings, and com-
20 puted tomography scans, for lung cancer among
21 target individuals;

22 (D) promote collaboration with community-
23 based organizations to ensure cultural com-
24 petency of health care professionals and lin-

1 guistic access for target individuals who are
2 persons with limited English 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 er, and a promotore 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 9 dem-
9 onstration projects, including the following:

10 (A) Two projects, each of which shall tar-
11 get different ethnic subpopulations, for each of
12 the 4 following major racial and ethnic minority
13 groups:

14 (i) American Indians and Alaska Na-
15 tives, Eskimos, and Aleuts.

16 (ii) Asian Americans.

17 (iii) Blacks and African Americans.

18 (iv) Latinos and Hispanics.

19 (v) Native Hawaiians and other Pa-
20 cific Islanders.

21 (B) One project within the Pacific Islands
22 or United States insular areas.

23 (C) At least one project in a rural area.

24 (D) At least one project in an inner-city
25 area.

1 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
2 TION OF DEMONSTRATION PROJECT RESULTS.—The
3 Secretary shall continue the existing demonstration
4 projects and may expand the number of demonstra-
5 tion projects if the initial report under subsection (c)
6 contains an evaluation that demonstration
7 projects—

8 (A) reduce expenditures under the Medi-
9 care program under title XVIII of the Social
10 Security Act (42 U.S.C. 1395 et seq.); or

11 (B) do not increase expenditures under
12 such Medicare program and reduce racial and
13 ethnic health disparities in the quality of health
14 care services provided to target individuals and
15 increase satisfaction of Medicare beneficiaries
16 and health care providers.

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) CONTENT 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 (42 U.S.C. 1395 et seq.) to such extent
18 and for such period as the Secretary determines is nec-
19 essary to conduct demonstration projects.

20 **SEC. 708. REDUCING CANCER DISPARITIES WITHIN MEDI-**
21 **CARE.**

22 (a) DEVELOPMENT OF MEASURES OF DISPARITIES
23 IN QUALITY OF CANCER CARE.—

24 (1) DEVELOPMENT OF MEASURES.—The Sec-
25 retary of Health and Human Services (in this sec-

1 tion referred to as the “Secretary”) shall enter into
2 an agreement with an entity that specializes in de-
3 veloping quality measures for cancer care under
4 which the entity shall develop a uniform set of meas-
5 ures to evaluate disparities in the quality of cancer
6 care and annually update such set of measures.

7 (2) MEASURES TO BE INCLUDED.—Such set of
8 measures shall include, with respect to the treatment
9 of cancer, measures of patient outcomes, the process
10 for delivering medical care related to such treat-
11 ment, patient counseling and engagement in deci-
12 sionmaking, patient experience of care, resource use,
13 and practice capabilities, such as care coordination.

14 (b) ESTABLISHMENT OF REPORTING PROCESS.—

15 (1) IN GENERAL.—The Secretary shall establish
16 a reporting process that requires and provides for a
17 method for health care providers specified under
18 paragraph (2) to submit to the Secretary and make
19 public data on the performance of such providers
20 during each reporting period through use of the
21 measures developed pursuant to subsection (a). Such
22 data shall be submitted in a form and manner and
23 at a time specified by the Secretary.

24 (2) SPECIFICATION OF PROVIDERS TO REPORT
25 ON MEASURES.—The Secretary shall specify the

1 classes of Medicare providers of services and sup-
2 pliers, including hospitals, cancer centers, physi-
3 cians, primary care providers, and specialty pro-
4 viders, that will be required under such process to
5 publicly report on the measures specified under sub-
6 section (a).

7 (3) ASSESSMENT OF CHANGES.—Under such
8 reporting process, the Secretary shall establish a for-
9 mat that assesses changes in both the absolute and
10 relative disparities in cancer care over time. These
11 measures shall be presented in an easily comprehen-
12 sible format, such as those presented in the final
13 publications relating to Healthy People 2010 or the
14 National Healthcare Disparities Report.

15 (4) INITIAL IMPLEMENTATION.—The Secretary
16 shall implement the reporting process under this
17 subsection for reporting periods beginning not later
18 than 6 months after the date that measures are first
19 established under subsection (a).

20 **SEC. 709. CANCER CLINICAL TRIALS.**

21 (a) SHORT TITLE.—This section may be cited as the
22 “Henrietta Lacks Enhancing Cancer Research Act of
23 2020”.

24 (b) FINDINGS.—Congress finds as follows:

1 (1) Only a small percent of patients participate
2 in cancer clinical trials, even though most express an
3 interest in clinical research. There are several obsta-
4 cles that restrict individuals from participating in-
5 cluding lack of available local trials, restrictive eligi-
6 bility criteria, transportation to trial sites, taking
7 time off from work, and potentially increased med-
8 ical and nonmedical costs. Ultimately, about 1 in 5
9 cancer clinical trials fail because of lack of patient
10 enrollment.

11 (2) Groups that are generally underrepresented
12 in clinical trials include racial and ethnic minorities
13 and older, rural, and lower-income individuals.

14 (3) Henrietta Lacks, an African-American
15 woman, was diagnosed with cervical cancer at the
16 age of 31, and despite receiving painful radium
17 treatments, passed away on October 4, 1951.

18 (4) Medical researchers took samples of Hen-
19 rietta Lacks' tumor during her treatment and the
20 HeLa cell line from her tumor proved remarkably
21 resilient.

22 (5) HeLa cells were the first immortal line of
23 human cells. Henrietta Lacks' cells were unique,
24 growing by the millions, commercialized and distrib-

1 uted worldwide to researchers, resulting in advances
2 in medicine.

3 (6) Henrietta Lacks' prolific cells continue to
4 grow and contribute to remarkable advances in med-
5 icine, including the development of the polio vaccine,
6 as well as drugs for treating the effects of cancer,
7 HIV/AIDS, hemophilia, leukemia, and Parkinson's
8 disease. These cells have been used in research that
9 has contributed to our understanding of the effects
10 of radiation and zero gravity on human cells. These
11 immortal cells have informed research on chromo-
12 somal conditions, cancer, gene mapping, and preci-
13 sion medicine.

14 (7) Henrietta Lacks and her immortal cells
15 have made a significant contribution to global
16 health, scientific research, quality of life, and patient
17 rights.

18 (8) For more than 20 years, the advances made
19 possible by Henrietta Lacks' cells were without her
20 or her family's consent, and the revenues they gen-
21 erated were not known to or shared with her family.

22 (9) Henrietta Lacks and her family's experience
23 is fundamental to modern and future bioethics poli-
24 cies and informed consent laws that benefit patients
25 nationwide by building patient trust; promoting eth-

1 ical research that benefits all individuals, including
2 traditionally underrepresented populations; and pro-
3 tecting research participants.

4 (c) GAO STUDY ON BARRIERS TO PARTICIPATION IN
5 FEDERALLY FUNDED CANCER CLINICAL TRIALS BY POP-
6 ULATIONS THAT HAVE BEEN TRADITIONALLY UNDER-
7 REPRESENTED IN SUCH TRIALS.—

8 (1) IN GENERAL.—Not later than 2 years after
9 the date of enactment of this Act, the Comptroller
10 General of the United States shall—

11 (A) complete a study that—

12 (i) reviews what actions Federal agen-
13 cies have taken to help to address barriers
14 to participation in federally funded cancer
15 clinical trials by populations that have
16 been traditionally underrepresented in such
17 trials, and identifies challenges, if any, in
18 implementing such actions; and

19 (ii) identifies additional actions that
20 can be taken by Federal agencies to ad-
21 dress barriers to participation in federally
22 funded cancer clinical trials by populations
23 that have been traditionally underrep-
24 resented in such trials; and

1 (B) submit a report to the Congress on the
2 results of such study, including recommenda-
3 tions on potential changes in practices and poli-
4 cies to improve participation in such trials by
5 such populations.

6 (2) INCLUSION OF CLINICAL TRIALS.—The
7 study under paragraph (1)(A) should include review
8 of cancer clinical trials that are largely funded by
9 Federal agencies, including the National Institutes
10 of Health, the Department of Defense, the Depart-
11 ment of Veterans Affairs, the Agency for Health Re-
12 search and Quality, the Food and Drug Administra-
13 tion, and such other Federal agencies as the Comp-
14 troller General of the United States may identify.

15 **Subtitle B—Viral Hepatitis and**
16 **Liver Cancer Control and Pre-**
17 **vention**

18 **SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL**
19 **AND PREVENTION.**

20 (a) SHORT TITLE.—This subtitle may be cited as the
21 “Viral Hepatitis and Liver Cancer Control and Prevention
22 Act of 2020”.

23 (b) FINDINGS.—Congress finds the following:

24 (1) In the United States, nearly 5,000,000 per-
25 sons are living with the hepatitis B virus (referred

1 to in this section as “HBV”) or the hepatitis C virus
2 (referred to in this section as “HCV”).

3 (2) In the United States, chronic HBV and
4 HCV are the most common causes of liver cancer,
5 the second deadliest and fastest growing cancer in
6 this country. Such viruses are the most common
7 cause of chronic liver disease, liver cirrhosis, and the
8 most common indications for liver transplantation.
9 At least 21,000 deaths per year in the United States
10 can be attributed to chronic HBV and HCV. Chron-
11 ic HCV is also a leading cause of death in Ameri-
12 cans living with HIV/AIDS; many of those living
13 with HIV/AIDS are coinfecting with chronic HBV,
14 chronic HCV, or both.

15 (3) According to the Centers for Disease Con-
16 trol and Prevention (referred to in this section as
17 the “CDC”), approximately 2 percent of the popu-
18 lation of the United States is living with chronic
19 HBV, chronic HCV, or both. The CDC has recog-
20 nized HCV as the Nation’s most common chronic
21 bloodborne virus infection and HBV as the deadliest
22 vaccine-preventable disease.

23 (4) HBV is transmitted through contact with
24 infectious blood, semen, or other bodily fluids and is
25 100 times more infectious than HIV. HCV is trans-

1 mitted by contact with infectious blood, particularly
2 through percutaneous exposures (such as puncture
3 through the skin).

4 (5) The CDC estimates that in 2016, more
5 than 41,000 people in the United States were newly
6 infected with HCV and nearly 21,000 people in the
7 United States were newly infected with HBV. These
8 estimates could be much higher due to many rea-
9 sons, including lack of screening education and
10 awareness, and perceived marginalization of the pop-
11 ulations at risk.

12 (6) In 2012, CDC released new guidelines rec-
13 ommending every person born between 1945 and
14 1965 receive a one-time test for HCV. Among the
15 estimated 102,000,000 (1,600,000 chronically HCV-
16 infected) eligible for screening, birth-cohort screen-
17 ing leads to 84,000 fewer cases of decompensated
18 cirrhosis, 46,000 fewer cases of hepatocellular car-
19 cinoma, 10,000 fewer liver transplants, and 78,000
20 fewer HCV-related deaths gained versus risk-based
21 screening.

22 (7) In 2013, the United States Preventive Serv-
23 ices Task Force (referred to in this section as the
24 “USPSTF”) issued a Grade B rating for screening
25 for HCV infection in persons at high risk for infec-

1 tion and adults born between 1945 and 1965. In
2 2014, the USPSTF issued a Grade B for screening
3 for HBV in persons at high risk of hepatitis B infec-
4 tion. In 2009, the USPSTF issued a Grade A for
5 screening pregnant women for HBV during their
6 first prenatal visit, and in 2019, reaffirmed this
7 grade.

8 (8) There were 59 outbreaks (24 of HBV and
9 36 of HCV, including one of both HBV and HCV)
10 reported to CDC for investigation from 2008
11 through 2016 related to health care-associated infec-
12 tion of HBV and HCV, 56 of which occurred in non-
13 hospital settings. There were more than 115,983 pa-
14 tients potentially exposed to one of the viruses.

15 (9) Chronic HBV and chronic HCV usually do
16 not cause symptoms early in the course of the dis-
17 ease, but after many years of a clinically “silent”
18 phase, CDC estimates show more than 33 percent of
19 infected individuals will develop cirrhosis, end-stage
20 liver disease, or liver cancer. Since most individuals
21 with chronic HBV, HCV, or both are unaware of
22 their infection, they do not know to take precautions
23 to prevent the spread of their infection and can un-
24 knowingly exacerbate their own disease progression.

1 (10) HBV and HCV disproportionately affect
2 certain populations in the United States. Although
3 representing only about 6 percent of the population,
4 Asian Americans and Pacific Islanders account for
5 half of all chronic HBV cases in the United States.
6 Baby Boomers (those born between 1945 and 1965)
7 account for approximately 75 percent of domestic
8 chronic HCV cases. In addition, African Americans,
9 Latinos, and American Indian and Native Alaskans
10 are among the groups which have disproportionately
11 high rates of HBV or HCV infections in the United
12 States.

13 (11) For both chronic HBV and chronic HCV,
14 behavioral changes and appropriate medical care can
15 slow disease progression if diagnosis is made early.
16 Early diagnosis, which is determined through simple
17 blood tests, can reduce the risk of transmission and
18 disease progression through education and vaccina-
19 tion of household members and other susceptible
20 persons at risk.

21 (12) Advancements have led to the development
22 of improved diagnostic tests for viral hepatitis.
23 These tests, including rapid, point-of-care testing
24 and others in development, can facilitate testing, no-
25 tification of results and post-test counseling, and re-

1 ferral to care at the time of the testing visit. In par-
2 ticular, these tests are also advantageous because
3 they can be used simultaneously with HIV rapid
4 testing for persons at risk for both HCV and HIV
5 infections.

6 (13) For those chronically infected with HBV
7 or HCV, regular monitoring can lead to the early de-
8 tection of liver cancer at a stage where a cure is still
9 possible. Liver cancer is the second deadliest cancer
10 in the United States; however, liver cancer has re-
11 ceived little funding for research, prevention, or
12 treatment.

13 (14) Treatment for chronic HCV can eradicate
14 the disease in approximately 90 percent of those cur-
15 rently treated. While there is no cure for chronic
16 HBV, available treatments can effectively suppress
17 viral replication in the overwhelming majority of
18 those treated, thereby reducing the risk of trans-
19 mission and progression to liver scarring or liver
20 cancer.

21 (15) To combat the viral hepatitis epidemic in
22 the United States, in February 2017, the Depart-
23 ment of Health and Human Services released its
24 “National Viral Hepatitis Action Plan 2017–2020”
25 (referred to in this section as the “HHS Action

1 Plan”). In March 2017, the National Academies of
2 Sciences, Engineering, and Medicine released a re-
3 port entitled, “A National Strategy for the Elimini-
4 nation of Hepatitis B and C: Phase Two Report”
5 (referred to in this section as the “NAS report”),
6 recommending specific actions to eliminate viral hep-
7 atitis as public health problems in the United States
8 by 2030.

9 (16) The annual health care costs attributable
10 to HBV and HCV in the United States are signifi-
11 cant. For HBV, it is estimated to be approximately
12 \$2,500,000,000 (\$2,000 per infected person). In
13 2000, the lifetime cost of HBV—before the avail-
14 ability of most current therapies—was approximately
15 \$80,000 per chronically infected person, totaling
16 more than \$100,000,000,000. For HCV, medical
17 costs for patients are expected to increase from
18 \$30,000,000,000 in 2009 to over \$85,000,000,000
19 in 2024. Avoiding these costs by screening and diag-
20 nosing individuals earlier—and connecting them to
21 appropriate treatment and care, will save lives and
22 critical health care dollars. Currently, without a
23 comprehensive screening, testing, and diagnosis pro-
24 gram, most patients are diagnosed too late when
25 they need a liver transplant costing at least

1 \$314,000 for uncomplicated cases or when they have
2 liver cancer or end-stage liver disease which costs
3 \$30,980 to \$110,576 per hospital admission. As
4 health care costs continue to grow, it is critical that
5 the Federal Government invests in effective mecha-
6 nisms to avoid documented cost drivers.

7 (17) According to the NAS report in 2010,
8 chronic HBV and HCV infections cause substantial
9 morbidity and mortality despite being preventable
10 and treatable. Deficiencies in the implementation of
11 established guidelines for the prevention, diagnosis,
12 and medical management of chronic HBV and HCV
13 infections perpetuate personal and economic bur-
14 dens. Existing grants are not sufficient for the scale
15 of the health burden presented by HBV and HCV.

16 (18) Screening and testing for HBV and HCV
17 is aligned with the goal of Healthy People 2020 to
18 increase immunization rates and reduce preventable
19 infectious diseases. Awareness of disease and access
20 to prevention and treatment remain essential compo-
21 nents for reducing infectious disease transmission.

22 (19) Federal support is necessary to increase
23 knowledge and awareness of HBV and HCV and to
24 assist State and local prevention and control efforts

1 in reducing the morbidity and mortality of these
2 epidemics.

3 (20) The Centers for Disease Control and Pre-
4 vention reported a 233 percent increase in hepatitis
5 C cases from 2010 to 2016, stemming from the
6 opioid, heroin, and overdose epidemics affecting com-
7 munities nationwide. From 2014 to 2015, the num-
8 ber of reported cases of acute hepatitis B infection
9 in the United States rose for the first time since
10 2006, increasing by 20.7 percent, which is also
11 largely attributable to the opioid epidemic.

12 (21) The Secretary of Health and Human Serv-
13 ices has the discretion to carry out this subtitle (in-
14 cluding the amendments made by this subtitle) di-
15 rectly and through whichever of the agencies of the
16 Public Health Service the Secretary determines to be
17 appropriate, which may (in the Secretary's discre-
18 tion) include the Centers for Disease Control and
19 Prevention, the Health Resources and Services Ad-
20 ministration, the Substance Abuse and Mental
21 Health Services Administration, the National Insti-
22 tutes of Health (including the National Institute on
23 Minority Health and Health Disparities), and other
24 agencies of such Service.

1 (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B
2 AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,
3 AND MEDICAL MANAGEMENT PLAN.—Title III of the
4 Public Health Service Act (42 U.S.C. 241 et seq.), as
5 amended by title V, is further amended—

6 (1) by striking section 317N (42 U.S.C. 247b–
7 15); and

8 (2) by adding after part W, as added by section
9 508, the following:

10 **“PART X—BIENNIAL ASSESSMENT OF HHS HEPA-**
11 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
12 **CATION, RESEARCH, AND MEDICAL MANAGE-**
13 **MENT PLAN**

14 **“SEC. 399PP. BIENNIAL UPDATE OF THE PLAN.**

15 “(a) IN GENERAL.—The Secretary shall conduct a bi-
16 ennial assessment of the Secretary’s plan for the preven-
17 tion, control, and medical management of, and education
18 and research relating to, hepatitis B and hepatitis C, for
19 the purposes of—

20 “(1) incorporating into such plan new knowl-
21 edge or observations relating to hepatitis B and hep-
22 atitis C (such as knowledge and observations that
23 may be derived from clinical, laboratory, and epide-
24 miological research and disease detection, preven-
25 tion, and surveillance outcomes);

1 “(2) addressing gaps in the coverage or effec-
2 tiveness of the plan; and

3 “(3) evaluating and, if appropriate, updating
4 recommendations, guidelines, or educational mate-
5 rials of the Centers for Disease Control and Preven-
6 tion or the National Institutes of Health for health
7 care providers or the public on viral hepatitis in
8 order to be consistent with the plan.

9 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
10 Not later than October 1 of the first even-numbered year
11 beginning after the date of the enactment of this part,
12 and October 1 of each even-numbered year thereafter, the
13 Secretary shall publish in the Federal Register a notice
14 of the results of the assessments conducted under para-
15 graph (1). Such notice shall include—

16 “(1) a description of any revisions to the plan
17 referred to in subsection (a) as a result of the as-
18 sessment;

19 “(2) an explanation of the basis for any such
20 revisions, including the ways in which such revisions
21 can reasonably be expected to further promote the
22 original goals and objectives of the plan; and

23 “(3) in the case of a determination by the Sec-
24 retary that the plan does not need revision, an expla-
25 nation of the basis for such determination.

1 **“SEC. 399PP-1. ELEMENTS OF PROGRAM.**

2 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
3 Secretary, acting through the Director of the Centers for
4 Disease Control and Prevention, the Administrator of the
5 Health Resources and Services Administration, and the
6 Administrator of the Substance Abuse and Mental Health
7 Services Administration, and in accordance with the plan
8 referred to in section 399PP(a), shall implement programs
9 to increase awareness and enhance knowledge and under-
10 standing of hepatitis B and hepatitis C. Such programs
11 shall include—

12 “(1) the conduct of culturally and linguistically
13 appropriate health education in primary and sec-
14 ondary schools, college campuses, public awareness
15 campaigns, and community outreach activities (espe-
16 cially to the ethnic communities with high rates of
17 chronic hepatitis B and chronic hepatitis C and
18 other high-risk groups) to promote public awareness
19 and knowledge about the value of hepatitis A and
20 hepatitis B immunization; risk factors, transmission,
21 and prevention of hepatitis B and hepatitis C; the
22 value of screening for the early detection of hepatitis
23 B and hepatitis C; and options available for the
24 treatment of chronic hepatitis B and chronic hepa-
25 titis C;

1 “(2) the promotion of immunization programs
2 that increase awareness and access to hepatitis A
3 and hepatitis B vaccines for susceptible adults and
4 children;

5 “(3) the training of health care professionals
6 regarding the importance of vaccinating individuals
7 infected with hepatitis C and individuals who are at
8 risk for hepatitis C infection against hepatitis A and
9 hepatitis B;

10 “(4) the training of health care professionals
11 regarding the importance of vaccinating individuals
12 chronically infected with hepatitis B and individuals
13 who are at risk for chronic hepatitis B infection
14 against the hepatitis A virus;

15 “(5) the training of health care professionals
16 and health educators to make them aware of the
17 high rates of chronic hepatitis B and chronic hepa-
18 titis C in certain adult ethnic populations, and the
19 importance of prevention, detection, and medical
20 management of hepatitis B and hepatitis C and of
21 liver cancer screening;

22 “(6) the development and distribution of health
23 education curricula (including information relating
24 to the special needs of individuals infected with or
25 at risk of hepatitis B and hepatitis C, such as the

1 importance of prevention and early intervention, reg-
2 ular monitoring, the recognition of psychosocial
3 needs, appropriate treatment, and liver cancer
4 screening) for individuals providing hepatitis B and
5 hepatitis C counseling; and

6 “(7) support for the implementation curricula
7 described in paragraph (6) by State and local public
8 health agencies.

9 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
10 PROGRAMS.—

11 “(1) IN GENERAL.—The Secretary, acting
12 through the Director of the Centers for Disease
13 Control and Prevention, shall support the integra-
14 tion of activities described in paragraph (3) into ex-
15 isting clinical and public health programs at State,
16 local, territorial, and Tribal levels (including commu-
17 nity health clinics, programs for the prevention and
18 treatment of HIV/AIDS, sexually transmitted infec-
19 tions, and substance abuse, and programs for indi-
20 viduals in correctional settings).

21 “(2) COORDINATION OF DEVELOPMENT OF
22 FEDERAL SCREENING GUIDELINES.—

23 “(A) REFERENCES.—For purposes of this
24 subsection, the term ‘CDC Director’ means the
25 Director of the Centers for Disease Control and

1 Prevention, and the term ‘AHRQ Director’
2 means the Director of the Agency for
3 Healthcare Research and Quality.

4 “(B) AGENCY FOR HEALTHCARE RE-
5 SEARCH AND QUALITY.—Due to the rapidly
6 evolving standard of care associated with diag-
7 nosing and treating viral hepatitis infection, the
8 AHRQ Director shall convene the Preventive
9 Services Task Force under section 915(a) to re-
10 view its recommendation for screening for HBV
11 and HCV infection every 3 years.

12 “(3) ACTIVITIES.—

13 “(A) VOLUNTARY TESTING PROGRAMS.—

14 “(i) IN GENERAL.—The Secretary
15 shall establish a mechanism by which to
16 support and promote the development of
17 State, local, territorial, and tribal vol-
18 untary hepatitis B and hepatitis C testing
19 programs to screen the high-prevalence
20 populations to aid in the early identifica-
21 tion of chronically infected individuals.

22 “(ii) CONFIDENTIALITY OF THE TEST
23 RESULTS.—The Secretary shall prohibit
24 the use of the results of a hepatitis B or
25 hepatitis C test conducted by a testing pro-

1 gram developed or supported under this
2 subparagraph for any of the following:

3 “(I) Issues relating to health in-
4 surance.

5 “(II) To screen or determine
6 suitability for employment.

7 “(III) To discharge a person
8 from employment.

9 “(B) COUNSELING REGARDING VIRAL HEP-
10 ATITIS.—The Secretary shall support State,
11 local, territorial, and tribal programs in a wide
12 variety of settings, including those providing
13 primary and specialty health care services in
14 nonprofit private and public sectors, to—

15 “(i) provide individuals with ongoing
16 risk factors for hepatitis B and hepatitis C
17 infection with client-centered education
18 and counseling which concentrates on—

19 “(I) promoting testing of individ-
20 uals that have been exposed to their
21 blood, family members, and their sex-
22 ual partners; and

23 “(II) changing behaviors that
24 place individuals at risk for infection;

1 “(ii) provide individuals chronically in-
2 fected with hepatitis B or hepatitis C with
3 education, health information, and coun-
4 seling to reduce their risk of—

5 “(I) dying from end-stage liver
6 disease and liver cancer; and

7 “(II) transmitting viral hepatitis
8 to others; and

9 “(iii) provide women chronically in-
10 fected with hepatitis B or hepatitis C who
11 are pregnant or of childbearing age with
12 culturally and linguistically appropriate
13 health information, such as how to prevent
14 hepatitis B perinatal infection, and to al-
15 leviate fears associated with pregnancy or
16 raising a family.

17 “(C) IMMUNIZATION.—The Secretary shall
18 support State, local, territorial, and tribal ef-
19 forts to expand the current vaccination pro-
20 grams to protect every child in the Nation and
21 all susceptible adults, particularly those infected
22 with hepatitis C and high-prevalence ethnic
23 populations and other high-risk groups, from
24 the risks of acute and chronic hepatitis B infec-
25 tion by—

1 “(i) ensuring continued funding for
2 hepatitis B vaccination for all children 18
3 years of age or younger through the Vac-
4 cines for Children program;

5 “(ii) ensuring that the recommenda-
6 tions of the Advisory Committee on Immu-
7 nization Practices of the Centers for Dis-
8 ease Control and Prevention are followed
9 regarding the birth dose of hepatitis B vac-
10 cinations for newborns;

11 “(iii) requiring proof of hepatitis B
12 vaccination for entry into public or private
13 daycare, preschool, elementary school, sec-
14 ondary school, and institutions of higher
15 education;

16 “(iv) expanding the availability of
17 hepatitis B vaccination for all adults to
18 protect them from becoming acutely or
19 chronically infected, including ethnic and
20 other populations with high prevalence
21 rates of chronic hepatitis B infection;

22 “(v) expanding the availability of hep-
23 atitis B vaccination for all adults, particu-
24 larly those of reproductive age (women and

1 men less than 45 years of age), to protect
2 them from the risk of hepatitis B infection;

3 “(vi) ensuring the vaccination of indi-
4 viduals infected, or at risk for infection,
5 with hepatitis C against hepatitis A, hepa-
6 titis B, and other infectious diseases, as
7 appropriate, for which such individuals
8 may be at increased risk; and

9 “(vii) ensuring the vaccination of indi-
10 viduals infected, or at risk for infection,
11 with hepatitis B against hepatitis A virus
12 and other infectious diseases, as appro-
13 priate, for which such individuals may be
14 at increased risk.

15 “(D) MEDICAL REFERRAL.—The Secretary
16 shall support State, local, territorial, and tribal
17 programs that support—

18 “(i) referral of persons chronically in-
19 fected with hepatitis B or hepatitis C—

20 “(I) for medical evaluation to de-
21 termine the appropriateness for
22 antiviral treatment to reduce the risk
23 of progression to cirrhosis and liver
24 cancer; and

1 “(II) for ongoing medical man-
2 agement including regular monitoring
3 of liver function and screening for
4 liver cancer; and

5 “(ii) referral of persons infected with
6 acute or chronic hepatitis B infection or
7 acute or chronic hepatitis C infection for
8 drug and alcohol abuse treatment where
9 appropriate.

10 “(4) INCREASED SUPPORT FOR ADULT VIRAL
11 HEPATITIS PREVENTION COORDINATORS.—The Sec-
12 retary, acting through the CDC Director, shall pro-
13 vide increased support to adult viral hepatitis pre-
14 vention coordinators in State, local, territorial, and
15 tribal health departments in order to enhance the
16 additional management, networking, and technical
17 expertise needed to ensure successful integration of
18 hepatitis B and hepatitis C prevention and control
19 activities into existing public health programs.

20 “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

21 “(1) IN GENERAL.—The Secretary, acting
22 through the Director of the Centers for Disease
23 Control and Prevention, shall support the establish-
24 ment and maintenance of a national chronic and

1 acute hepatitis B and hepatitis C surveillance pro-
2 gram, in order to identify—

3 “(A) trends in the incidence of acute and
4 chronic hepatitis B and acute and chronic hepa-
5 titis C;

6 “(B) trends in the prevalence of acute and
7 chronic hepatitis B and acute and chronic hepa-
8 titis C infection among groups that may be dis-
9 proportionately affected; and

10 “(C) trends in liver cancer and end-stage
11 liver disease incidence and deaths, caused by
12 chronic hepatitis B and chronic hepatitis C in
13 the high-risk ethnic populations.

14 “(2) SEROPREVALENCE AND LIVER CANCER
15 STUDIES.—The Secretary, acting through the Direc-
16 tor of the Centers for Disease Control and Preven-
17 tion, shall prepare a report outlining the population-
18 based seroprevalence studies currently underway, fu-
19 ture planned studies, the criteria involved in deter-
20 mining which seroprevalence studies to conduct,
21 defer, or suspend, and the scope of those studies, the
22 economic and clinical impact of hepatitis B and hep-
23 atitis C, and the impact of chronic hepatitis B and
24 chronic hepatitis C infections on the quality of life.
25 Not later than one year after the date of the enact-

1 ment of this part, the Secretary shall submit the re-
2 port to the Committee on Health, Education, Labor,
3 and Pensions of the Senate and the Committee on
4 Energy and Commerce of the House of Representa-
5 tives.

6 “(3) CONFIDENTIALITY.—The Secretary shall
7 not disclose any individually identifiable information
8 identified under paragraph (1) or derived through
9 studies under paragraph (2).

10 “(d) RESEARCH.—The Secretary, acting through the
11 Director of the Centers for Disease Control and Preven-
12 tion, the Director of the National Cancer Institute, and
13 the Director of the National Institutes of Health, shall—

14 “(1) conduct epidemiologic and community-
15 based research to develop, implement, and evaluate
16 best practices for hepatitis B and hepatitis C pre-
17 vention especially in the ethnic populations with high
18 rates of chronic hepatitis B and chronic hepatitis C
19 and other high-risk groups;

20 “(2) conduct research on hepatitis B and hepa-
21 titis C natural history, pathophysiology, improved
22 treatments and prevention (such as the hepatitis C
23 vaccine), and noninvasive tests that help to predict
24 the risk of progression to liver cirrhosis and liver
25 cancer;

1 “(3) conduct research that will lead to better
2 noninvasive or blood tests to screen for liver cancer,
3 and more effective treatments of liver cancer caused
4 by chronic hepatitis B and chronic hepatitis C; and

5 “(4) conduct research comparing the effective-
6 ness of screening, diagnostic, management, and
7 treatment approaches for chronic hepatitis B, chron-
8 ic hepatitis C, and liver cancer in the affected com-
9 munities.

10 “(e) **UNDERSERVED AND DISPROPORTIONATELY AF-**
11 **FFECTED POPULATIONS.**—In carrying out this section, the
12 Secretary shall provide expanded support for individuals
13 with limited access to health education, testing, and health
14 care services and groups that may be disproportionately
15 affected by hepatitis B and hepatitis C.

16 “(f) **EVALUATION OF PROGRAM.**—The Secretary
17 shall develop benchmarks for evaluating the effectiveness
18 of the programs and activities conducted under this sec-
19 tion and make determinations as to whether such bench-
20 marks have been achieved.

21 **“SEC. 399PP-2. GRANTS.**

22 “(a) **IN GENERAL.**—The Secretary may award grants
23 to, or enter into contracts or cooperative agreements with,
24 States, political subdivisions of States, territories, Indian
25 tribes, or nonprofit entities that have special expertise re-

1 lating to hepatitis B, hepatitis C, or both, to carry out
2 activities under this part.

3 “(b) APPLICATION.—To be eligible for a grant, con-
4 tract, or cooperative agreement under subsection (a), an
5 entity shall prepare and submit to the Secretary an appli-
6 cation at such time, in such manner, and containing such
7 information as the Secretary may require.

8 **“SEC. 399PP-3. AUTHORIZATION OF APPROPRIATIONS.**

9 “There are authorized to be appropriated to carry out
10 this part \$90,000,000 for fiscal year 2021, \$90,000,000
11 for fiscal year 2022, \$110,000,000 for fiscal year 2023,
12 \$130,000,000 for fiscal year 2024, and \$150,000,000 for
13 fiscal year 2025.”.

14 **Subtitle C—Acquired Bone Marrow**
15 **Failure Diseases**

16 **SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

17 (a) SHORT TITLE.—This subtitle may be cited as the
18 “Bone Marrow Failure Disease Research and Treatment
19 Act of 2020”.

20 (b) FINDINGS.—The Congress finds the following:

21 (1) Between 20,000 and 30,000 people in the
22 United States are diagnosed each year with
23 myelodysplastic syndromes, aplastic anemia, parox-
24 ysmal nocturnal hemoglobinuria, and other acquired
25 bone marrow failure diseases.

1 (2) Acquired bone marrow failure diseases have
2 a debilitating and often fatal impact on those diag-
3 nosed with these diseases.

4 (3) While some treatments for acquired bone
5 marrow failure diseases can prolong and improve the
6 quality of patients' lives, there is no single cure for
7 these diseases.

8 (4) The prevalence of acquired bone marrow
9 failure diseases in the United States will continue to
10 grow as the general public ages.

11 (5) Evidence exists suggesting that acquired
12 bone marrow failure diseases occur more often in
13 minority populations, particularly in Asian-American
14 and Latino or Hispanic populations.

15 (6) The National Heart, Lung, and Blood Insti-
16 tute and the National Cancer Institute have con-
17 ducted important research into the causes of and
18 treatments for acquired bone marrow failure dis-
19 eases.

20 (7) The National Marrow Donor Program Reg-
21 istry has made significant contributions to the fight
22 against bone marrow failure diseases by connecting
23 millions of potential marrow donors with individuals
24 and families suffering from these conditions.

1 “(A) develop a system to collect data on
2 acquired bone marrow failure diseases; and

3 “(B) establish and maintain a national and
4 publicly available registry, to be known as the
5 National Acquired Bone Marrow Failure Dis-
6 ease Registry, in accordance with paragraph
7 (3).

8 “(2) RECOMMENDATIONS OF ADVISORY COM-
9 MITTEE.—In carrying out this subsection, the Sec-
10 retary shall take into consideration the recommenda-
11 tions of the Advisory Committee on Acquired Bone
12 Marrow Failure Diseases established under sub-
13 section (b).

14 “(3) PURPOSES OF REGISTRY.—The National
15 Acquired Bone Marrow Failure Disease Registry
16 shall—

17 “(A) identify the incidence and prevalence
18 of acquired bone marrow failure diseases in the
19 United States;

20 “(B) be used to collect and store data on
21 acquired bone marrow failure diseases, includ-
22 ing data concerning—

23 “(i) the age, race or ethnicity, general
24 geographic location, sex, and family history
25 of individuals who are diagnosed with ac-

1 required bone marrow failure diseases, and
2 any other characteristics of such individ-
3 uals determined appropriate by the Sec-
4 retary;

5 “(ii) the genetic and environmental
6 factors that may be associated with devel-
7 oping acquired bone marrow failure dis-
8 eases;

9 “(iii) treatment approaches for deal-
10 ing with acquired bone marrow failure dis-
11 eases;

12 “(iv) outcomes for individuals treated
13 for acquired bone marrow failure diseases,
14 including outcomes for recipients of stem
15 cell therapeutic products as contained in
16 the database established pursuant to sec-
17 tion 379A; and

18 “(v) any other factors pertaining to
19 acquired bone marrow failure diseases de-
20 termined appropriate by the Secretary; and
21 “(C) be made available—

22 “(i) to the general public; and

23 “(ii) to researchers to facilitate fur-
24 ther research into the causes of, and treat-
25 ments for, acquired bone marrow failure

1 diseases in accordance with standard prac-
2 tices of the Centers for Disease Control
3 and Preventions.

4 “(b) ADVISORY COMMITTEE.—

5 “(1) ESTABLISHMENT.—Not later than 6
6 months after the date of the enactment of this sec-
7 tion, the Secretary, acting through the Director of
8 the Centers for Disease Control and Prevention,
9 shall establish an advisory committee, to be known
10 as the Advisory Committee on Acquired Bone Mar-
11 row Failure Diseases.

12 “(2) MEMBERS.—The members of the Advisory
13 Committee on Acquired Bone Marrow Failure Dis-
14 eases shall be appointed by the Secretary, acting
15 through the Director of the Centers for Disease
16 Control and Prevention, and shall include at least
17 one representative from each of the following:

18 “(A) A national patient advocacy organiza-
19 tion with experience advocating on behalf of pa-
20 tients suffering from acquired bone marrow
21 failure diseases.

22 “(B) The National Institutes of Health, in-
23 cluding at least one representative from each
24 of—

25 “(i) the National Cancer Institute;

1 “(ii) the National Heart, Lung, and
2 Blood Institute; and

3 “(iii) the Office of Rare Diseases.

4 “(C) The Centers for Disease Control and
5 Prevention.

6 “(D) Clinicians with experience in—

7 “(i) diagnosing or treating acquired
8 bone marrow failure diseases; or

9 “(ii) medical data registries.

10 “(E) Epidemiologists who have experience
11 with data registries.

12 “(F) Publicly or privately funded research-
13 ers who have experience researching acquired
14 bone marrow failure diseases.

15 “(G) The entity operating the C.W. Bill
16 Young Cell Transplantation Program estab-
17 lished pursuant to section 379 and the entity
18 operating the C.W. Bill Young Cell Transplan-
19 tation Program Outcomes Database.

20 “(3) RESPONSIBILITIES.—The Advisory Com-
21 mittee on Acquired Bone Marrow Failure Diseases
22 shall provide recommendations to the Secretary on
23 the establishment and maintenance of the National
24 Acquired Bone Marrow Failure Disease Registry, in-

1 including recommendations on the collection, mainte-
2 nance, and dissemination of data.

3 “(4) PUBLIC AVAILABILITY.—The Secretary
4 shall make the recommendations of the Advisory
5 Committee on Acquired Bone Marrow Failure Dis-
6 ease publicly available.

7 “(c) GRANTS.—The Secretary, acting through the
8 Director of the Centers for Disease Control and Preven-
9 tion, may award grants to, and enter into contracts and
10 cooperative agreements with, public or private nonprofit
11 entities for the management of, as well as the collection,
12 analysis, and reporting of data to be included in, the Na-
13 tional Acquired Bone Marrow Failure Disease Registry.

14 “(d) DEFINITION.—In this section, the term ‘ac-
15 quired bone marrow failure disease’ means—

16 “(1) myelodysplastic syndromes;

17 “(2) aplastic anemia;

18 “(3) paroxysmal nocturnal hemoglobinuria;

19 “(4) pure red cell aplasia;

20 “(5) acute myeloid leukemia that has pro-
21 gressed from myelodysplastic syndromes; or

22 “(6) large granular lymphocytic leukemia.

23 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section
25 \$3,000,000 for each of fiscal years 2021 through 2025.”.

1 (d) PILOT STUDIES THROUGH THE AGENCY FOR
2 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

3 (1) PILOT STUDIES.—The Secretary of Health
4 and Human Services, acting through the Director of
5 the Agency for Toxic Substances and Disease Reg-
6 istry, shall conduct pilot studies to determine which
7 environmental factors, including exposure to toxins,
8 may cause acquired bone marrow failure diseases.

9 (2) COLLABORATION WITH THE RADIATION IN-
10 JURY TREATMENT NETWORK.—In carrying out the
11 directives of this section, the Secretary may collabo-
12 rate with the Radiation Injury Treatment Network
13 of the C.W. Bill Young Cell Transplantation Pro-
14 gram established pursuant to section 379 of the
15 Public Health Service Act (42 U.S.C. 274k) to—

16 (A) augment data for the pilot studies au-
17 thorized by this section;

18 (B) access technical assistance that may be
19 provided by the Radiation Injury Treatment
20 Network; or

21 (C) perform joint research projects.

22 (3) AUTHORIZATION OF APPROPRIATIONS.—
23 There is authorized to be appropriated to carry out
24 this section \$1,000,000 for each of fiscal years 2021
25 through 2025.

1 (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
2 BONE MARROW FAILURE DISEASES.—Title XVII of the
3 Public Health Service Act (42 U.S.C. 300u et seq.) is
4 amended by inserting after section 1707A the following:

5 **“SEC. 1707B. MINORITY-FOCUSED PROGRAMS ON AC-**
6 **QUIRED BONE MARROW FAILURE DISEASE.**

7 “(a) INFORMATION AND REFERRAL SERVICES.—

8 “(1) IN GENERAL.—Not later than 6 months
9 after the date of the enactment of this section, the
10 Secretary, acting through the Deputy Assistant Sec-
11 retary for Minority Health, shall establish and co-
12 ordinate outreach and informational programs tar-
13 geted to minority populations affected by acquired
14 bone marrow failure diseases.

15 “(2) PROGRAM REQUIREMENTS.—Minority-fo-
16 cused outreach and informational programs author-
17 ized by this section at the National Minority Health
18 Resource Center supported under section 1707(b)(8)
19 (including by means of the Center’s website, through
20 appropriate locations such as the Center’s knowledge
21 center, and through appropriate programs such as
22 the Center’s resource persons network) and through
23 minority health consultants located at each Depart-
24 ment of Health and Human Services regional of-
25 fice—

1 “(A) shall make information about treat-
2 ment options and clinical trials for acquired
3 bone marrow failure diseases publicly available;
4 and

5 “(B) shall provide referral services for
6 treatment options and clinical trials.

7 “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
8 ISLANDER OUTREACH.—

9 “(1) IN GENERAL.—The Secretary, acting
10 through the Deputy Assistant Secretary for Minority
11 Health, shall undertake a coordinated outreach ef-
12 fort to connect Hispanic, Asian-American, and Pa-
13 cific Islander communities with comprehensive serv-
14 ices focused on treatment of, and information about,
15 acquired bone marrow failure diseases.

16 “(2) COLLABORATION.—In carrying out this
17 subsection, the Secretary may collaborate with public
18 health agencies, nonprofit organizations, community
19 groups, and online entities to disseminate informa-
20 tion about treatment options and clinical trials for
21 acquired bone marrow failure diseases.

22 “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

23 “(1) IN GENERAL.—Not later than 6 months
24 after the date of the enactment of this section, the
25 Secretary, acting through the Deputy Assistant Sec-

1 retary for Minority Health, shall award grants to, or
2 enter into cooperative agreements with, entities to
3 perform research on acquired bone marrow failure
4 diseases.

5 “(2) REQUIREMENT.—Grants and cooperative
6 agreements authorized by this subsection shall be
7 awarded or entered into on a competitive, peer-re-
8 viewed basis.

9 “(3) SCOPE OF RESEARCH.—Research funded
10 under this section shall examine factors affecting the
11 incidence of acquired bone marrow failure diseases
12 in minority populations.

13 “(d) DEFINITION.—In this section, the term ‘ac-
14 quired bone marrow failure disease’ has the meaning given
15 to such term in section 317W(d).

16 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
17 is authorized to be appropriated to carry out this section
18 \$2,000,000 for each of fiscal years 2021 through 2025.”.

19 (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-
20 QUIRED BONE MARROW FAILURE DISEASES.—

21 (1) GRANTS.—The Secretary of Health and
22 Human Services, acting through the Director of the
23 Agency for Healthcare Research and Quality, shall
24 award grants to entities to improve diagnostic prac-

1 tices and quality of care with respect to patients
2 with acquired bone marrow failure diseases.

3 (2) AUTHORIZATION OF APPROPRIATIONS.—

4 There is authorized to be appropriated to carry out
5 this section \$2,000,000 for each of fiscal years 2021
6 through 2025.

7 (g) DEFINITION.—In this section, the term “acquired
8 bone marrow failure disease” has the meaning given such
9 term in section 317W(d) of the Public Health Service Act,
10 as added by subsection (c).

11 **Subtitle D—Cardiovascular Dis-**
12 **ease, Chronic Disease, Obesity,**
13 **and Other Disease Issues**

14 **SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MI-**
15 **NORITY PATIENTS.**

16 (a) IN GENERAL.—The Secretary, acting through the
17 Director of the Agency for Healthcare Research and Qual-
18 ity, shall convene a series of meetings to develop guidelines
19 for disease screening for minority patient populations that
20 have a higher than average risk for many chronic diseases
21 and cancers.

22 (b) PARTICIPANTS.—In convening meetings under
23 subsection (a), the Secretary shall ensure that meeting
24 participants include representatives of—

25 (1) professional societies and associations;

1 (2) minority health organizations;

2 (3) health care researchers and providers, in-
3 cluding those with expertise in minority health;

4 (4) Federal health agencies, including the Of-
5 fice of Minority Health, the National Institute on
6 Minority Health and Health Disparities, and the
7 National Institutes of Health; and

8 (5) other experts as the Secretary determines
9 appropriate.

10 (c) DISEASES.—Screening guidelines for minority
11 populations shall be developed as appropriate under sub-
12 section (a) for—

13 (1) hypertension;

14 (2) hypercholesterolemia;

15 (3) diabetes;

16 (4) cardiovascular disease;

17 (5) cancers, including breast, prostate, colon,
18 cervical, and lung cancer;

19 (6) other pulmonary problems including sleep
20 apnea;

21 (7) asthma;

22 (8) diabetes;

23 (9) kidney diseases;

24 (10) eye diseases and disorders, including glau-
25 coma;

1 (11) HIV/AIDS and sexually transmitted infec-
2 tions;

3 (12) uterine fibroids;

4 (13) autoimmune disease;

5 (14) mental health conditions;

6 (15) dental health conditions and oral diseases,
7 including oral cancer;

8 (16) environmental and related health illnesses
9 and conditions;

10 (17) sickle cell disease and sickle cell trait;

11 (18) violence and injury prevention and control;

12 (19) genetic and related conditions;

13 (20) heart disease and stroke;

14 (21) tuberculosis;

15 (22) chronic obstructive pulmonary disease;

16 (23) musculoskeletal diseases, arthritis, and
17 obesity; and

18 (24) other diseases determined appropriate by
19 the Secretary.

20 (d) DISSEMINATION.—Not later than 2 years after
21 the date of enactment of this Act, the Secretary shall pub-
22 lish and disseminate to health care provider organizations
23 the guidelines developed under subsection (a).

24 (e) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of fiscal years
2 2021 through 2025.

3 **SEC. 732. CDC WISEWOMAN SCREENING PROGRAM.**

4 Section 1509 of the Public Health Service Act (42
5 U.S.C. 300n-4a) is amended—

6 (1) in subsection (a)—

7 (A) by striking the heading and inserting
8 “IN GENERAL.—”; and

9 (B) in the matter preceding paragraph (1),
10 by striking “may make grants” and all that fol-
11 lows through “purpose” and inserting the fol-
12 lowing: “may make grants to such States for
13 the purpose”; and

14 (2) in subsection (d)(1), by striking “there are
15 authorized” and all that follows through the period
16 and inserting “there are authorized to be appro-
17 priated \$23,000,000 for fiscal year 2021,
18 \$25,300,000 for fiscal year 2022, \$27,800,000 for
19 fiscal year 2023, \$30,800,000 for fiscal year 2024,
20 and \$34,000,000 for fiscal year 2025.”.

21 **SEC. 733. REPORT ON CARDIOVASCULAR CARE FOR WOMEN**
22 **AND MINORITIES.**

23 Part P of title III of the Public Health Service Act
24 (42 U.S.C. 280g et seq.), as amended by section 531, is
25 further amended by adding at the end the following:

1 **“SEC. 399V-8. REPORT ON CARDIOVASCULAR CARE FOR**
2 **WOMEN AND MINORITIES.**

3 “Not later than September 30, 2021, and annually
4 thereafter, the Secretary shall prepare and submit to Con-
5 gress a report on the quality of and access to care for
6 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. 734. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
14 **SATION SERVICES IN MEDICAID AND PRI-**
15 **VATE HEALTH INSURANCE.**

16 (a) **REQUIRING MEDICAID COVERAGE OF COUN-**
17 **SELING AND PHARMACOTHERAPY FOR CESSATION OF TO-**
18 **BACCO USE.**—Section 1905 of the Social Security Act (42
19 U.S.C. 1396d) is amended—

20 (1) in subsection (a)(4)(D), by striking “by
21 pregnant women”; and

22 (2) in subsection (bb)—

23 (A) by striking “by pregnant women” each
24 place it appears;

1 (B) in paragraph (1), in the matter before
2 subparagraph (A), by inserting “by individuals”
3 before “who use tobacco”; and

4 (C) in paragraph (2)(A), by striking “with
5 respect to pregnant women”.

6 (b) EXCEPTION FROM OPTIONAL RESTRICTION
7 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
8 Section 1927(d)(2)(F) of the Social Security Act (42
9 U.S.C. 1396r–8(d)(2)(F)) is amended—

10 (1) by striking “in the case of pregnant
11 women”; and

12 (2) by striking “under the over-the-counter
13 monograph process”.

14 (c) STATE MONITORING AND PROMOTING OF COM-
15 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
16 MEDICAID.—Section 1902(a) of the Social Security Act
17 (42 U.S.C. 1396a(a)), as amended by section 462(a), is
18 amended—

19 (1) by striking “and” at the end of paragraph
20 (85);

21 (2) by striking the period at the end of para-
22 graph (86) and inserting “; and”; and

23 (3) by inserting after paragraph (86) the fol-
24 lowing new paragraph:

1 “(87) provide for the State to monitor and pro-
2 mote the use of comprehensive tobacco cessation
3 services under the State plan, including conducting
4 an outreach campaign to increase awareness of, and
5 the benefits of using, such services among—

6 “(A) individuals entitled to medical assist-
7 ance under the State plan who use tobacco
8 products; and

9 “(B) clinicians and others who provide
10 services to individuals entitled to medical assist-
11 ance under the State plan.”.

12 (d) FEDERAL REIMBURSEMENT FOR MEDICAID OUT-
13 REACH CAMPAIGN TO INCREASE AWARENESS.—Section
14 1903(a) of the Social Security Act (42 U.S.C. 1396b(a))
15 is amended—

16 (1) by striking the period at the end of para-
17 graph (7) and inserting “; plus”; and

18 (2) by inserting after paragraph (7) the fol-
19 lowing new paragraph:

20 “(8) an amount equal to 90 percent of the
21 sums expended during each quarter which are attrib-
22 utable to the development, implementation, and eval-
23 uation of an outreach campaign to—

1 “(A) increase awareness of comprehensive
2 tobacco cessation services covered in the State
3 plan among—

4 “(i) individuals who are likely to be el-
5 igible for medical assistance under the
6 State plan; and

7 “(ii) clinicians and others who provide
8 services to individuals who are likely to be
9 eligible for medical assistance under the
10 State plan; and

11 “(B) increase awareness of the benefits of
12 using comprehensive tobacco cessation services
13 covered in the State plan among—

14 “(i) individuals who are likely to be el-
15 igible for medical assistance under the
16 State plan; and

17 “(ii) clinicians and others who provide
18 services to individuals who are likely to be
19 eligible for medical assistance under the
20 State plan about the benefits of using com-
21 prehensive tobacco cessation services.”.

22 (e) REMOVAL OF COST SHARING FOR COUNSELING
23 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
24 USE UNDER MEDICAID.—

1 (1) GENERAL COST SHARING LIMITATIONS.—
2 Section 1916 of the Social Security Act (42 U.S.C.
3 1396o) is amended—

4 (A) in subsections (a)(2)(B) and (b)(2)(B),
5 by striking “and counseling and pharmacother-
6 apy for cessation of tobacco use by pregnant
7 women (as defined in section 1905(bb) of this
8 title) and covered outpatient drugs (as defined
9 in subsection (k)(2) of section 1927 and includ-
10 ing nonprescription drugs described in sub-
11 section (d)(2) of such section) that are pre-
12 scribed for purposes of promoting, and when
13 used to promote, tobacco cessation by pregnant
14 women in accordance with the Guideline re-
15 ferred to in section 1905(bb)(2)(A)” each place
16 it appears; and

17 (B) in each of subsections (a)(2)(B) and
18 (b)(2)(B) by inserting “and counseling and
19 pharmacotherapy for cessation of tobacco use
20 (as defined in section 1905d(bb) of this title)
21 and covered outpatient drugs (as defined in
22 subsection (k)(2) of section 1927 and including
23 nonprescription drugs described in subsection
24 (d)(2) of such section) that are prescribed for
25 purposes of promoting, and when used to pro-

1 mote, tobacco cessation in accordance with the
2 Guideline referred to in section
3 1905(bb)(2)(A)” after “(or at the option of the
4 State, any services furnished to pregnant
5 women”.

6 (2) APPLICATION TO ALTERNATIVE COST SHAR-
7 ING.—Section 1916A(b)(3)(B) of such Act (42
8 U.S.C. 1396o–1(b)(3)(B)) is amended—

9 (A) in clause (iii), by striking “, and coun-
10 seling and pharmacotherapy for cessation of to-
11 bacco use by pregnant women (as defined in
12 section 1905(bb))”; and

13 (B) by adding at the end the following:

14 “(xi) Counseling and pharmacothe-
15 rapy for cessation of tobacco use (as defined
16 in section 1905(bb)) and covered out-
17 patient drugs (as defined in subsection
18 (k)(2) of section 1927 and including non-
19 prescription drugs described in subsection
20 (d)(2) of such section) that are prescribed
21 for purposes of promoting, and when used
22 to promote, tobacco cessation in accord-
23 ance with the Guideline referred to in sec-
24 tion 1396d (bb)(2)(A) of this title.”.

1 (f) NO PRIOR AUTHORIZATION FOR TOBACCO CES-
2 SATION DRUGS UNDER MEDICAID.—Section 1927(d) of
3 the Social Security Act (42 U.S.C. 1396r–8) is amended—

4 (1) by striking in paragraph (1)(A) “A State”
5 and inserting “Except as otherwise provided in para-
6 graph (6), a State”;

7 (2) by redesignating paragraphs (6) and (7) as
8 paragraphs (7) and (8), respectively; and

9 (3) by inserting after paragraph (5) the fol-
10 lowing:

11 “(6) NO PRIOR AUTHORIZATION PROGRAMS FOR
12 TOBACCO CESSATION DRUGS.—A State plan under
13 this title shall not require, as a condition of coverage
14 or payment for a covered outpatient drug for which
15 Federal financial participation is available in accord-
16 ance with this section, the approval of an agent
17 when used to promote smoking cessation, including
18 agents approved by the Food and Drug Administra-
19 tion for the purposes of promoting, and when used
20 to promote, tobacco cessation.”.

21 (g) COMPREHENSIVE COVERAGE OF TOBACCO CES-
22 SATION COVERAGE IN PRIVATE HEALTH INSURANCE.—
23 Section 2713 of the Public Health Service Act (42 U.S.C.
24 300gg–3) is amended by adding at the end the following:

1 “(d) NO PRIOR AUTHORIZATION.—A group health
2 plan and a health insurance issuer offering group or indi-
3 vidual health insurance coverage shall not impose any
4 prior authorization requirement for tobacco cessation
5 counseling and pharmacotherapy that has in effect a rat-
6 ing of ‘A’ or ‘B’ in the current recommendations of the
7 United States Preventive Services Task Force.”.

8 (h) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to items and services furnished on
10 or after January 1, 2021.

11 **SEC. 735. CLINICAL RESEARCH FUNDING FOR ORAL**
12 **HEALTH.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services shall expand and intensify the conduct
15 and support of the research activities of the National In-
16 stitutes of Health and the National Institute of Dental
17 and Craniofacial Research to improve the oral health of
18 the population through the prevention and management
19 of oral diseases and conditions.

20 (b) INCLUDED RESEARCH ACTIVITIES.—Research
21 activities under subsection (a) shall include—

22 (1) comparative effectiveness research and clin-
23 ical disease management research addressing early
24 childhood caries and oral cancer; and

1 “(2) EXCLUSION.—For purposes of paragraph
2 (1), routine patient costs does not include—

3 “(A) the investigational item, device, or
4 service itself;

5 “(B) items and services that are provided
6 solely to satisfy data collection and analysis
7 needs and that are not used in the direct clin-
8 ical management of the patient; or

9 “(C) a service that is clearly inconsistent
10 with widely accepted and established standards
11 of care for a particular diagnosis.

12 “(3) INFORMATION CONCERNING CLINICAL
13 TRIALS.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B), the Secretary, in consultation with
16 relevant stakeholders, shall develop a single
17 standardized electronic form for use by the indi-
18 vidual or the referring health care provider to
19 submit to the State agency administering the
20 State plan in order to verify that the clinical
21 trial meets the conditions established for an ap-
22 proved clinical trial (as defined in subsection
23 (c)).

24 “(B) EXCLUDED INFORMATION.—For pur-
25 poses of subparagraph (A) or any such request

1 by the State agency for information regarding
2 a clinical trial, an individual or referring health
3 care provider shall not be required to submit—

4 “(i) the clinical protocol document for
5 the clinical trial; or

6 “(ii) subject to subparagraph (C), any
7 additional information other than such in-
8 formation as is required pursuant to the
9 form described in subparagraph (A).

10 “(C) OPTIONAL INFORMATION.—For pur-
11 poses of subparagraphs (A) and (B)(ii), the
12 form may include a requirement that the refer-
13 ring health care provider attest that the indi-
14 vidual is eligible to participate in the clinical
15 trial pursuant to the trial protocol and that in-
16 dividual participation in such trial would be ap-
17 propriate.

18 “(D) REVIEW OF INFORMATION.—

19 “(i) IN GENERAL.—A State plan
20 under this title shall establish a process for
21 timely review by the State agency of the
22 form and information submitted pursuant
23 to subparagraph (A) and, not later than
24 48 hours after receipt of such form, con-
25 firmation that the information provided in

1 such form satisfies the requirements estab-
2 lished under such subparagraph, with such
3 process to include establishment and oper-
4 ation of a 24-hour, toll-free telephone num-
5 ber and email address to provide for expe-
6 dited communication.

7 “(ii) FAILURE TO RESPOND.—If an
8 individual or the referring health care pro-
9 vider does not receive a response or re-
10 quest for additional information from the
11 State agency following the 48-hour period
12 described in clause (i), the information
13 provided in the form may be presumed to
14 satisfy the requirements established under
15 this paragraph.

16 “(b) ENCOURAGEMENT OF PARTICIPATION IN AP-
17 PROVED CLINICAL TRIALS.—

18 “(1) REASONABLY ACCESSIBLE PROVIDER.—
19 For purposes of participation in an approved clinical
20 trial by an individual eligible for medical assistance
21 under this title, the State agency administering the
22 State plan shall make reasonable efforts to ensure
23 that the individual is provided with access to a pro-
24 vider who is—

1 “(A) participating in the approved clinical
2 trial;

3 “(B) located not more than 25 miles from
4 the residence of the individual (or, if no such
5 provider is available, as close as possible to the
6 residence of the individual); and

7 “(C) a participating provider under the
8 State plan or has been deemed to be a partici-
9 pating provider under the State plan for pur-
10 poses of providing medical assistance to the in-
11 dividual during their participation in the ap-
12 proved clinical trial.

13 “(2) INFORMATIONAL MATERIALS.—The State
14 agency administering the plan approved under this
15 title shall develop informational materials and pro-
16 grams to encourage participating providers to make
17 appropriate referrals to physicians and other appro-
18 priate health care professionals who can provide in-
19 dividuals with access to approved clinical trials.

20 “(c) DEFINITION OF APPROVED CLINICAL TRIAL.—
21 The term ‘approved clinical trial’ has the same meaning
22 as provided under subsection (d) of the section 2709 of
23 the Public Health Service Act that relates to coverage for
24 individuals participating in approved clinical trials.”.

1 (b) CONFORMING AMENDMENT.—Section 1902(a) of
2 the Social Security Act (42 U.S.C. 1396a(a)), as amended
3 by section 734(c), is amended—

4 (1) by striking “and” at the end of paragraph
5 (86);

6 (2) by striking the period at the end of para-
7 graph (87) and inserting “; and”; and

8 (3) by inserting after paragraph (87) the fol-
9 lowing new paragraph:

10 “(88) provide that participation in an approved
11 clinical trial and coverage of routine patient costs
12 associated with such trial for an individual eligible
13 for medical assistance under this title is conducted
14 in accordance with the requirements under section
15 1944.”.

16 (c) EFFECTIVE DATE.—

17 (1) IN GENERAL.—Except as provided in para-
18 graph (2), the amendments made by this section
19 shall apply to calendar quarters beginning on or
20 after October 1, 2020.

21 (2) DELAY PERMITTED FOR STATE PLAN
22 AMENDMENT.—In the case of a State plan for med-
23 ical assistance under title XIX of the Social Security
24 Act (42 U.S.C. 1396 et seq.) which the Secretary of
25 Health and Human Services determines requires

1 State legislation (other than legislation appro-
2 priating funds) in order for the plan to meet the ad-
3 ditional requirements imposed by the amendments
4 made by this section, the State plan shall not be re-
5 garded as failing to comply with the requirements of
6 such title solely on the basis of its failure to meet
7 these additional requirements before the first day of
8 the first calendar quarter beginning after the close
9 of the first regular session of the State legislature
10 that begins after the date of enactment of this Act.
11 For purposes of the previous sentence, in the case
12 of a State that has a 2-year legislative session, each
13 year of such session shall be deemed to be a sepa-
14 rate regular session of the State legislature.

15 **SEC. 737. GUIDE ON EVIDENCE-BASED STRATEGIES FOR**
16 **PUBLIC HEALTH DEPARTMENT OBESITY PRE-**
17 **VENTION PROGRAMS.**

18 (a) DEVELOPMENT AND DISSEMINATION OF AN EVI-
19 DENCE-BASED STRATEGIES GUIDE.—The Secretary of
20 Health and Human Services (referred to in this section
21 as the “Secretary”), acting through the Director of the
22 Centers for Disease Control and Prevention, not later than
23 2 years after the date of enactment of this Act, shall—

24 (1) develop a guide on evidence-based strategies
25 for State, territorial, and local health departments to

1 use to build and maintain effective obesity preven-
2 tion and reduction programs, and, in consultation
3 with stakeholders that have expertise in Tribal
4 health, a guide on such evidence-based strategies
5 with respect to Indian Tribes and Tribal organiza-
6 tions for such Indian Tribes and Tribal organiza-
7 tions to use for such purpose, both of which guides
8 shall—

9 (A) describe an integrated program struc-
10 ture for implementing interventions proven to
11 be effective in preventing and reducing the inci-
12 dence of obesity; and

13 (B) recommend—

14 (i) optimal resources, including staff-
15 ing and infrastructure, for promoting nu-
16 trition and obesity prevention and reduc-
17 tion; and

18 (ii) strategies for effective obesity pre-
19 vention programs for State and local
20 health departments, Indian Tribes, and
21 Tribal organizations, including strategies
22 related to—

23 (I) the application of evidence-
24 based and evidence-informed practices
25 to prevent and reduce obesity rates;

- 1 (II) the development, implemen-
2 tation, and evaluation of obesity pre-
3 vention and reduction strategies for
4 specific communities and populations;
- 5 (III) demonstrated knowledge of
6 obesity prevention practices that re-
7 duce associated preventable diseases,
8 health conditions, death, and health
9 care costs;
- 10 (IV) best practices for the coordi-
11 nation of efforts to prevent and re-
12 duce obesity and related chronic dis-
13 eases;
- 14 (V) addressing the underlying
15 risk factors and social determinants of
16 health that impact obesity rates; and
- 17 (VI) interdisciplinary coordina-
18 tion between relevant public health of-
19 ficials specializing in fields such as
20 nutrition, physical activity, epidemi-
21 ology, communications, and policy im-
22 plementation, and collaboration be-
23 tween public health officials and com-
24 munity-based organizations; and

1 (2) expand targeted efforts to prevent HIV in-
2 fection using a combination of effective, evidence-
3 based approaches, including routine HIV screening,
4 and universal access to HIV prevention tools in com-
5 munities disproportionately impacted by HIV, par-
6 ticularly communities of color;

7 (3) ensure laws, policies, and regulations do not
8 impede access to prevention, treatment, and care for
9 people living with HIV or disproportionately im-
10 pacted by HIV;

11 (4) accelerate research for more efficacious HIV
12 prevention and treatments tools, a cure, and a vac-
13 cine; and

14 (5) respect the human rights and dignity of
15 persons living with HIV.

16 **SEC. 742. FINDINGS.**

17 The Congress finds the following:

18 (1) Over 1,100,000 people are estimated to be
19 living with HIV in the United States according to
20 the Centers for Disease Control and Prevention, 14
21 percent of whom are unaware they are living with
22 HIV.

23 (2) Annually there are about 37,600 new HIV
24 infections and 15,800 deaths in people with an HIV

1 diagnoses in 50 States and 6 dependent areas of the
2 United States.

3 (3) The Centers for Disease Control and Pre-
4 vention estimates that, in 2017, there were approxi-
5 mately 38,700 people newly diagnosed with HIV.
6 The estimated number of annual new HIV infections
7 declined 9 percent from 2010 to 2016. However, the
8 number of new infections is increasing among cer-
9 tain populations, such as Latino gay and bisexual
10 men, where annual infections increase 21 percent.

11 (4) HIV disproportionately affects certain popu-
12 lations in the United States. Though African Ameri-
13 cans represent approximately 12 percent of the pop-
14 ulation, African Americans account for almost half
15 (42 percent) of all people living with HIV in the
16 United States. African-American men who have sex
17 with men account for 26 percent of all new HIV in-
18 fections and have remained stable from 2010 to
19 2016.

20 (5) Disparities continue to exist among Latinos
21 and Hispanics; in 2017, Latinos and Hispanics
22 made up 18 percent of the United States population
23 and 26 percent of new infections.

24 (6) Though the rate of new infections among
25 American Indians and Alaska Natives (referred to in

1 this section as “AI/AN”) is proportional to their
2 population size, from 2010 to 2016, the annual
3 number of HIV diagnoses increased 46 percent
4 among AI/AN overall and 81 percent among AI/AN
5 gay and bisexual men.

6 (7) Asian Americans account for about 2 per-
7 cent of new HIV infections, but in 2013, 22 percent
8 were undiagnosed, the highest rate of undiagnosed
9 HIV among any race or ethnicity. Between 2010
10 and 2016, the number of Asians receiving an HIV
11 diagnosis increased by 42 percent.

12 (8) The latest data from the Centers for Dis-
13 ease Control and Prevention indicates that new in-
14 fections among women declined 21 percent between
15 2010 and 2016.

16 (9) The history of HIV shows that culturally
17 relevant and gender-responsive supportive services,
18 including psychosocial support, treatment literacy,
19 case management, and transportation are necessary
20 strategies to reach and engage women and girls in
21 medical care.

22 (10) Among the 3 million HIV testing events
23 reported to the Centers for Disease Control and Pre-
24 vention in 2017, the percentage of transgender peo-
25 ple who received a new HIV diagnosis was 3 times

1 the national average. A 2019 systematic review and
2 meta-analysis found that an estimated 14 percent of
3 transgender women have HIV. By race/ethnicity, an
4 estimated 44 percent of Black/African-American
5 transgender women, 26 percent of Hispanic/Latina
6 transgender women, and 7 percent of White
7 transgender women have HIV. The limited data
8 available on transgender individuals point to a dis-
9 proportionate burden of HIV infection.

10 (11) Stigma and discrimination contribute to
11 such disparities.

12 (12) The Centers for Disease Control and Pre-
13 vention has determined that increasing the propor-
14 tion of people who know their HIV status is an es-
15 sential component of comprehensive HIV treatment
16 and prevention efforts and that early diagnosis is
17 critical in order for people with HIV to receive life-
18 extending therapy. Additionally, the Centers for Dis-
19 ease Control and Prevention recommend routine
20 HIV screening in health care settings for all patients
21 aged 13 to 64, regardless of risk.

22 (13) In 1998, Congress created the National
23 Minority AIDS Initiative to provide technical assist-
24 ance, build capacity, and strengthen outreach efforts
25 among local institutions and community-based orga-

1 nizations that serve racial and ethnic minorities liv-
2 ing with or vulnerable to HIV.

3 (14) To combat the HIV epidemic in the United
4 States, the National HIV/AIDS Strategy (referred
5 to in this section as “NHAS”) provides a framework
6 of increasing access to care, reducing new infections,
7 and eliminating HIV-related health disparities. The
8 vision of NHAS is “The United States will become
9 a place where new HIV infections are rare and when
10 they do occur, every person, regardless of age, gen-
11 der, race/ethnicity, gender identity, or socioeconomic
12 circumstance, will have unfettered access to high
13 quality, life-extending care, free from stigma and
14 discrimination.”.

15 (15) In January 2019, the Department of
16 Health and Human Services began implementing the
17 “Ending the HIV Epidemic: A Plan for America”.
18 The initiative seeks to reduce the number of new
19 HIV infections in the United States by 75 percent
20 by 2025, and then by at least 90 percent by 2030,
21 for an estimated 250,000 total HIV infection avert-
22 ed.

23 (16) At present, many States and United
24 States territories have criminal statutes based on
25 “exposure” to HIV. Most of these laws were adopted

1 before the availability of effective antiretroviral
2 treatment for HIV/AIDS.

3 (17) Research shows that stable housing leads
4 to better health outcomes for those living with HIV.
5 Inadequate or unstable housing is not only a barrier
6 to effective treatment, but also increases the likeli-
7 hood of engaging in risky behaviors leading to HIV
8 infection. Insecure housing puts people with HIV/
9 AIDS at risk of premature death from exposure to
10 other diseases, poor nutrition, and lack of medical
11 care.

12 (18) Due to advances in treatment, many peo-
13 ple living with HIV today are living healthy lives and
14 have the ability and desire to fully participate in all
15 aspects of community life, including employment.
16 Research associates being employed with tremendous
17 economic, social, and health benefits for many people
18 living with HIV.

19 (19) The common benefits associated with em-
20 ployment include income, autonomy, productivity,
21 and status within society, daily structure, making a
22 contribution to one's community, and increased skills
23 and self-esteem. Research also indicates that many
24 people with disabilities, including people living with
25 HIV, report perceiving themselves as being less dis-

1 abled or not disabled at all, when working. Further-
2 more, some studies link working with better physical
3 and mental health outcomes for people living with
4 HIV when compared to those who are not working.
5 Preliminary data also suggest that transitioning to
6 employment is associated with reduced HIV-related
7 health risk behavior for many people.

8 (20) In July 2012, the Food and Drug Admin-
9 istration approved the first drug to be used as pre-
10 exposure prophylaxis (PrEP). PrEP reduces the risk
11 of HIV infection in HIV-negative individuals. Stud-
12 ies have shown that PrEP reduces HIV transmission
13 from sex by about 99 percent when taken consist-
14 ently. Despite increases in PrEP uptake, PrEP use
15 remains low among gay and bisexual men of color.
16 The Centers for Disease Control and Prevention
17 found that uptake was lower among African-Amer-
18 ican (26 percent) and Latino (30 percent) men com-
19 pared with White men (42 percent). Similarly, PrEP
20 awareness was lower among African-American (86
21 percent) and Latino (87 percent) men compared
22 with White men (95 percent). While clinical research
23 on transgender populations and PrEP is currently
24 limited, the Centers for Disease Control and Preven-
25 tion recommends PrEP use in transgender popu-

1 lations. In September 2019, the Food and Drug Ad-
2 ministration approved the second drug to be used as
3 PrEP.

4 (21) Syringe service programs have been associ-
5 ated with lowered HIV infections, lower hepatitis C
6 infections, and increased linkage to substance use
7 treatment.

8 (22) There is now conclusive scientific evidence
9 that a person living with HIV who is on
10 antiretroviral therapy and is durably virally sup-
11 pressed (defined as having a consistent viral load of
12 less than <200 copies/ml) does not sexually trans-
13 mit HIV. The conclusive evidence about the highly
14 effective preventative benefits of antiretroviral ther-
15 apy provides an unprecedented opportunity to im-
16 prove the lives of people living with HIV, improve
17 treatment uptake and adherence, and advocate for
18 expanded access to treatment and care.

19 **SEC. 743. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
20 **ANCE PROGRAM TREATMENTS.**

21 Section 2623 of the Public Health Service Act (42
22 U.S.C. 300ff–31b) is amended by adding at the end the
23 following:

24 “(c) **ADDITIONAL FUNDING FOR AIDS DRUG AS-**
25 **SISTANCE PROGRAM TREATMENTS.**—In addition to

1 amounts otherwise authorized to be appropriated for car-
2 rying out this subpart, there are authorized to be appro-
3 priated such sums as may be necessary to carry out sec-
4 tions 2612(b)(3)(B) and 2616 for each of fiscal years
5 2021 through 2024.”.

6 **SEC. 744. ENHANCING THE NATIONAL HIV SURVEILLANCE**
7 **SYSTEM.**

8 (a) GRANTS.—The Secretary of Health and Human
9 Services, acting through the Director of the Centers for
10 Disease Control and Prevention, shall make grants to
11 States to support integration of public health surveillance
12 systems into all electronic health records in order to allow
13 rapid communications between the clinical setting and
14 health departments, by means that include—

15 (1) providing technical assistance and policy
16 guidance to State and local health departments, clin-
17 ical providers, and other agencies serving individuals
18 with HIV to improve the interoperability of data sys-
19 tems relevant to monitoring HIV care and sup-
20 portive services;

21 (2) capturing longitudinal data pertaining to
22 the initiation and ongoing prescription or dispensing
23 of antiretroviral therapy for individuals diagnosed
24 with HIV (such as through pharmacy-based report-
25 ing);

1 (3) obtaining information—

2 (A) on a voluntary basis, on sexual orienta-
3 tion and gender identity; and

4 (B) on sources of coverage (or the lack of
5 coverage) for medical treatment (including cov-
6 erage through the Medicaid program, the Medi-
7 care program, the program under title XXVI of
8 the Public Health Service Act (42 U.S.C.
9 300ff–11 et seq.); commonly referred to as the
10 “Ryan White HIV/AIDS Program”), other pub-
11 lic funding, private insurance, and health main-
12 tenance organizations); and

13 (4) obtaining and using current geographic
14 markers of residence (such as current address, zip
15 code, partial zip code, and census block).

16 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
17 rying out this section, the Secretary of Health and Human
18 Services shall ensure that appropriate privacy and security
19 safeguards are met to prevent unauthorized disclosure of
20 protected health information and compliance with the
21 HIPAA privacy and security law (as defined in section
22 3009 of the Public Health Service Act (42 U.S.C. 300jj–
23 19)) and other relevant laws and regulations.

24 (c) PROHIBITION AGAINST IMPROPER USE OF
25 DATA.—No grant under this section may be used to allow

1 or facilitate the collection or use of surveillance or clinical
2 data or records—

3 (1) for punitive measures of any kind, civil or
4 criminal, against the subject of such data or records;
5 or

6 (2) for imposing any requirement or restriction
7 with respect to an individual without the individual's
8 written consent.

9 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
10 out this section, there are authorized to be appropriated
11 such sums as may be necessary for each of fiscal years
12 2021 through 2024.

13 **SEC. 745. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
14 **LINKAGE TO AND RETENTION IN APPRO-**
15 **PRIATE CARE.**

16 (a) STRATEGIES.—The Secretary of Health and
17 Human Services, in collaboration with the Director of the
18 Centers for Disease Control and Prevention, the Assistant
19 Secretary for Mental Health and Substance Use, the Di-
20 rector of the Office of AIDS Research, the Administrator
21 of the Health Resources and Services Administration, and
22 the Administrator of the Centers for Medicare & Medicaid
23 Services, shall—

24 (1) identify evidence-based strategies most ef-
25 fective at addressing the multifaceted issues that im-

1 pede disease status awareness and linkage to and re-
2 tention in appropriate care, taking into consideration
3 health care systems issues, clinic and provider
4 issues, and individual psychosocial, environmental,
5 and other contextual factors;

6 (2) support the wide-scale implementation of
7 the evidence-based strategies identified pursuant to
8 paragraph (1), including through incorporating such
9 strategies into health care coverage supported by the
10 Medicaid program under title XIX of the Social Se-
11 curity Act (42 U.S.C. 1396 et seq.), the program
12 under title XXVI of the Public Health Service Act
13 (42 U.S.C. 300ff–11 et seq.; commonly referred to
14 as the “Ryan White HIV/AIDS Program”), and
15 health plans purchased through an American Health
16 Benefit Exchange established pursuant to section
17 1311 of the Patient Protection and Affordable Care
18 Act (42 U.S.C. 18031); and

19 (3) not later than 1 year after the date of the
20 enactment of this Act, submit a report to the Con-
21 gress on the status of activities under paragraphs
22 (1) and (2).

23 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
24 out this section, there are authorized to be appropriated

1 such sums as may be necessary for fiscal years 2021
2 through 2024.

3 **SEC. 746. IMPROVING ENTRY INTO AND RETENTION IN**
4 **CARE AND ANTIRETROVIRAL ADHERENCE**
5 **FOR PERSONS WITH HIV.**

6 (a) SENSE OF CONGRESS.—It is the sense of Con-
7 gress that AIDS research has led to scientific advance-
8 ments that have—

9 (1) saved the lives of millions of people living
10 with HIV;

11 (2) prevented millions from new diagnoses; and

12 (3) had broad benefits that extend far beyond
13 helping people at risk for or living with HIV.

14 (b) IN GENERAL.—The Secretary of Health and
15 Human Services, acting through the Director of the Na-
16 tional Institutes of Health, shall expand, intensify, and co-
17 ordinate operational and translational research and other
18 activities of the National Institutes of Health regarding
19 methods—

20 (1) to increase adoption of evidence-based ad-
21 herence strategies within HIV care and treatment
22 programs;

23 (2) to increase HIV testing and case detection
24 rates;

25 (3) to reduce HIV-related health disparities;

1 (4) to ensure that research to improve adher-
2 ence to HIV care and treatment programs address
3 the unique concerns of women;

4 (5) to integrate HIV prevention and care serv-
5 ices with mental health and substance use preven-
6 tion and treatment delivery systems;

7 (6) to increase knowledge on the implementa-
8 tion of preexposure prophylaxis (referred to in this
9 section as “PrEP”), including with respect to—

10 (A) who can benefit most from PrEP;

11 (B) how to provide PrEP safely and effi-
12 ciently;

13 (C) how to integrate PrEP with other es-
14 sential prevention methods such as condoms;
15 and

16 (D) how to ensure high levels of adherence;
17 and

18 (7) to increase knowledge of undetectable and
19 untransmittable when a person living with HIV who
20 is on antiretroviral therapy and is durably virally
21 suppressed (defined as having a consistent viral load
22 of less than <200 copies/ml) cannot sexually trans-
23 mit HIV.

24 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
25 out this section, there are authorized to be appropriated

1 such sums as may be necessary for fiscal years 2021
2 through 2024.

3 **SEC. 747. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
4 **ETHNIC MINORITY COMMUNITIES.**

5 (a) IN GENERAL.—For the purpose of reducing new
6 HIV diagnoses in racial and ethnic minority communities,
7 the Secretary of Health and Human Services, acting
8 through the Deputy Assistant Secretary for Minority
9 Health, may make grants to public health agencies and
10 faith-based organizations to conduct—

11 (1) outreach activities related to HIV preven-
12 tion and testing activities;

13 (2) HIV prevention activities; and

14 (3) HIV testing activities.

15 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
16 out this section, there are authorized to be appropriated
17 such sums as may be necessary for fiscal years 2021
18 through 2024.

19 **SEC. 748. MINORITY AIDS INITIATIVE.**

20 (a) EXPANDED FUNDING.—The Secretary of Health
21 and Human Services, in collaboration with the Deputy As-
22 sistant Secretary for Minority Health, the Director of the
23 Centers for Disease Control and Prevention, the Adminis-
24 trator of the Health Resources and Services Administra-
25 tion, and the Assistant Secretary for Mental Health and

1 Substance Use, shall provide funds and carry out activities
2 to expand the Minority HIV/AIDS Initiative.

3 (b) USE OF FUNDS.—The additional funds made
4 available under this section may be used, through the Mi-
5 nority AIDS Initiative, to support the following activities:

6 (1) Providing technical assistance and infra-
7 structure support to reduce HIV/AIDS in minority
8 populations.

9 (2) Increasing minority populations' access to
10 HIV prevention and care services.

11 (3) Building strong community programs and
12 partnerships to address HIV prevention and the
13 health care needs of specific racial and ethnic minor-
14 ity populations.

15 (c) PRIORITY INTERVENTIONS.—Within the racial
16 and ethnic minority populations referred to in subsection
17 (b), priority in conducting intervention services shall be
18 given to—

19 (1) men who have sex with men;

20 (2) youth;

21 (3) persons who engage in intravenous drug
22 abuse;

23 (4) women;

24 (5) homeless individuals; and

1 (3) Training health care professionals to pro-
2 vide care to individuals living with HIV.

3 (4) Development by grant recipients under title
4 XXVI of the Public Health Service Act (42 U.S.C.
5 300ff–11 et seq.; commonly referred to as the “Ryan
6 White HIV/AIDS Program”) and other persons, of
7 policies for providing culturally relevant and sen-
8 sitive treatment to individuals living with HIV, with
9 particular emphasis on treatment to racial and eth-
10 nic minorities, men who have sex with men, and
11 women, young people, and children living with HIV.

12 (5) Development and implementation of pro-
13 grams to increase the use of telehealth to respond to
14 HIV-specific health care needs in rural and minority
15 communities, with particular emphasis given to
16 medically underserved communities and insular
17 areas.

18 (6) Evaluating interdisciplinary medical pro-
19 vider care team models that promote high-quality
20 care, with particular emphasis on care to racial and
21 ethnic minorities.

22 (7) Training health care professionals to make
23 them aware of the high rates of chronic hepatitis B
24 and chronic hepatitis C in adult racial and ethnic
25 populations, and the importance of prevention, de-

1 (2) the Secretary agrees to make payments in
2 accordance with subsection (b) on the professional
3 education loans of the physician, nurse practitioner,
4 or physician assistant.

5 (b) MANNER OF PAYMENTS.—The payments de-
6 scribed in subsection (a) shall be made by the Secretary
7 as follows:

8 (1) Upon completion by the physician, nurse
9 practitioner, or physician assistant for whom the
10 payments are to be made of the first year of the
11 service specified in the agreement entered into with
12 the Secretary under subsection (a), the Secretary
13 shall pay 30 percent of the principal of and the in-
14 terest on the individual's professional education
15 loans.

16 (2) Upon completion by the physician, nurse
17 practitioner, or physician assistant of the second
18 year of such service, the Secretary shall pay another
19 30 percent of the principal of and the interest on
20 such loans.

21 (3) Upon completion by that individual of a
22 third year of such service, the Secretary shall pay
23 another 25 percent of the principal of and the inter-
24 est on such loans.

1 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
2 part III of part D of title III of the Public Health Service
3 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent
4 with this section, apply to the program carried out under
5 this section in the same manner and to the same extent
6 as such provisions apply to the National Health Service
7 Corps loan repayment program.

8 (d) REPORTS.—Not later than 18 months after the
9 date of the enactment of this Act, and annually thereafter,
10 the Secretary shall prepare and submit to Congress a re-
11 port describing the program carried out under this section,
12 including statements regarding the following:

13 (1) The number of physicians, nurse practi-
14 tioners, and physician assistants enrolled in the pro-
15 gram.

16 (2) The number and amount of loan repay-
17 ments.

18 (3) The placement location of loan repayment
19 recipients at facilities described in subsection (a)(1).

20 (4) The default rate and actions required.

21 (5) The amount of outstanding default funds.

22 (6) To the extent that it can be determined, the
23 reason for the default.

24 (7) The demographics of individuals partici-
25 pating in the program.

1 (8) An evaluation of the overall costs and bene-
2 fits of the program.

3 (e) DEFINITIONS.—In this section:

4 (1) HIV/AIDS.—The term “HIV/AIDS” means
5 human immunodeficiency virus and acquired im-
6 mune deficiency syndrome.

7 (2) NURSE PRACTITIONER.—The term “nurse
8 practitioner” means a registered nurse who has com-
9 pleted an accredited graduate degree program in ad-
10 vanced nurse practice and has successfully passed a
11 national certification exam.

12 (3) PHYSICIAN.—The term “physician” means
13 a graduate of a school of medicine who has com-
14 pleted postgraduate training in general or pediatric
15 medicine.

16 (4) PHYSICIAN ASSISTANT.—The term “physi-
17 cian assistant” means a medical provider who com-
18 pleted an accredited physician assistant training pro-
19 gram and successfully passed the Physician Assist-
20 ant National Certifying Examination.

21 (5) PROFESSIONAL EDUCATION LOAN.—The
22 term “professional education loan”—

23 (A) means a loan that is incurred for the
24 cost of attendance (including tuition, other rea-
25 sonable educational expenses, and reasonable

1 living costs) at a school of medicine, nursing, or
2 physician assistant training program; and

3 (B) includes only the portion of the loan
4 that is outstanding on the date the physician,
5 nurse practitioner, or physician assistant in-
6 volved begins the service specified in the agree-
7 ment under subsection (a).

8 (6) RYAN WHITE-FUNDED.—The term “Ryan
9 White-funded” means, with respect to a facility, re-
10 ceiving funds under title XXVI of the Public Health
11 Service Act (42 U.S.C. 300ff–11 et seq.).

12 (7) SECRETARY.—The term “Secretary” means
13 the Secretary of Health and Human Services.

14 (8) SCHOOL OF MEDICINE.—The term “school
15 of medicine” has the meaning given to that term in
16 section 799B of the Public Health Service Act (42
17 U.S.C. 295p).

18 (9) TITLE X-FUNDED.—The term “title X-fund-
19 ed” means, with respect to a facility, receiving funds
20 under title X of the Public Health Service Act (42
21 U.S.C. 300 et seq.).

22 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
23 out this section, there are authorized to be appropriated
24 such sums as may be necessary for fiscal years 2021
25 through 2024.

1 **SEC. 751. DENTAL EDUCATION LOAN REPAYMENT PRO-**
2 **GRAM.**

3 (a) **IN GENERAL.**—The Secretary may enter into an
4 agreement with any dentist under which—

5 (1) the dentist agrees to serve as a dentist for
6 a period of not less than 2 years at a facility with
7 a critical shortage of dentists (as determined by the
8 Secretary) in an area with a high incidence of HIV;
9 and

10 (2) the Secretary agrees to make payments in
11 accordance with subsection (b) on the dental edu-
12 cation loans of the dentist.

13 (b) **MANNER OF PAYMENTS.**—The payments de-
14 scribed in subsection (a) shall be made by the Secretary
15 as follows:

16 (1) Upon completion by the dentist for whom
17 the payments are to be made of the first year of the
18 service specified in the agreement entered into with
19 the Secretary under subsection (a), the Secretary
20 shall pay 30 percent of the principal of and the in-
21 terest on the dental education loans of the dentist.

22 (2) Upon completion by the dentist of the sec-
23 ond year of such service, the Secretary shall pay an-
24 other 30 percent of the principal of and the interest
25 on such loans.

1 (3) Upon completion by that individual of a
2 third year of such service, the Secretary shall pay
3 another 25 percent of the principal of and the inter-
4 est on such loans.

5 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
6 part III of part D of title III of the Public Health Service
7 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent
8 with this section, apply to the program carried out under
9 this section in the same manner and to the same extent
10 as such provisions apply to the National Health Service
11 Corps Loan Repayment Program.

12 (d) REPORTS.—Not later than 18 months after the
13 date of the enactment of this Act, and annually thereafter,
14 the Secretary shall prepare and submit to the Congress
15 a report describing the program carried out under this sec-
16 tion, including statements regarding the following:

17 (1) The number of dentists enrolled in the pro-
18 gram.

19 (2) The number and amount of loan repay-
20 ments.

21 (3) The placement location of loan repayment
22 recipients at facilities described in subsection (a)(1).

23 (4) The default rate and actions required.

24 (5) The amount of outstanding default funds.

1 (6) To the extent that it can be determined, the
2 reason for the default.

3 (7) The demographics of individuals partici-
4 pating in the program.

5 (8) An evaluation of the overall costs and bene-
6 fits of the program.

7 (e) DEFINITIONS.—In this section:

8 (1) DENTAL EDUCATION LOAN.—The term
9 “dental education loan”—

10 (A) means a loan that is incurred for the
11 cost of attendance (including tuition, other rea-
12 sonable educational expenses, and reasonable
13 living costs) at a school of dentistry; and

14 (B) includes only the portion of the loan
15 that is outstanding on the date the dentist in-
16 volved begins the service specified in the agree-
17 ment under subsection (a).

18 (2) DENTIST.—The term “dentist” means a
19 graduate of a school of dentistry who has completed
20 postgraduate training in general or pediatric den-
21 tistry.

22 (3) HIV/AIDS.—The term “HIV/AIDS” means
23 human immunodeficiency virus and acquired im-
24 mune deficiency syndrome.

1 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 such sums as may be necessary for fiscal years 2021
4 through 2024.

5 **SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE**
6 **POPULATIONS.**

7 (a) IN GENERAL.—The Secretary shall submit to
8 Congress and the President an annual report on the im-
9 pact of HIV for racial and ethnic minority communities,
10 women, and youth aged 24 and younger.

11 (b) CONTENTS.—The report under subsection (a)
12 shall include information on the—

13 (1) progress that has been made in reducing
14 the impact of HIV/AIDS in such communities;

15 (2) opportunities that exist to make additional
16 progress in reducing the impact of HIV/AIDS in
17 such communities;

18 (3) challenges that may impede such additional
19 progress; and

20 (4) Federal funding necessary to achieve sub-
21 stantial reductions in HIV in racial and ethnic mi-
22 nority communities.

23 **SEC. 754. NATIONAL HIV/AIDS OBSERVANCE DAYS.**

24 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
25 of Congress that national observance days highlighting the

1 impact of HIV on communities of color include the fol-
2 lowing:

3 (1) National Black HIV/AIDS Awareness Day.

4 (2) National Latino AIDS Awareness Day.

5 (3) National Asian and Pacific Islander HIV/
6 AIDS Awareness Day.

7 (4) National Native American HIV/AIDS
8 Awareness Day.

9 (5) National Youth HIV/AIDS Awareness Day.

10 (b) CALL TO ACTION.—It is the sense of Congress
11 that the President should call on members of communities
12 of color—

13 (1) to become involved at the local community
14 level in HIV testing, policy, and advocacy;

15 (2) to become aware, engaged, and empowered
16 on the HIV epidemic within their communities; and

17 (3) to urge members of their communities to re-
18 duce risk factors, practice safe sex and other preven-
19 tive measures, be tested for HIV, and seek care
20 when appropriate.

21 **SEC. 755. REVIEW OF ALL FEDERAL AND STATE LAWS,**
22 **POLICIES, AND REGULATIONS REGARDING**
23 **THE CRIMINAL PROSECUTION OF INDIVID-**
24 **UALS FOR HIV-RELATED OFFENSES.**

25 (a) DEFINITIONS.—In this section:

1 (1) HIV.—The term “HIV” has the meaning
2 given to the term in section 2689 of the Public
3 Health Service Act (42 U.S.C. 300ff–88).

4 (2) STATE.—The term “State” includes the
5 District of Columbia, American Samoa, the Com-
6 monwealth of the Northern Mariana Islands, Guam,
7 Puerto Rico, and the United States Virgin Islands.

8 (b) SENSE OF CONGRESS REGARDING LAWS OR REG-
9 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV.—
10 It is the sense of Congress that Federal and State laws,
11 policies, and regulations regarding people living with
12 HIV—

13 (1) should not place unique or additional bur-
14 dens on such individuals solely as a result of their
15 HIV status; and

16 (2) should instead demonstrate a public health-
17 oriented, evidence-based, medically accurate, and
18 contemporary understanding of—

19 (A) the multiple factors that lead to HIV
20 transmission;

21 (B) the relative risk of HIV transmission
22 routes;

23 (C) the current health implications of liv-
24 ing with HIV;

1 (D) the associated benefits of treatment
2 and support services for people living with HIV;

3 (E) the impact of punitive HIV-specific
4 laws and policies on public health, on people liv-
5 ing with or affected by HIV, and on their fami-
6 lies and communities; and

7 (F) the current science on HIV prevention
8 and treatment, including pre-exposure prophylaxis (PrEP),
9 post-exposure prophylaxis (PEP),
10 and viral suppression.

11 (c) REVIEW OF ALL FEDERAL AND STATE LAWS,
12 POLICIES, AND REGULATIONS REGARDING THE CRIMINAL
13 PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OF-
14 FENSES.—

15 (1) REVIEW OF FEDERAL AND STATE LAWS.—

16 (A) IN GENERAL.—Not later than 90 days
17 after the date of the enactment of this Act, the
18 Attorney General, the Secretary of Health and
19 Human Services, and the Secretary of Defense
20 acting jointly (in this paragraph and paragraph
21 (2) referred to as the “designated officials”)
22 shall initiate a national review of Federal and
23 State laws, policies, regulations, and judicial
24 precedents and decisions regarding criminal and
25 related civil commitment cases involving people

1 living with HIV, including in regards to the
2 Uniform Code of Military Justice.

3 (B) CONSULTATION.—In carrying out the
4 review under subparagraph (A), the designated
5 officials shall ensure diverse participation and
6 consultation from each State, including with—

7 (i) State attorneys general (or their
8 representatives);

9 (ii) State public health officials (or
10 their representatives);

11 (iii) State judicial and court system
12 officers, including judges, district attor-
13 neys, prosecutors, defense attorneys, law
14 enforcement, and correctional officers;

15 (iv) members of the United States
16 Armed Forces, including members of other
17 Federal services subject to the Uniform
18 Code of Military Justice;

19 (v) people living with HIV, particu-
20 larly those who have been subject to HIV-
21 related prosecution or who are from com-
22 munities whose members have been dis-
23 proportionately subject to HIV-specific ar-
24 rests and prosecutions;

1 (vi) legal advocacy and HIV service
2 organizations that work with people living
3 with HIV;

4 (vii) nongovernmental health organi-
5 zations that work on behalf of people living
6 with HIV; and

7 (viii) trade organizations or associa-
8 tions representing persons or entities de-
9 scribed in clauses (i) through (vii).

10 (C) RELATION TO OTHER REVIEWS.—In
11 carrying out the review under subparagraph
12 (A), the designated officials may utilize other
13 existing reviews of criminal and related civil
14 commitment cases involving people living with
15 HIV, including any such review conducted by
16 any Federal or State agency or any public
17 health, legal advocacy, or trade organization or
18 association if the designated officials determine
19 that such reviews were conducted in accordance
20 with the principles set forth in subsection (b).

21 (2) REPORT.—No later than 180 days after ini-
22 tiating the review required by paragraph (1), the At-
23 torney General shall transmit to Congress and make
24 publicly available a report containing the results of
25 the review, which includes the following:

1 (A) For each State and for the Uniform
2 Code of Military Justice, a summary of the rel-
3 evant laws, policies, regulations, and judicial
4 precedents and decisions regarding criminal
5 cases involving people living with HIV, includ-
6 ing, if applicable, the following:

7 (i) A determination of whether such
8 laws, policies, regulations, and judicial
9 precedents and decisions place any unique
10 or additional burdens upon people living
11 with HIV.

12 (ii) A determination of whether such
13 laws, policies, regulations, and judicial
14 precedents and decisions demonstrate a
15 public health-oriented, evidence-based,
16 medically accurate, and contemporary un-
17 derstanding of—

18 (I) the multiple factors that lead
19 to HIV transmission;

20 (II) the relative risk of HIV
21 transmission routes;

22 (III) the current health implica-
23 tions of living with HIV;

1 (IV) the associated benefits of
2 treatment and support services for
3 people living with HIV;

4 (V) the impact of punitive HIV-
5 specific laws and policies on public
6 health, on people living with or af-
7 fected by HIV, and on their families
8 and communities; and

9 (VI) the current science on HIV
10 prevention and treatment, including
11 pre-exposure prophylaxis (PrEP),
12 post-exposure prophylaxis (PEP), and
13 viral suppression.

14 (iii) An analysis of the public health
15 and legal implications of such laws, poli-
16 cies, regulations, and judicial precedents,
17 including an analysis of the consequences
18 of having a similar penal scheme applied to
19 comparable situations involving other com-
20 municable diseases.

21 (iv) An analysis of the proportionality
22 of punishments imposed under HIV-spe-
23 cific laws, policies, regulations, and judicial
24 precedents, taking into consideration pen-
25 alties attached to violation of State laws

1 against similar degrees of endangerment or
2 harm, such as driving while intoxicated or
3 transmission of other communicable dis-
4 eases, or more serious harms, such as ve-
5 hicular manslaughter offenses.

6 (B) An analysis of common elements
7 shared among State laws, policies, regulations,
8 and judicial precedents.

9 (C) A set of best practice recommendations
10 directed to State governments, including State
11 attorneys general, public health officials, and
12 judicial officers, in order to ensure that laws,
13 policies, regulations, and judicial precedents re-
14 garding people living with HIV are in accord-
15 ance with the principles set forth in subsection
16 (b).

17 (D) Recommendations for adjustments to
18 the Uniform Code of Military Justice, as may
19 be necessary, in order to ensure that laws, poli-
20 cies, regulations, and judicial precedents re-
21 garding people living with HIV are in accord-
22 ance with the principles set forth in subsection
23 (b).

24 (3) GUIDANCE.—Within 90 days of the release
25 of the report required by paragraph (2), the Attor-

1 ney General and the Secretary of Health and
2 Human Services, acting jointly, shall develop and
3 publicly release updated guidance for States based
4 on the set of best practice recommendations required
5 by paragraph (2)(C) in order to assist States dealing
6 with criminal and related civil commitment cases re-
7 garding people living with HIV.

8 (4) MONITORING AND EVALUATION SYSTEM.—

9 Within 60 days of the release of the guidance re-
10 quired by paragraph (3), the Attorney General and
11 the Secretary of Health and Human Services, acting
12 jointly, shall establish an integrated monitoring and
13 evaluation system which includes, where appropriate,
14 objective and quantifiable performance goals and in-
15 dicators to measure progress toward statewide im-
16 plementation in each State of the best practice rec-
17 ommendations required in paragraph (2)(C), includ-
18 ing to monitor, track, and evaluate the effectiveness
19 of assistance provided pursuant to subsection (d).

20 (5) ADJUSTMENTS TO FEDERAL LAWS, POLI-

21 CIES, OR REGULATIONS.—Within 90 days of the re-
22 lease of the report required by paragraph (2), the
23 Attorney General, the Secretary of Health and
24 Human Services, and the Secretary of Defense, act-
25 ing jointly, shall develop and transmit to the Presi-

1 dent and the Congress, and make publicly available,
2 such proposals as may be necessary to implement
3 adjustments to Federal laws, policies, or regulations,
4 including to the Uniform Code of Military Justice,
5 based on the recommendations required by para-
6 graph (2)(D), either through Executive order or
7 through changes to statutory law.

8 (6) AUTHORIZATION OF APPROPRIATIONS.—

9 (A) IN GENERAL.—There are authorized to
10 be appropriated such sums as may be necessary
11 for the purpose of carrying out this subsection.
12 Amounts authorized to be appropriated by the
13 preceding sentence are in addition to amounts
14 otherwise authorized to be appropriated for
15 such purpose.

16 (B) AVAILABILITY OF FUNDS.—Amounts
17 appropriated pursuant to the authorization of
18 appropriations in subparagraph (A) are author-
19 ized to remain available until expended.

20 (d) AUTHORIZATION TO PROVIDE GRANTS.—

21 (1) GRANTS BY ATTORNEY GENERAL.—

22 (A) IN GENERAL.—The Attorney General
23 may provide assistance to eligible State and
24 local entities and eligible nongovernmental orga-
25 nizations for the purpose of incorporating the

1 best practice recommendations developed under
2 subsection (c)(2)(C) within relevant State laws,
3 policies, regulations, and judicial decisions re-
4 garding people living with HIV.

5 (B) AUTHORIZED ACTIVITIES.—The assist-
6 ance authorized by subparagraph (A) may in-
7 clude—

8 (i) direct technical assistance to eligi-
9 ble State and local entities in order to de-
10 velop, disseminate, or implement State
11 laws, policies, regulations, or judicial deci-
12 sions that conform with the best practice
13 recommendations developed under sub-
14 section (c)(2)(C);

15 (ii) direct technical assistance to eligi-
16 ble nongovernmental organizations in order
17 to provide education and training, includ-
18 ing through classes, conferences, meetings,
19 and other educational activities, to eligible
20 State and local entities; and

21 (iii) subcontracting authority to allow
22 eligible State and local entities and eligible
23 nongovernmental organizations to seek
24 technical assistance from legal and public
25 health experts with a demonstrated under-

1 standing of the principles underlying the
2 best practice recommendations developed
3 under subsection (c)(2)(C).

4 (2) GRANTS BY SECRETARY OF HEALTH AND
5 HUMAN SERVICES.—

6 (A) IN GENERAL.—The Secretary of
7 Health and Human Services, acting through the
8 Director of the Centers for Disease Control and
9 Prevention, may provide assistance to State and
10 local public health departments and eligible
11 nongovernmental organizations for the purpose
12 of supporting eligible State and local entities to
13 incorporate the best practice recommendations
14 developed under subsection (c)(2)(C) within rel-
15 evant State laws, policies, regulations, and judi-
16 cial decisions regarding people living with HIV.

17 (B) AUTHORIZED ACTIVITIES.—The assist-
18 ance authorized by subparagraph (A) may in-
19 clude—

20 (i) direct technical assistance to State
21 and local public health departments in
22 order to support the development, dissemi-
23 nation, or implementation of State laws,
24 policies, regulations, or judicial decisions
25 that conform with the set of best practice

1 recommendations developed under sub-
2 section (c)(2)(C);

3 (ii) direct technical assistance to eligi-
4 ble nongovernmental organizations in order
5 to provide education and training, includ-
6 ing through classes, conferences, meetings,
7 and other educational activities, to State
8 and local public health departments; and

9 (iii) subcontracting authority to allow
10 State and local public health departments
11 and eligible nongovernmental organizations
12 to seek technical assistance from legal and
13 public health experts with a demonstrated
14 understanding of the principles underlying
15 the best practice recommendations devel-
16 oped under subsection (c)(2)(C).

17 (3) LIMITATION.—As a condition of receiving
18 assistance through this subsection, eligible State and
19 local entities, State and local public health depart-
20 ments, and eligible nongovernmental organizations
21 shall agree—

22 (A) not to place any unique or additional
23 burdens on people living with HIV solely as a
24 result of their HIV status; and

1 (B) that if the entity, department, or orga-
2 nization promulgates any laws, policies, regula-
3 tions, or judicial decisions regarding people liv-
4 ing with HIV, such actions shall demonstrate a
5 public health-oriented, evidence-based, medically
6 accurate, and contemporary understanding of—

7 (i) the multiple factors that lead to
8 HIV transmission;

9 (ii) the relative risk of HIV trans-
10 mission routes;

11 (iii) the current health implications of
12 living with HIV;

13 (iv) the associated benefits of treat-
14 ment and support services for people living
15 with HIV;

16 (v) the impact of punitive HIV-spe-
17 cific laws and policies on public health, on
18 people living with or affected by HIV, and
19 on their families and communities; and

20 (vi) the current science on HIV pre-
21 vention and treatment, including pre-expo-
22 sure prophylaxis (PrEP), post-exposure
23 prophylaxis (PEP), and viral suppression.

24 (4) REPORT.—No later than 1 year after the
25 date of the enactment of this Act, and annually

1 thereafter, the Attorney General and the Secretary
2 of Health and Human Services, acting jointly, shall
3 transmit to Congress and make publicly available a
4 report describing, for each State, the impact and ef-
5 fectiveness of the assistance provided through this
6 section. Each such report shall include—

7 (A) a detailed description of the progress
8 each State has made, if any, in implementing
9 the best practice recommendations developed
10 under subsection (c)(2)(C) as a result of the as-
11 sistance provided under this subsection, and
12 based on the performance goals and indicators
13 established as part of the monitoring and eval-
14 uation system in subsection (c)(4);

15 (B) a brief summary of any outreach ef-
16 forts undertaken during the prior year by the
17 Attorney General and the Secretary of Health
18 and Human Services to encourage States to
19 seek assistance under this subsection in order
20 to implement the best practice recommenda-
21 tions developed under subsection (c)(2)(C);

22 (C) a summary of how assistance provided
23 through this subsection is being utilized by eli-
24 gible State and local entities, State and local
25 public health departments, and eligible non-

1 governmental organizations and, if applicable,
2 any contractors, including with respect to non-
3 governmental organizations, the type of tech-
4 nical assistance provided, and an evaluation of
5 the impact of such assistance on eligible State
6 and local entities; and

7 (D) a summary and description of eligible
8 State and local entities, State and local public
9 health departments, and eligible nongovern-
10 mental organizations receiving assistance
11 through this subsection, including if applicable,
12 a summary and description of any contractors
13 selected to assist in implementing such assist-
14 ance.

15 (5) DEFINITIONS.—For the purposes of this
16 subsection:

17 (A) ELIGIBLE STATE AND LOCAL ENTI-
18 TIES.—The term “eligible State and local enti-
19 ties” means the relevant individuals, offices, or
20 organizations that directly participate in the de-
21 velopment, dissemination, or implementation of
22 State laws, policies, regulations, or judicial deci-
23 sions, including—

24 (i) State governments, including State
25 attorneys general, State departments of

1 justice, and State National Guards, or
2 their equivalents;

3 (ii) State judicial and court systems,
4 including trial courts, appellate courts,
5 State supreme courts and courts of appeal,
6 and State correctional facilities, or their
7 equivalents; and

8 (iii) local governments, including city
9 and county governments, district attorneys,
10 and local law enforcement departments, or
11 their equivalents.

12 (B) STATE AND LOCAL PUBLIC HEALTH
13 DEPARTMENTS.—The term “State and local
14 public health departments” means the fol-
15 lowing:

16 (i) State public health departments, or
17 their equivalents, including the chief officer
18 of such departments and infectious disease
19 and communicable disease specialists with-
20 in such departments.

21 (ii) Local public health departments,
22 or their equivalents, including city and
23 county public health departments, the chief
24 officer of such departments, and infectious

1 disease and communicable disease special-
2 ists within such departments.

3 (iii) Public health departments or offi-
4 cials, or their equivalents, within State or
5 local correctional facilities.

6 (iv) Public health departments or offi-
7 cials, or their equivalents, within State Na-
8 tional Guards.

9 (v) Any other recognized State or
10 local public health organization or entity
11 charged with carrying out official State or
12 local public health duties.

13 (C) ELIGIBLE NONGOVERNMENTAL ORGA-
14 NIZATIONS.—The term “eligible nongovern-
15 mental organizations” means the following:

16 (i) Nongovernmental organizations,
17 including trade organizations or associa-
18 tions that represent—

19 (I) State attorneys general, or
20 their equivalents;

21 (II) State public health officials,
22 or their equivalents;

23 (III) State judicial and court offi-
24 cers, including judges, district attor-
25 neys, prosecutors, defense attorneys,

1 law enforcement, and correctional offi-
2 cers;

3 (IV) State National Guards;

4 (V) people living with HIV;

5 (VI) legal advocacy and HIV
6 service organizations that work with
7 people living with HIV; and

8 (VII) nongovernmental health or-
9 ganizations that work on behalf of
10 people living with HIV.

11 (ii) Nongovernmental organizations,
12 including trade organizations or associa-
13 tions that demonstrate a public-health ori-
14 ented, evidence-based, medically accurate,
15 and contemporary understanding of—

16 (I) the multiple factors that lead
17 to HIV transmission;

18 (II) the relative risk of HIV
19 transmission routes;

20 (III) the current health implica-
21 tions of living with HIV;

22 (IV) the associated benefits of
23 treatment and support services for
24 people living with HIV;

1 (V) the impact of punitive HIV-
2 specific laws and policies on public
3 health, on people living with or af-
4 fected by HIV, and on their families
5 and communities; and

6 (VI) the current science on HIV
7 prevention and treatment, including
8 pre-exposure prophylaxis (PrEP),
9 post-exposure prophylaxis (PEP), and
10 viral suppression.

11 (6) AUTHORIZATION OF APPROPRIATIONS.—

12 (A) IN GENERAL.—In addition to amounts
13 otherwise made available, there are authorized
14 to be appropriated to the Attorney General and
15 the Secretary of Health and Human Services
16 such sums as may be necessary to carry out
17 this subsection for each of the fiscal years 2021
18 through 2024.

19 (B) AVAILABILITY OF FUNDS.—Amounts
20 appropriated pursuant to the authorizations of
21 appropriations in subparagraph (A) are author-
22 ized to remain available until expended.

23 **SEC. 756. EXPANDING SUPPORT FOR CONDOMS IN PRIS-**
24 **ONS.**

25 (a) DEFINITIONS.—For the purposes of this section:

1 (1) COMMUNITY ORGANIZATION.—The term
2 “community organization” means a public health
3 care facility or a nonprofit organization which pro-
4 vides health- or STI-related services according to es-
5 tablished public health standards.

6 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
7 The term “comprehensive sexuality education”
8 means sexuality education—

9 (A) that includes information about absti-
10 nence and about the proper use and disposal of
11 sexual barrier protection devices; and

12 (B) which is—

13 (i) evidence-based;

14 (ii) medically accurate;

15 (iii) age and developmentally appro-
16 priate;

17 (iv) gender and identity sensitive;

18 (v) culturally and linguistically appro-
19 priate; and

20 (vi) structured to promote critical
21 thinking, self-esteem, respect for others,
22 and the development of healthy attitudes
23 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 gonorrhea, chlamydia, syphilis, genital herpes, viral
14 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 (b) AUTHORITY TO ALLOW COMMUNITY ORGANIZA-
2 TIONS TO PROVIDE STI COUNSELING, STI PREVENTION
3 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-
4 VICES IN FEDERAL CORRECTIONAL FACILITIES.—

5 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not
6 later than 30 days after the date of enactment of
7 this Act, the Attorney General shall direct the Direc-
8 tor of the Bureau of Prisons to allow community or-
9 ganizations to, in accordance with all relevant Fed-
10 eral laws and regulations which govern visitation in
11 correctional facilities—

12 (A) distribute sexual barrier protection de-
13 vices in Federal correctional facilities; and

14 (B) engage in STI counseling and STI pre-
15 vention education in Federal correctional facili-
16 ties.

17 (2) INFORMATION REQUIREMENT.—Any com-
18 munity organization permitted to distribute sexual
19 barrier protection devices under paragraph (1) shall
20 ensure that the persons to whom the devices are dis-
21 tributed are informed about the proper use and dis-
22 posal of sexual barrier protection devices in accord-
23 ance with established public health practices. Any
24 community organization conducting STI counseling

1 or STI prevention education under paragraph (1)
2 shall offer comprehensive sexuality education.

3 (3) POSSESSION OF DEVICE PROTECTED.—A
4 Federal correctional facility may not, because of the
5 possession or use of a sexual barrier protection de-
6 vice—

7 (A) take adverse action against an incar-
8 cerated person; or

9 (B) consider possession or use as evidence
10 of prohibited activity for the purpose of any
11 Federal correctional facility administrative pro-
12 ceeding.

13 (4) IMPLEMENTATION.—The Attorney General
14 and Bureau of Prisons shall implement this section
15 according to established public health practices in a
16 manner that protects the health, safety, and privacy
17 of incarcerated persons and of correctional facility
18 staff.

19 (c) SENSE OF CONGRESS REGARDING DISTRIBUTION
20 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
21 PRISON SYSTEMS.—It is the sense of the Congress that
22 States should allow for the legal distribution of sexual bar-
23 rier protection devices in State correctional facilities to re-
24 duce the prevalence and spread of STIs in those facilities.

1 (d) SURVEY OF AND REPORT ON CORRECTIONAL FA-
2 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
3 STIs.—

4 (1) SURVEY.—Not later than 180 days after
5 the date of enactment of this Act, and annually
6 thereafter for 5 years, the Attorney General, after
7 consulting with the Secretary of Health and Human
8 Services, State officials, and community organiza-
9 tions, shall, to the maximum extent practicable, con-
10 duct a survey of all Federal and State correctional
11 facilities, to determine the following:

12 (A) COUNSELING, TREATMENT, AND SUP-
13 PORTIVE SERVICES.—Whether the correctional
14 facility—

15 (i) requires incarcerated persons to
16 participate in counseling, treatment, and
17 supportive services related to STIs; or

18 (ii) offers such programs to incarcer-
19 ated persons.

20 (B) ACCESS TO SEXUAL BARRIER PROTEC-
21 TION DEVICES.—Whether incarcerated persons
22 can—

23 (i) possess sexual barrier protection
24 devices;

- 1 (ii) purchase sexual barrier protection
2 devices;
3 (iii) purchase sexual barrier protection
4 devices at a reduced cost; or
5 (iv) obtain sexual barrier protection
6 devices without cost.

7 (C) INCIDENCE OF SEXUAL VIOLENCE.—
8 The incidence of sexual violence and assault
9 committed by incarcerated persons and by cor-
10 rectional facility staff.

11 (D) PREVENTION EDUCATION OFFERED.—
12 The type of prevention education, information,
13 or training offered to incarcerated persons and
14 correctional facility staff regarding sexual vio-
15 lence and the spread of STIs, including whether
16 such education, information, or training—

- 17 (i) constitutes comprehensive sexuality
18 education;
19 (ii) is compulsory for new incarcerated
20 persons and for new staff; and
21 (iii) is offered on an ongoing basis.

22 (E) STI TESTING.—Whether the correc-
23 tional facility tests incarcerated persons for
24 STIs or gives them the option to undergo such
25 testing—

- 1 (i) at intake;
- 2 (ii) on a regular basis; and
- 3 (iii) prior to release.

4 (F) STI TEST RESULTS.—The number of
5 incarcerated persons who are tested for STIs
6 and the outcome of such tests at each correc-
7 tional facility, disaggregated to include results
8 for—

- 9 (i) the type of sexually transmitted in-
10 fection tested for;
- 11 (ii) the race and ethnicity of individ-
12 uals tested;
- 13 (iii) the age of individuals tested; and
- 14 (iv) the gender of individuals tested.

15 (G) PRERELEASE REFERRAL POLICY.—
16 Whether incarcerated persons are informed
17 prior to release about STI-related services or
18 other health services in their communities, in-
19 cluding free and low-cost counseling and treat-
20 ment options.

21 (H) PRERELEASE REFERRALS MADE.—
22 The number of referrals to community-based
23 organizations or public health facilities offering
24 STI-related or other health services provided to
25 incarcerated persons prior to release, and the

1 type of counseling or treatment for which the
2 referral was made.

3 (I) REINSTATEMENT OF MEDICAID BENE-
4 FITS.—Whether the correctional facility assists
5 incarcerated persons that were enrolled in the
6 State Medicaid program prior to their incarcer-
7 ation, in reinstating their enrollment upon re-
8 lease and whether such individuals receive refer-
9 rals as provided by subparagraph (G) to entities
10 that accept the State Medicaid program, includ-
11 ing if applicable—

12 (i) the number of such individuals, in-
13 cluding those diagnosed with HIV, that
14 have been reinstated;

15 (ii) a list of obstacles to reinstating
16 enrollment or to making determinations of
17 eligibility for reinstatement, if any; and

18 (iii) the number of individuals denied
19 enrollment.

20 (J) OTHER ACTIONS TAKEN.—Whether the
21 correctional facility has taken any other action,
22 in conjunction with community organizations or
23 otherwise, to reduce the prevalence and spread
24 of STIs in that facility.

1 (2) PRIVACY.—In conducting the survey under
2 paragraph (1), the Attorney General shall not re-
3 quest or retain the identity of any person who has
4 sought or been offered counseling, treatment, test-
5 ing, or prevention education information regarding
6 an STI (including information about sexual barrier
7 protection devices), or who has tested positive for an
8 STI.

9 (3) REPORT.—

10 (A) IN GENERAL.—The Attorney General
11 shall transmit to Congress and make publicly
12 available the results of the survey required
13 under paragraph (1), both for the United
14 States as a whole and disaggregated as to each
15 State and each correctional facility.

16 (B) DEADLINES.—To the maximum extent
17 possible, the Attorney General shall—

18 (i) issue the first report under sub-
19 paragraph (A) not later than 1 year after
20 the date of enactment of this Act; and

21 (ii) issue reports under subparagraph
22 (A) annually thereafter for 5 years.

23 (e) STRATEGY.—

24 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
25 Attorney General, in consultation with the Secretary

1 of Health and Human Services, State officials, and
2 community organizations, shall develop and imple-
3 ment a 5-year strategy to reduce the prevalence and
4 spread of STIs in Federal and State correctional fa-
5 cilities. To the maximum extent possible, the strat-
6 egy shall be developed, transmitted to Congress, and
7 made publicly available no later than 180 days after
8 the transmission of the first report required under
9 subsection (d)(3).

10 (2) CONTENTS OF STRATEGY.—The strategy
11 developed under paragraph (1) shall include the fol-
12 lowing:

13 (A) PREVENTION EDUCATION.—A plan for
14 improving prevention education, information,
15 and training offered to incarcerated persons
16 and correctional facility staff, including infor-
17 mation and training on sexual violence and the
18 spread of STIs, and comprehensive sexuality
19 education.

20 (B) SEXUAL BARRIER PROTECTION DEVICE
21 ACCESS.—A plan for expanding access to sexual
22 barrier protection devices in correctional facili-
23 ties.

24 (C) SEXUAL VIOLENCE REDUCTION.—A
25 plan for reducing the incidence of sexual vio-

1 lence among incarcerated persons and correc-
2 tional facility staff, developed in consultation
3 with the National Prison Rape Elimination
4 Commission.

5 (D) COUNSELING AND SUPPORTIVE SERV-
6 ICES.—A plan for expanding access to coun-
7 seling and supportive services related to STIs in
8 correctional facilities.

9 (E) TESTING.—A plan for testing incarcer-
10 ated persons for STIs during intake, during
11 regular health exams, and prior to release, and
12 that—

13 (i) is conducted in accordance with
14 guidelines established by the Centers for
15 Disease Control and Prevention;

16 (ii) includes pretest counseling;

17 (iii) requires that incarcerated persons
18 are notified of their option to decline test-
19 ing at any time;

20 (iv) requires that incarcerated persons
21 are confidentially notified of their test re-
22 sults in a timely manner; and

23 (v) ensures that incarcerated persons
24 testing positive for STIs receive post-test

1 counseling, care, treatment, and supportive
2 services.

3 (F) TREATMENT.—A plan for ensuring
4 that correctional facilities have the necessary
5 medicine and equipment to treat and monitor
6 STIs and for ensuring that incarcerated per-
7 sons living with or testing positive for STIs re-
8 ceive and have access to care and treatment
9 services.

10 (G) STRATEGIES FOR DEMOGRAPHIC
11 GROUPS.—A plan for developing and imple-
12 menting culturally appropriate, sensitive, and
13 specific strategies to reduce the spread of STIs
14 among demographic groups heavily impacted by
15 STIs.

16 (H) LINKAGES WITH COMMUNITIES AND
17 FACILITIES.—A plan for establishing and
18 strengthening linkages to local communities and
19 health facilities that—

20 (i) provide counseling, testing, care,
21 and treatment services;

22 (ii) may receive persons recently re-
23 leased from incarceration who are living
24 with STIs; and

1 (iii) accept payment through the State
2 Medicaid program.

3 (I) ENROLLMENT IN STATE MEDICAID
4 PROGRAMS.—Plans to ensure that—

5 (i) incarcerated persons who were en-
6 rolled in their State Medicaid program
7 prior to incarceration in a correctional fa-
8 cility are automatically reenrolled in such
9 program upon their release; and

10 (ii) incarcerated persons who were not
11 enrolled in their State Medicaid program
12 prior to incarceration, and who are diag-
13 nosed with HIV while incarcerated in a
14 correctional facility, are automatically en-
15 rolled in such program upon their release.

16 (J) OTHER PLANS.—Any other plans de-
17 veloped by the Attorney General for reducing
18 the spread of STIs or improving the quality of
19 health care in correctional facilities.

20 (K) MONITORING SYSTEM.—A monitoring
21 system that establishes performance goals re-
22 lated to reducing the prevalence and spread of
23 STIs in correctional facilities and which, where
24 feasible, expresses such goals in quantifiable
25 form.

1 (L) MONITORING SYSTEM PERFORMANCE
2 INDICATORS.—Performance indicators that
3 measure or assess the achievement of the per-
4 formance goals described in subparagraph (K).

5 (M) COST ESTIMATE.—A detailed estimate
6 of the funding necessary to implement the
7 strategy at the Federal and State levels for all
8 5 years, including the amount of funds required
9 by community organizations to implement the
10 parts of the strategy in which they take part.

11 (3) REPORT.—Not later than 1 year after the
12 date of the enactment of this Act, and annually
13 thereafter, the Attorney General shall transmit to
14 Congress and make publicly available an annual
15 progress report regarding the implementation and
16 effectiveness of the strategy described in paragraph
17 (1). The progress report shall include an evaluation
18 of the implementation of the strategy using the mon-
19 itoring system and performance indicators provided
20 for in subparagraphs (K) and (L) of paragraph (2).

21 (f) AUTHORIZATION OF APPROPRIATIONS.—

22 (1) IN GENERAL.—There are authorized to be
23 appropriated such sums as may be necessary to
24 carry out this section for each of fiscal years 2021
25 through 2025.

1 (2) AVAILABILITY OF FUNDS.—Amounts made
2 available under paragraph (1) are authorized to re-
3 main available until expended.

4 **SEC. 757. AUTOMATIC REINSTATEMENT OR ENROLLMENT**
5 **IN MEDICAID FOR PEOPLE WHO TEST POSI-**
6 **TIVE FOR HIV BEFORE REENTERING COMMU-**
7 **NITIES.**

8 (a) IN GENERAL.—Section 1902(e) of the Social Se-
9 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
10 the end the following:

11 “(16) ENROLLMENT OF EX-OFFENDERS.—

12 “(A) AUTOMATIC ENROLLMENT OR REIN-
13 STATEMENT.—

14 “(i) IN GENERAL.—The State plan
15 shall provide for the automatic enrollment
16 or reinstatement of enrollment of an eligi-
17 ble individual—

18 “(I) if such individual is sched-
19 uled to be released from a public insti-
20 tution due to the completion of sen-
21 tence, not less than 30 days prior to
22 the scheduled date of the release; and

23 “(II) if such individual is to be
24 released from a public institution on
25 parole or on probation, as soon as

1 possible after the date on which the
2 determination to release such indi-
3 vidual was made, and before the date
4 such individual is released.

5 “(ii) EXCEPTION.—If a State makes a
6 determination that an individual is not eli-
7 gible to be enrolled under the State plan—

8 “(I) on or before the date by
9 which the individual would be enrolled
10 under clause (i), such clause shall not
11 apply to such individual; or

12 “(II) after such date, the State
13 may terminate the enrollment of such
14 individual.

15 “(B) RELATIONSHIP OF ENROLLMENT TO
16 PAYMENT FOR SERVICES.—

17 “(i) IN GENERAL.—Subject to sub-
18 paragraph (A)(ii), an eligible individual
19 who is enrolled, or whose enrollment is re-
20 instated, under subparagraph (A) shall be
21 eligible for all services for which medical
22 assistance is provided under the State plan
23 after the date that the eligible individual is
24 released from the public institution.

1 “(ii) RELATIONSHIP TO PAYMENT
2 PROHIBITION FOR INMATES.—No provision
3 of this paragraph may be construed to per-
4 mit payment for care or services for which
5 payment is excluded under subdivision (A)
6 following paragraph (29) of section
7 1905(a).

8 “(C) TREATMENT OF CONTINUOUS ELIGI-
9 BILITY.—

10 “(i) SUSPENSION FOR INMATES.—Any
11 period of continuous eligibility under this
12 title shall be suspended on the date an in-
13 dividual enrolled under this title becomes
14 an inmate of a public institution (except as
15 a patient of a medical institution).

16 “(ii) DETERMINATION OF REMAINING
17 PERIOD.—Notwithstanding any changes to
18 State law related to continuous eligibility
19 during the time that an individual is an in-
20 mate of a public institution (except as a
21 patient of a medical institution), subject to
22 clause (iii), with respect to an eligible indi-
23 vidual who was subject to a suspension
24 under clause (i), on the date that such in-
25 dividual is released from a public institu-

1 tion the suspension of continuous eligibility
2 under such clause shall be lifted for a pe-
3 riod that is equal to the time remaining in
4 the period of continuous eligibility for such
5 individual on the date that such period was
6 suspended under such clause.

7 “(iii) EXCEPTION.—If a State makes
8 a determination that an individual is not
9 eligible to be enrolled under the State
10 plan—

11 “(I) on or before the date that
12 the suspension of continuous eligibility
13 is lifted under clause (ii), such clause
14 shall not apply to such individual; or

15 “(II) after such date, the State
16 may terminate the enrollment of such
17 individual.

18 “(D) AUTOMATIC ENROLLMENT OR REIN-
19 STATEMENT OF ENROLLMENT DEFINED.—For
20 purposes of this paragraph, the term ‘automatic
21 enrollment or reinstatement of enrollment’
22 means that the State determines eligibility for
23 medical assistance under the State plan without
24 a program application from, or on behalf of, the
25 eligible individual, but an individual can only be

1 automatically enrolled in the State Medicaid
2 plan if the individual affirmatively consents to
3 being enrolled through affirmation in writing,
4 by telephone, orally, through electronic signa-
5 ture, or through any other means specified by
6 the Secretary.

7 “(E) ELIGIBLE INDIVIDUAL DEFINED.—

8 For purposes of this paragraph, the term ‘eligi-
9 ble individual’ means an individual who is an
10 inmate of a public institution (except as a pa-
11 tient in a medical institution)—

12 “(i) who was enrolled under the State
13 plan for medical assistance immediately be-
14 fore becoming an inmate of such an insti-
15 tution; or

16 “(ii) who is diagnosed with human im-
17 munodeficiency virus.”.

18 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
19 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
20 ICAID BENEFITS.—

21 (1) IN GENERAL.—Subject to paragraphs (3),
22 with respect to a State, for each of the first 4 cal-
23 endar quarters in which the State plan meets the re-
24 quirements of paragraph (16) of section 1902(e) of
25 the Social Security Act (42 U.S.C. 1396a(e)) (as

1 added by subsection (a)), the Federal matching pay-
2 ments (including payments based on the Federal
3 medical assistance percentage) made to such State
4 under section 1903 of the Social Security Act (42
5 U.S.C. 1396b) for the State expenditures described
6 in paragraph (2) shall be increased by 5 percentage
7 points.

8 (2) EXPENDITURES.—The expenditures de-
9 scribed in this paragraph are the following:

10 (A) Expenditures for which payment is
11 available under section 1903 of the Social Secu-
12 rity Act (42 U.S.C. 1396b) and which are at-
13 tributable to strengthening the State’s enroll-
14 ment and administrative resources for the pur-
15 pose of improving processes for enrolling (or re-
16 instating the enrollment of) eligible individuals
17 (as such term is defined in subparagraph (E) of
18 paragraph (16) of section 1902(e) of the Social
19 Security Act (42 U.S.C. 1396a(e)) (as amended
20 by subsection (a)).

21 (B) Expenditures for medical assistance
22 (as such term is defined in section 1905(a) of
23 the Social Security Act (42 U.S.C. 1396d(a)))
24 provided to such eligible individuals.

25 (3) REQUIREMENTS; LIMITATION.—

1 (A) REPORT.—A State is not eligible for
2 an increase in its Federal matching payments
3 under paragraph (1) unless the State agrees to
4 submit to the Secretary of Health and Human
5 Services, and make publicly available, a report
6 that contains the information required under
7 paragraph (4) by the end of the 1-year period
8 during which the State receives increased Fed-
9 eral matching payments in accordance with that
10 paragraph.

11 (B) MAINTENANCE OF ELIGIBILITY.—

12 (i) IN GENERAL.—Subject to clause
13 (ii), a State is not eligible for an increase
14 in its Federal matching payments under
15 paragraph (1) if eligibility standards,
16 methodologies, or procedures under its
17 State plan under title XIX of the Social
18 Security Act (42 U.S.C. 1396 et seq.), or
19 waiver of such a plan, are more restrictive
20 than the eligibility standards, methodolo-
21 gies, or procedures, respectively, under
22 such plan or waiver as in effect on the date
23 of enactment of this Act.

24 (ii) STATE REINSTATEMENT OF ELIGI-
25 BILITY PERMITTED.—A State that has re-

1 stricted eligibility standards, methodolo-
2 gies, or procedures under its State plan
3 under title XIX of the Social Security Act
4 (42 U.S.C. 1396 et seq.), or a waiver of
5 such plan, after the date of enactment of
6 this Act, is no longer ineligible under
7 clause (i) beginning with the first calendar
8 quarter in which the State has reinstated
9 eligibility standards, methodologies, or pro-
10 cedures that are no more restrictive than
11 the eligibility standards, methodologies, or
12 procedures, respectively, under such plan
13 (or waiver) as in effect on such date.

14 (C) LIMITATION OF MATCHING PAYMENTS
15 TO 100 PERCENT.—In no case shall an increase
16 in Federal matching payments under paragraph
17 (1) result in Federal matching payments that
18 exceed 100 percent of State expenditures.

19 (4) REQUIRED REPORT INFORMATION.—The in-
20 formation that is required in the report under para-
21 graph (3)(A) shall include—

22 (A) the results of an evaluation of the im-
23 pact of the implementation of the requirements
24 of paragraph (16) of section 1902(e) of the So-
25 cial Security Act (42 U.S.C. 1396a(e)) on im-

1 proving the State's processes for enrolling indi-
2 viduals who are released from public institu-
3 tions under the State Medicaid plan;

4 (B) the number of individuals who were
5 automatically enrolled (or whose enrollment was
6 reinstated) under such paragraph during the 1-
7 year period during which the State received in-
8 creased payments under this subsection; and

9 (C) any other information that is required
10 by the Secretary of Health and Human Serv-
11 ices.

12 (c) EFFECTIVE DATE.—

13 (1) IN GENERAL.—Except as provided in para-
14 graph (2), the amendments made by subsection (a)
15 shall take effect 180 days after the date of the en-
16 actment of this Act.

17 (2) RULE FOR CHANGES REQUIRING STATE
18 LEGISLATION.—In the case of a State plan for med-
19 ical assistance under title XIX of the Social Security
20 Act (42 U.S.C. 1396 et seq.) which the Secretary of
21 Health and Human Services determines requires
22 State legislation (other than legislation appro-
23 priating funds) in order for the plan to meet the ad-
24 ditional requirement imposed by the amendments
25 made by subsection (a), the State plan shall not be

1 regarded as failing to comply with the requirements
2 of such title solely on the basis of its failure to meet
3 this additional requirement before the first day of
4 the first calendar quarter beginning after the close
5 of the first regular session of the State legislature
6 that begins after the date of the enactment of this
7 Act. For purposes of the previous sentence, in the
8 case of a State that has a 2-year legislative session,
9 each year of such session shall be deemed to be a
10 separate regular session of the State legislature.

11 **SEC. 758. STOP HIV IN PRISON.**

12 (a) **SHORT TITLE.**—This section may be cited as the
13 “Stop HIV in Prison Act”.

14 (b) **IN GENERAL.**—The Director of the Bureau of
15 Prisons (referred to in this section as the “Director”) shall
16 develop a comprehensive policy to provide HIV testing,
17 treatment, and prevention for inmates within the correc-
18 tional setting and upon reentry.

19 (c) **PURPOSE.**—The purposes of the policy required
20 to be developed under subsection (b) shall be as follows:

21 (1) To stop the spread of HIV among inmates.

22 (2) To protect prison guards and other per-
23 sonnel from HIV infection.

24 (3) To provide comprehensive medical treat-
25 ment to inmates who are living with HIV.

1 (4) To promote HIV awareness and prevention
2 among inmates.

3 (5) To encourage inmates to take personal re-
4 sponsibility for their health.

5 (6) To reduce the risk that inmates will trans-
6 mit HIV to other persons in the community fol-
7 lowing their release from prison.

8 (d) CONSULTATION.—The Director shall consult with
9 appropriate officials of the Department of Health and
10 Human Services, the Office of National Drug Control Pol-
11 icy, and the Centers for Disease Control and Prevention
12 regarding the development of the policy required under
13 subsection (b).

14 (e) TIME LIMIT.—Not later than 1 year after the
15 date of enactment of this Act, the Director shall draft ap-
16 propriate regulations to implement the policy required to
17 be developed under subsection (b).

18 (f) REQUIREMENTS FOR POLICY.—The policy re-
19 quired to be developed under subsection (b) shall provide
20 for the following:

21 (1) TESTING AND COUNSELING UPON IN-
22 TAKE.—

23 (A) Health care personnel shall provide
24 routine HIV testing to all inmates as a part of
25 a comprehensive medical examination imme-

1 diately following admission to a facility. Health
2 care personnel need not provide routine HIV
3 testing to an inmate who is transferred to a fa-
4 cility from another facility if the inmate's med-
5 ical records are transferred with the inmate and
6 indicate that the inmate has been tested pre-
7 viously.

8 (B) To all inmates admitted to a facility
9 prior to the effective date of this policy, health
10 care personnel shall provide routine HIV testing
11 within no more than 6 months. HIV testing for
12 these inmates may be performed in conjunction
13 with other health services provided to these in-
14 mates by health care personnel.

15 (C) All HIV tests under this paragraph
16 shall comply with the opt-out provision.

17 (2) PRE-TEST AND POST-TEST COUNSELING.—

18 Health care personnel shall provide confidential pre-
19 test and post-test counseling to all inmates who are
20 tested for HIV. Counseling may be included with
21 other general health counseling provided to inmates
22 by health care personnel.

23 (3) HIV PREVENTION EDUCATION.—

24 (A) Health care personnel shall improve
25 HIV awareness through frequent educational

1 programs for all inmates. HIV educational pro-
2 grams may be provided by community-based or-
3 ganizations, local health departments, and in-
4 mate peer educators.

5 (B) HIV educational materials shall be
6 made available to all inmates at orientation, at
7 health care clinics, at regular educational pro-
8 grams, and prior to release. Both written and
9 audiovisual materials shall be made available to
10 all inmates.

11 (C)(i) The HIV educational programs and
12 materials under this paragraph shall include in-
13 formation on—

14 (I) modes of transmission, including
15 transmission through tattooing, sexual con-
16 tact, and intravenous drug use;

17 (II) prevention methods;

18 (III) treatment; and

19 (IV) disease progression.

20 (ii) The programs and materials shall be
21 culturally sensitive, written or designed for low-
22 literacy levels, available in a variety of lan-
23 guages, and present scientifically accurate in-
24 formation in a clear and understandable man-
25 ner.

1 (4) HIV TESTING UPON REQUEST.—

2 (A) Health care personnel shall allow in-
3 mates to obtain HIV tests upon request once
4 per year or whenever an inmate has a reason to
5 believe the inmate may have been exposed to
6 HIV. Health care personnel shall, both orally
7 and in writing, inform inmates, during orienta-
8 tion and periodically throughout incarceration,
9 of their right to obtain HIV tests.

10 (B) Health care personnel shall encourage
11 inmates to request HIV tests if the inmate is
12 sexually active, has been raped, uses intra-
13 venous drugs, receives a tattoo, or if the inmate
14 is concerned that the inmate may have been ex-
15 posed to HIV.

16 (C) An inmate's request for an HIV test
17 shall not be considered an indication that the
18 inmate has put him/herself at risk of infection
19 and/or committed a violation of prison rules.

20 (5) HIV TESTING OF PREGNANT WOMAN.—

21 (A) Health care personnel shall provide
22 routine HIV testing to all inmates who become
23 pregnant.

24 (B) All HIV tests under this paragraph
25 shall comply with the opt-out provision.

1 (6) COMPREHENSIVE TREATMENT.—

2 (A) Health care personnel shall provide all
3 inmates who test positive for HIV—

4 (i) timely, comprehensive medical
5 treatment;

6 (ii) confidential counseling on man-
7 aging their medical condition and pre-
8 venting its transmission to other persons;
9 and

10 (iii) voluntary partner notification
11 services.

12 (B) Health care provided under this para-
13 graph shall be consistent with current Depart-
14 ment of Health and Human Services guidelines
15 and standard medical practice. Health care per-
16 sonnel shall discuss treatment options, the im-
17 portance of adherence to antiretroviral therapy,
18 and the side effects of medications with inmates
19 receiving treatment.

20 (C) Health care personnel and pharmacy
21 personnel shall ensure that the facility for-
22 mulary contains all Food and Drug Administra-
23 tion-approved medications necessary to provide
24 comprehensive treatment for inmates living with
25 HIV, and that the facility maintains adequate

1 supplies of such medications to meet inmates'
2 medical needs. Health care personnel and phar-
3 macy personnel shall also develop and imple-
4 ment automatic renewal systems for these medi-
5 cations to prevent interruptions in care.

6 (D) Correctional staff, health care per-
7 sonnel, and pharmacy personnel shall develop
8 and implement distribution procedures to en-
9 sure timely and confidential access to medica-
10 tions.

11 (7) PROTECTION OF CONFIDENTIALITY.—

12 (A) Health care personnel shall develop
13 and implement procedures to ensure the con-
14 fidentiality of inmate tests, diagnoses, and
15 treatment. Health care personnel and correc-
16 tional staff shall receive regular training on the
17 implementation of these procedures. Penalties
18 for violations of inmate confidentiality by health
19 care personnel or correctional staff shall be
20 specified and strictly enforced.

21 (B) HIV testing, counseling, and treat-
22 ment shall be provided in a confidential setting
23 where other routine health services are provided
24 and in a manner that allows the inmate to re-

1 quest and obtain these services as routine med-
2 ical services.

3 (8) TESTING, COUNSELING, AND REFERRAL
4 PRIOR TO REENTRY.—

5 (A) Health care personnel shall provide
6 routine HIV testing to all inmates not earlier
7 than 3 months prior to their release and re-
8 entry into the community. Inmates who are al-
9 ready known to be infected need not be tested
10 again. This requirement may be waived if an in-
11 mate's release occurs without sufficient notice
12 to the Bureau to allow health care personnel to
13 perform a routine HIV test and notify the in-
14 mate of the results.

15 (B) All HIV tests under this paragraph
16 shall comply with the opt-out provision.

17 (C) To all inmates who test positive for
18 HIV and all inmates who already are known to
19 have HIV, health care personnel shall provide—

20 (i) confidential prerelease counseling
21 on managing their medical condition in the
22 community, accessing appropriate treat-
23 ment and services in the community, and
24 preventing the transmission of their condi-

1 tion to family members and other persons
2 in the community;

3 (ii) referrals to appropriate health
4 care providers and social service agencies
5 in the community that meet the inmate's
6 individual needs, including voluntary part-
7 ner notification services and prevention
8 counseling services for people living with
9 HIV; and

10 (iii) a 30-day supply of any medically
11 necessary medications the inmate is cur-
12 rently receiving.

13 (9) OPT-OUT PROVISION.—Inmates shall have
14 the right to refuse routine HIV testing. Inmates
15 shall be informed both orally and in writing of this
16 right. Oral and written disclosure of this right may
17 be included with other general health information
18 and counseling provided to inmates by health care
19 personnel. If an inmate refuses a routine test for
20 HIV, health care personnel shall make a note of the
21 inmate's refusal in the inmate's confidential medical
22 records. However, the inmate's refusal shall not be
23 considered a violation of prison rules or result in dis-
24 ciplinary action. Any reference in this section to the

1 “opt-out provision” shall be deemed a reference to
2 the requirement of this paragraph.

3 (10) EXCLUSION OF TESTS PERFORMED UNDER
4 SECTION 4014(b) FROM THE DEFINITION OF ROU-
5 TINE HIV TESTING.—HIV testing of an inmate
6 under section 4014(b) of title 18, United States
7 Code, is not routine HIV testing for the purposes of
8 the opt-out provision. Health care personnel shall
9 document the reason for testing under section
10 4014(b) of title 18, United States Code, in the in-
11 mate’s confidential medical records.

12 (11) TIMELY NOTIFICATION OF TEST RE-
13 SULTS.—Health care personnel shall provide timely
14 notification to inmates of the results of HIV tests.

15 (g) CHANGES IN EXISTING LAW.—

16 (1) SCREENING IN GENERAL.—Section 4014(a)
17 of title 18, United States Code, is amended—

18 (A) by striking “for a period of 6 months
19 or more”;

20 (B) by striking “, as appropriate,”; and

21 (C) by striking “if such individual is deter-
22 mined to be at risk for infection with such virus
23 in accordance with the guidelines issued by the
24 Bureau of Prisons relating to infectious disease
25 management” and inserting “unless the indi-

1 vidual declines. The Attorney General shall also
2 cause such individual to be so tested before re-
3 lease unless the individual declines.”.

4 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
5 CIVIL AND CRIMINAL PROCEEDINGS.—Section
6 4014(d) of title 18, United States Code, is amended
7 by inserting “or under the Stop HIV in Prison Act”
8 after “under this section”.

9 (3) SCREENING AS PART OF ROUTINE SCREEN-
10 ING.—Section 4014(e) of title 18, United States
11 Code, is amended by adding at the end the fol-
12 lowing: “Such rules shall also provide that the initial
13 test under this section be performed as part of the
14 routine health screening conducted at intake.”.

15 (h) REPORTING REQUIREMENTS.—

16 (1) REPORT ON HEPATITIS, LIVER, AND OTHER
17 DISEASES.—Not later than 1 year after the date of
18 enactment of this Act, the Director shall provide a
19 report to the Congress on the policies and proce-
20 dures of the Bureau of Prisons to provide testing,
21 treatment, and prevention education programs for
22 hepatitis, liver failure, and other liver-related dis-
23 eases transmitted through sexual activity, intra-
24 venous drug use, or other means. The Director shall
25 consult with appropriate officials of the Department

1 of Health and Human Services, the Office of Na-
2 tional Drug Control Policy, the Office of National
3 AIDS Policy, and the Centers for Disease Control
4 and Prevention regarding the development of this re-
5 port.

6 (2) ANNUAL REPORTS.—

7 (A) GENERALLY.—Not later than 2 years
8 after the date of enactment of this Act, and
9 then annually thereafter, the Director shall re-
10 port to Congress on the incidence among in-
11 mates of diseases transmitted through sexual
12 activity and intravenous drug use.

13 (B) MATTERS PERTAINING TO VARIOUS
14 DISEASES.—Each report under paragraph (1)
15 shall discuss—

16 (i) the incidence among inmates of
17 HIV, hepatitis, and other diseases trans-
18 mitted through sexual activity and intra-
19 venous drug use; and

20 (ii) updates on the testing, treatment,
21 and prevention education programs for
22 these diseases conducted by the Bureau of
23 Prisons.

1 (C) MATTERS PERTAINING TO HIV
2 ONLY.—Each report under paragraph (1) shall
3 also include—

4 (i) the number of inmates who tested
5 positive for HIV upon intake;

6 (ii) the number of inmates who tested
7 positive prior to reentry;

8 (iii) the number of inmates who were
9 not tested prior to reentry because they
10 were released without sufficient notice;

11 (iv) the number of inmates who opted-
12 out of taking the test;

13 (v) the number of inmates who were
14 tested under section 4014(b) of title 18,
15 United States Code; and

16 (vi) the number of inmates under
17 treatment for HIV.

18 (D) CONSULTATION.—The Director shall
19 consult with appropriate officials of the Depart-
20 ment of Health and Human Services, the Office
21 of National Drug Control Policy, and the Cen-
22 ters for Disease Control and Prevention regard-
23 ing the development of each report under para-
24 graph (1).

1 **SEC. 759. SUPPORT DATA SYSTEM REVIEW AND INDICA-**
2 **TORS FOR MONITORING HIV CARE.**

3 The Secretary of Health and Human Services, in col-
4 laboration with the Assistant Secretary for Health, the Di-
5 rector of the Office of Infectious Disease and HIV/AIDS
6 Policy, the Director of the Centers for Disease Control and
7 Prevention, the Assistant Secretary for Mental Health and
8 Substance Use, the Director of the Department of Hous-
9 ing and Urban Development, the Director of the Office
10 of AIDS Research, the Administrator of the Health Re-
11 sources and Services Administration, and the Adminis-
12 trator of the Centers for Medicare & Medicaid Services,
13 shall expand and coordinate efforts to align metrics across
14 agencies and modify Federal data systems, to—

15 (1) adopt the National Academy of Medicine’s
16 clinical HIV care indicators as the core metrics for
17 monitoring the quality of HIV care, mental health,
18 substance abuse, and supportive services;

19 (2) better enable assessment of the impact of
20 the National HIV/AIDS Strategy and the Patient
21 Protection and Affordable Care Act (Public Law
22 111–148) on improving HIV care and access to sup-
23 portive services for individuals with HIV;

24 (3) expand the demographic data elements to be
25 captured by Federal data systems relevant to HIV
26 care to permit calculation of the indicators for sub-

1 groups of the population of people with diagnosed
2 HIV infection, including—

3 (A) age;

4 (B) race;

5 (C) ethnicity;

6 (D) sex (assigned at birth);

7 (E) gender identity;

8 (F) sexual orientation;

9 (G) current geographic marker of resi-
10 dence;

11 (H) income or poverty level; and

12 (I) primary means of reimbursement for
13 medical services (including a State Medicaid
14 program, the Medicare program, the Ryan
15 White HIV Program, private insurance, health
16 maintenance organizations, and no coverage);
17 and

18 (4) streamline data collection and systematically
19 review all existing reporting requirements for feder-
20 ally funded HIV programs to ensure that only essen-
21 tial data are collected.

1 **SEC. 760. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**
2 **ENDING THE HIV EPIDEMIC: A PLAN FOR**
3 **AMERICA.**

4 Title II of the Public Health Service Act (42 U.S.C.
5 202 et seq.) is amended by inserting after section 241 the
6 following:

7 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
8 **OF NATIONAL HIV/AIDS STRATEGY.**

9 “(a) **TRANSFER AUTHORIZATION.**—Of the discre-
10 tionary appropriations made available to the Department
11 of Health and Human Services for any fiscal year for pro-
12 grams and activities that, as determined by the Secretary,
13 pertain to HIV, the Secretary may transfer up to 1 per-
14 cent of such appropriations to the Office of the Assistant
15 Secretary for Health for implementation of the Ending the
16 HIV Epidemic: A Plan for America.

17 “(b) **CONGRESSIONAL NOTIFICATION.**—Not less than
18 30 days before making any transfer under this section,
19 the Secretary shall give notice of the transfer to the Con-
20 gress.

21 “(c) **DEFINITIONS.**—In this section, the term ‘End-
22 ing the HIV Epidemic: A Plan for America’ means the
23 initiative that seeks to reduce the number of new HIV in-
24 fections in the United States by 75 percent by 2025, and
25 then by at least 90 percent by 2030, for an estimated
26 250,000 total HIV infections averted.”.

Subtitle F—Diabetes

SEC. 771. RESEARCH, TREATMENT, AND EDUCATION.

Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) is amended by adding at the end the following new section:

“SEC. 434B. DIABETES IN MINORITY POPULATIONS.

“(a) IN GENERAL.—The Director of NIH shall expand, intensify, and support ongoing research and other activities with respect to prediabetes and diabetes, particularly type 2, in minority populations.

“(b) RESEARCH.—

“(1) DESCRIPTION.—Research under subsection (a) shall include investigation into—

“(A) the causes of diabetes, including socioeconomic, geographic, clinical, environmental, genetic, and other factors that may contribute to increased rates of diabetes in minority populations; and

“(B) the causes of increased incidence of diabetes complications in minority populations, and possible interventions to decrease such incidence.

“(2) INCLUSION OF MINORITY PARTICIPANTS.—

In conducting and supporting research described in subsection (a), the Director of NIH shall seek to in-

1 include minority participants as study subjects in clin-
2 ical trials.

3 “(c) REPORT; COMPREHENSIVE PLAN.—

4 “(1) IN GENERAL.—The Diabetes Mellitus
5 Interagency Coordinating Committee shall—

6 “(A) prepare and submit to the Congress,
7 not later than 6 months after the date of enact-
8 ment of this section, a report on Federal re-
9 search and public health activities with respect
10 to prediabetes and diabetes in minority popu-
11 lations; and

12 “(B) develop and submit to Congress, not
13 later than 1 year after the date of enactment of
14 this section, an effective and comprehensive
15 Federal plan (including all appropriate Federal
16 health programs) to address prediabetes and di-
17 abetes in minority populations.

18 “(2) CONTENTS.—The report under paragraph
19 (1)(A) shall at minimum address each of the fol-
20 lowing:

21 “(A) Research on diabetes and prediabetes
22 in minority populations, including such research
23 on—

24 “(i) genetic, behavioral, and environ-
25 mental factors; and

1 “(ii) prevention and complications
2 among individuals within these populations
3 who have already developed diabetes.

4 “(B) Surveillance and data collection on
5 diabetes and prediabetes in minority popu-
6 lations, including with respect to—

7 “(i) efforts to better determine the
8 prevalence of diabetes among Asian-Amer-
9 ican and Pacific Islander subgroups; and

10 “(ii) efforts to coordinate data collec-
11 tion on the American Indian population.

12 “(C) Community-based interventions to ad-
13 dress diabetes and prediabetes targeting minor-
14 ity populations, including—

15 “(i) the evidence base for such inter-
16 ventions;

17 “(ii) the cultural appropriateness of
18 such interventions; and

19 “(iii) efforts to educate the public on
20 the causes and consequences of diabetes.

21 “(D) Education and training programs for
22 health professionals (including community
23 health workers) on the prevention and manage-
24 ment of diabetes and its related complications
25 that is supported by the Health Resources and

1 Services Administration, including such pro-
2 grams supported by—

3 “(i) the National Health Service
4 Corps; or

5 “(ii) the community health centers
6 program under section 330.

7 “(d) EDUCATION.—The Director of NIH shall—

8 “(1) through the National Institute on Minority
9 Health and Health Disparities and the National Di-
10 abetes Education Program—

11 “(A) make grants to programs funded
12 under section 464z-4 for the purpose of estab-
13 lishing a mentoring program for health care
14 professionals to be more involved in weight
15 counseling, obesity 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 program internships and men-
24 toring opportunities for recruitment.

25 “(e) DEFINITIONS.—For purposes of this section:

1 “(1) DIABETES MELLITUS INTERAGENCY CO-
2 ORDINATING COMMITTEE.—The ‘Diabetes Mellitus
3 Interagency Coordinating Committee’ means the Di-
4 abetes Mellitus Interagency Coordinating Committee
5 established under section 429.

6 “(2) MINORITY POPULATION.—The term ‘mi-
7 nority population’ means a racial and ethnic minor-
8 ity group, as defined in section 1707.”.

9 **SEC. 772. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

10 Part B of title III of the Public Health Service Act
11 (42 U.S.C. 243 et seq.), as amended by section 721, is
12 further amended by inserting after section 317W the fol-
13 lowing section:

14 **“SEC. 317X. DIABETES IN MINORITY POPULATIONS.**

15 “(a) RESEARCH AND OTHER ACTIVITIES.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Director of the Centers for Disease
18 Control and Prevention, shall conduct and support
19 research and public health activities with respect to
20 diabetes in minority populations.

21 “(2) CERTAIN ACTIVITIES.—Activities under
22 paragraph (1) regarding diabetes in minority popu-
23 lations shall include the following:

24 “(A) Further enhancing the National
25 Health and Nutrition Examination Survey by

1 oversampling Asian Americans, Native Hawai-
2 ians, and Pacific Islanders in appropriate geo-
3 graphic areas to better determine the preva-
4 lence of diabetes in such populations as well as
5 to improve the data collection of diabetes pene-
6 tration disaggregated into major ethnic groups
7 within such populations. The Secretary shall en-
8 sure that any such oversampling does not re-
9 duce the oversampling of other minority popu-
10 lations including African-American and Latino
11 populations.

12 “(B) Through the Division of Diabetes
13 Translation—

14 “(i) providing for prevention research
15 to better understand how to influence
16 health care systems changes to improve
17 quality of care being delivered to such pop-
18 ulations;

19 “(ii) carrying out model demonstra-
20 tion projects to design, implement, and
21 evaluate effective diabetes prevention and
22 control interventions for minority popu-
23 lations, including culturally appropriate
24 community-based interventions;

1 “(iii) developing and implementing a
2 strategic plan to reduce diabetes in minor-
3 ity populations through applied research to
4 reduce disparities and culturally and lin-
5 guistically appropriate community-based
6 interventions;

7 “(iv) supporting, through the national
8 diabetes prevention program under section
9 399V–3, diabetes prevention program sites
10 in underserved regions highly impacted by
11 diabetes; and

12 “(v) implementing, through the na-
13 tional diabetes prevention program under
14 section 399V–3, a demonstration program
15 developing new metrics measuring health
16 outcomes related to diabetes that can be
17 stratified by specific minority populations.

18 “(b) EDUCATION.—The Secretary, acting through
19 the Director of the Centers for Disease Control and Pre-
20 vention, shall direct the Division of Diabetes Translation
21 to conduct and support both programs to educate the pub-
22 lic on diabetes in minority populations and programs to
23 educate minority populations about the causes and effects
24 of diabetes.

1 “(c) DIABETES; HEALTH PROMOTION, PREVENTION
2 ACTIVITIES, AND ACCESS.—The Secretary, acting through
3 the Director of the Centers for Disease Control and Pre-
4 vention and the National Diabetes Education Program,
5 shall conduct and support programs to educate specific
6 minority populations through culturally appropriate and
7 linguistically appropriate information campaigns about
8 prevention of, and managing, diabetes.

9 “(d) DEFINITION.—For purposes of this section, the
10 term ‘minority population’ means a racial and ethnic mi-
11 nority group, as defined in section 1707.”.

12 **SEC. 773. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

13 Part P of title III of the Public Health Service Act
14 (42 U.S.C. 280g et seq.), as amended by section 733, is
15 further amended by adding at the end the following new
16 section:

17 **“SEC. 399V-9. PROGRAMS TO EDUCATE HEALTH PRO-**
18 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
19 **ABETES IN MINORITY POPULATIONS.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Director of the Health Resources and Services Admin-
22 istration, shall conduct and support programs described
23 in subsection (b) to educate health professionals on the
24 causes and effects of diabetes in minority populations.

1 “(b) PROGRAMS.—Programs described in this sub-
2 section, with respect to education on diabetes in minority
3 populations, shall include the following:

4 “(1) Giving priority, under the primary care
5 training and enhancement program under section
6 747—

7 “(A) to awarding grants to focus on or ad-
8 dress diabetes; and

9 “(B) to adding minority populations to the
10 list of vulnerable populations that should be
11 served by such grants.

12 “(2) Providing additional funds for the Health
13 Careers Opportunity Program, the Centers for Ex-
14 cellence, and the Minority Faculty Fellowship Pro-
15 gram to partner with the Office of Minority Health
16 under section 1707 and the National Institutes of
17 Health to strengthen programs for career opportuni-
18 ties focused on diabetes treatment and care within
19 underserved regions highly impacted by diabetes.

20 “(3) Developing a diabetes focus within, and
21 providing additional funds for, the National Health
22 Service Corps scholarship program—

23 “(A) to place individuals in areas that are
24 disproportionately affected by diabetes and to

1 provide diabetes treatment and care in such
2 areas; and

3 “(B) to provide such individuals continuing
4 medical education specific to diabetes care.”.

5 **SEC. 774. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

6 Part P of title III of the Public Health Service Act
7 (42 U.S.C. 280g et seq.), as amended by section 773, is
8 further amended by adding at the end the following sec-
9 tion:

10 **“SEC. 399V-10. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
11 **TIES REGARDING DIABETES IN AMERICAN IN-**
12 **DIAN POPULATIONS.**

13 “In addition to activities under sections 399V-6 and
14 434B, the Secretary, acting through the Indian Health
15 Service and in collaboration with other appropriate Fed-
16 eral agencies, shall—

17 “(1) conduct and support research and other
18 activities with respect to diabetes; and

19 “(2) coordinate the collection of data on clini-
20 cally and culturally appropriate diabetes treatment,
21 care, prevention, and services by health care profes-
22 sionals to the American Indian population.”.

1 **SEC. 775. UPDATED REPORT ON HEALTH DISPARITIES.**

2 The Secretary of Health and Human Services shall
3 seek to enter into an arrangement with the National Acad-
4 emy of Medicine under which the National Academy will—

5 (1) not later than 1 year after the date of en-
6 actment of this Act, submit to Congress an updated
7 version of the 2002 report entitled “Unequal Treat-
8 ment: Confronting Racial and Ethnic Disparities in
9 Health Care”; and

10 (2) in such updated version, address how racial
11 and ethnic health disparities have changed since the
12 publication of the original report.

13 **Subtitle G—Lung Disease**

14 **SEC. 776. EXPANSION OF THE NATIONAL ASTHMA EDU-
15 CATION AND PREVENTION PROGRAM.**

16 (a) FINDINGS.—Congress finds as follows:

17 (1) The prevalence of asthma has increased
18 since 1980 and affects more than 26,000,000 people
19 in the United States.

20 (2) Significant disparities in asthma morbidity
21 and mortality exist for both adults and children par-
22 ticularly for low-income and minority populations,
23 particularly African Americans and Puerto Ricans.

24 (3) African-American children are twice as like-
25 ly to have asthma as White children.

1 (4) In 2016, almost 4,500,000 non-Hispanic
2 African Americans reported having asthma. African
3 Americans with asthma are 3 times as likely to visit
4 the emergency department and twice as likely to get
5 hospitalized as White patients with asthma.

6 (5) Puerto Ricans are 3.4 times as likely to die
7 from asthma compared with all other Hispanic or
8 Latino groups. Overall Hispanic Americans are 30
9 percent more likely to be hospitalized for asthma
10 than non-Hispanic Whites.

11 (6) The majority of adults with asthma are
12 women.

13 (b) IN GENERAL.—Not later than 2 years after the
14 date of the enactment of this Act, the Secretary of Health
15 and Human Services shall convene a working group com-
16 prised of patient groups, nonprofit organizations, medical
17 societies, and other relevant governmental and nongovern-
18 mental entities, including those that participate in the Na-
19 tional Asthma Education and Prevention Program, to de-
20 velop a report to Congress that—

21 (1) catalogs, with respect to asthma prevention,
22 management, and surveillance—

23 (A) the activities of the Federal Govern-
24 ment, including identifying all Federal pro-
25 grams that carry out asthma-related activities,

1 as well as assessment of the progress of the
2 Federal Government and States, with respect to
3 achieving the goals of Healthy People 2020;
4 and

5 (B) the activities of other entities that par-
6 ticipate in the program, including nonprofit or-
7 ganizations, patient advocacy groups, and med-
8 ical societies; and

9 (2) makes recommendations for the future di-
10 rection of asthma activities, in consultation with re-
11 searchers from the National Institutes of Health and
12 other member bodies of the National Asthma Edu-
13 cation and Prevention Program who are qualified to
14 review and analyze data and evaluate interventions,
15 including—

16 (A) a description of how the Federal Gov-
17 ernment may better coordinate and improve its
18 response to asthma including identifying any
19 barriers that may exist;

20 (B) a description of how the Federal Gov-
21 ernment may continue, expand, and improve its
22 private-public partnerships with respect to asth-
23 ma including identifying any barriers that may
24 exist;

1 (C) identification of steps that may be
2 taken to reduce the—

3 (i) morbidity, mortality, and overall
4 prevalence of asthma;

5 (ii) financial burden of asthma on so-
6 ciety;

7 (iii) burden of asthma on dispropor-
8 tionately affected areas, particularly those
9 in medically underserved populations (as
10 defined in section 330(b)(3) of the Public
11 Health Service Act (42 U.S.C.
12 254b(b)(3))); and

13 (iv) burden of asthma as a chronic
14 disease;

15 (D) identification of programs and policies
16 that have achieved the steps described in sub-
17 paragraph (C), and steps that may be taken to
18 expand such programs and policies to benefit
19 larger populations; and

20 (E) recommendations for future research
21 and interventions.

22 (c) REPORT TO CONGRESS.—At the end of the 5-year
23 period following the submission of the report under this
24 section, the National Asthma Education and Prevention
25 Program shall evaluate the analyses and recommendations

1 under such report and determine whether a new report
2 to the Congress is necessary, and make appropriate rec-
3 ommendations to the Congress.

4 **SEC. 777. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
5 **FOR DISEASE CONTROL AND PREVENTION.**

6 Section 317I of the Public Health Service Act (42
7 U.S.C. 247b–10) is amended to read as follows:

8 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
9 **FOR DISEASE CONTROL AND PREVENTION.**

10 “(a) PROGRAM FOR PROVIDING INFORMATION AND
11 EDUCATION TO THE PUBLIC.—The Secretary, acting
12 through the Director of the Centers for Disease Control
13 and Prevention, shall collaborate with State and local
14 health departments to conduct activities, including the
15 provision of information and education to the public re-
16 garding asthma including—

17 “(1) deterring the harmful consequences of un-
18 controlled asthma; and

19 “(2) disseminating health education and infor-
20 mation regarding prevention of asthma episodes and
21 strategies for managing asthma.

22 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—
23 The Secretary, acting through the Director of the Centers
24 for Disease Control and Prevention, shall collaborate with
25 State and local health departments to develop State plans

1 incorporating public health responses to reduce the burden
2 of asthma, particularly regarding disproportionately af-
3 fected populations.

4 “(c) COMPILATION OF DATA.—The Secretary, acting
5 through the Director of the Centers for Disease Control
6 and Prevention, shall, in cooperation with State and local
7 public health officials—

8 “(1) conduct asthma surveillance activities to
9 collect data on the prevalence and severity of asth-
10 ma, the effectiveness of public health asthma inter-
11 ventions, and the quality of asthma management, in-
12 cluding—

13 “(A) collection of household data on the
14 local burden of asthma;

15 “(B) surveillance of health care facilities;
16 and

17 “(C) collection of data not containing indi-
18 vidually identifiable information from electronic
19 health records or other electronic communica-
20 tions;

21 “(2) compile and annually publish data regard-
22 ing the prevalence and incidence of childhood asth-
23 ma, the child mortality rate, and the number of hos-
24 pital admissions and emergency department visits by
25 children associated with asthma nationally and in

1 each State and at the county level by age, sex, race,
2 and ethnicity, as well as lifetime and current preva-
3 lence; and

4 “(3) compile and annually publish data regard-
5 ing the prevalence and incidence of adult asthma,
6 the adult mortality rate, and the number of hospital
7 admissions and emergency department visits by
8 adults associated with asthma nationally and in each
9 State and at the county level by age, sex, race, eth-
10 nicity, industry, and occupation, as well as lifetime
11 and current prevalence.

12 “(d) COORDINATION OF DATA COLLECTION.—The
13 Director of the Centers for Disease Control and Preven-
14 tion, in conjunction with State and local health depart-
15 ments, shall coordinate data collection activities under
16 subsection (c)(2) so as to maximize comparability of re-
17 sults.

18 “(e) COLLABORATION.—The Centers for Disease
19 Control and Prevention are encouraged to collaborate with
20 national, State, and local nonprofit organizations to pro-
21 vide information and education about asthma, and to
22 strengthen such collaborations when possible.

23 “(f) ADDITIONAL FUNDING.—In addition to any
24 other authorization of appropriations that is available to
25 the Centers for Disease Control and Prevention for the

1 purpose of carrying out this section, there are authorized
2 to be appropriated to such Centers such sums as may be
3 necessary for each of fiscal years 2021 through 2025 for
4 the purpose of carrying out this section.”.

5 **SEC. 778. INFLUENZA AND PNEUMONIA VACCINATION CAM-**
6 **PAIGN.**

7 (a) IN GENERAL.—The Secretary of Health and
8 Human Services shall—

9 (1) enhance the annual campaign by the De-
10 partment of Health and Human Services to increase
11 the number of people vaccinated each year for influ-
12 enza and pneumonia; and

13 (2) include in such campaign the use of written
14 educational materials, public service announcements,
15 physician education, and any other means which the
16 Secretary deems effective.

17 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
18 out the annual campaign described in subsection (a), the
19 Secretary of Health and Human Services shall ensure
20 that—

21 (1) educational materials and public service an-
22 nouncements are readily and widely available in
23 communities experiencing disparities in the incidence
24 and mortality rates of influenza and pneumonia; and

1 (4) It is estimated that over 13,500,000 adults
2 in the United States have COPD.

3 (5) COPD is the third-leading cause of death in
4 the United States, claiming over 134,000 lives in
5 2010.

6 (6) Since 2000, deaths for women with COPD
7 have exceeded deaths in men.

8 (7) Although African Americans have a lower
9 prevalence of COPD in the United States, research-
10 ers have shown that African Americans may be
11 underdiagnosed. Furthermore, research has shown
12 that African Americans develop COPD with less cu-
13 mulative smoke exposure and at a younger age.

14 (b) IN GENERAL.—The Director of the Centers for
15 Disease Control and Prevention shall conduct, support,
16 and expand public health strategies, prevention, diagnosis,
17 surveillance, and public and professional awareness activi-
18 ties regarding chronic obstructive pulmonary disease.

19 (c) NATIONAL ACTION PLAN.—

20 (1) DEVELOPMENT.—Not later than 2 years
21 after the date of the enactment of this Act, the Di-
22 rector of the National Heart, Lung, and Blood Insti-
23 tute, in consultation with the Director of the Centers
24 for Disease Control and Prevention, shall develop a
25 national action plan to address chronic obstructive

1 pulmonary disease in the United States with partici-
2 pation from patients, caregivers, health profes-
3 sionals, patient advocacy organizations, researchers,
4 providers, public health professionals, and other
5 stakeholders.

6 (2) CONTENTS.—At a minimum, such plan
7 shall include recommendations for—

8 (A) public health interventions for the pur-
9 pose of implementation of the national plan;

10 (B) biomedical, health services, and public
11 health research on chronic obstructive pul-
12 monary disease; and

13 (C) inclusion of chronic obstructive pul-
14 monary disease in the health data collections of
15 all Federal agencies.

16 (3) CONSIDERATION.—In developing such plan,
17 the Director of the National Heart, Lung, and Blood
18 Institute shall consider the recommendations and
19 findings of the National Academy of Medicine in the
20 report entitled “A Nationwide Framework for Sur-
21 veillance of Cardiovascular and Chronic Lung Dis-
22 eases” (July 22, 2011).

23 (d) CHRONIC DISEASE PREVENTION PROGRAMS.—
24 The Director of the National Heart, Lung, and Blood In-
25 stitute shall carry out the following:

1 (1) Conduct public education and awareness ac-
2 tivities with patient and professional organizations
3 to stimulate earlier diagnosis and improve patient
4 outcomes from treatment of chronic obstructive pul-
5 monary disease. To the extent known and relevant,
6 such public education and awareness activities shall
7 reflect differences in chronic obstructive pulmonary
8 disease by cause (tobacco, environmental, occupa-
9 tional, biological, and genetic) and include a focus
10 on outreach to undiagnosed and, as appropriate, mi-
11 nority populations.

12 (2) Supplement and expand upon the activities
13 of the National Heart, Lung, and Blood Institute by
14 making grants to nonprofit organizations, State and
15 local jurisdictions, and Indian tribes for the purpose
16 of reducing the burden of chronic obstructive pul-
17 monary disease, especially in disproportionately im-
18 pacted communities, through public health interven-
19 tions and related activities.

20 (3) Coordinate with the Centers for Disease
21 Control and Prevention, the Indian Health Service,
22 the Health Resources and Services Administration,
23 and the Department of Veterans Affairs to develop
24 pilot programs to demonstrate best practices for the

1 diagnosis and management of chronic obstructive
2 pulmonary disease.

3 (4) Develop improved techniques and identify
4 best practices, in coordination with the Secretary of
5 Veterans Affairs, for assisting chronic obstructive
6 pulmonary disease patients to successfully stop
7 smoking, including identification of subpopulations
8 with different needs. Initiatives under this para-
9 graph may include research to determine whether
10 successful smoking cessation strategies are different
11 for chronic obstructive pulmonary disease patients
12 compared to such strategies for patients with other
13 chronic diseases.

14 (e) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
15 PROGRAMS.—The Director of the Centers for Disease
16 Control and Prevention shall—

17 (1) support research into the environmental and
18 occupational causes and biological mechanisms that
19 contribute to chronic obstructive pulmonary disease;
20 and

21 (2) develop and disseminate public health inter-
22 ventions that will lessen the impact of environmental
23 and occupational causes of chronic obstructive pul-
24 monary disease.

1 (f) DATA COLLECTION.—Not later than 180 days
2 after the enactment of this Act, the Director of the Na-
3 tional Heart, Lung, and Blood Institute and the Director
4 of the Centers for Disease Control and Prevention, acting
5 jointly, shall assess the depth and quality of information
6 on chronic obstructive pulmonary disease that is collected
7 in surveys and population studies conducted by the Cen-
8 ters for Disease Control and Prevention, including wheth-
9 er there are additional opportunities for information to be
10 collected in the National Health and Nutrition Examina-
11 tion Survey, the National Health Interview Survey, and
12 the Behavioral Risk Factors Surveillance System surveys.
13 The Director of the National Heart, Lung, and Blood In-
14 stitute shall include the results of such assessment in the
15 national action plan under subsection (c).

16 (g) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2021 through 2025.

20 **Subtitle H—Tuberculosis**

21 **SEC. 781. ELIMINATION OF ALL FORMS OF TUBERCULOSIS.**

22 (a) SHORT TITLE.—This subtitle may be cited as the
23 “End Tuberculosis Act”.

24 (b) FINDINGS.—Congress makes the following find-
25 ings:

1 (1) In the United States, 9,025 people were di-
2 agnosed with tuberculosis (referred to in this section
3 as “TB”) in 2018.

4 (2) Disparities in TB exist and significantly im-
5 pact minority communities in the United States. The
6 Centers for Disease Control and Prevention (re-
7 ferred to in this section as “CDC”) finds that 70
8 percent of people diagnosed with TB in 2018 self-
9 identified as racial and ethnic minorities.

10 (3) African Americans comprised 20 percent of
11 people diagnosed with TB during 2018. The popu-
12 lation-adjusted rate of TB among African Americans
13 is 1.7 times higher than the national total, and 8.0
14 times higher than among Whites.

15 (4) Asian Americans, Native Hawaiians, and
16 other Pacific Islanders comprised 37 percent of peo-
17 ple diagnosed with TB during 2018. The population-
18 adjusted rate of TB among Asian Americans is 6.2
19 times higher than the national total, and 31 times
20 higher than among Whites. The population-adjusted
21 rate of TB among Native Hawaiians and other Pa-
22 cific Islanders is 4.8 times higher than the national
23 total, and 23.2 times higher than among Whites.

24 (5) Hispanics and Latinos comprised 26 per-
25 cent of people diagnosed with TB during 2018. The

1 population-adjusted rate of TB among Hispanics
2 and Latinos is 1.6 times higher than the national
3 total, and 8.0 times higher than among Whites.

4 (6) TB is both preventable and curable, but the
5 current rate of decline of TB in the United States
6 remains too slow to achieve TB elimination in this
7 century.

8 (7) TB is transmitted through the air when a
9 person who has TB disease in their lungs coughs or
10 sneezes. People who are in close proximity to the
11 person with TB can breathe in the TB bacteria, and
12 the bacteria will initially settle in their lungs. With-
13 out proper and timely diagnosis and access to treat-
14 ment, the TB bacteria may grow and spread to
15 other parts of their body.

16 (8) As many as 13,000,000 people in the
17 United States may have latent TB Infection (re-
18 ferred to in this section as “LTBI”). People with
19 LTBI have TB bacteria in their bodies, but their
20 immune system is containing the bacteria, and they
21 are not sick, nor do they have any current risk of
22 spreading TB to others. LTBI can activate into in-
23 fectious, life-threatening TB if not treated. Modeling
24 has shown that eliminating TB is not possible with-
25 out addressing LTBI.

1 (9) Comorbidities associated with TB include
2 cancer, diabetes mellitus, and HIV. People with
3 these medical conditions and compromised immune
4 systems are more likely to develop active TB disease
5 and to have worse outcomes from TB.

6 (10) Forms of active TB that do not show drug
7 resistance are classified as drug-susceptible TB (re-
8 ferred to in this section as “DS-TB”). Drug-resist-
9 ant TB (referred to in this section as “DR-TB”) is
10 a rising threat to the public health of the United
11 States. DR-TB that exhibits resistance to two or
12 more first-line drugs is referred to as multi-drug re-
13 sistant TB (referred to in this section as “MDR-
14 TB”). MDR-TB that also is resistant to at least
15 one injectable second-line medication and at least
16 one fluoroquinolone is classified as extensively drug-
17 resistant TB (referred to in this section as “XDR-
18 TB”).

19 (11) Approximately 97 people in the United
20 States were diagnosed with MDR-TB in 2018. One
21 person was diagnosed with XDR-TB in the same
22 year.

23 (12) In the United States, \$480 million was
24 spent in 2018 to treat TB; direct treatment costs
25 average \$19,000 to treat a patient with DS-TB,

1 \$175,000 to treat a patient with MDR-TB, and
2 \$544,000 to treat a patient with XDR-TB. When
3 factoring in productivity losses during treatment,
4 DS-TB averages \$46,000, MDR-TB averages
5 \$294,000 and XDR-TB averages \$694,000. Treat-
6 ment is often difficult, with daily complex multi-pill
7 regimens and injections, with side-effects ranging
8 from hearing and vision loss to mental health issues.

9 (13) Recognizing the public health, economic
10 and societal costs to the threat of MDR-TB, the
11 National Action Plan to Combat MDR-TB was de-
12 veloped by the White House to provide the United
13 States with a comprehensive three-pronged strategy
14 to address MDR-TB by strengthening domestic ca-
15 pacity to combat MDR-TB; improve international
16 capacity and cooperation to combat MDR-TB; accel-
17 erate basic and applied research and development
18 for new therapies, diagnostics and prevention strate-
19 gies to combat MDR-TB.

20 (14) Additional Federal support is necessary to
21 expand TB control efforts in case finding and treat-
22 ment to address LTBI in a national prevention ini-
23 tiative. Key policy and research breakthroughs in-
24 crease the success of a TB prevention initiative: the
25 U.S. Preventative Services Task Force recommenda-

1 addition to amounts otherwise authorized to be ap-
2 propriated to carry out this section, there are au-
3 thorized to be appropriated such sums as may be
4 necessary to carry out section 317 for each of fiscal
5 years 2020 through 2021.”.

6 **SEC. 783. STRENGTHENING CLINICAL RESEARCH FUNDING**
7 **FOR TUBERCULOSIS.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services shall expand and intensify support for
10 current and prospective research activities of the National
11 Institutes of Health, the Biomedical Advanced Research
12 and Development Authority, and the Centers for Disease
13 Control and Prevention Division of Tuberculosis Elimini-
14 nation to develop new therapeutics, diagnostics, vaccines,
15 and other prevention modalities in addressing all forms
16 of tuberculosis (referred to in this section as “TB”).

17 (b) INCLUDED RESEARCH ACTIVITIES.—Research
18 activities under subsection (a) shall include—

19 (1) research and development, and pathways to
20 approval, for novel, safe drugs and drug regimens
21 for the treatment of TB, including in adolescent and
22 pediatric populations and in pregnant and lactating
23 women;

24 (2) research to develop rapid diagnostic tests
25 for all forms of TB, including diagnostics that can

1 be used for pediatric populations and people living
2 with HIV, diagnostics that can detect extra pul-
3 monary TB and drug resistance, and diagnostics
4 that can be used at the point of care;

5 (3) research to advance basic knowledge of the
6 pathogenesis of TB and its major comorbidities, in-
7 cluding HIV and diabetes mellitus;

8 (4) research to improve knowledge and under-
9 standings of the role of latency in TB and the fac-
10 tors that increase the risk of latent TB infection
11 progressing to active, symptomatic TB disease;

12 (5) awarding grants and contracts to specifi-
13 cally develop new and needed vaccines to address
14 TB;

15 (6) awarding grants and contracts to support
16 the training and development of clinical researchers
17 whose research improves the landscape of tools to
18 combat TB; and

19 (7) awarding grants and contracts to support
20 capacity-building and develop clinical trial site infra-
21 structure in the United States and in TB endemic
22 countries to support the aforementioned research ac-
23 tivities.

1 **Subtitle I—Osteoarthritis and**
2 **Musculoskeletal Diseases**

3 **SEC. 785. FINDINGS.**

4 Congress finds as follows:

5 (1) Eighty percent of African-American women
6 and nearly 74 percent of Hispanic men are either
7 overweight or obese, speeding the onset and progres-
8 sion of arthritis.

9 (2) Arthritis affects 46,000,000 people in the
10 United States, and that number will rise to
11 67,000,000 by the year 2030.

12 (3) Twenty-seven million people in the United
13 States suffer from osteoarthritis, the most common
14 form of arthritis, making it the leading cause of dis-
15 ability in the United States. Osteoarthritis is some-
16 times referred to as degenerative joint disease.

17 (4) Obesity accelerates the onset of arthritis: 70
18 percent of obese adults with mild osteoarthritis of
19 the knee at age 60 will develop advanced end-stage
20 disease by age 80. In contrast, just 43 percent of
21 non-obese adults will have end-stage disease over the
22 same time period.

23 (5) Arthritis affects 1 in 5 people in the United
24 States and is the single greatest cause of chronic
25 pain and disability in the United States.

1 (6) Women, African Americans, and Hispanics
2 have more severe arthritis and functional limitations.
3 These same individuals are more likely to be obese,
4 diabetic, and have higher incidence of heart dis-
5 ease—medical conditions that can be improved with
6 physical activity. Instead of moving, however, these
7 groups have an inactivity rate of 40 to 50 percent,
8 which continues to increase.

9 (7) Arthritis costs \$128,000,000,000 a year, in-
10 cluding \$81,000,000,000 in direct costs (medical)
11 and \$47,000,000,000 in indirect costs (lost earn-
12 ings). Each year, \$309,000,000,000 in direct and in-
13 direct costs is lost due to disparities in osteoarthritis
14 and musculoskeletal diseases.

15 (8) Obesity and other chronic health conditions
16 exacerbate the debilitating impact of arthritis, lead-
17 ing to inactivity, loss of independence, and a per-
18 petual cycle of comorbid chronic conditions.

19 (9) Sixty-one percent of arthritis sufferers are
20 women, and women represent 64 percent of an esti-
21 mated 43,000,000 annual visits to physicians' offices
22 and outpatient clinics where arthritis was the pri-
23 mary diagnosis. Women also represented 60 percent
24 of approximately 1,000,000 hospitalizations that oc-

1 curred in 2003 for which arthritis was the primary
2 diagnosis.

3 (10) Women ages 65 and older have up to 2½
4 times more disabilities than men of the same age.
5 Higher rates of obesity and arthritis among this
6 group explained up to 48 percent of the gender gap
7 in disability, above all other common chronic health
8 conditions.

9 (11) The primary indication for total knee
10 arthroplasty (referred to in this section as “TKA”),
11 also known as knee replacement, is relief of signifi-
12 cant, disabling pain caused by severe arthritis.

13 (12) Knee replacement is surgery for people
14 with severe knee damage. Knee replacement can re-
15 lieve pain and allow you to be more active. When
16 you have a total knee replacement, the surgeon re-
17 moves damaged cartilage and bone from the surface
18 of your knee joint and replaces them with a man-
19 made surface of metal and plastic. In a partial knee
20 replacement, the surgeon only replaces one part of
21 your knee joint.

22 (13) Total hip replacement, also called total hip
23 arthroplasty (referred to in this section as “THA”),
24 is used if your hip pain interferes with daily activi-
25 ties and more conservative treatments have not

1 helped. Arthritis damage is the most common reason
2 to need hip replacement.

3 (14) The odds of a family practice physician
4 recommending TKA to a male patient with moderate
5 arthritis are twice that of a female patient, while the
6 odds of an orthopaedic surgeon recommending TKA
7 to a male patient with moderate arthritis are 22
8 times that of a female patient.

9 (15) African Americans with doctor-diagnosed
10 arthritis have a higher prevalence of severe pain at-
11 tributable to arthritis, compared with Whites (34.0
12 percent versus 22.6 percent). African Americans,
13 compared to Whites, report a higher proportion of
14 work limitations (39.5 percent versus 28.0 percent)
15 and a higher prevalence of arthritis-attributable
16 work limitation (6.6 percent versus 4.6 percent).

17 (16) Hispanics are 50 percent more likely than
18 non-Hispanic Whites to report needing assistance
19 with at least one instrumental activity of daily living
20 and to have difficulty walking.

21 (17) African Americans and Hispanics were 1.3
22 times more likely to have activity limitation, 1.6
23 times more likely to have work limitations, and 1.9
24 times more likely to have severe joint pain than
25 Whites.

1 (18) In 2003, the National Academy of Medi-
2 cine reported that the rates of TKA and THA
3 among African-American and Hispanic patients are
4 significantly lower than for Whites—even for those
5 with equitable health care coverage such as through
6 Medicare or the Department of Veterans Affairs.

7 (19) According to the Centers for Disease Con-
8 trol and Prevention, in 2000, African-American
9 Medicare enrollees were 37 percent less likely than
10 White Medicare enrollees to undergo total knee re-
11 placements. In 2006, the disparity increased to 39
12 percent.

13 (20) Even after adjusting for insurance and
14 health access, Hispanics and African Americans are
15 almost 50 percent less likely to undergo total knee
16 replacement than Whites.

17 **SEC. 786. OSTEOARTHRITIS AND OTHER MUSCULO-**
18 **SKELETAL HEALTH-RELATED ACTIVITIES OF**
19 **THE CENTERS FOR DISEASE CONTROL AND**
20 **PREVENTION.**

21 (a) EDUCATION AND AWARENESS ACTIVITIES.—The
22 Secretary of Health and Human Services, acting through
23 the Director of the Centers for Disease Control and Pre-
24 vention, shall direct the National Center for Chronic Dis-
25 ease Prevention and Health Promotion to conduct and ex-

1 pand the Health Community Program and Arthritis Pro-
2 gram to educate the public on—

3 (1) the causes of, preventive health actions for,
4 and effects of arthritis and other musculoskeletal
5 conditions in minority patient populations; and

6 (2) the effects of such conditions on other
7 comorbidities including obesity, hypertension, and
8 cardiovascular disease.

9 (b) PROGRAMS ON ARTHRITIS AND MUSCULO-
10 SKELETAL CONDITIONS.—Education and awareness pro-
11 grams of the Centers for Disease Control and Prevention
12 on arthritis and other musculoskeletal conditions in minor-
13 ity communities shall—

14 (1) be culturally and linguistically appropriate
15 to minority patients, targeting musculoskeletal
16 health promotion and prevention programs of each
17 major ethnic group, including—

18 (A) Native Americans and Alaska Natives;

19 (B) Asian Americans;

20 (C) African Americans and Blacks;

21 (D) Hispanic and Latino Americans; and

22 (E) Native Hawaiians and Pacific Island-
23 ers; and

24 (2) include public awareness campaigns directed
25 toward these patient populations that emphasize the

1 importance of musculoskeletal health, physical activ-
2 ity, diet and healthy lifestyle, and weight reduction
3 for overweight and obese patients.

4 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out this section, there are authorized to be appropriated
6 such sums as are necessary for fiscal year 2021 and each
7 subsequent fiscal year.

8 **SEC. 787. GRANTS FOR COMPREHENSIVE OSTEOARTHRITIS**
9 **AND MUSCULOSKELETAL DISEASE HEALTH**
10 **EDUCATION WITHIN HEALTH PROFESSIONS**
11 **SCHOOLS.**

12 (a) PROGRAM AUTHORIZED.—The Secretary of
13 Health and Human Services (in this section referred to
14 as the “Secretary”), in coordination with the Secretary of
15 Education, shall award grants, on a competitive basis, to
16 academic health science centers, health professions
17 schools, and other institutions of higher education to en-
18 able such institutions to provide people with comprehen-
19 sive education on arthritis and musculoskeletal health,
20 particularly—

- 21 (1) obesity-related musculoskeletal diseases;
22 (2) arthritis and osteoarthritis;
23 (3) arthritis and musculoskeletal health dispari-
24 ties; and

1 (4) the relationship between arthritis and mus-
2 culoskeletal diseases and metabolic activity, psycho-
3 logical health, and comorbidities such as diabetes,
4 cardiovascular disease, and hypertension.

5 (b) DURATION.—Grants awarded under this section
6 shall be for a period of 5 years.

7 (c) APPLICATIONS.—An academic health science cen-
8 ter, health professions school, or other institution of high-
9 er education seeking a grant under this section shall sub-
10 mit an application to the Secretary at such time, in such
11 manner, and containing such information as the Secretary
12 may require.

13 (d) PRIORITY.—In awarding grants under this sec-
14 tion, the Secretary shall give priority to an institution of
15 higher education that—

16 (1) has an enrollment of needy students, as de-
17 fined in section 318(b) of the Higher Education Act
18 of 1965 (20 U.S.C. 1059e(b));

19 (2) is a Hispanic-serving institution, as defined
20 in section 502(a) of such Act (20 U.S.C. 1101a(a));

21 (3) is a Tribal College or University, as defined
22 in section 316(b) of such Act (20 U.S.C. 1059c(b));

23 (4) is an Alaska Native-serving institution, as
24 defined in section 317(b) of such Act (20 U.S.C.
25 1059d(b));

1 (5) is a Native Hawaiian-serving institution, as
2 defined in section 317(b) of such Act (20 U.S.C.
3 1059d(b));

4 (6) is a Predominately Black Institution, as de-
5 fined in section 318(b) of such Act (20 U.S.C.
6 1059e(b));

7 (7) is a Native American-serving, non-Tribal in-
8 stitution, as defined in section 319(b) of such Act
9 (20 U.S.C. 1059f(b));

10 (8) is an Asian American and Native American
11 Pacific Islander-serving institution, as defined in
12 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

13 (9) is a minority institution, as defined in sec-
14 tion 365 of such Act (20 U.S.C. 1067k), with an en-
15 rollment of needy students, as defined in section 312
16 of such Act (20 U.S.C. 1058).

17 (e) USES OF FUNDS.—An institution of higher edu-
18 cation receiving a grant under this section may use grant
19 funds to integrate issues relating to comprehensive arthri-
20 tis and musculoskeletal health into the academic or sup-
21 port sectors of the institution in order to reach a large
22 number of students, by carrying out 1 or more of the fol-
23 lowing activities:

24 (1) Developing educational content for issues
25 relating to comprehensive arthritis and musculo-

1 skeletal health education that will be incorporated
2 into first-year orientation or core courses.

3 (2) Creating innovative technology-based ap-
4 proaches to deliver arthritis and musculoskeletal
5 health education to students, faculty, and staff.

6 (3) Developing and employing peer-outreach
7 and education programs to generate discussion, edu-
8 cate, and raise awareness among students about
9 issues relating to arthritis and musculoskeletal
10 health disorders, and their relationship to diabetes,
11 hypertension, cardiovascular disease, psychological
12 health, and other comorbid conditions.

13 (f) REPORT TO CONGRESS.—

14 (1) IN GENERAL.—Not later than 1 year after
15 the date of the enactment of this Act, and annually
16 thereafter for a period of 5 years, the Secretary shall
17 prepare and submit to the appropriate committees of
18 Congress a report on the activities to provide health
19 professions students with comprehensive arthritis
20 and musculoskeletal health education funded under
21 this section.

22 (2) REPORT ELEMENTS.—The report described
23 in paragraph (1) shall include information about—

24 (A) the number of entities that are receiv-
25 ing grant funds;

1 (B) the specific activities supported by
2 grant funds;

3 (C) the number of students served by
4 grant programs; and

5 (D) the status of program evaluations.

6 **Subtitle J—Sleep and Circadian**
7 **Rhythm Disorders**

8 **SEC. 791. SHORT TITLE; FINDINGS.**

9 (a) SHORT TITLE.—This subtitle may be cited as the
10 “Sleep and Circadian Rhythm Disorders Health Dispari-
11 ties Act”.

12 (b) FINDINGS.—Congress finds the following:

13 (1) Decrements in sleep health such as sleep
14 apnea, insufficient sleep time, and insomnia, affect
15 50,000,000 to 70,000,000 adults in the United
16 States. Twelve to eighteen million United States
17 adults have sleep apnea, a chronic disorder charac-
18 terized by one or more pauses in breathing which
19 can last from a few seconds to minutes. They may
20 occur 30 times or more an hour, disrupting sleep
21 and resulting in excessive daytime sleepiness and
22 loss in productivity.

23 (2) Seventy percent of high school students are
24 not getting enough sleep on school nights, while 33
25 percent of people in the United States get fewer

1 than 7 hours of sleep per night, and roughly 6,000
2 fatal motor vehicle crashes are caused by drowsy
3 drivers.

4 (3) Insufficient sleep and insomnia are more
5 prevalent in women. Women who are pregnant and
6 have sleep apnea are at an increased risk of cardio-
7 vascular complications during pregnancy. The im-
8 pact of disparities in sleep health is associated with
9 a growing number of health problems, including the
10 following:

11 (A) Hypertension.

12 (B) Cancer.

13 (C) Stroke.

14 (D) Cardiac arrhythmia.

15 (E) Chronic heart failure and heart dis-
16 ease.

17 (F) Diabetes.

18 (G) Cognitive functioning and behavior.

19 (H) Depression and bipolar disorder.

20 (I) Substance abuse.

21 (4) A sleep disparity exists in that poor sleep
22 quality is strongly associated with poverty and race.
23 Factors such as employment, education, and health
24 status, amongst others, significantly mediated this
25 effect only in poor subjects, suggesting a differential

1 vulnerability to these factors in poor relative to
2 nonpoor individuals in the context of sleep quality.

3 (5) African Americans sleep worse than Cauca-
4 sian Americans. African Americans take longer to
5 fall asleep, report poorer sleep quality, have more
6 light and less deep sleep, and nap more often and
7 longer.

8 (6) African Americans and individuals in lower
9 socioeconomic status groups may be at an increased
10 risk for sleep disturbances and associated health
11 consequences.

12 (7) Among young African Americans, the likeli-
13 hood of having sleep disordered breathing and exhib-
14 iting risk factors for poor sleep is twice that in
15 young Caucasians. Frequent snoring is more com-
16 mon among African-American and Hispanic women
17 and Hispanic men compared to non-Hispanic Cauca-
18 sians, independent of other factors including obesity.

19 (8) African Americans with sleep-disordered
20 breathing develop symptoms at a younger age than
21 Caucasians but appear less likely to be diagnosed
22 and treated in a timely manner. This delay may at
23 least in part be due to reduced access to care.

24 (9) Sleep loss contributes to increased risk for
25 chronic conditions such as obesity, diabetes, and hy-

1 pertension, all of which have increased prevalence in
2 underserved, underrepresented minorities. Racial
3 and ethnic disparities related to obesity may also
4 contribute to disparities in health outcomes related
5 to sleep-disordered breathing.

6 (10) Non-Caucasian adults report an insomnia
7 rate of 12.9 percent compared to only 6.6 percent
8 for Caucasians.

9 (11) African-American women have a higher in-
10 cidence of insomnia than African-American men,
11 perhaps related in part to higher risk for chronic
12 persisting symptoms.

13 **SEC. 792. SLEEP AND CIRCADIAN RHYTHM DISORDERS RE-**
14 **SEARCH ACTIVITIES OF THE NATIONAL IN-**
15 **STITUTES OF HEALTH.**

16 (a) IN GENERAL.—The Director of the National In-
17 stitutes of Health, acting through the Director of the Na-
18 tional Heart, Lung, and Blood Institute, shall—

19 (1) continue to expand research activities ad-
20 dressing sleep health disparities; and

21 (2) continue implementation of the NIH Sleep
22 Disorders Research Plan across all institutes and
23 centers of the National Institutes of Health to im-
24 prove treatment and prevention of sleep health dis-
25 parities.

1 (b) REQUIRED RESEARCH ACTIVITIES.—In con-
2 ducting or supporting research relating to sleep and circa-
3 dian rhythm, the Director of the National Heart, Lung,
4 and Blood Institute shall—

5 (1) advance epidemiology and clinical research
6 to achieve a more complete understanding of dispari-
7 ties in domains of sleep health and across population
8 subgroups for which cardiovascular and metabolic
9 health disparities exist, including—

10 (A) prevalence and severity of sleep apnea;

11 (B) habitual sleep duration;

12 (C) sleep timing and regularity; and

13 (D) insomnia;

14 (2) develop study designs and analytical ap-
15 proaches to explain and predict multilevel and life-
16 course determinants of sleep health and to elucidate
17 the sleep-related causes of cardiovascular and meta-
18 bolic health disparities across the age spectrum, in-
19 cluding such determinants and causes that are—

20 (A) environmental;

21 (B) biological or genetic;

22 (C) psychosocial;

23 (D) societal;

24 (E) political; or

25 (F) economic;

1 (3) determine the contribution of sleep impair-
2 ments such as sleep apnea, insufficient sleep dura-
3 tion, irregular sleep schedules, and insomnia to un-
4 explained disparities in cardiovascular and metabolic
5 risk and disease outcomes;

6 (4) develop study designs, data sampling and
7 collection tools, and analytical approaches to opti-
8 mize understanding of mediating and moderating
9 factors, and feedback mechanisms coupling sleep to
10 cardiovascular and metabolic health disparities;

11 (5) advance research to understand cultural
12 and linguistic barriers (on the person, provider, or
13 system level) to access to care, medical diagnosis,
14 and treatment of sleep disorders in diverse popu-
15 lation groups;

16 (6) develop and test multilevel interventions (in-
17 cluding sleep health education in diverse commu-
18 nities) to reduce disparities in sleep health that will
19 impact ability to improve disparities in cardio-
20 vascular and metabolic risk or disease;

21 (7) create opportunities to integrate sleep and
22 health disparity science by strategically utilizing re-
23 sources (existing or anticipated cohorts), exchanging
24 scientific data and ideas (cross-over into scientific

1 meetings), and develop multidisciplinary investi-
2 gator-initiated grant applications; and

3 (8) enhance the diversity and foster career de-
4 velopment of young investigators involved in sleep
5 and health disparities science.

6 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
7 out this section, there are authorized to be appropriated
8 such sums as may be necessary for fiscal year 2021 and
9 each subsequent fiscal year.

10 **SEC. 793. SLEEP AND CIRCADIAN RHYTHM HEALTH DIS-**
11 **PARITIES-RELATED ACTIVITIES OF THE CEN-**
12 **TERS FOR DISEASE CONTROL AND PREVEN-**
13 **TION.**

14 (a) IN GENERAL.—The Director of the Centers for
15 Disease Control and Prevention shall conduct, support,
16 and expand public health strategies and prevention, diag-
17 nosis, surveillance, and public and professional awareness
18 activities regarding sleep and circadian rhythm disorders.

19 (b) FINDINGS.—Congress finds as follows:

20 (1) Sleep disorders and sleep deficiency unre-
21 lated to a primary sleep disorder are underdiagnosed
22 and are increasingly detrimental to health status.

23 (2) The consequences to society include addi-
24 tional diseases, motor vehicle accidents, decreased
25 longevity, elevated direct medical costs, and indirect

1 costs related to work absenteeism and property dam-
2 age.

3 (c) REQUIRED SURVEILLANCE AND EDUCATION
4 AWARENESS ACTIVITIES.—In conducting or supporting
5 research relating to sleep and circadian rhythm disorders
6 surveillance and education awareness activities, the Direc-
7 tor of the Centers for Disease Control and Prevention
8 shall—

9 (1) ensure that such activities are culturally
10 and linguistically appropriate to minority patients,
11 targeting sleep and circadian rhythm health pro-
12 motion and prevention programs of each major eth-
13 nic group, including—

14 (A) Native Americans and Alaska Natives;

15 (B) Asian Americans;

16 (C) African Americans and Blacks;

17 (D) Hispanic and Latino Americans; and

18 (E) Native Hawaiians and Pacific Island-

19 ers;

20 (2) collect and compile national and State sur-
21 veillance data on sleep disorders health disparities;

22 (3) continue to develop and implement new
23 sleep questions in public health surveillance systems
24 to increase public awareness of sleep health and
25 sleep disorders and their impact on health;

1 (4) publish monthly reports highlighting geo-
2 graphic, racial, and ethnic disparities in sleep health,
3 as well as relationships between insufficient sleep
4 and chronic disease, health risk behaviors, and other
5 outcomes as determined necessary by the Director;
6 and

7 (5) include public awareness campaigns that in-
8 form patient populations from major ethnic groups
9 about the prevalence of sleep and circadian rhythm
10 disorders and emphasize the importance of sleep
11 health.

12 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there are authorized to be appropriated
14 such sums as may be necessary for fiscal year 2021 and
15 each subsequent fiscal year.

16 **SEC. 794. GRANTS FOR COMPREHENSIVE SLEEP AND CIR-**
17 **CADIAN HEALTH EDUCATION WITHIN**
18 **HEALTH PROFESSIONS SCHOOLS.**

19 (a) PROGRAM AUTHORIZED.—The Secretary of
20 Health and Human Services (referred to in this section
21 as the “Secretary”), in coordination with the Secretary of
22 Education, shall award grants, on a competitive basis, to
23 academic health science centers, health professions
24 schools, and other institutions of higher education to en-
25 able such institutions to provide people with comprehen-

1 sive education on sleep and circadian health, particu-
2 larly—

3 (1) poor sleep health;

4 (2) sleep disorders;

5 (3) sleep health disparities; and

6 (4) the relationship between sleep and circadian
7 health on metabolic activity, neurological activity,
8 comorbidities, and other diseases.

9 (b) DURATION.—Grants awarded under this section
10 shall be for a period of 5 years.

11 (c) APPLICATIONS.—Any academic health science
12 center, health professions school, or other institutions of
13 higher education seeking a grant under this section shall
14 submit an application to the Secretary at such time, in
15 such manner, and containing such information as the Sec-
16 retary may require.

17 (d) PRIORITY.—In awarding grants under this sec-
18 tion, the Secretary shall give priority to an institution
19 that—

20 (1) has an enrollment of needy students, as de-
21 fined in section 318(b) of the Higher Education Act
22 of 1965 (20 U.S.C. 1059e(b));

23 (2) is a Hispanic-serving institution, as defined
24 in section 502(a) of such Act (20 U.S.C. 1101a(a));

1 (3) is a Tribal College or University, as defined
2 in section 316(b) of such Act (20 U.S.C. 1059c(b));

3 (4) is an Alaska Native-serving institution, as
4 defined in section 317(b) of such Act (20 U.S.C.
5 1059d(b));

6 (5) is a Native Hawaiian-serving institution, as
7 defined in section 317(b) of such Act (20 U.S.C.
8 1059d(b));

9 (6) is a Predominately Black Institution, as de-
10 fined in section 318(b) of such Act (20 U.S.C.
11 1059e(b));

12 (7) is a Native American-serving, nontribal in-
13 stitution, as defined in section 319(b) of such Act
14 (20 U.S.C. 1059f(b));

15 (8) is an Asian American and Native American
16 Pacific Islander-serving institution, as defined in
17 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

18 (9) is a minority institution, as defined in sec-
19 tion 365 of such Act (20 U.S.C. 1067k), with an en-
20 rollment of needy students, as defined in section 312
21 of such Act (20 U.S.C. 1058).

22 (e) USES OF FUNDS.—An institution of higher edu-
23 cation receiving a grant under this section may use grant
24 funds to integrate issues relating to comprehensive sleep
25 and circadian health into the academic or support sectors

1 of the institution in order to reach a large number of stu-
2 dents, by carrying out 1 or more of the following activities:

3 (1) Developing educational content for issues
4 relating to comprehensive sleep and circadian health
5 education that will be incorporated into first-year
6 orientation or core courses.

7 (2) Creating innovative technology-based ap-
8 proaches to deliver sleep health education to stu-
9 dents, faculty, and staff.

10 (3) Developing and employing peer-outreach
11 and education programs to generate discussion, edu-
12 cate, and raise awareness among students about
13 issues relating to poor quality sleep, sleep and circa-
14 dian disorders, and the role sleep health plays in
15 other diseases and comorbidities.

16 (f) REPORT TO CONGRESS.—

17 (1) IN GENERAL.—Not later than 1 year after
18 the date of the enactment of this Act, and annually
19 thereafter for a period of 5 years, the Secretary shall
20 prepare and submit to the appropriate committees of
21 Congress a report on the activities to provide health
22 professions students with comprehensive sleep and
23 circadian health education funded under this section.

24 (2) REPORT ELEMENTS.—The report described
25 in paragraph (1) shall include information about—

1 (A) the number of eligible entities and in-
2 stitutions of higher education that are receiving
3 grant funds;

4 (B) the specific activities supported by
5 grant funds;

6 (C) the number of students served by
7 grant programs; and

8 (D) the status of program evaluations.

9 **SEC. 795. REPORT ON IMPACT OF SLEEP AND CIRCADIAN**
10 **HEALTH DISORDERS IN VULNERABLE AND**
11 **RACIAL/ETHNIC POPULATIONS.**

12 (a) IN GENERAL.—Not later than 1 year after the
13 date of enactment of this Act, the Secretary of Health and
14 Human Services shall submit to Congress and the Presi-
15 dent a report on the impact of sleep and circadian health
16 disorders for racial and ethnic minority communities and
17 other vulnerable populations.

18 (b) CONTENTS.—The report under subsection (a)
19 shall include information on the—

20 (1) progress that has been made in reducing
21 the impact of sleep and circadian health disorders in
22 such communities and populations;

23 (2) opportunities that exist to make additional
24 progress in reducing the impact of sleep and circa-

1 dian health disorders in such communities and popu-
2 lations;

3 (3) challenges that may impede such additional
4 progress; and

5 (4) Federal funding necessary to achieve sub-
6 stantial reductions in sleep and circadian health dis-
7 orders in racial and ethnic minority communities.

8 **Subtitle K—Kidney Disease Re-**
9 **search, Surveillance, Preven-**
10 **tion, and Treatment**

11 **SEC. 797. KIDNEY DISEASE, RESEARCH, SURVEILLANCE,**
12 **PREVENTION, AND TREATMENT.**

13 (a) **SHORT TITLE.**—This section may be cited as the
14 “Kidney Disease Research, Surveillance, Prevention and
15 Treatment Improvement Act of 2020”.

16 (b) **FINDINGS.**—Congress makes the following find-
17 ings:

18 (1) Kidney diseases impact 37 million Ameri-
19 cans.

20 (2) African Americans comprise just 13 percent
21 of the United States population, but 33 percent of
22 the United States dialysis patient population. Com-
23 pared to Caucasians, kidney failure prevalence is
24 about 3.7 times greater in African Americans, 1.4

1 times greater in Native Americans, and 1.5 times
2 greater in Asian Americans.

3 (3) Peritoneal dialysis and home hemodialysis
4 use is 40–50 percent lower among African Ameri-
5 cans and Hispanics.

6 (4) Every racial/ethnic minority group in the
7 United States is significantly less likely to be treated
8 with home dialysis than Whites, and demographic
9 and clinical characteristics are insufficient to explain
10 this differential use.

11 (5) African Americans on dialysis, irrespective
12 of dialysis modality, and Hispanics undergoing PD
13 or in-center HD, are significantly less likely than
14 their White counterparts to receive a kidney trans-
15 plant.

16 (6) African Americans, Hispanics, and Asian
17 Americans are less likely to receive living donor kid-
18 ney transplants than Whites. Efforts to reduce dis-
19 parities in live donor kidney transplantation for Afri-
20 can-American, Hispanic, and Asian patients with
21 kidney failure have been unsuccessful.

22 (7) Medicare and Medicaid patients are less
23 likely to receive a preemptive transplant from a de-
24 ceased donor compared to private insurance patients
25 (5 percent and 11 percent versus 24 percent), and

1 Black and Hispanic patients are less likely to receive
2 a preemptive transplant from a deceased donor com-
3 pared with White patients even after changes to the
4 kidney allocation system (5 percent of Black patients
5 and 5 percent of Hispanic patients compared with
6 18 percent of White patients).

7 (8) Low-income populations are significantly
8 more likely to progress to kidney failure.

9 (9) Low socioeconomic status is associated with
10 increased incidence of chronic kidney disease, pro-
11 gression to kidney failure, inadequate dialysis treat-
12 ment, and reduced access to kidney transplantation.

13 (10) The three goals of the recent Executive
14 Order on Advancing American Kidney Health recog-
15 nizes the need for more transplants, better preven-
16 tion and education and improved access to treatment
17 modalities.

18 **SEC. 798. KIDNEY DISEASE RESEARCH IN MINORITY POPU-**
19 **LATIONS.**

20 (a) IN GENERAL.—The Director of the National In-
21 stitutes of Health shall expand, intensify, and support on-
22 going research and other activities with respect to kidney
23 disease in minority populations.

24 (b) RESEARCH.—

1 (1) DESCRIPTION.—Research under subsection
2 (a) shall include investigation into—

3 (A) the causes of kidney disease, including
4 socioeconomic, geographic, clinical, environ-
5 mental, genetic, and other factors that may
6 contribute to increased rates of kidney disease
7 in minority populations; and

8 (B) the causes of increased incidence of
9 kidney disease complications in minority popu-
10 lations, and possible interventions to decrease
11 such incidence.

12 (2) INCLUSION OF MINORITY PARTICIPANTS.—
13 In conducting and supporting research described in
14 subsection (a), the Director of the National Insti-
15 tutes of Health shall seek to include minority par-
16 ticipants as study subjects in clinical trials.

17 (c) REPORT; COMPREHENSIVE PLAN.—

18 (1) IN GENERAL.—The Secretary of Health and
19 Human Services shall—

20 (A) prepare and submit to the Congress,
21 not later than 6 months after the date of enact-
22 ment of this section, a report on Federal re-
23 search and public health activities with respect
24 to kidney disease in minority populations; and

1 (B) develop and submit to Congress, not
2 later than 1 year after the date of enactment of
3 this section, an effective and comprehensive
4 Federal plan (including all appropriate Federal
5 health programs) to address kidney disease in
6 minority populations.

7 (2) CONTENTS.—The report under paragraph
8 (1)(A) shall at minimum address each of the fol-
9 lowing:

10 (A) Research on kidney disease in minority
11 populations, including such research on—

12 (i) genetic, behavioral, and environ-
13 mental factors; and

14 (ii) prevention and complications
15 among individuals within these populations
16 who have already developed kidney disease.

17 (B) Surveillance and data collection on
18 kidney disease in minority populations, includ-
19 ing with respect to—

20 (i) efforts to better determine the
21 prevalence of kidney disease among Asian-
22 American and Pacific Islander subgroups;
23 and

24 (ii) efforts to coordinate data collec-
25 tion on the American Indian population.

1 (C) Community-based interventions to ad-
2 dress kidney disease targeting minority popu-
3 lations, including—

4 (i) the evidence base for such inter-
5 ventions;

6 (ii) the cultural appropriateness of
7 such interventions; and

8 (iii) efforts to educate the public on
9 the causes and consequences of kidney dis-
10 ease.

11 (D) Education and training programs for
12 health professionals (including community
13 health workers) on the prevention and manage-
14 ment of kidney disease and its related complica-
15 tions that are supported by the Health Re-
16 sources and Services Administration, including
17 such programs supported by the Bureau of
18 Health Workforce, the Bureau of Primary
19 Health Care, and the Healthcare Systems Bu-
20 reau.

21 **SEC. 799. KIDNEY DISEASE 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 kidney 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 Institute of Diabetes and Di-
7 gestive and Kidney Disease, in consultation with the
8 Director of the Centers for Disease Control and Pre-
9 vention, shall develop a national action plan to ad-
10 dress kidney disease in the United States with par-
11 ticipation 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 kidney disease; and

21 (C) inclusion of kidney disease in the
22 health data collections of all Federal agencies.

23 (c) KIDNEY DISEASE PREVENTION PROGRAMS.—The
24 Director of the National Institute of Diabetes and Diges-
25 tive and Kidney Disease shall carry out the following:

1 (1) Conduct public education and awareness ac-
2 tivities with patient and professional organizations
3 to stimulate earlier diagnosis and improve patient
4 outcomes from treatment of kidney disease. To the
5 extent known and relevant, such public education
6 and awareness activities shall reflect differences in
7 kidney disease by cause (such as hypertension, dia-
8 betes, and polycystic kidney disease) and include a
9 focus on outreach to undiagnosed and, as appro-
10 prium, minority populations.

11 (2) Supplement and expand upon the activities
12 of the National Institute of Diabetes and Digestive
13 and Kidney Disease by making grants to nonprofit
14 organizations, State and local jurisdictions, and In-
15 dian tribes for the purpose of reducing the burden
16 of kidney disease, especially in disproportionately im-
17 pacted communities, through public health interven-
18 tions and related activities.

19 (3) Coordinate with the Centers for Disease
20 Control and Prevention, the Indian Health Service,
21 the Health Resources and Services Administration,
22 and the Department of Veterans Affairs to develop
23 pilot programs to demonstrate best practices for the
24 diagnosis and management of kidney disease.

1 (4) Develop improved techniques and identify
2 best practices, in coordination with the Secretary of
3 Veterans Affairs, for assisting kidney disease pa-
4 tients.

5 (d) DATA COLLECTION.—Not later than 180 days
6 after the date of enactment of this Act, the Director of
7 the National Institute of Diabetes and Digestive and Kid-
8 ney Disease and the Director of the Centers for Disease
9 Control and Prevention, acting jointly, shall assess the
10 depth and quality of information on kidney disease that
11 is collected in surveys and population studies conducted
12 by the Centers for Disease Control and Prevention, includ-
13 ing whether there are additional opportunities for informa-
14 tion to be collected in the National Health and Nutrition
15 Examination Survey, the National Health Interview Sur-
16 vey, and the Behavioral Risk Factors Surveillance System
17 surveys. The Director of the National Institute of Diabetes
18 and Digestive and Kidney Disease shall include the results
19 of such assessment in the national action plan under sub-
20 section (b).

21 (e) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 \$1,000,000 for fiscal year 2021, \$1,000,000 for fiscal year
24 2022, \$1,000,000 for fiscal year 2023, \$1,000,000 for fis-
25 cal year 2024, and \$1,000,000 for fiscal year 2025.

1 **SEC. 799A. HOME DIALYSIS AND INCREASING END-STAGE**
2 **RENAL DISEASE TREATMENT MODALITIES IN**
3 **MINORITY COMMUNITIES ACTION PLAN.**

4 (a) NATIONAL ACTION PLAN.—

5 (1) DEVELOPMENT.—Not later than 2 years
6 after the date of the enactment of this Act, the Di-
7 rector of the National Institute of Diabetes and Di-
8 gestive and Kidney Disease, in consultation with the
9 Director of the Centers for Disease Control and Pre-
10 vention, shall develop a national action plan to in-
11 crease the number of home dialyzers and choice in
12 dialysis treatment modality in the United States
13 with participation from patients, caregivers, health
14 professionals, patient advocacy organizations, re-
15 searchers, providers, public health professionals, and
16 other stakeholders in the minority community.

17 (2) CONTENTS.—At a minimum, such plan
18 shall include recommendations for—

19 (A) public health officials for the purpose
20 of implementation of the national plan;

21 (B) biomedical, health services, and public
22 health research on home dialysis and modalities
23 in minority communities; and

24 (C) inclusion of dialysis location and mo-
25 dality in the health data collections of all Fed-
26 eral agencies.

1 (b) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$1,000,000 for fiscal year 2021, \$1,000,000 for fiscal year
4 2022, \$1,000,000 for fiscal year 2023, \$1,000,000 for fis-
5 cal year 2024, and \$1,000,000 for fiscal year 2025.

6 **SEC. 799B. INCREASING KIDNEY TRANSPLANTS IN MINOR-**
7 **ITY COMMUNITIES.**

8 (a) IN GENERAL.—The Director of the National In-
9 stitutes of Health shall expand, intensify, and support on-
10 going research and other activities with respect to kidney
11 transplants in minority populations.

12 (b) RESEARCH.—Research under subsection (a) shall
13 include investigation into—

14 (1) the causes of lower rates of kidney trans-
15 plants in minority communities, including socio-
16 economic, geographic, clinical, environmental, ge-
17 netic, and other factors that may contribute to lower
18 rates of kidney transplants in minority populations;
19 and

20 (2) possible interventions to increase kidney
21 transplants.

22 (c) REPORT; COMPREHENSIVE PLAN.—

23 (1) IN GENERAL.—The Secretary of Health and
24 Human Services shall—

1 (A) prepare and submit to the Congress,
2 not later than 6 months after the date of enact-
3 ment of this section, a report on Federal re-
4 search and public health activities with respect
5 to kidney transplants as a treatment for end-
6 stage renal disease in minority populations; and

7 (B) develop and submit to the Congress,
8 not later than 1 year after the date of enact-
9 ment of this section, an effective and com-
10 prehensive Federal plan (including all appro-
11 priate Federal health programs) to increase the
12 number of kidney transplants in minority popu-
13 lations.

14 (2) CONTENTS.—The report under paragraph
15 (1)(A) shall at a minimum address each of the fol-
16 lowing:

17 (A) Research on kidney transplants in mi-
18 nority populations, including such research on
19 financial, insurance coverage, genetic, behav-
20 ioral, and environmental factors.

21 (B) Surveillance and data collection on
22 kidney transplants in minority populations, in-
23 cluding with respect to—

24 (i) efforts to increase kidney trans-
25 plants disease among Asian-American and

1 Pacific Islander subgroups with end-stage
2 renal disease; and

3 (ii) efforts to increase kidney trans-
4 plants in the American Indian population.

5 (C) Community-based efforts to increase
6 kidney transplants targeting minority popu-
7 lations, including—

8 (i) the evidence base for such in-
9 creases;

10 (ii) the cultural appropriateness of
11 such increases; and

12 (iii) efforts to educate the public on
13 the kidney transplants.

14 (D) Education and training programs for
15 health professionals (including community
16 health workers) on the kidney transplants that
17 are supported by the Health Resources and
18 Services Administration, including such pro-
19 grams supported by the Bureau of Health
20 Workforce, the Bureau of Primary Health Care,
21 and the Healthcare Systems Bureau.

22 **SEC. 799C. ENVIRONMENTAL AND OCCUPATIONAL HEALTH**
23 **PROGRAMS.**

24 The Director of the Centers for Disease Control and
25 Prevention shall—

1 (1) support research into the environmental and
2 occupational causes and biological mechanisms that
3 contribute to kidney disease; and

4 (2) develop and disseminate public health inter-
5 ventions that will lessen the impact of environmental
6 and occupational causes of kidney disease.

7 **SEC. 799D. UNDERSTANDING THE TREATMENT PATTERNS**
8 **ASSOCIATED WITH PROVIDING CARE AND**
9 **TREATMENT OF KIDNEY FAILURE IN MINOR-**
10 **ITY POPULATIONS.**

11 (a) **STUDY.**—The Secretary of Health and Human
12 Services (in this section referred to as the “Secretary”)
13 shall conduct a study on treatment patterns associated
14 with providing care, under the Medicare program under
15 title XVIII of the Social Security Act (42 U.S.C. 1395
16 et seq.), the Medicaid program under title XIX of such
17 Act (42 U.S.C. 1396 et seq.), and through private health
18 insurance, to minority populations that are disproportion-
19 ately affected by kidney failure.

20 (b) **REPORT.**—Not later than 1 year after the date
21 of the enactment of this Act, the Secretary shall submit
22 to Congress a report on the study conducted under sub-
23 section (a), together with such recommendations as the
24 Secretary determines to be appropriate.

1 **SEC. 799E. IMPROVING ACCESS IN UNDERSERVED AREAS.**

2 (a) DEFINITION OF PRIMARY CARE SERVICES.—Sec-
3 tion 331(a)(3)(D) of the Public Health Service Act (42
4 U.S.C. 254d(a)(3)(D)) is amended by inserting “renal di-
5 alysis,” after “dentistry,”.

6 (b) NATIONAL HEALTH SERVICE CORPS SCHOLAR-
7 SHIP PROGRAM.—Section 338A(a)(2) of the Public Health
8 Service Act (42 U.S.C. 254l(a)(2)) is amended by insert-
9 ing “, which may include nephrology health professionals”
10 before the period at the end.

11 (c) NATIONAL HEALTH SERVICE CORPS LOAN RE-
12 PAYMENT PROGRAM.—Section 338B(a)(2) of the Public
13 Health Service Act (42 U.S.C. 254l–1(a)(2)) is amended
14 by inserting “, which may include nephrology health pro-
15 fessionals” before the period at the end.

16 **TITLE VIII—HEALTH**
17 **INFORMATION TECHNOLOGY**

18 **SEC. 800. DEFINITIONS.**

19 In this title:

20 (1) CERTIFIED ELECTRONIC HEALTH RECORD
21 TECHNOLOGY.—The term “certified EHR tech-
22 nology” has the meaning given such term in section
23 3000 of the Public Health Service Act (42 U.S.C.
24 300jj).

25 (2) EHR.—The term “EHR” means an elec-
26 tronic health record.

1 (3) INTEROPERABILITY.—The term “interoper-
2 ability” has the meaning given such term in section
3 3000 of the Public Health Service Act (42 U.S.C.
4 300jj). Evaluation and measurement of interoper-
5 ability shall consider exchange of electronic health
6 information, usability of exchanged electronic health
7 information, effective application and use of the ex-
8 changed electronic health information, and impact
9 on outcomes of interoperability.

10 (4) ACCESS.—The term “access” has the mean-
11 ing given such term within the definition of “inter-
12 operability” in section 3000 of the Public Health
13 Service Act (42 U.S.C. 300jj) and within HIPAA’s
14 Privacy Rule (45 C.F.R. 164.524).

15 (5) CERTIFIED ELECTRONIC HEALTH RECORD
16 TECHNOLOGY; EHR.—The term “certified electronic
17 health record technology” and the term “EHR” both
18 include the health information infrastructure for
19 interoperability, access, exchange, and use of elec-
20 tronic health information required by sections 4003
21 and 4006 of the 21st Century Cures Act, and are
22 not limited solely to doctors’ electronic health
23 records.

1 **Subtitle A—Reducing Health**
2 **Disparities Through Health IT**

3 **SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR**
4 **PROMOTION OF HEALTH IT.**

5 The Secretary of Health and Human Services, acting
6 through the Administrator of the Health Resources and
7 Services Administration, shall expand and intensify the
8 programs and activities of the Administration (directly or
9 through grants or contracts) to provide technical assist-
10 ance and resources to health centers (as defined in section
11 330(a) of the Public Health Service Act (42 U.S.C.
12 254b(a))) to adopt and meaningfully use certified EHR
13 technology for the management of chronic diseases and
14 health conditions and reduction of health disparities.

15 **SEC. 802. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**
16 **CIAL AND ETHNIC MINORITY COMMUNITIES;**
17 **OUTREACH AND ADOPTION OF HEALTH IT IN**
18 **SUCH COMMUNITIES.**

19 (a) NATIONAL COORDINATOR FOR HEALTH INFOR-
20 MATION TECHNOLOGY.—Not later than 18 months after
21 the date of enactment of this Act, the National Coordi-
22 nator for Health Information Technology (referred to in
23 this section as the “National Coordinator”) shall—

24 (1) conduct an evaluation of the level of inter-
25 operability, access, use, and accessibility of electronic

1 health records in racial and ethnic minority commu-
2 nities, focusing on whether patients in such commu-
3 nities have providers who use electronic health
4 records, and the degree to which patients in such
5 communities can access, exchange, and use without
6 special effort their health information in those elec-
7 tronic health records, and indicating whether such
8 providers—

9 (A) are participating in the Medicare pro-
10 gram under title XVIII of the Social Security
11 Act (42 U.S.C. 1395 et seq.) or a State plan
12 under title XIX of such Act (42 U.S.C. 1396 et
13 seq.) (or a waiver of such plan);

14 (B) have received incentive payments or in-
15 centive payment adjustments under Medicare
16 and Medicaid Electronic Health Records Incen-
17 tive Programs (as defined in subsection (c)(2));

18 (C) are MIPS eligible professionals, as de-
19 fined in paragraph (1)(C) of section 1848(q) of
20 the Social Security Act (42 U.S.C. 1395w-
21 4(q)), for purposes of the Merit-Based Incentive
22 Payment System under such section; or

23 (D) have been recruited by any of the
24 Health Information Technology Regional Ex-
25 tension Centers established under section 3012

1 of the Public Health Service Act (42 U.S.C.
2 300jj-32);

3 (2) publish the results of such evaluation in-
4 cluding the race and ethnicity of such providers and
5 the populations served by such providers; and

6 (3) not later than 12 months after the enact-
7 ment of this Act, shall promulgate a certification cri-
8 terion and module of certified EHR technology that
9 stratifies quality measures by disparity characteris-
10 tics, including race, ethnicity, language, gender, gen-
11 der identity, sexual orientation, socio-economic sta-
12 tus, and disability status, as those characteristics
13 are defined in certified EHR technology; and reports
14 to Centers for Medicare & Medicaid Services the
15 quality measures stratified by race and at least two
16 other disparity characteristics.

17 The term “quality measures” refers to the quality meas-
18 ures specified in MIPS.

19 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—
20 As soon as practicable after the date of enactment of this
21 Act, the Director of the National Center for Health Statis-
22 tics shall provide to Congress a more detailed analysis of
23 the data presented in National Center for Health Statis-
24 tics data brief entitled “Adoption of Certified Electronic
25 Health Record Systems and Electronic Information Shar-

1 ing in Physician Offices: United States, 2013 and 2014”
2 (NCHS Data Brief No. 236).

3 (c) CENTERS FOR MEDICARE & MEDICAID SERV-
4 ICES.—

5 (1) IN GENERAL.—As part of the process of
6 collecting information, with respect to a provider, at
7 registration and attestation for purposes of Medicare
8 and Medicaid Electronic Health Records Incentive
9 Programs (as defined in paragraph (2)) or the
10 Merit-Based Incentive Payment System under sec-
11 tion 1848(q) of the Social Security Act (42 U.S.C.
12 1395w-4(q)), the Secretary of Health and Human
13 Services shall collect the race and ethnicity of such
14 provider.

15 (2) MEDICARE AND MEDICAID ELECTRONIC
16 HEALTH RECORDS INCENTIVE PROGRAMS DE-
17 FINED.—For purposes of paragraph (1), the term
18 “Medicare and Medicaid Electronic Health Records
19 Incentive Programs” means the incentive programs
20 under section 1814(l)(3), subsections (a)(7) and (o)
21 of section 1848, subsections (l) and (m) of section
22 1853, subsections (b)(3)(B)(ix)(I) and (n) of section
23 1886, and subsections (a)(3)(F) and (t) of section
24 1903 of the Social Security Act (42 U.S.C.

1 1395f(l)(3), 1395w-4, 1395w-23, 1395ww, and
2 1396b).

3 (d) NATIONAL COORDINATOR'S ASSESSMENT OF IM-
4 PACT OF HIT.—Section 3001(e)(6)(C) of the Public
5 Health Service Act (42 U.S.C. 300jj-11(e)(6)(C)) is
6 amended—

7 (1) in the heading by inserting “, RACIAL AND
8 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
9 DISPARITIES”;

10 (2) by inserting “, in communities with a high
11 proportion of individuals from racial and ethnic mi-
12 nority groups (as defined in section 1707(g)), in-
13 cluding people with disabilities in these groups,”
14 after “communities with health disparities”;

15 (3) by striking “The National Coordinator” and
16 inserting the following:

17 “(i) IN GENERAL.—The National Co-
18 ordinator”; and

19 (4) by adding at the end the following:

20 “(ii) CRITERIA.—In any publication
21 under clause (i), the National Coordinator
22 shall include best practices for encouraging
23 partnerships between the Federal Govern-
24 ment, States, and private entities to ex-
25 pand outreach for and the adoption of cer-

1 tified EHR technology in communities with
2 a high proportion of individuals from racial
3 and ethnic minority groups (as so defined),
4 while also maintaining the accessibility re-
5 quirements of section 508 of the Rehabili-
6 tation Act of 1973 to encourage patient in-
7 volvement in patient health care. The Na-
8 tional Coordinator shall—

9 “(I) not later than 6 months
10 after the submission of the report re-
11 quired under section 822 of the
12 Health Equity and Accountability Act
13 of 2020, establish criteria for evalu-
14 ating the impact of health information
15 technology on communities with a
16 high proportion of individuals from
17 racial and ethnic minority groups (as
18 so defined) taking into account the
19 findings in such report; and

20 “(II) not later than 1 year after
21 the submission of such report, conduct
22 and publish the results of an evalua-
23 tion of such impact.”.

1 **SEC. 803. NONDISCRIMINATION AND HEALTH EQUITY IN**
2 **HEALTH INFORMATION TECHNOLOGY.**

3 Covered entities shall ensure that electronic and in-
4 formation technology in their health programs or activities
5 does not exclude individuals from participation in, deny
6 them the benefits of, or subject them to discrimination
7 under any health program or activity on the basis of race,
8 color, national origin, sex, age, or disability. The term
9 “covered entity” means—

10 (1) an entity that operates a health program or
11 activity, any part of which receives Federal financial
12 assistance;

13 (2) an entity established under title I of the Pa-
14 tient Protection and Affordable Care Act that ad-
15 ministers a health program or activity; and

16 (3) the U.S. Department of Health and Human
17 Services.

18 **SEC. 804. LANGUAGE ACCESS IN HEALTH INFORMATION**
19 **TECHNOLOGY.**

20 The National Coordinator shall—

21 (1) not later than 18 months following enact-
22 ment of this Act, require the Office of the National
23 Coordinator to provide access to certified EHR tech-
24 nology to provide patients access to their personal
25 health information in a computable format, includ-
26 ing using patient portals or third-party applications

1 (as described in the 21st Century Cures Act), in the
2 ten (10) most common non-English languages;

3 (2) hold a public hearing to identify best prac-
4 tices for such a requirement listed in paragraph (1);
5 and

6 (3) not later than 6 months after the public
7 hearing, promulgate a regulation and subsequent
8 proposed rulemaking.

9 **Subtitle B—Modifications To**
10 **Achieve Parity in Existing Pro-**
11 **grams**

12 **SEC. 811. EXTENDING FUNDING TO STRENGTHEN THE**
13 **HEALTH IT INFRASTRUCTURE IN RACIAL**
14 **AND ETHNIC MINORITY COMMUNITIES.**

15 Section 3011 of the Public Health Service Act (42
16 U.S.C. 300jj–31) is amended—

17 (1) in subsection (a), in the matter preceding
18 paragraph (1), by inserting “, including with respect
19 to communities with a high proportion of individuals
20 from racial and ethnic minority groups (as defined
21 in section 1707(g))” before the colon; and

22 (2) by adding at the end the following new sub-
23 section:

1 “(e) ANNUAL REPORT ON EXPENDITURES.—The
2 National Coordinator shall report annually to Congress on
3 activities and expenditures under this section.”.

4 **SEC. 812. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
5 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
6 **TATE ADOPTION OF CERTIFIED EHR TECH-**
7 **NOLOGY BY PROVIDERS SERVING RACIAL**
8 **AND ETHNIC MINORITY GROUPS.**

9 Section 3014(e) of the Public Health Service Act (42
10 U.S.C. 300jj–34(e)) is amended, in the matter preceding
11 paragraph (1), by inserting “, including with respect to
12 communities with a high proportion of individuals from
13 racial and ethnic minority groups (as defined in section
14 1707(g))” after “health care provider to”.

15 **SEC. 813. AUTHORIZATION OF APPROPRIATIONS.**

16 Section 3018 of the Public Health Service Act (42
17 U.S.C. 300jj–38) is amended by striking “fiscal years
18 2009 through 2013” and inserting “fiscal years 2021
19 through 2026”.

1 **Subtitle C—Additional Research**
2 **and Studies**

3 **SEC. 821. DATA COLLECTION AND ASSESSMENTS CON-**
4 **DUCTED IN COORDINATION WITH MINORITY-**
5 **SERVING INSTITUTIONS.**

6 Section 3001(c)(6) of the Public Health Service Act
7 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
8 end the following new subparagraph:

9 “(F) DATA COLLECTION AND ASSESS-
10 MENTS CONDUCTED IN COORDINATION WITH
11 MINORITY-SERVING INSTITUTIONS.—

12 “(i) IN GENERAL.—In carrying out
13 subparagraph (C) with respect to commu-
14 nities with a high proportion of individuals
15 from racial and ethnic minority groups (as
16 defined in section 1707(g)), the National
17 Coordinator shall, to the greatest extent
18 possible, coordinate with an entity de-
19 scribed in clause (ii).

20 “(ii) MINORITY-SERVING INSTITU-
21 TIONS.—For purposes of clause (i), an en-
22 tity described in this clause is a historically
23 Black college or university, a Hispanic-
24 serving institution, a Tribal College or
25 University, or an Asian American, Native

1 American, or Pacific Islander-serving insti-
2 tution with an accredited public health,
3 health policy, or health services research
4 program.”.

5 **SEC. 822. STUDY OF HEALTH INFORMATION TECHNOLOGY**
6 **IN MEDICALLY UNDERSERVED COMMU-**
7 **NITIES.**

8 (a) IN GENERAL.—Not later than 2 years after the
9 date of enactment of this Act, the Secretary of Health and
10 Human Services shall—

11 (1) enter into an agreement with the National
12 Academies of Sciences, Engineering, and Medicine to
13 conduct a study on the development, implementa-
14 tion, and effectiveness of health information tech-
15 nology within medically underserved areas (as de-
16 scribed in subsection (c)); and

17 (2) submit a report to Congress describing the
18 results of such study, including any recommenda-
19 tions for legislative or administrative action.

20 (b) STUDY.—The study described in subsection
21 (a)(1) shall—

22 (1) identify barriers to successful implementa-
23 tion of health information technology in medically
24 underserved areas;

1 (2) survey a cross-section of individuals in
2 medically underserved areas and report their opin-
3 ions about the various topics of study;

4 (3) examine the degree of interoperability
5 among health information technology and users of
6 health information technology in medically under-
7 served areas, including patients, providers, and com-
8 munity services;

9 (4) examine the impact of health information
10 technology on providing quality care and reducing
11 the cost of care to individuals in such areas, includ-
12 ing the impact of such technology on improved
13 health outcomes for individuals, including which
14 technology worked for which population and how it
15 improved health outcomes for that population;

16 (5) examine the impact of health information
17 technology on improving health care-related deci-
18 sions by both patients and providers in such areas;

19 (6) identify specific best practices for using
20 health information technology to foster the con-
21 sistent provision of physical accessibility and reason-
22 able policy accommodations in health care to individ-
23 uals with disabilities in such areas;

1 (7) assess the feasibility and costs associated
2 with the use of health information technology in
3 such areas;

4 (8) evaluate whether the adoption and use of
5 qualified electronic health records (as defined in sec-
6 tion 3000 of the Public Health Service Act (42
7 U.S.C. 300jj)) is effective in reducing health dispari-
8 ties, including analysis of clinical quality measures
9 reported by providers who are participating in the
10 Medicare program under title XVIII of the Social
11 Security Act (42 U.S.C. 1395 et seq.) or a State
12 plan under title XIX of such Act (42 U.S.C. 1396
13 et seq.) (or a waiver of such plan), pursuant to pro-
14 grams to encourage the adoption and use of certified
15 EHR technology;

16 (9) identify providers in medically underserved
17 areas that are not electing to adopt and use elec-
18 tronic health records and determine what barriers
19 are preventing those providers from adopting and
20 using such records; and

21 (10) examine urban and rural community
22 health systems and determine the impact that health
23 information technology may have on the capacity of
24 primary health providers in those systems.

1 (c) MEDICALLY UNDERSERVED AREA.—The term
2 “medically underserved area” means—

3 (1) a population that has been designated as a
4 medically underserved population under section
5 330(b)(3) of the Public Health Service Act (42
6 U.S.C. 254b(b)(3));

7 (2) an area that has been designated as a
8 health professional shortage area under section 332
9 of the Public Health Service Act (42 U.S.C. 254e);

10 (3) an area or population that has been des-
11 ignated as a medically underserved community under
12 section 799B of the Public Health Service Act (42
13 U.S.C. 295p); or

14 (4) another area or population that—

15 (A) experiences significant barriers to ac-
16 cessing quality health services; and

17 (B) has a high prevalence of diseases or
18 conditions described in title VII, with such dis-
19 eases or conditions having a disproportionate
20 impact on racial and ethnic minority groups (as
21 defined in section 1707(g) of the Public Health
22 Service Act (42 U.S.C. 300u–6(g))) or a sub-
23 group of people with disabilities who have spe-
24 cific functional impairments.

1 **SEC. 823. ASSESSMENT OF USE AND MISUSE OF DE-IDENTI-**
2 **FIED HEALTH DATA.**

3 (a) IN GENERAL.—Not later than 18 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 Office of
7 the National Coordinator to conduct a study on the
8 impact of digital health technology on medically un-
9 derserved areas (as described in section 822(c) of
10 the Health Equity and Accountability Act of 2020)
11 in consultation with relevant stakeholders; and

12 (2) submit a report to Congress describing the
13 results of such study, including any recommenda-
14 tions for legislative or administrative action.

15 (b) STUDY.—The study described in subsection
16 (a)(1) shall—

17 (1) examine the overall prevalence, and histor-
18 ical and existing practices and their respective preva-
19 lence, of use and misuse of de-identified protected
20 health information, as it is defined in section
21 160.103, title 45, Code of Federal Regulations, to
22 discriminate against or benefit medically under-
23 served areas;

24 (2) identify best practices and tools to leverage
25 the benefits and prevent misuse of de-identified pro-

1 pended under section 1903(a)(3)(F) of the Social Security
2 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
3 ginning on or after the date of the enactment of this Act.

4 **TITLE IX—ACCOUNTABILITY**
5 **AND EVALUATION**

6 **SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL**
7 **ASSISTED HEALTH CARE SERVICES AND RE-**
8 **SEARCH PROGRAMS ON THE BASIS OF SEX**
9 **(INCLUDING SEX ORIENTATION, GENDER**
10 **IDENTITY, AND PREGNANCY, INCLUDING**
11 **TERMINATION OF PREGNANCY), RACE,**
12 **COLOR, NATIONAL ORIGIN, MARITAL STATUS,**
13 **FAMILIAL STATUS, SEXUAL ORIENTATION,**
14 **GENDER IDENTITY, OR DISABILITY STATUS.**

15 (a) IN GENERAL.—No person in the United States
16 shall, on the basis of sex (including sex orientation, gender
17 identity, and pregnancy, including termination of preg-
18 nancy), race, color, national origin, marital status, familial
19 status, sexual orientation, gender identity, or disability
20 status, be excluded from participation in, be denied the
21 benefits of, or be subjected to discrimination under any
22 health program or activity, including any health research
23 program or activity, receiving Federal financial assistance,
24 including credits, subsidies, or contracts of insurance or

1 any health program or activity that is administered by an
2 executive agency.

3 (b) DEFINITION.—In this section, the term “familial
4 status” means, with respect to one or more individuals—

5 (1) being domiciled with any individual related
6 by blood or affinity whose close association with the
7 individual is the equivalent of a family relationship;

8 (2) being in the process of securing legal cus-
9 tody of any individual; or

10 (3) being pregnant.

11 **SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER**
12 **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

13 A payment to a provider of services, physician, or
14 other supplier under part B, C, or D of title XVIII of
15 the Social Security Act shall be deemed a grant, and not
16 a contract of insurance or guaranty, for the purposes of
17 title VI of the Civil Rights Act of 1964.

18 **SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
19 **THE DEPARTMENT OF HEALTH AND HUMAN**
20 **SERVICES.**

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

1 **“Subtitle D—Strengthening**
2 **Accountability**

3 **“SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

4 “(a) IN GENERAL.—The Secretary shall establish
5 within the Office for Civil Rights an Office of Health Dis-
6 parities, which shall be headed by a director to be ap-
7 pointed by the Secretary.

8 “(b) PURPOSE.—The Office of Health Disparities
9 shall ensure that the health programs, activities, and oper-
10 ations of health entities that receive Federal financial as-
11 sistance are in compliance with title VI of the Civil Rights
12 Act, including through the following activities:

13 “(1) The development and implementation of
14 an action plan to address racial and ethnic health
15 care disparities, which shall address concerns relat-
16 ing to the Office for Civil Rights as released by the
17 United States Commission on Civil Rights in the re-
18 port entitled ‘Health Care Challenge: Acknowledging
19 Disparity, Confronting Discrimination, and Ensur-
20 ing Equity’ (September 1999) in conjunction with
21 the reports by the National Academy of Sciences
22 (formerly known as the Institute of Medicine) enti-
23 tled ‘Unequal Treatment: Confronting Racial and
24 Ethnic Disparities in Health Care’, ‘Crossing the
25 Quality Chasm: A New Health System for the 21st

1 Century’, ‘In the Nation’s Compelling Interest: En-
2 suring Diversity in the Health Care Workforce’,
3 ‘The National Partnership for Action to End Health
4 Disparities’, and ‘The Health of Lesbian, Gay, Bi-
5 sexual, and Transgender People’, and other related
6 reports by the National Academy of Sciences. This
7 plan shall be publicly disclosed for review and com-
8 ment and the final plan shall address any comments
9 or concerns that are received by the Office.

10 “(2) Investigative and enforcement actions
11 against intentional discrimination and policies and
12 practices that have a disparate impact on minorities.

13 “(3) The review of racial, ethnic, gender iden-
14 tity, sexual orientation, sex, disability status, socio-
15 economic status, and primary language health data
16 collected by Federal health agencies to assess health
17 care disparities related to intentional discrimination
18 and policies and practices that have a disparate im-
19 pact on minorities. Such review shall include an as-
20 sessment of health disparities in communities with a
21 combination of these classes.

22 “(4) Outreach and education activities relating
23 to compliance with title VI of the Civil Rights Act.

1 “(5) The provision of technical assistance for
2 health entities to facilitate compliance with title VI
3 of the Civil Rights Act.

4 “(6) Coordination and oversight of activities of
5 the civil rights compliance offices established under
6 section 3442.

7 “(7) Ensuring—

8 “(A) at a minimum, compliance with the
9 most recent version of the Office of Manage-
10 ment and Budget statistical policy directive en-
11 titled ‘Standards for Maintaining, Collecting,
12 and Presenting Federal Data on Race and Eth-
13 nicity’; and

14 “(B) consideration of available data and
15 language standards such as—

16 “(i) the standards for collecting and
17 reporting data under section 3101; and

18 “(ii) the National Standards on Cul-
19 turally and Linguistically Appropriate
20 Services of the Office of Minority Health.

21 “(c) FUNDING AND STAFF.—The Secretary shall en-
22 sure the effectiveness of the Office of Health Disparities
23 by ensuring that the Office is provided with—

24 “(1) adequate funding to enable the Office to
25 carry out its duties under this section; and

1 “(2) staff with expertise in—

2 “(A) epidemiology;

3 “(B) statistics;

4 “(C) health quality assurance;

5 “(D) minority health and health dispari-
6 ties;

7 “(E) cultural and linguistic competency;

8 “(F) civil rights; and

9 “(G) social, behavioral, and economic de-
10 terminants of health.

11 “(d) REPORT.—Not later than December 31, 2021,
12 and annually thereafter, the Secretary, in collaboration
13 with the Director of the Office for Civil Rights and the
14 Deputy Assistant Secretary for Minority Health, shall
15 submit a report to the Committee on Health, Education,
16 Labor, and Pensions of the Senate and the Committee on
17 Energy and Commerce of the House of Representatives
18 that includes—

19 “(1) the number of cases filed, broken down by
20 category;

21 “(2) the number of cases investigated and
22 closed by the office;

23 “(3) the outcomes of cases investigated;

24 “(4) the staffing levels of the office including
25 staff credentials;

1 “(5) the number of other lingering and emerg-
2 ing cases in which civil rights inequities can be dem-
3 onstrated; and

4 “(6) the number of cases remaining open and
5 an explanation for their open status.

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2021 through 2026.

10 **“SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OF-**
11 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**
12 **HEALTH AND HUMAN SERVICES AGENCIES.**

13 “(a) IN GENERAL.—The Secretary shall establish
14 civil rights compliance offices in each agency within the
15 Department of Health and Human Services that admin-
16 isters health programs.

17 “(b) PURPOSE OF OFFICES.—Each office established
18 under subsection (a) shall ensure that recipients of Fed-
19 eral financial assistance under Federal health programs
20 administer programs, services, and activities in a manner
21 that—

22 “(1) does not discriminate, either intentionally
23 or in effect, on the basis of race, national origin, lan-
24 guage, ethnicity, sex, age, disability, sexual orienta-
25 tion, and gender identity; and

1 “(2) promotes the reduction and elimination of
2 disparities in health and health care based on race,
3 national origin, language, ethnicity, sex, age, dis-
4 ability, sexual orientation, and gender identity.

5 “(c) POWERS AND DUTIES.—The offices established
6 in subsection (a) shall have the following powers and du-
7 ties:

8 “(1) The establishment of compliance and pro-
9 gram participation standards for recipients of Fed-
10 eral financial assistance under each program admin-
11 istered by the applicable agency, including the estab-
12 lishment of disparity reduction standards to encom-
13 pass disparities in health and health care related to
14 race, national origin, language, ethnicity, sex, age,
15 disability, sexual orientation, and gender identity.

16 “(2) The development and implementation of
17 program-specific guidelines that interpret and apply
18 Department of Health and Human Services guid-
19 ance under title VI of the Civil Rights Act of 1964
20 and section 1557 of the Patient Protection and Af-
21 fordable Care Act to each Federal health program
22 administered by the agency.

23 “(3) The development of a disparity-reduction
24 impact analysis methodology that shall be applied to
25 every rule issued by the agency and published as

1 part of the formal rulemaking process under sections
2 555, 556, and 557 of title 5, United States Code.

3 “(4) Oversight of data collection, analysis, and
4 publication requirements for all recipients of Federal
5 financial assistance under each Federal health pro-
6 gram administered by the agency; compliance with,
7 at a minimum, the most recent version of the Office
8 of Management and Budget statistical policy direc-
9 tive entitled ‘Standards for Maintaining, Collecting,
10 and Presenting Federal Data on Race and Eth-
11 nicity’; and consideration of available data and lan-
12 guage standards such as—

13 “(A) the standards for collecting and re-
14 porting data under section 3101; and

15 “(B) the National Standards on Culturally
16 and Linguistically Appropriate Services of the
17 Office of Minority Health.

18 “(5) The conduct of publicly available studies
19 regarding discrimination within Federal health pro-
20 grams administered by the agency as well as dis-
21 parity reduction initiatives by recipients of Federal
22 financial assistance under Federal health programs.

23 “(6) Annual reports to the Committee on
24 Health, Education, Labor, and Pensions and the
25 Committee on Finance of the Senate and the Com-

1 mittee on Energy and Commerce and the Committee
2 on Ways and Means of the House of Representatives
3 on the progress in reducing disparities in health and
4 health care through the Federal programs adminis-
5 tered by the agency.

6 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
7 IN THE DEPARTMENT OF JUSTICE.—

8 “(1) DEPARTMENT OF HEALTH AND HUMAN
9 SERVICES.—The Office for Civil Rights of the De-
10 partment of Health and Human Services shall pro-
11 vide standard-setting and compliance review inves-
12 tigation support services to the Civil Rights Compli-
13 ance Office for each agency described in subsection
14 (a), subject to paragraph (2).

15 “(2) DEPARTMENT OF JUSTICE.—The Office
16 for Civil Rights of the Department of Justice may,
17 as appropriate, institute formal proceedings when a
18 civil rights compliance office established under sub-
19 section (a) determines that a recipient of Federal fi-
20 nancial assistance is not in compliance with the dis-
21 parity reduction standards of the applicable agency.

22 “(e) DEFINITION.—In this section, the term ‘Federal
23 health programs’ mean programs—

1 “(1) under the Social Security Act (42 U.S.C.
2 301 et seq.) that pay for health care and services;
3 and

4 “(2) under this Act that provide Federal finan-
5 cial assistance for health care, biomedical research,
6 health services research, and programs designed to
7 improve the public’s health, including health service
8 programs.”.

9 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

10 (a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3(a) of the Civil Rights Commission Act
11 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-
12 TIES.—Section 3(a) of the Civil Rights Commission Act
13 of 1983 (42 U.S.C. 1975a(a)) is amended—

14 (1) in paragraph (1), by striking “and” at the
15 end;

16 (2) in paragraph (2), by striking the period at
17 the end and inserting “; and”; and

18 (3) by adding at the end the following:

19 “(3) shall, with respect to activities carried out
20 in health care and correctional facilities toward the
21 goal of eliminating health disparities between the
22 general population and members of minority groups
23 based on race or color, promote coordination of such
24 activities of—

1 (1) The health status of the population of the
2 United States is declining and the United States
3 currently ranks below most industrialized nations in
4 health status measured by longevity, sickness, and
5 mortality.

6 (2) Racial and ethnic minority populations tend
7 to have the poorest health status and face substan-
8 tial cultural, social, and economic barriers to obtain-
9 ing quality health care.

10 (3) Lesbian, gay, bisexual, transgender, queer,
11 and questioning populations experience significant
12 personal and structural barriers to obtaining high-
13 quality health care.

14 (4) Efforts to improve minority health have
15 been limited by inadequate resources (funding, staff-
16 ing, and stewardship) and lack of accountability.

17 (b) SENSE OF CONGRESS.—It is the sense of Con-
18 gress that—

19 (1) health disparities negatively impact out-
20 comes for health and human security of the Nation;

21 (2) reducing racial, ethnic, sexual, and gender
22 disparities in prevention and treatment are unique
23 civil and human rights challenges and, as such, Fed-
24 eral agencies and health care entities and systems

1 receiving Federal funds should be accountable for
2 their role in causing disparities and inequity;

3 (3) funding for the National Institute on Mi-
4 nority Health and Health Disparities, the Office of
5 Civil Rights in the Department of Health and
6 Human Services, the National Institute of Nursing
7 Research, and the Office of Minority Health should
8 be doubled by fiscal year 2022;

9 (4) adequate funding by fiscal year 2022, and
10 subsequent funding increases, should be provided for
11 health and human service professions training pro-
12 grams, the Racial and Ethnic Approaches to Com-
13 munity Health Initiative at the Centers for Disease
14 Control and Prevention, the Minority HIV/AIDS
15 Initiative, and the Excellence Centers to Eliminate
16 Ethnic/Racial Disparities Program at the Agency for
17 Healthcare Research and Quality;

18 (5) funding should be fully restored to the Ra-
19 cial and Ethnic Approaches to Community Health
20 Initiative at the Centers for Disease Control and
21 Prevention, which has been a successful program at
22 the community health level, and efforts should con-
23 tinue to place a strong emphasis on building commu-
24 nity capacity to secure financial resources and tech-
25 nical assistance to eliminate health disparities;

1 (6) adequate funding for fiscal year 2022 and
2 increased funding for future years should be pro-
3 vided for the Racial and Ethnic Approaches to Com-
4 munity Health Initiative’s United States Risk Fac-
5 tor Survey to ensure adequate data collection to
6 track health disparities, and there should be appro-
7 priate avenues provided to disseminate findings to
8 the general public;

9 (7) current and newly created health disparity
10 elimination incentives, programs, agencies, and de-
11 partments under this Act (and the amendments
12 made by this Act) should receive adequate staffing
13 and funding by fiscal year 2022; and

14 (8) stewardship and accountability should be
15 provided to the Congress and the President for
16 measurable and sustainable progress toward health
17 disparity elimination.

18 **SEC. 906. GAO AND NIH REPORTS.**

19 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-
20 NIC DIVERSITY.—

21 (1) IN GENERAL.—The Comptroller General of
22 the United States shall conduct a study on the racial
23 and ethnic diversity among the following groups:

24 (A) All applicants for grants, contracts,
25 and cooperative agreements awarded by the Na-

1 tional Institutes of Health during the period be-
2 ginning on January 1, 2009, and ending De-
3 cember 31, 2019.

4 (B) All recipients of such grants, con-
5 tracts, and cooperative agreements during such
6 period.

7 (C) All members of the peer review panels
8 of such applicants and recipients, respectively.

9 (2) REPORT.—Not later than 6 months after
10 the date of the enactment of this Act, the Comp-
11 troller General shall complete the study under para-
12 graph (1) and submit to Congress a report con-
13 taining the results of such study.

14 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
15 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
16 DISPARITIES.—Not later than 6 months after the date of
17 the enactment of this Act, and biennially thereafter, the
18 Director of the National Institutes of Health, in collabora-
19 tion with the Director of the National Institute on Minor-
20 ity Health and Health Disparities, shall submit to Con-
21 gress a report that details and evaluates—

22 (1) the steps taken during the applicable report
23 period by the Director of the National Institutes of
24 Health to enforce the expanded planning, coordina-
25 tion, review, and evaluation authority provided the

1 National Institute on Minority Health and Health
2 Disparities under section 464z-3(h) of the Public
3 Health Service Act (42 U.S.C. 285(h)) over all mi-
4 nority health and health disparity research that is
5 conducted or supported by the Institutes and Cen-
6 ters at the National Institutes of Health; and

7 (2) the outcomes of such steps.

8 (c) GAO REPORT RELATED TO RECIPIENTS OF
9 PPACA FUNDING.—Not later than one year after the
10 date of the enactment of this Act and biennially thereafter
11 until 2024, the Comptroller General of the United States
12 shall submit to Congress a report that identifies—

13 (1) the racial and ethnic diversity of commu-
14 nity-based organizations that applied for Federal en-
15 rollment funding provided pursuant to the Patient
16 Protection and Affordable Care Act (Public Law
17 111-148) (including the amendments made by such
18 Act);

19 (2) the percentage of such organizations that
20 were awarded such funding; and

21 (3) the impact of such community-based organi-
22 zations' enrollment efforts on the insurance status of
23 their communities.

24 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
25 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-

1 PARITIES.—The Director of the National Institute on Mi-
2 nority Health and Health Disparities shall prepare an an-
3 nual report on the activities carried out or to be carried
4 out by such institute, and shall submit each such report
5 to the Committee on Health, Education, Labor, and Pen-
6 sions of the Senate, the Committee on Energy and Com-
7 merce of the House of Representatives, the Secretary of
8 Health and Human Services, and the Director of the Na-
9 tional Institutes of Health. With respect to the fiscal year
10 involved, the report shall—

11 (1) describe and evaluate the progress made in
12 health disparities research conducted or supported
13 by institutes and centers of the National Institutes
14 of Health;

15 (2) summarize and analyze expenditures made
16 for activities with respect to health disparities re-
17 search conducted or supported by the National Insti-
18 tutes of Health;

19 (3) include a separate statement applying the
20 requirements of paragraphs (1) and (2) specifically
21 to minority health disparities research; and

22 (4) contain such recommendations as the Direc-
23 tor of the Institute considers appropriate.

1 **TITLE X—ADDRESSING SOCIAL**
2 **DETERMINANTS AND IM-**
3 **PROVING ENVIRONMENTAL**
4 **JUSTICE**

5 **Subtitle A—In General**

6 **SEC. 1001. DEFINITIONS.**

7 In this title:

8 (1) **DETERMINANTS OF HEALTH.**—The term
9 “determinants of health”—

10 (A) means the range of personal, social,
11 economic, and environmental factors that influ-
12 ence health status; and

13 (B) includes social determinants of health
14 (which are sometimes referred to as “social and
15 economic determinants of health”, “socio-
16 economic determinants of health”, “environ-
17 mental determinants of health”, “social drivers
18 of inequality”, and “personal determinants of
19 health”).

20 (2) **ENVIRONMENTAL DETERMINANTS OF**
21 **HEALTH.**—The term “environmental determinants
22 of health” means the broad physical (including man-
23 made and natural environments), psychological, so-
24 cial, spiritual, cultural and aesthetic environment.

1 (3) BUILT ENVIRONMENT.—The term “built
2 environment” means the components of the environ-
3 ment, and the location of these components in a geo-
4 graphically defined space, that are created or modi-
5 fied by individuals to form the physical and social
6 characteristics of a community or enhance quality of
7 human life, including—

8 (A) homes, schools, and places of work and
9 worship;

10 (B) parks, recreation areas, and green-
11 ways;

12 (C) transportation systems;

13 (D) business, industry, and agriculture;
14 and

15 (E) land-use plans, projects, and policies
16 that impact the physical or social characteris-
17 tics of a community, including access to services
18 and amenities.

19 (4) PERSONAL DETERMINANTS OF HEALTH.—
20 The term “personal determinants of health” means
21 an individual’s behavior, biology, and genetics.

22 (5) SOCIAL DETERMINANTS OF HEALTH.—The
23 term “social determinants of health” means a subset
24 of determinants of the health of individuals and en-
25 vironments (such as communities, neighborhoods,

1 and societies) that describe an individual’s or group
2 of people’s social identity, describe the social and
3 economic resources to which such individual or
4 group has access, and describe the conditions in
5 which an individual or group of people works, lives,
6 and plays.

7 (6) ECONOMIC DETERMINANTS OF HEALTH.—
8 The term “economic determinants of health” refers
9 to income and social status. Higher income and so-
10 cioeconomic status (SES) are linked to decreased
11 rates of morbidity and mortality. The higher your
12 SES, the healthier you are the longer you’ll live.
13 Low SES leads to an increased risk of illness and
14 death.

15 **SEC. 1002. FINDINGS.**

16 Congress finds as follows:

17 (1) Social determinants of health are the larg-
18 est predictors of health outcomes.

19 (2) Social determinants of health, including
20 health-related behaviors, social and economic factors,
21 and physical environment factors account for 80 per-
22 cent of health outcomes, whereas clinical care ac-
23 counts for 20 percent of improved health outcomes.
24 Yet, in 2017, public health spending only rep-

1 resented 2.5 percent of all health spending in the
2 United States.

3 (3) There are more opportunities to improve
4 health for everyone when we understand that health
5 starts, first, not in a medical setting, but in our
6 families, in our schools and workplaces, in our
7 neighborhoods, in the air we breathe, and in the
8 water we drink.

9 (4)(A) Healthy People 2020 identifies health
10 and health care quality as a function of not only ac-
11 cess to health care, but also the social determinants
12 of health, categorized into the following: neighbor-
13 hoods and the built environment; social and commu-
14 nity context; education; and economic stability.

15 (B) The following examples illustrate the nexus
16 between the unequal distribution of the social deter-
17 minants of health and health disparities:

18 (i) The built environment influences resi-
19 dents' level of physical activity. Neighborhoods
20 with high levels of poverty are significantly less
21 likely to have places where children can be
22 physically active, such as parks, green spaces,
23 and bike paths and lanes. Neighborhoods and
24 communities can provide opportunities for phys-
25 ical activity and support active lifestyles

1 through accessible and safe parks and open
2 spaces and through land use policy, zoning, and
3 healthy community design.

4 (ii) Emotional and physical health and
5 well-being are directly impacted by perceived
6 levels of safety, such as unlit streets at night.
7 Community members have expressed that safety
8 is not only a barrier to accessing programs and
9 services that increase quality of life but they
10 are also not able to access physical activity in
11 their community through the built environment.

12 (iii) In many workplace environments.

13 (iv) Historical and institutional racism in
14 the United States has shaped the way in which
15 social and economic resources and exposure to
16 health promoting environments are distributed.
17 Income, education, occupation, neighborhood
18 conditions, schools, workplaces, the use of
19 health and social services, and experiences with
20 the criminal justice system are all highly pat-
21 terned by race, with people of color experiencing
22 more that is health harming. Finding ways to
23 uncouple the link between race and access to re-
24 sources and healthy environments is a principal
25 means of reducing health disparities. Addition-

1 ally, the anticipation of racism itself causes
2 higher psychological and cardiovascular stress
3 levels that are linked to poor health outcomes.
4 Remediating discriminatory practices at the indi-
5 vidual and systemic levels will likely reduce
6 health disparities caused by this unequal dis-
7 tribution of stress.

8 (v) Poor health among Native Americans
9 has largely been driven by post-colonial oppres-
10 sion and historical trauma. The expropriation of
11 native lands and territories to the American
12 state had severe consequences on Native Amer-
13 ican health. This resulted in the deprivation of
14 traditional food sources—and nutrients—for
15 Native Americans and also the destruction of
16 traditional economies and community organiza-
17 tion. Today, Native Americans have twice the
18 rate of diabetes of non-Hispanic Whites. Rec-
19 ognition of the origins of the diabetes as having
20 a social and community context, rather than
21 just individual responsibility and genetic pre-
22 disposition, will shape better policy to provide
23 food security.

24 (vi) In the context of prisons, overcrowding
25 has led to the deterioration of the physical and

1 mental health of individuals after they leave
2 prison. In particular, the mass incarceration of
3 African-American males as a result of unequal
4 contact with and treatment in the criminal jus-
5 tice system has contributed to an overburdening
6 of certain infectious diseases within the African-
7 American community. As a social institution,
8 incarceration amplifies existing adverse health
9 conditions by concentrating diseases and harm-
10 ful health behaviors such as tobacco use, drug
11 use, and violence.

12 (vii) Educational attainment is the strong-
13 est predictor of adult mortality. It is a basic
14 component of socioeconomic status that shapes
15 earning potential to access resources that pro-
16 mote health. People with more education are
17 less likely to report that they are in poor health,
18 and are also less likely to have diabetes and
19 other chronic diseases.

20 (viii) Individuals with lower levels of edu-
21 cational attainment are much more likely to re-
22 port to be current smokers. In 2017, smoking
23 prevalence was 36.8 percent among adults with
24 a GED diploma, 23.1 percent with less than a
25 high school diploma, and 18.7 percent with a

1 high school diploma, while dropping signifi-
2 cantly to 7.1 percent among adults with an un-
3 dergraduate college degree and 4.1 percent with
4 a postgraduate college degree.

5 (ix) Income inequality differences account
6 for a large part of health disparities. For exam-
7 ple, children living in poverty experience poorer
8 housing conditions, increased exposure to in-
9 door allergens and toxins (such as pesticides,
10 lead, mercury, radon, air pollution, and carcino-
11 gens), increased food insecurity, and more psy-
12 chological stress. These experiences culminate
13 in worse adult health as compared with children
14 with higher socioeconomic status. Specifically,
15 children living in lower socioeconomic neighbor-
16 hoods have higher rates of asthma due to high-
17 er rates of psychological stress resulting from
18 higher rates of violence. Food insecurity is asso-
19 ciated with obesity and racial and ethnic mi-
20 norities have higher rates of food insecurity.

21 (x) Lesbian, gay, bisexual, transgender,
22 queer, questioning and intersex (LGBTQIA) in-
23 dividuals face health disparities linked to soci-
24 etal stigma, discrimination, and denial of their
25 civil and human rights. Discrimination against

1 LGBTQIA individuals has been associated with
2 high rates of psychiatric disorders, substance
3 abuse, and suicide. Experiences of violence and
4 victimization are frequent for LGBTQIA indi-
5 viduals, and have long-lasting effects on the in-
6 dividual and the community. Personal, family,
7 and social acceptance of sexual orientation and
8 gender identity affects the mental health and
9 personal safety of LGBTQIA individuals.

10 (xi) Individuals in older and cheaper hous-
11 ing are at higher risks to be exposed to lead,
12 particularly in housing built prior to 1960. The
13 threat of lead poisoning disproportionately af-
14 fects vulnerable populations, with children living
15 in poverty (5.6 percent) and Black children
16 (5.6) experiencing the highest rates. According
17 to the Department of Housing and Urban De-
18 velopment, about 3,600,000 homes nationwide
19 that house young children have lead hazards
20 such as contaminated drinking water, peeling
21 paint, contaminated dust, or toxic soil. The
22 combined cost of medical treatment and special
23 education for lead poisoned children averages
24 about \$5,600 per child per year, and lead-poi-

1 soning costs the United States an estimated
2 \$50,000,000,000 annually.

3 (xii) Individuals with disabilities, as a
4 group, experience health disparities in routine
5 public health arenas such as health behaviors,
6 clinical preventive services, and chronic condi-
7 tions. Compared with individuals without dis-
8 abilities, individuals with disabilities are—

9 (I) less likely to receive recommended
10 preventive health care services, such as
11 routine teeth cleanings and cancer
12 screenings;

13 (II) at a high risk for poor health out-
14 comes such as obesity, hypertension, falls-
15 related injuries, and mood disorders such
16 as depression; and

17 (III) more likely to engage in
18 unhealthy behaviors that put their health
19 at risk, such as cigarette smoking and in-
20 adequate physical activity (from Healthy
21 People 2020).

22 (5) Laws and regulations that improve opportu-
23 nities to live in safe neighborhoods, with more social
24 cohesion, attain higher education, sustain stable em-

1 ployment, and bridge class differences help foster
2 the health and safety of individuals.

3 (6) The global public health community has
4 reached consensus through the Rio Political Declara-
5 tion of Social Determinants of Health adopted by
6 the World Health Organization in October 2011 that
7 “[c]ollaboration in coordinated and intersectoral pol-
8 icy actions has proven to be effective. Health in All
9 Policies, an initiative of the American Public Health
10 Association, together with intersectoral cooperation
11 and action, is one promising approach to enhance
12 accountability in other sectors of health, as well as
13 the promotion of health equity and more inclusive
14 and productive societies.”.

15 **SEC. 1003. HEALTH IMPACT ASSESSMENTS.**

16 (a) FINDINGS.—Congress makes the following find-
17 ings:

18 (1) Health Impact Assessment is a tool to help
19 planners, health officials, decisionmakers, and the
20 public make more informed decisions about the po-
21 tential health effects of proposed plans, policies, pro-
22 grams, and projects in order to maximize health
23 benefits and minimize harms.

1 (2) Health Impact Assessments fosters commu-
2 nity leadership, ownership and participation in deci-
3 sion-making processes.

4 (3) Health Impact Assessments can build com-
5 munity support and reduce opposition to a project or
6 policy, thereby facilitating economic growth by aid-
7 ing the development of consensus regarding new de-
8 velopment proposals.

9 (4) Health Impact Assessments facilitate col-
10 laboration across sectors.

11 (b) PURPOSES.—It is the purpose of this section to—

12 (1) provide more information about the poten-
13 tial human health effects of policy decisions and the
14 distribution of those effects;

15 (2) improve how health is considered in plan-
16 ning and decision-making processes; and

17 (3) build stronger, healthier communities
18 through the use of Health Impact Assessment.

19 (c) HEALTH IMPACT ASSESSMENTS.—Part P of title
20 III of the Public Health Service Act (42 U.S.C. 280g et
21 seq.), as amended by section 796A, is further amended
22 by adding at the end the following:

23 **“SEC. 399V-12. HEALTH IMPACT ASSESSMENTS.**

24 “(a) DEFINITIONS.—In this section:

1 “(1) ADMINISTRATOR.—The term ‘Adminis-
2 trator’ means the Administrator of the Environ-
3 mental Protection Agency.

4 “(2) DIRECTOR.—The term ‘Director’ means
5 the Director of the Centers for Disease Control and
6 Prevention.

7 “(3) HEALTH IMPACT ASSESSMENT.—The term
8 ‘health impact assessment’ means a systematic proc-
9 ess that uses an array of data sources and analytic
10 methods and considers input from stakeholders to
11 determine the potential effects of a proposed policy,
12 plan, program, or project on the health of a popu-
13 lation and the distribution of those effects within the
14 population. Such term includes identifying and rec-
15 ommending appropriate actions on monitoring and
16 maximizing potential benefits and minimizing the
17 potential harms.

18 “(4) HEALTH DISPARITY.—The term ‘health
19 disparity’ means a particular type of health dif-
20 ference that is closely linked with social, economic,
21 or environmental disadvantage and that adversely
22 affects groups of people who have systematically ex-
23 perienced greater obstacles to health based on their
24 racial or ethnic group; religion; socioeconomic status;
25 gender; age; mental health; cognitive, sensory, or

1 physical disability; sexual orientation or gender iden-
2 tity; geographic location; citizenship status; or other
3 characteristics historically linked to discrimination
4 or exclusion.

5 “(b) ESTABLISHMENT.—The Secretary, acting
6 through the Director and in collaboration with the Admin-
7 istrator, shall—

8 “(1) in consultation with the Director of the
9 National Center for Chronic Disease Prevention and
10 Health Promotion and relevant offices within the
11 Department of Housing and Urban Development,
12 the Department of Transportation, and the Depart-
13 ment of Agriculture, establish a program at the Na-
14 tional Center for Environmental Health at the Cen-
15 ters for Disease Control and Prevention focused on
16 advancing the field of health impact assessment that
17 includes—

18 “(A) collecting and disseminating best
19 practices;

20 “(B) administering capacity building
21 grants to States to support grantees in initi-
22 ating health impact assessments, in accordance
23 with subsection (d);

24 “(C) providing technical assistance;

1 “(D) developing training tools and pro-
2 viding training on conducting health impact as-
3 sessment and the implementation of built envi-
4 ronment and health indicators;

5 “(E) making information available, as ap-
6 propriate, regarding the existence of other com-
7 munity healthy living tools, checklists, and indi-
8 ces that help connect public health to other sec-
9 tors, and tools to help examine the effect of the
10 indoor built environment and building codes on
11 population health;

12 “(F) conducting research and evaluations
13 of health impact assessments; and

14 “(G) awarding competitive extramural re-
15 search grants;

16 “(2) develop guidance and guidelines to conduct
17 health impact assessments in accordance with sub-
18 section (c); and

19 “(3) establish a grant program to allow States
20 to fund eligible entities to conduct health impact as-
21 sessments.

22 “(c) GUIDANCE.—

23 “(1) IN GENERAL.—Not later than 1 year after
24 the date of enactment of the Health Equity and Ac-
25 countability Act of 2020, the Secretary, acting

1 through the Director, shall issue final guidance for
2 conducting the health impact assessments. In devel-
3 oping such guidance the Secretary shall—

4 “(A) consult with the Director of the Na-
5 tional Center for Environmental Health and the
6 Director of the National Center for Chronic
7 Disease Prevention and Health Promotion, and
8 relevant offices within the Department of Hous-
9 ing and Urban Development, the Department of
10 Transportation, and the Department of Agri-
11 culture; and

12 “(B) consider available international health
13 impact assessment guidance, North American
14 health impact assessment practice standards,
15 and recommendations from the National Acad-
16 emy of Science.

17 “(2) CONTENT.—The guidance under this sub-
18 section shall include—

19 “(A) background on national and inter-
20 national efforts to bridge urban planning, cli-
21 mate forecasting, and public health institutions
22 and disciplines, including a review of health im-
23 pact assessment best practices internationally;

24 “(B) evidence-based direct and indirect
25 pathways that link land-use planning, transpor-

1 tation, and housing policy and objectives to
2 human health outcomes;

3 “(C) data resources and quantitative and
4 qualitative forecasting methods to evaluate both
5 the status of health determinants and health ef-
6 fects, including identification of existing pro-
7 grams that can disseminate these resources;

8 “(D) best practices for inclusive public in-
9 volvement in conducting health impact assess-
10 ments; and

11 “(E) technical assistance for other agen-
12 cies seeking to develop their own guidelines and
13 procedures for health impact assessment.

14 “(d) GRANT PROGRAM.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Director and in collaboration with the
17 Administrator, shall—

18 “(A) award grants to States to fund eligi-
19 ble entities for capacity building or to prepare
20 health impact assessments; and

21 “(B) ensure that States receiving a grant
22 under this subsection further support training
23 and technical assistance for grantees under the
24 program by funding and overseeing appropriate
25 local, State, Tribal, Federal, institution of high-

1 er education, or nonprofit health impact assess-
2 ment experts to provide such technical assist-
3 ance.

4 “(2) APPLICATIONS.—

5 “(A) IN GENERAL.—To be eligible to re-
6 ceive a grant under this section, an eligible enti-
7 ty shall—

8 “(i) be a State, Indian tribe, or tribal
9 organization that includes individuals or
10 populations the health of which are, or will
11 be, affected by an activity or a proposed
12 activity; and

13 “(ii) submit to the Secretary an appli-
14 cation in accordance with this subsection,
15 at such time, in such manner, and con-
16 taining such additional information as the
17 Secretary may require.

18 “(B) INCLUSION.—An application under
19 this subsection shall include a list of proposed
20 activities that require or would benefit from
21 conducting a health impact assessment within
22 six months of awarding funds. The list should
23 be accompanied by supporting documentation,
24 including letters of support, from potential con-
25 ductors of health impact assessments for the

1 listed proposed activities. Each application
2 should also include an assessment by the eligi-
3 ble entity of the health of the population of its
4 jurisdiction and describe potential adverse or
5 positive effects on health that the proposed ac-
6 tivities may create.

7 “(C) PREFERENCE.—Preference in award-
8 ing funds under this section may be given to el-
9 igible entities that demonstrate the potential to
10 significantly improve population health or lower
11 health care costs as a result of potential health
12 impact assessment work.

13 “(3) USE OF FUNDS.—

14 “(A) IN GENERAL.—An entity receiving a
15 grant under this section shall use such grant
16 funds to conduct health impact assessment ca-
17 pacity building or to fund subgrantees in con-
18 ducting a health impact assessment for a pro-
19 posed activity in accordance with this sub-
20 section.

21 “(B) PURPOSES.—The purposes of a
22 health impact assessment under this subsection
23 are—

24 “(i) to facilitate the involvement of
25 tribal, State, and local public health offi-

1 cials in community planning, transpor-
2 tation, housing, and land use decisions and
3 other decisions affecting the built environ-
4 ment to identify any potential health con-
5 cern or health benefit relating to an activ-
6 ity or proposed activity;

7 “(ii) to provide for an investigation of
8 any health-related issue of concern raised
9 in a planning process, an environmental
10 impact assessment process, or policy ap-
11 praisal relating to a proposed activity;

12 “(iii) to describe and compare alter-
13 natives (including no-action alternatives) to
14 a proposed activity to provide clarification
15 with respect to the potential health out-
16 comes associated with the proposed activity
17 and, where appropriate, to the related ben-
18 efit-cost or cost-effectiveness of the pro-
19 posed activity and alternatives;

20 “(iv) to contribute, when applicable,
21 to the findings of a planning process, pol-
22 icy appraisal, or an environmental impact
23 statement with respect to the terms and
24 conditions of implementing a proposed ac-

1 tivity or related mitigation recommenda-
2 tions, as necessary;

3 “(v) to ensure that the disproportio-
4 nate distribution of negative impacts
5 among vulnerable populations is minimized
6 as much as possible;

7 “(vi) to engage affected community
8 members and ensure adequate opportunity
9 for public comment on all stages of the
10 health impact assessment;

11 “(vii) where appropriate, to consult
12 with local and county health departments
13 and appropriate organizations, including
14 planning, transportation, and housing or-
15 ganizations and providing them with infor-
16 mation and tools regarding how to conduct
17 and integrate health impact assessment
18 into their work; and

19 “(viii) to inspect homes, water sys-
20 tems, and other elements that pose risks to
21 lead exposure, with an emphasis on areas
22 that pose a higher risk to children.

23 “(4) ASSESSMENTS.—Health impact assess-
24 ments carried out using grant funds under this sec-
25 tion shall—

1 “(A) take appropriate health factors into
2 consideration as early as practicable during the
3 planning, review, or decision-making processes;

4 “(B) assess the effect on the health of in-
5 dividuals and populations of proposed policies,
6 projects, or plans that result in modifications to
7 the built environment; and

8 “(C) assess the distribution of health ef-
9 fects across various factors, such as race, in-
10 come, ethnicity, age, disability status, gender,
11 and geography.

12 “(5) ELIGIBLE ACTIVITIES.—

13 “(A) IN GENERAL.—Eligible entities fund-
14 ed under this subsection shall conduct an eval-
15 uation of any proposed activity to determine
16 whether it will have a significant adverse or
17 positive effect on the health of the affected pop-
18 ulation in the jurisdiction of the eligible entity,
19 based on the criteria described in subparagraph
20 (B).

21 “(B) CRITERIA.—The criteria described in
22 this subparagraph include, as applicable to the
23 proposed activity, the following:

24 “(i) Any substantial adverse effect or
25 significant health benefit on health out-

1 comes or factors known to influence health,
2 including the following:

3 “(I) Physical activity.

4 “(II) Injury.

5 “(III) Mental health.

6 “(IV) Accessibility to health-pro-
7 moting goods and services.

8 “(V) Respiratory health.

9 “(VI) Chronic disease.

10 “(VII) Nutrition.

11 “(VIII) Land use changes that
12 promote local, sustainable food
13 sources.

14 “(IX) Infectious disease.

15 “(X) Health disparities.

16 “(XI) Existing air quality,
17 ground or surface water quality or
18 quantity, or noise levels.

19 “(XII) Lead exposure.

20 “(XIII) Drinking water quality
21 and accessibility.

22 “(ii) Other factors that may be con-
23 sidered, including—

24 “(I) the potential for a proposed
25 activity to result in systems failure

1 that leads to a public health emer-
2 gency;

3 “(II) the probability that the pro-
4 posed activity will result in a signifi-
5 cant increase in tourism, economic de-
6 velopment, or employment in the ju-
7 risdiction of the eligible entity;

8 “(III) any other significant po-
9 tential hazard or enhancement to
10 human health, as determined by the
11 eligible entity; or

12 “(IV) whether the evaluation of a
13 proposed activity would duplicate an-
14 other analysis or study being under-
15 taken in conjunction with the pro-
16 posed activity.

17 “(C) FACTORS FOR CONSIDERATION.—In
18 evaluating a proposed activity under subpara-
19 graph (A), an eligible entity may take into con-
20 sideration any reasonable, direct, indirect, or
21 cumulative effect that can be clearly related to
22 potential health effects and that is related to
23 the proposed activity, including the effect of
24 any action that is—

1 “(i) included in the long-range plan
2 relating to the proposed activity;

3 “(ii) likely to be carried out in coordi-
4 nation with the proposed activity;

5 “(iii) dependent on the occurrence of
6 the proposed activity; or

7 “(iv) likely to have a disproportionate
8 impact on high-risk or vulnerable popu-
9 lations.

10 “(6) REQUIREMENTS.—A health impact assess-
11 ment prepared with funds awarded under this sub-
12 section shall incorporate the following, after con-
13 ducting the screening phase (identifying projects or
14 policies for which a health impact assessment would
15 be valuable and feasible) through the application
16 process:

17 “(A) SCOPING.—Identifying which health
18 effects to consider and the research methods to
19 be utilized.

20 “(B) ASSESSING RISKS AND BENEFITS.—
21 Assessing the baseline health status and factors
22 known to influence the health status in the af-
23 fected community, which may include aggreg-
24 ating and synthesizing existing health assess-
25 ment evidence and data from the community.

1 “(C) DEVELOPING RECOMMENDATIONS.—
2 Suggesting changes to proposals to promote
3 positive or mitigate adverse health effects.

4 “(D) REPORTING.—Synthesizing the as-
5 sessment and recommendations and commu-
6 nicating the results to decisionmakers.

7 “(E) MONITORING AND EVALUATING.—
8 Tracking the decision and implementation effect
9 on health determinants and health status.

10 “(7) PLAN.—An eligible entity that is awarded
11 a grant under this section shall develop and imple-
12 ment a plan, to be approved by the Director, for
13 meaningful and inclusive stakeholder involvement in
14 all phases of the health impact assessment. Stake-
15 holders may include community leaders, community-
16 based organizations, youth-serving organizations,
17 planners, public health experts, State and local pub-
18 lic health departments and officials, health care ex-
19 perts or officials, housing experts or officials, and
20 transportation experts or officials.

21 “(8) SUBMISSION OF FINDINGS.—An eligible
22 entity that is awarded a grant under this section
23 shall submit the findings of any funded health im-
24 pact assessment activities to the Secretary and make
25 these findings publicly available.

1 “(9) ASSESSMENT OF IMPACTS.—An eligible en-
2 tity that is awarded a grant under this section shall
3 ensure the assessment of the distribution of health
4 impacts (related to the proposed activity) across
5 race, ethnicity, income, age, gender, disability status,
6 and geography.

7 “(10) CONDUCT OF ASSESSMENT.—To the
8 greatest extent feasible, a health impact assessment
9 shall be conducted under this section in a manner
10 that respects the needs and timing of the decision-
11 making process it evaluates.

12 “(11) METHODOLOGY.—In preparing a health
13 impact assessment under this subsection, an eligible
14 entity or partner shall follow the guidance published
15 under subsection (c).

16 “(e) HEALTH IMPACT ASSESSMENT DATABASE.—
17 The Secretary, acting through the Director and in collabo-
18 ration with the Administrator, shall establish, maintain,
19 and make publicly available a health impact assessment
20 database, including—

21 “(1) a catalog of health impact assessments re-
22 ceived under this section;

23 “(2) an inventory of tools used by eligible enti-
24 ties to conduct health impact assessments; and

1 “(3) guidance for eligible entities with respect
2 to the selection of appropriate tools described in
3 paragraph (2).

4 “(f) EVALUATION OF GRANTEE ACTIVITIES.—The
5 Secretary shall award competitive grants to Prevention
6 Research Centers, or nonprofit organizations or academic
7 institutions with expertise in health impact assessments
8 to—

9 “(1) assist grantees with the provision of train-
10 ing and technical assistance in the conducting of
11 health impact assessments;

12 “(2) evaluate the activities carried out with
13 grants under subsection (d); and

14 “(3) assist the Secretary in disseminating evi-
15 dence, best practices, and lessons learned from
16 grantees.

17 “(g) REPORT TO CONGRESS.—Not later than 1 year
18 after the date of enactment of the Health Equity and Ac-
19 countability Act of 2020, the Secretary shall submit to
20 Congress a report concerning the evaluation of the pro-
21 grams under this section, including recommendations as
22 to how lessons learned from such programs can be incor-
23 porated into future guidance documents developed and
24 provided by the Secretary and other Federal agencies, as
25 appropriate.

1 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary.

4 **“SEC. 399V-13. IMPLEMENTATION OF RESEARCH FINDINGS**
5 **TO IMPROVE HEALTH OUTCOMES THROUGH**
6 **THE BUILT ENVIRONMENT.**

7 “(a) RESEARCH GRANT PROGRAM.—The Secretary,
8 in collaboration with the Administrator of the Environ-
9 mental Protection Agency (referred to in this section as
10 the ‘Administrator’), shall award grants to public agencies
11 or private nonprofit institutions to implement evidence-
12 based programming to improve human health through im-
13 provements to the built environment and subsequently
14 human health, by addressing—

15 “(1) levels of physical activity;

16 “(2) consumption of nutritional foods;

17 “(3) rates of crime;

18 “(4) air, water, and soil quality;

19 “(5) risk or rate of injury;

20 “(6) accessibility to health-promoting goods and
21 services;

22 “(7) chronic disease rates;

23 “(8) community design;

24 “(9) housing; or transportation options; and

1 “(10) other factors, as the Secretary determines
2 appropriate.

3 “(b) APPLICATIONS.—A public agency or private
4 nonprofit institution desiring a grant under this section
5 shall submit to the Secretary an application at such time,
6 in such manner, and containing such agreements, assur-
7 ances, and information as the Secretary, in consultation
8 with the Administrator, may require.

9 “(c) RESEARCH.—The Secretary, in consultation
10 with the Administrator, shall support, through grants
11 awarded under this section, research that—

12 “(1) uses evidence-based research to improve
13 the built environment and human health;

14 “(2) examines—

15 “(A) the scope and intensity of the impact
16 that the built environment (including the var-
17 ious characteristics of the built environment)
18 has on the human health; or

19 “(B) the distribution of such impacts by—

20 “(i) location; and

21 “(ii) population subgroup;

22 “(3) is used to develop—

23 “(A) measures and indicators to address
24 health impacts and the connection of health to
25 the built environment;

1 “(B) efforts to link the measures to trans-
2 portation, land use, and health databases; and

3 “(C) efforts to enhance the collection of
4 built environment surveillance data;

5 “(4) distinguishes carefully between personal
6 attitudes and choices and external influences on be-
7 havior to determine how much the association be-
8 tween the built environment and the health of resi-
9 dents, versus the lifestyle preferences of the people
10 that choose to live in the neighborhood, reflects the
11 physical characteristics of the neighborhood; and

12 “(5)(A) identifies or develops effective interven-
13 tion strategies focusing on enhancements to the built
14 environment that promote increased use physical ac-
15 tivity, access to nutritious foods, or other health-pro-
16 moting activities by residents; and

17 “(B) in developing the intervention strategies
18 under subparagraph (A), ensures that the interven-
19 tion strategies will reach out to high-risk or vulner-
20 able populations, including low-income urban and
21 rural communities and aging populations, in addi-
22 tion to the general population.

23 “(d) SURVEYS.—The Secretary may allow recipients
24 of grants under this section to use such grant funds to
25 support the expansion of national surveys and data track-

1 ing systems to provide more detailed information about
2 the connection between the built environment and health.

3 “(e) PRIORITY.—In awarding grants under this sec-
4 tion, the Secretary and the Administrator shall give pri-
5 ority to entities with programming that incorporates—

6 “(1) interdisciplinary approaches; or

7 “(2) the expertise of the public health, physical
8 activity, urban planning, land use, and transpor-
9 tation research communities in the United States
10 and abroad.

11 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated such sums as may be
13 necessary to carry out this section. The Secretary may al-
14 locate not more than 20 percent of the amount so appro-
15 priated for a fiscal year for purposes of conducting re-
16 search under subsection (c).”.

17 **SEC. 1004. IMPLEMENTATION OF RECOMMENDATIONS BY**
18 **ENVIRONMENTAL PROTECTION AGENCY.**

19 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The
20 Administrator of the Environmental Protection Agency
21 (referred to in this section as the “Administrator”) shall,
22 as promptly as practicable, carry out each of the following
23 recommendations of the Inspector General of the Environ-
24 mental Protection Agency as described in the report enti-
25 tled “EPA needs to conduct environmental justice reviews

1 of its programs, policies and activities” (Report No. 2006–
2 P–00034):

3 (1) The recommendation that the program and
4 regional offices of the Environmental Protection
5 Agency identify which programs, policies, and activi-
6 ties need environmental justice reviews and the Ad-
7 ministrator require those offices to establish a plan
8 to complete the necessary reviews.

9 (2) The recommendation that the Administrator
10 ensure that the reviews described in paragraph (1)
11 determine whether the programs, policies, and activi-
12 ties may have a disproportionately high and adverse
13 health or environmental impact on minority and low-
14 income populations.

15 (3) The recommendation that each program
16 and regional office of the Environmental Protection
17 Agency develop specific environmental justice review
18 guidance for conducting environmental justice re-
19 views.

20 (4) The recommendation that the Administrator
21 designate a responsible office to compile results of
22 environmental justice reviews and recommend appro-
23 priate actions.

24 (b) GAO RECOMMENDATIONS.—In promulgating reg-
25 ulations of the Environmental Protection Agency, the Ad-

1 administrator shall, as promptly as practicable, carry out
2 each of the following recommendations of the Comptroller
3 General of the United States as described in the report
4 entitled “EPA Should Devote More Attention to Environ-
5 mental Justice when Developing Clean Air Rules” (GAO–
6 05–289):

7 (1) The recommendation that the Administrator
8 ensure that workgroups involved in developing a rule
9 devote attention to environmental justice while draft-
10 ing and finalizing the rule.

11 (2) The recommendation that the Administrator
12 enhance the ability of the workgroups described in
13 paragraph (1) to identify potential environmental
14 justice issues through steps such as—

15 (A) providing workgroup members with
16 guidance and training to help those members
17 identify potential environmental justice prob-
18 lems; and

19 (B) involving environmental justice coordi-
20 nators in the workgroups if appropriate.

21 (3) The recommendation that the Administrator
22 improve assessments of potential environmental jus-
23 tice impacts in economic reviews by identifying the
24 data and developing the modeling techniques needed
25 to assess those impacts.

1 (4) The recommendation that the Administrator
2 direct appropriate officers and employees of the En-
3 vironmental Protection Agency, if feasible, to re-
4 spond fully to public comments on environmental
5 justice, including by—

6 (A) improving the explanation by the Ad-
7 ministrator of the basis for any conclusions re-
8 lating to environmental justice; and

9 (B) including in an explanation under sub-
10 paragraph (A) supporting data.

11 (c) 2004 INSPECTOR GENERAL REPORT.—

12 (1) IN GENERAL.—The Administrator shall, as
13 promptly as practicable, carry out each of the fol-
14 lowing recommendations of the Inspector General of
15 the Environmental Protection Agency as described
16 in the report entitled “EPA Needs to Consistently
17 Implement the Intent of the Executive Order on En-
18 vironmental Justice” (Report No. 2004–P–00007):

19 (A) The recommendation that the Admin-
20 istrator clearly define the mission of the Office
21 of Environmental Justice and provide Environ-
22 mental Protection Agency staff with an under-
23 standing of the roles and responsibilities of that
24 Office.

1 (B) The recommendation that the Admin-
2 istrator—

3 (i) establish, through the issuance of
4 guidance or a policy statement, specific
5 timeframes for the development of defini-
6 tions, goals, and measurements regarding
7 environmental justice; and

8 (ii) provide the regions and program
9 offices a standard and consistent definition
10 for a minority and low-income community,
11 with instructions on how the Environ-
12 mental Protection Agency will implement
13 and put into operation environmental jus-
14 tice in the daily activities of the Environ-
15 mental Protection Agency.

16 (C) The recommendation that the Adminis-
17 trator ensure that the comprehensive training
18 program under development (as of the date of
19 enactment of this Act) includes standard and
20 consistent definitions of the key environmental
21 justice concepts, such as “low-income”, “minor-
22 ity”, and “disproportionately impacted”, and
23 instructions for implementation of those con-
24 cepts.

25 (2) REPORTS.—

1 (A) INITIAL REPORT.—Not later than 180
2 days after the date of enactment of this Act,
3 the Administrator shall submit to Congress an
4 initial report on the strategy of the Adminis-
5 trator for implementing the recommendations
6 described in subparagraphs (A), (B), and (C) of
7 paragraph (1).

8 (B) SUBSEQUENT REPORTS.—After sub-
9 mitting the initial report under subparagraph
10 (A), the Administrator shall submit to Congress
11 semiannual reports on the progress of the Ad-
12 ministrator in—

13 (i) implementing the recommendations
14 referred to in subparagraph (A); and

15 (ii) modifying the emergency manage-
16 ment procedures of the Administrator to
17 incorporate environmental justice in the
18 Incident Command Structure of the Envi-
19 ronmental Protection Agency, in accord-
20 ance with the December 18, 2006, letter
21 from the Deputy Administrator to the Act-
22 ing Inspector General of the Environ-
23 mental Protection Agency.

1 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,
2 PROTECTING PEOPLE AND THEIR FAMILIES FROM
3 RADON.—

4 (1) FINDINGS.—Congress finds that radon is a
5 naturally occurring radioactive gas that is—

6 (A) recognized as the leading cause of lung
7 cancer among nonsmokers; and

8 (B) a particular environmental threat for
9 low-income and minority individuals because of
10 the lack of information about radon levels in
11 the homes of those individuals.

12 (2) IMPLEMENTATION.—Not later than 180
13 days after the date of the enactment of this Act, the
14 Administrator shall implement the action plan enti-
15 tled “Protecting People and Families from Radon: A
16 Federal Action Plan for Saving Lives” (June 20,
17 2011), in consultation with the Director of the Cen-
18 ters for Disease Control and Prevention and any
19 other Federal agencies referred to in the action plan.

20 (3) SPECIFIC STEPS.—In carrying out para-
21 graph (2), the Administrator shall ensure that—

22 (A) the workgroup comprised of the Fed-
23 eral agencies participating in the development
24 of the action plan referred to in paragraph (2)
25 implements specific steps within the existing

1 authority and activities of each Federal agency
2 to reduce exposure to radon; and

3 (B) not later than the date that is 1 year
4 after the date on which the Administrator be-
5 gins implementation of the action plan de-
6 scribed in paragraph (2), the workgroup de-
7 scribed in subparagraph (A) meets to assess
8 and recognize achievements of the plan.

9 (4) REPORT.—After the progress meeting of
10 the workgroup under paragraph (3)(B), the Admin-
11 istrator shall submit to Congress a report on the im-
12 plementation of the action plan described in para-
13 graph (2), including the challenges remaining and
14 the progress in reducing radon exposure, particularly
15 for low-income and minority families.

16 (e) FEDERAL ACTION PLAN FOR PREVENTING
17 CHILDHOOD LEAD POISONING.—

18 (1) FINDINGS.—Congress finds that—

19 (A) the effects of lead poisoning are irre-
20 versible and cost the United States millions an-
21 nually in medical and education costs;

22 (B) the cognitive effects suffered by chil-
23 dren exposed to lead result in a lifetime of
24 health and behavioral problems, which makes
25 prevention efforts more critical; and

1 (C) the risk is especially high for vulner-
2 able minority populations who are more likely
3 to live in older homes, where lead-based paint
4 is more likely to be present.

5 (2) ACTION PLAN.—Not later than 180 days
6 after the date of enactment of this Act, the Adminis-
7 trator, in consultation with the Director of the Cen-
8 ters for Disease Control and Prevention and other
9 relevant Federal agencies, shall develop an action
10 plan to reduce exposure to lead.

11 (3) SPECIFIC STEPS.—In carrying out para-
12 graph (2), the Administrator shall—

13 (A) establish a working group, comprised
14 of representatives of the Federal agencies par-
15 ticipating in the development of the action plan
16 described in paragraph (2), to make rec-
17 ommendations for the implementation of spe-
18 cific steps within the existing authority and ac-
19 tivities of each Federal agency to reduce expo-
20 sure to lead; and

21 (B) assist other Federal agencies in the de-
22 velopment of materials on the hazards of lead-
23 based paint for the purpose of educating ten-
24 ants and landlords, how to recognize potential

1 sources of exposure, and how to remediate those
2 sources.

3 **SEC. 1005. GRANT PROGRAM TO CONDUCT ENVIRON-**
4 **MENTAL HEALTH IMPROVEMENT ACTIVITIES**
5 **AND TO IMPROVE SOCIAL DETERMINANTS OF**
6 **HEALTH.**

7 (a) DEFINITIONS.—In this section:

8 (1) DIRECTOR.—The term “Director” means
9 the Director of the Centers for Disease Control and
10 Prevention, acting in collaboration with the Adminis-
11 trator of the Environmental Protection Agency and
12 the Director of the National Institute of Environ-
13 mental Health Sciences.

14 (2) ELIGIBLE ENTITY.—The term “eligible enti-
15 ty” means a State or local community that—

16 (A) bears a disproportionate burden of ex-
17 posure to environmental health hazards;

18 (B) bears a disproportionate burden of ex-
19 posure to unhealthy living conditions, low
20 standard housing conditions, low socioeconomic
21 status, poor nutrition, less opportunity for edu-
22 cational attainment, disproportionately high un-
23 employment rates, or lower literacy levels and
24 access to information;

25 (C) has established a coalition—

- 1 (i) with not less than 1 community-
2 based organization or demonstration pro-
3 gram; and
- 4 (ii) with not less than 1—
- 5 (I) public health entity;
- 6 (II) health care provider organi-
7 zation;
- 8 (III) academic institution, includ-
9 ing any minority-serving institution
10 (including a Hispanic-serving institu-
11 tion, a historically Black college or
12 university, or a Tribal College or Uni-
13 versity);
- 14 (IV) child-serving institution; or
- 15 (V) landlord or housing provider
16 working on lead remediation;
- 17 (D) ensures planned activities and funding
18 streams are coordinated to improve community
19 health; and
- 20 (E) submits an application in accordance
21 with subsection (c).
- 22 (b) ESTABLISHMENT.—The Director shall establish a
23 grant program under which eligible entities shall receive
24 grants to conduct environmental health improvement ac-
25 tivities and to improve social determinants of health.

1 (c) APPLICATION.—To receive a grant under this sec-
2 tion, an eligible entity shall submit an application to the
3 Director at such time, in such manner, and accompanied
4 by such information as the Director may require.

5 (d) USE OF GRANT FUNDS.—An eligible entity may
6 use a grant under this section—

7 (1) to promote environmental health;

8 (2) to address environmental health disparities
9 among all populations, including children; and

10 (3) to address racial and ethnic disparities in
11 social determinants of health.

12 (e) AMOUNT OF COOPERATIVE AGREEMENT.—The
13 Director shall award grants to eligible entities at the fol-
14 lowing 3 funding levels:

15 (1) LEVEL 1 COOPERATIVE AGREEMENTS.—

16 (A) IN GENERAL.—An eligible entity
17 awarded a grant under this paragraph shall use
18 the funds to identify environmental health prob-
19 lems and solutions by—

20 (i) establishing a planning and
21 prioritizing council in accordance with sub-
22 paragraph (B); and

23 (ii) conducting an environmental
24 health assessment in accordance with sub-
25 paragraph (C).

1 (B) PLANNING AND PRIORITIZING COUN-
2 CIL.—

3 (i) IN GENERAL.—A prioritizing and
4 planning council established under sub-
5 paragraph (A)(i) (referred to in this para-
6 graph as a “PPC”) shall assist the envi-
7 ronmental health assessment process and
8 environmental health promotion activities
9 of the eligible entity.

10 (ii) MEMBERSHIP.—Membership of a
11 PPC shall consist of representatives from
12 various organizations within public health,
13 planning, development, and environmental
14 services and shall include stakeholders
15 from vulnerable groups such as children,
16 the elderly, disabled, and minority ethnic
17 groups that are often not actively involved
18 in democratic or decision-making proc-
19 esses.

20 (iii) DUTIES.—A PPC shall—

21 (I) identify key stakeholders and
22 engage and coordinate potential part-
23 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 (2) 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 (1)).

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 (1)(C)(ii), including—

22 (I) geography;

23 (II) the built environment;

24 (III) air quality;

25 (IV) water quality;

- 1 (V) land use;
2 (VI) solid waste;
3 (VII) housing;
4 (VIII) violence;
5 (IX) socioeconomic status;
6 (X) ethnicity, social construct
7 and language preference;
8 (XI) educational attainment;
9 (XII) employment;
10 (XIII) food safety, accessibility,
11 and affordability;
12 (XIV) nutrition;
13 (XV) health care services; and
14 (XVI) injuries;
- 15 (ii) building partnerships between
16 planning, public health, and other sectors,
17 including child-serving institutions, to ad-
18 dress how the built environment impacts
19 food availability and access and physical
20 activity to promote healthy behaviors and
21 lifestyles and reduce overweight and obe-
22 sity, musculoskeletal diseases, respiratory
23 conditions, dental, oral and mental health
24 conditions, poverty, and related co-
25 morbidities;

1 (iii) establishing programs to ad-
2 dress—

3 (I) how environmental and social
4 conditions of work and living choices
5 influence physical activity and dietary
6 intake; or

7 (II) how the conditions described
8 in subclause (I) influence the concerns
9 and needs of people who have im-
10 paired mobility and use assistance de-
11 vices, including wheelchairs, lower
12 limb prostheses, and hip, knee, and
13 other joint replacements; and

14 (iv) convening intervention and dem-
15 onstration programs that examine the role
16 of the social environment in connection
17 with the physical and chemical environ-
18 ment in—

19 (I) determining access to nutri-
20 tional food;

21 (II) improving physical activity to
22 reduce overweight, obesity, and co-
23 morbidities and increase quality of
24 life; and

1 (III) location and access to med-
2 ical facilities.

3 (3) LEVEL 3 COOPERATIVE AGREEMENTS.—

4 (A) IN GENERAL.—An eligible entity
5 awarded a grant under this paragraph shall use
6 the funds to identify and address racial and
7 ethnic disparities in social determinants of
8 health by creating demonstration programs that
9 assess the feasibility of establishing a federally
10 funded comprehensive program and describe
11 key outcomes that address racial and ethnic dis-
12 parities in social determinants of health.

13 (B) PROGRAM DESIGN.—

14 (i) EVALUATION.—No later than 1
15 year after enactment of this Act, the Di-
16 rector shall evaluate the best practices of
17 existing programs from the private, public,
18 community-based, and academically sup-
19 ported initiatives focused on reducing dis-
20 parities in the social determinants of
21 health for racial and ethnic populations.

22 (ii) DEMONSTRATION PROJECTS.—
23 Not later than two years after the date of
24 enactment of this Act, the Director shall
25 implement at least ten demonstration

1 projects including at least one project for
2 each major racial and ethnic minority
3 group, each of which is unique to the cul-
4 tural and linguistic needs of each of the
5 following groups:

6 (I) Native Americans and Alaska
7 Natives.

8 (II) Asian Americans.

9 (III) African Americans/Blacks.

10 (IV) Hispanic/Latino Americans.

11 (V) Native Hawaiians and Pacific
12 Islanders.

13 (iii) REPORT TO CONGRESS.—No later
14 than 2 years after the implementation of
15 the initial demonstration projects, the Di-
16 rector shall submit to Congress a report
17 which includes—

18 (I) a description of each dem-
19 onstration project and design;

20 (II) an evaluation of the cost-ef-
21 fectiveness of each project's preven-
22 tion and treatment efforts;

23 (III) an evaluation of the cultural
24 and linguistic appropriateness of each

1 project by racial and ethnic group;
2 and

3 (IV) an evaluation of the bene-
4 ficiary's health status improvement
5 under the demonstration project.

6 (iv) ANY OTHER INFORMATION
7 DEEMED APPROPRIATE BY THE DIREC-
8 TOR.—The Director shall require eligible
9 entities awarded a grant under this para-
10 graph to report any other information the
11 Director determines appropriate to be
12 shared by or developed by such entity, in-
13 cluding the following:

14 (I) Developing models and evalu-
15 ating methods that improve the cul-
16 tural and linguistically appropriate
17 services provided through the Centers
18 for Disease Control and Prevention to
19 target individuals impacted by health
20 disparities based on their race, eth-
21 nicity, and gender.

22 (II) Promoting the collaboration
23 between primary and specialty care
24 health care providers and patients, to
25 ensure patients impacted by health

1 disparities based on race, ethnicity,
2 and gender are receiving comprehen-
3 sive and organized treatment and
4 care.

5 (III) Educating health care pro-
6 fessionals on the causes and effects of
7 disparities in the social determinants
8 of health as it relates to minority and
9 racial and ethnic communities and the
10 need for culturally and linguistically
11 appropriate care in the prevention and
12 treatment of high-impact diseases.

13 (IV) Encouraging collaboration
14 among community and patient-based
15 organizations which work to address
16 disparities in the social determinants
17 of health as it relates to high-impact
18 diseases in minority and racial and
19 ethnic populations.

20 (f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this sec-
22 tion—

23 (1) \$25,000,000 for fiscal year 2021; and

24 (2) such sums as may be necessary for fiscal
25 years 2022 through 2024.

1 **SEC. 1006. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
2 **BETWEEN THE BUILT ENVIRONMENT AND**
3 **THE HEALTH OF COMMUNITY RESIDENTS.**

4 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
5 section, the term “eligible institution” means a public or
6 private nonprofit institution that submits to the Secretary
7 of Health and Human Services (in this section referred
8 to as the “Secretary”) and the Administrator of the Envi-
9 ronmental Protection Agency (in this section referred to
10 as the “Administrator”) an application for a grant under
11 the grant program authorized under subsection (b)(2) at
12 such time, in such manner, and containing such agree-
13 ments, assurances, and information as the Secretary and
14 Administrator may require.

15 (b) RESEARCH GRANT PROGRAM.—

16 (1) DEFINITION OF HEALTH.—In this section,
17 the term “health” includes—

18 (A) levels of physical activity;

19 (B) degree of mobility due to factors such
20 as musculoskeletal diseases, arthritis, and obe-
21 sity;

22 (C) consumption of nutritional foods;

23 (D) rates of crime;

24 (E) air, water, and soil quality;

25 (F) risk of injury;

26 (G) accessibility to health care services;

1 (H) levels of educational attainment; and

2 (I) other indicators as determined appro-
3 priate by the Secretary.

4 (2) GRANTS.—The Secretary, in collaboration
5 with the Administrator, shall provide grants to eligi-
6 ble institutions to conduct and coordinate research
7 on the built environment and its influence on indi-
8 vidual and population-based health.

9 (3) RESEARCH.—The Secretary shall support
10 research that—

11 (A) investigates and defines the causal
12 links between all aspects of the built environ-
13 ment and the health of residents;

14 (B) examines—

15 (i) the extent of the impact of the
16 built environment (including the various
17 characteristics of the built environment) on
18 the health of residents;

19 (ii) the variance in the health of resi-
20 dents by—

21 (I) location (such as inner cities,
22 inner suburbs, and outer suburbs);
23 and

1 (II) population subgroup (includ-
2 ing children, the elderly, the disadvan-
3 tagged); or

4 (iii) the importance of the built envi-
5 ronment to the total health of residents,
6 which is the primary variable of interest
7 from a public health perspective;

8 (C) is used to develop—

9 (i) measures to address health and the
10 connection of health to the built environ-
11 ment; and

12 (ii) efforts to link the measures to
13 travel and health databases;

14 (D) distinguishes carefully between per-
15 sonal attitudes and choices and external influ-
16 ences on observed behavior to determine how
17 much an observed association between the built
18 environment and the health of residents, versus
19 the lifestyle preferences of the people that
20 choose to live in the neighborhood, reflects the
21 physical characteristics of the neighborhood;
22 and

23 (E)(i) identifies or develops effective inter-
24 vention strategies to promote better health
25 among residents with a focus on behavioral

1 interventions and enhancements of the built en-
2 vironment that promote increased use by resi-
3 dents; and

4 (ii) in developing the intervention strate-
5 gies under clause (i), ensures that the interven-
6 tion strategies will reach out to high-risk popu-
7 lations, including racial and ethnic minorities,
8 low-income urban and rural communities, and
9 children.

10 (4) PRIORITY.—In providing assistance under
11 the grant program authorized under paragraph (2),
12 the Secretary and the Administrator shall give pri-
13 ority to research that incorporates—

14 (A) minority-serving institutions as grant-
15 ees;

16 (B) interdisciplinary approaches; or

17 (C) the expertise of the public health,
18 physical activity, nutrition and health care (in-
19 cluding child health), urban planning, and
20 transportation research communities in the
21 United States and abroad.

22 **SEC. 1007. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**
23 **TION.**

24 (a) FINDINGS.—

1 (1) GENERAL FINDINGS.—Congress finds
2 that—

3 (A) humans share an environment with a
4 wide variety of habitats and ecosystems that
5 nurture and sustain a diversity of species;

6 (B) the abundance of natural resources in
7 the environment forms the basis for the econ-
8 omy and has greatly contributed to human de-
9 velopment throughout history;

10 (C) the accelerated pace of human develop-
11 ment over the last several hundred years has
12 significantly impacted—

13 (i) the natural environment and its re-
14 sources;

15 (ii) the health and diversity of plant
16 and animal life;

17 (iii) the availability of critical habi-
18 tats;

19 (iv) the quality of the air and water;
20 and

21 (v) the global climate;

22 (D) the intervention of the Federal Gov-
23 ernment is necessary to minimize and mitigate
24 human impact on the environment—

25 (i) for the benefit of public health;

1 (ii) to maintain air quality and water
2 quality;

3 (iii) to sustain the diversity of plants
4 and animals;

5 (iv) to combat global climate change;
6 and

7 (v) to protect the environment;

8 (E) laws and regulations in the United
9 States have been enacted and promulgated to
10 minimize and mitigate human impact on the en-
11 vironment for the benefit of public health, to
12 maintain air quality and water quality, to sus-
13 tain wildlife, and to protect the environment, in-
14 cluding—

15 (i) chapter 3203 of title 54, United
16 States Code (commonly known as the “An-
17 tiquities Act of 1906”), which was initiated
18 by President Theodore Roosevelt to create
19 the National Park System;

20 (ii) the National Environmental Policy
21 Act of 1969 (42 U.S.C. 4321 et seq.);

22 (iii) the Clean Air Act (42 U.S.C.
23 7401 et seq.);

24 (iv) the Federal Water Pollution Con-
25 trol Act (33 U.S.C. 1251 et seq.);

1 (v) the Comprehensive Environmental
2 Response, Compensation, and Liability Act
3 of 1980 (42 U.S.C. 9601 et seq.);

4 (vi) the Endangered Species Act of
5 1973 (16 U.S.C. 1531 et seq.); and

6 (vii) the National Forest Management
7 Act of 1976 (Public Law 94–588; 90 Stat.
8 2949) and the amendments made by that
9 Act; and

10 (F) attempts to repeal or weaken key envi-
11 ronmental safeguards pose dangers to the pub-
12 lic health, air quality, water quality, wildlife,
13 and the environment.

14 (2) FINDINGS ON CHANGES AND PROPOSED
15 CHANGES IN LAW.—Congress finds that, since 2001,
16 the following changes and proposed changes to exist-
17 ing law or regulations have negatively impacted or
18 will negatively impact the environment and public
19 health:

20 (A) CLEAN WATER.—

21 (i) FILL MATERIAL.—

22 (I) On May 9, 2002, the Envi-
23 ronmental Protection Agency and the
24 Corps of Engineers issued a final rule,
25 entitled “Final Revisions to the Clean

1 Water Act Regulatory Definitions of
2 ‘Fill Material’ and ‘Discharge of Fill
3 Material’” (67 Fed. Reg. 31129),
4 that reconciled regulations imple-
5 menting section 404 of the Federal
6 Water Pollution Control Act (33
7 U.S.C. 1344) by redefining the term
8 “fill material” and amending the defi-
9 nition of the term “discharge of fill
10 material”, reversing a 25-year-old reg-
11 ulation.

12 (II) The rule described in sub-
13 clause (I)—

14 (aa) fails to restrict the
15 dumping of hardrock mining
16 waste, construction debris, and
17 other industrial wastes into riv-
18 ers, streams, lakes, and wetlands;
19 and

20 (bb) allows destructive
21 mountaintop removal coal mining
22 companies to dump waste into
23 streams and lakes, polluting the
24 surrounding natural habitat and
25 poisoning plants and animals

1 that depend on those water
2 sources.

3 (ii) LIVESTOCK WASTE REGULA-
4 TIONS.—

5 (I) On February 12, 2003, the
6 Environmental Protection Agency
7 published the rule entitled “National
8 Pollutant Discharge Elimination Sys-
9 tem Permit Regulation and Effluent
10 Limitation Guidelines and Standards
11 for Concentrated Animal Feeding Op-
12 erations (CAFOs)” (68 Fed. Reg.
13 7176), new livestock waste regulations
14 that aimed to control factory farm
15 pollution but which would severely un-
16 dermine then-existing protections
17 under the Federal Water Pollution
18 Control Act (33 U.S.C. 1251 et seq.).

19 (II) The regulation described in
20 subclause (I) allows large-scale animal
21 factories to foul waters in the United
22 States with animal waste, allows live-
23 stock owners to draft their own pollu-
24 tion-management plans and avoid
25 ground water monitoring, legalizes the

1 discharge of contaminated runoff
2 water rich in nitrogen, phosphorus,
3 bacteria, and metals, and ensures that
4 large factory farms are not held liable
5 for the environmental damage they
6 cause.

7 (III) In a 2005 Federal court de-
8 cision, *Waterkeeper Alliance, et al. v.*
9 *Environmental Protection Agency*,
10 399 F.3d 486 (2nd Cir. 2005), major
11 parts of the rule were upheld, others
12 vacated, and still others remanded
13 back to the Environmental Protection
14 Agency.

15 (IV) On November 20, 2008, the
16 Environmental Protection Agency
17 published a revised final rule, entitled
18 “Revised National Pollutant Dis-
19 charge Elimination System Permit
20 Regulation and Effluent Limitations
21 Guidelines for Concentrated Animal
22 Feeding Operations in Response to
23 the Waterkeeper Decision” (73 Fed.
24 Reg. 70418), that undermines envi-
25 ronmental protection provisions by re-

1 moving mandatory permitting require-
2 ments and allowing large animal
3 farms to self-certify the absence of
4 pollutant discharge activity.

5 (iii) TOTAL MAXIMUM DAILY LOAD.—

6 (I) On March 19, 2003, the En-
7 vironmental Protection Agency pub-
8 lished a new rule regarding the total
9 maximum daily load program under
10 section 303(d) of the Federal Water
11 Pollution Control Act (33 U.S.C.
12 1313(d)), entitled “Withdrawal of Re-
13 visions to the Water Quality Planning
14 and Management Regulation and Re-
15 visions to the National Pollutant Dis-
16 charge Elimination System Program
17 in Support of Revisions to the Water
18 Quality Planning and Management
19 Regulation” (68 Fed. Reg. 13608),
20 that regulates the maximum amount
21 of a particular pollutant that can be
22 present in a body of water and still
23 meet water quality standards.

24 (II) The new rule described in
25 subclause (I) withdrew the then-exist-

1 ing regulation issued on July 13,
2 2000, and entitled “Revisions to the
3 Water Quality Planning and Manage-
4 ment Regulation and Revisions to the
5 National Pollutant Discharge Elimini-
6 tion System Program in Support of
7 Revisions to the Water Quality Plan-
8 ning and Management Regulation”
9 (65 Fed. Reg. 43586) and halted mo-
10 mentum in cleaning up polluted wa-
11 terways throughout the United States.

12 (III) By abandoning the then-ex-
13 isting rule, the Environmental Protec-
14 tion Agency is undermining the effec-
15 tiveness of cleanup plans and is allow-
16 ing States to avoid cleaning polluted
17 waters entirely by dropping them from
18 their cleanup lists.

19 (IV) Waterways play a crucial
20 role in the lives of the people of the
21 United States and are critical to the
22 livelihood of fish and wildlife.

23 (V) The result of dropping the
24 rule described in subclause (II) is that
25 the restoration of polluted rivers,

1 shorelines, and lakes will be delayed,
2 harming more fish and wildlife and
3 worsening the quality of drinking
4 water.

5 (iv) WATERS OF THE UNITED
6 STATES.—

7 (I) On December 2, 2008, the
8 Environmental Protection Agency and
9 the Corps of Engineers jointly issued
10 a guidance document, entitled “Clean
11 Water Act Jurisdiction Following the
12 U.S. Supreme Court’s Decision in
13 *Rapanos v. United States & Carabell*
14 *v. United States*”.

15 (II) The guidance described in
16 subclause (I) dictates enforcement ac-
17 tions under the Federal Water Pollu-
18 tion Control Act (33 U.S.C. 1251 et
19 seq.) and calls for a complicated
20 “case-by-case” analysis to determine
21 jurisdiction for waterways that do not
22 flow all year.

23 (III) Enforcement actions de-
24 scribed in subclause (II) endanger
25 small streams and wetlands that serve

1 as important habitats for aquatic life,
2 which play a fundamental role in safe-
3 guarding sources of clean drinking
4 water and mitigate the risks and ef-
5 fects of floods and droughts.

6 (IV) The definition provided in
7 the guidance described in subclause
8 (I) for “waters of the United States”
9 is applicable to the Federal Water
10 Pollution Control Act (33 U.S.C.
11 1251 et seq.) as a whole, potentially
12 affecting programs that control indus-
13 trial pollution and sewage levels, pre-
14 vent oil spills, and set water quality
15 standards for all waters in the United
16 States protected under that Act.

17 (B) FORESTS AND LAND MANAGEMENT.—

18 (i) HEALTHY FORESTS RESTORATION
19 ACT OF 2003.—

20 (I) On December 3, 2003, the
21 President signed into law the Healthy
22 Forests Restoration Act of 2003 (16
23 U.S.C. 6501 et seq.) (referred to in
24 this clause as the “law”).

1 (II) Although the law attempts to
2 reduce the risk of catastrophic forest
3 fires, the law provides a boon to tim-
4 ber companies by accelerating the ag-
5 gressive thinning of backcountry for-
6 ests that are located far from at-risk
7 communities.

8 (III) The law allows for increased
9 logging of large, fire-resistant trees
10 that are not in close proximity to
11 homes and communities.

12 (IV) The law undermines critical
13 protections for endangered species by
14 exempting Federal land management
15 agencies from consulting with the
16 United States Fish and Wildlife Serv-
17 ice before approving any action that
18 could harm endangered plants or wild-
19 life.

20 (V) The law limits public partici-
21 pation by reducing the number of en-
22 vironmental reviews for projects car-
23 ried out under the law.

1 (ii) NFS LAND MANAGEMENT PLAN-
2 NING FINAL PLANNING RULE AND RECORD
3 OF DECISION.—

4 (I) On April 21, 2008, the Sec-
5 retary of Agriculture issued a final
6 rule entitled “National Forest System
7 Land Management Planning” (73
8 Fed. Reg. 21486 (April 21, 2008))
9 (referred to in this clause as the “re-
10 vised rule”).

11 (II) The revised rule is a revision
12 of a similar final rule entitled “Na-
13 tional Forest System Land Manage-
14 ment Planning” (70 Fed Reg. 1022
15 (January 5, 2005)), which the United
16 States District Court for the Northern
17 District of California remanded to the
18 Secretary of Agriculture in the case
19 styled *Citizens for Better Forestry v.*
20 *United States Department of Agri-*
21 *culture* (481 F. Supp. 2d 1059 (N.D.
22 Cal. 2007)) for violating—

23 (aa) the National Environ-
24 mental Policy Act of 1969 (42
25 U.S.C. 4321 et seq.);

1 (bb) the Endangered Species
2 Act of 1973 (16 U.S.C. 1531 et
3 seq.); and

4 (cc) subchapter II of chapter
5 5, and chapter 7, of title 5,
6 United States Code (commonly
7 known as the “Administrative
8 Procedure Act”).

9 (III) The revised rule eliminates
10 strict forest planning standards estab-
11 lished in 1982.

12 (IV) The revised rule opens mil-
13 lions of acres of public land to dam-
14 aging and invasive logging, mining,
15 and drilling operations.

16 (V) The revised rule would re-
17 verse more than 20 years of protec-
18 tions for wildlife and national forests
19 by—

20 (aa) removing the overall
21 goal of ensuring ecological sus-
22 tainability in managing the Na-
23 tional Forest System;

24 (bb) weakening the effect of
25 the National Forest Management

1 Act of 1976 (Public Law 94–588;
2 90 Stat. 2949) and the amend-
3 ments made by that Act; and

4 (cc) effectively ending the
5 review of forest management
6 plans under the National Envi-
7 ronmental Policy Act of 1969 (42
8 U.S.C. 4321 et seq.).

9 (iii) INVENTORIED ROADLESS AREA
10 RULES.—

11 (I) On September 20, 2006, the
12 United States District Court for the
13 Northern District of California va-
14 cated the final rule entitled “Special
15 Areas; State Petitions for Inventoried
16 Roadless Area Management” (70 Fed.
17 Reg. 25654 (May 13, 2005)) (referred
18 to in this clause as the “2005 rule”),
19 which gave each Governor of a State
20 18 months to petition the Federal
21 Government—

22 (aa) to restore the inven-
23 toried roadless area rules applica-
24 ble to the State of the Governor
25 before the effective date of the

1 final rule entitled “Special Areas;
2 Roadless Area Conservation” (66
3 Fed. Reg. 3244 (January 12,
4 2001)) (referred to in this clause
5 as the “2001 rule”); or

6 (bb) to submit a new man-
7 agement and development plan
8 for National Forest System
9 inventoried roadless areas within
10 the State.

11 (II) Despite the enjoinder of
12 the 2005 rule and the subsequent res-
13 toration of the 2001 rule, the Forest
14 Service has continued to allow States
15 to petition for a special rule under the
16 authority of section 553(e) of title 5,
17 United States Code, and has issued a
18 final rule entitled “Special Areas;
19 Roadless Area Conservation; Applica-
20 bility to the National Forests in
21 Idaho” (73 Fed. Reg. 61456 (October
22 16, 2008)).

23 (III) As a result, 58,500,000
24 acres of wild National Forest System
25 land are still vulnerable to logging,

1 road building, and other developments
2 that may fragment natural habitats
3 and negatively impact fish and wild-
4 life.

5 (iv) BLM RESOURCE MANAGEMENT
6 PLANS.—

7 (I) On November 28, 2008, the
8 Bureau of Land Management an-
9 nounced the record of decision entitled
10 “Record of Decision for Oil Shale and
11 Tar Sands Resources to Address
12 Land Use Allocations in Colorado,
13 Utah, and Wyoming” (73 Fed. Reg.
14 72519 (November 28, 2008)), which
15 amended 12 resource management
16 plans in the States of Colorado, Utah,
17 and Wyoming, opening 2,000,000
18 acres of public land to commercial tar
19 sands and oil shale exploration and
20 development.

21 (II) On November 18, 2008, the
22 Bureau of Land Management issued
23 the final rule entitled “Oil Shale Man-
24 agement—General” (73 Fed. Reg.
25 69414 (November 18, 2008)), setting

1 the policies and procedures for a com-
2 mercial leasing program for the man-
3 agement of federally owned oil shale
4 in the States referred to in subclause
5 (I).

6 (III) Previously barred by a con-
7 gressional moratorium on the com-
8 mercial leasing regulations for oil
9 shale until September 30, 2008, the
10 development of oil shale on public
11 land poses a serious threat to land
12 conservation, endangered and threat-
13 ened species, and critical habitat.

14 (IV) Domestic shale oil produc-
15 tion authorized by the final rules de-
16 scribed in subclauses (I) and (II)—

17 (aa) is water- and energy-in-
18 tensive; and

19 (bb) will intensify existing
20 water scarcity in the arid West-
21 ern United States and potentially
22 degrade air and water quality for
23 surrounding populations.

24 (C) SCIENTIFIC REVIEW.—

1 (i) On December 16, 2008, the United
2 States Fish and Wildlife Service and the
3 National Marine Fisheries Service jointly
4 issued a new rule, entitled “Interagency
5 Cooperation Under the Endangered Spe-
6 cies Act” (73 Fed. Reg. 76272) amending
7 regulations governing interagency coopera-
8 tion under section 7 of the Endangered
9 Species Act of 1973 (16 U.S.C. 1536).

10 (ii) The rule described in clause (i)
11 undermines the intention of the Endan-
12 gered Species Act (16 U.S.C. 1531 et seq.)
13 to protect species and the ecosystems on
14 which those species depend by allowing
15 Federal agencies to carry out, permit, or
16 fund an action without proper environ-
17 mental review and expert third-party con-
18 sultation from Federal wildlife experts.

19 (iii) Under the rule described in
20 clause (i), Federal agencies can unilaterally
21 circumvent the formal review process,
22 eliminating longstanding and scientifically
23 grounded safeguards that serve to protect
24 the biodiversity of ecosystems in the
25 United States and avert harm to thou-

1 sands of endangered and threatened spe-
2 cies.

3 (b) STATEMENT OF POLICY.—It is the policy of the
4 Federal Government to work in conjunction with States,
5 territories, Tribal governments, international organiza-
6 tions, and foreign governments as a steward of the envi-
7 ronment for the benefit of public health, to maintain air
8 quality and water quality, to sustain the diversity of plant
9 and animal species, to combat global climate change, and
10 to protect the environment for future generations.

11 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
12 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
13 TIONS, LAWS, OR PROPOSED LAWS.—

14 (1) STUDY.—Not later than 30 days after the
15 date of enactment of this Act, the President shall
16 enter into an arrangement under which the National
17 Academy of Sciences shall conduct a study to deter-
18 mine the impact on public health, air quality, water
19 quality, wildlife, and the environment of the fol-
20 lowing regulations, laws, and proposed laws:

21 (A) CLEAN WATER.—

22 (i) The final rule of the Environ-
23 mental Protection Agency and the Corps of
24 Engineers entitled “Final Revisions to the
25 Clean Water Act Regulatory Definitions of

1 ‘Fill Material’ and ‘Discharge of Fill Mate-
2 rial’” (67 Fed. Reg. 31129 (May 9,
3 2002)).

4 (ii) The final rule of the Environ-
5 mental Protection Agency entitled “Re-
6 vised National Pollutant Discharge Elim-
7 nation System Permit Regulation and Ef-
8 fluent Limitations Guidelines for Con-
9 centrated Animal Feeding Operations in
10 Response to the Waterkeeper Decision”
11 (73 Fed. Reg. 70418 (November 20,
12 2008)).

13 (iii) The final rule entitled “With-
14 drawal of Revisions to the Water Quality
15 Planning and Management Regulation and
16 Revisions to the National Pollutant Dis-
17 charge Elimination System Program in
18 Support of Revisions to the Water Quality
19 Planning and Management Regulation”
20 (68 Fed. Reg. 13608 (March 19, 2003)).

21 (iv) The guidance document of the
22 Environmental Protection Agency and the
23 Corps of Engineers entitled “Clean Water
24 Act Jurisdiction Following the U.S. Su-
25 preme Court’s Decision in Rapanos v.

1 United States & Carabell v. United States”
2 (December 2, 2008).

3 (B) FORESTS AND LAND MANAGEMENT.—

4 (i) The Healthy Forests Restoration
5 Act of 2003 (16 U.S.C. 6501 et seq.).

6 (ii) The application of section 553(e)
7 of title 5, United States Code, such that a
8 State may petition for a special rule for
9 the National Forest System inventoried
10 roadless areas within the State.

11 (iii) The final rule entitled “National
12 Forest System Land Management Plan-
13 ning” (73 Fed. Reg. 21486 (April 21,
14 2008)).

15 (iv) The final rule entitled “Oil Shale
16 Management—General” (73 Fed. Reg.
17 69414 (November 18, 2008)).

18 (v) The record of decision entitled
19 “Record of Decision for Oil Shale and Tar
20 Sands Resources To Address Land Use Al-
21 locations in Colorado, Utah, and Wyo-
22 ming” (73 Fed. Reg. 72519 (November
23 28, 2008)).

24 (C) SCIENTIFIC REVIEW.—The final rule
25 of the United States Fish and Wildlife Service

1 and the National Marine Fisheries Service enti-
2 tled “Interagency Cooperation Under the En-
3 dangered Species Act” (73 Fed. Reg. 76272
4 (December 16, 2008)).

5 (2) METHOD.—In conducting the study under
6 paragraph (1), the National Academy of Sciences
7 may use and compare existing scientific studies re-
8 garding the regulations, laws, and proposed laws de-
9 scribed in paragraph (1).

10 (3) REPORT.—Not later than 270 days after
11 the date on which the President enters into the ar-
12 rangement under paragraph (1), the National Acad-
13 emy of Sciences shall make publicly available and
14 shall submit to the Congress and to the head of each
15 department and agency of the Federal Government
16 that issued, implements, or would implement a regu-
17 lation, law, or proposed law described in paragraph
18 (1), a report that includes—

19 (A) a description of the impact of each
20 regulation, law, or proposed law described in
21 paragraph (1) on public health, air quality,
22 water quality, wildlife, and the environment,
23 compared to the impact of preexisting regula-
24 tions, or laws in effect, as applicable, includ-
25 ing—

1 (i) any negative impacts to air quality
2 or water quality;

3 (ii) any negative impacts to wildlife;

4 (iii) any delays in hazardous waste
5 cleanup that are projected to be hazardous
6 to public health; and

7 (iv) any other negative impact on pub-
8 lic health or the environment; and

9 (B) any recommendations that the Na-
10 tional Academy of Sciences considers appro-
11 priate to maintain, restore, or improve in whole
12 or in part protections for public health, air
13 quality, water quality, wildlife, and the environ-
14 ment for each of the regulations, laws, and pro-
15 posed laws described in paragraph (1), which
16 may include recommendations for the adoption
17 of any regulation or law in place or proposed
18 prior to January 1, 2001.

19 (d) DEPARTMENT AND AGENCY REVISION OF EXIST-
20 ING RULES, REGULATIONS, OR LAWS.—Not later than
21 180 days after the date on which the report is submitted
22 pursuant to subsection (c)(3), the head of each depart-
23 ment or agency that has issued or implemented a regula-
24 tion or law described in subsection (c)(1) shall submit to
25 Congress a plan describing the steps the department or

1 agency will take, or has taken, to restore or improve pro-
2 tections for public health and the environment in whole
3 or in part that were in existence prior to the issuance of
4 the applicable regulation or law.

5 **SEC. 1008. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
6 **WATER HORIZON OIL RIG EXPLOSION IN THE**
7 **GULF COAST.**

8 (a) STUDY.—The Comptroller General of the United
9 States shall conduct a study on the type and scope of
10 health care services administered through the Department
11 of Health and Human Services addressing the provision
12 of health care to racial and ethnic minorities, including
13 residents, cleanup workers, and volunteers, affected by the
14 blowout and explosion of the mobile offshore drilling unit
15 Deepwater Horizon that occurred on April 20, 2010, and
16 resulting hydrocarbon releases into the environment.

17 (b) SPECIFIC COMPONENTS.—In carrying out sub-
18 section (a), the Comptroller General shall—

19 (1) assess the type, size, and scope of programs
20 administered by the Secretary of Health and Human
21 Services that focus on the provision of health care
22 to communities on the Gulf Coast;

23 (2) identify the merits and disadvantages asso-
24 ciated with each of the programs;

1 (3) perform an analysis of the costs and bene-
2 fits of the programs; and

3 (4) determine whether there is any duplication
4 of programs.

5 (c) REPORT.—Not later than 180 days after the date
6 of enactment of this Act, the Comptroller General shall
7 submit to Congress a report that includes—

8 (1) the findings of the study conducted under
9 subsection (a); and

10 (2) recommendations for improving access to
11 health care for racial and ethnic minorities.

12 **SEC. 1009. ESTABLISH AN INTERAGENCY COUNSEL AND**
13 **GRANT PROGRAMS ON SOCIAL DETER-**
14 **MINANTS OF HEALTH.**

15 (a) SHORT TITLE.—This section may be cited as the
16 “Social Determinants Accelerator Act of 2020”.

17 (b) FINDINGS; PURPOSES.—

18 (1) FINDINGS.—Congress finds the following:

19 (A) There is a significant body of evidence
20 showing that economic and social conditions
21 have a powerful impact on individual and popu-
22 lation health outcomes and well-being, as well
23 as medical costs.

24 (B) State, local, and Tribal governments
25 and the service delivery partners of such gov-

1 ernments face significant challenges in coordi-
2 nating benefits and services delivered through
3 the Medicaid program and other social services
4 programs because of the fragmented and com-
5 plex nature of Federal and State funding and
6 administrative requirements.

7 (C) The Federal Government should
8 prioritize and proactively assist State and local
9 governments to strengthen the capacity of State
10 and local governments to improve health and
11 social outcomes for individuals, thereby improv-
12 ing cost-effectiveness and return on investment.

13 (2) PURPOSES.—The purposes of this Act are
14 as follows:

15 (A) To establish effective, coordinated Fed-
16 eral technical assistance to help State and local
17 governments to improve outcomes and cost-ef-
18 fectiveness of, and return on investment from,
19 health and social services programs.

20 (B) To build a pipeline of State and locally
21 designed, cross-sector interventions and strate-
22 gies that generate rigorous evidence about how
23 to improve health and social outcomes, and in-
24 crease the cost-effectiveness of, and return on

1 investment from, Federal, State, local, and
2 Tribal health and social services programs.

3 (C) To enlist State and local governments
4 and the service providers of such governments
5 as partners in identifying Federal statutory,
6 regulatory, and administrative challenges in im-
7 proving the health and social outcomes of, cost-
8 effectiveness of, and return on investment from,
9 Federal spending on individuals enrolled in
10 Medicaid.

11 (D) To develop strategies to improve
12 health and social outcomes without denying
13 services to, or restricting the eligibility of, vul-
14 nerable populations.

15 (c) SOCIAL DETERMINANTS ACCELERATOR COUN-
16 CIL.—

17 (1) ESTABLISHMENT.—The Secretary of Health
18 and Human Services (referred to in this Act as the
19 “Secretary”), in coordination with the Administrator
20 of the Centers for Medicare & Medicaid Services (re-
21 ferred to in this Act as the “Administrator”), shall
22 establish an interagency council, to be known as the
23 Social Determinants Accelerator Interagency Council
24 (referred to in this Act as the “Council”) to achieve
25 the purposes listed in subsection (b)(1).

1 (2) MEMBERSHIP.—

2 (A) FEDERAL COMPOSITION.—The Council
3 shall be composed of at least one designee from
4 each of the following Federal agencies:

5 (i) The Office of Management and
6 Budget.

7 (ii) The Department of Agriculture.

8 (iii) The Department of Education.

9 (iv) The Indian Health Service.

10 (v) The Department of Housing and
11 Urban Development.

12 (vi) The Department of Labor.

13 (vii) The Department of Transpor-
14 tation.

15 (viii) Any other Federal agency the
16 Chair of the Council determines necessary.

17 (B) DESIGNATION.—

18 (i) IN GENERAL.—The head of each
19 agency specified in subparagraph (A) shall
20 designate at least one employee to serve as
21 a member of the Council.

22 (ii) RESPONSIBILITIES.—An employee
23 described in this clause shall be a senior
24 employee of the agency—

1 (I) whose responsibilities relate
2 to authorities, policies, and procedures
3 with respect to the health and well-
4 being of individuals receiving medical
5 assistance under a State plan (or a
6 waiver of such plan) under title XIX
7 of the Social Security Act (42 U.S.C.
8 1396 et seq.); or

9 (II) who has authority to imple-
10 ment and evaluate transformative ini-
11 tiatives that harness data or conducts
12 rigorous evaluation to improve the im-
13 pact and cost-effectiveness of federally
14 funded services and benefits.

15 (C) HHS REPRESENTATION.—In addition
16 to the designees under subparagraph (A), the
17 Council shall include designees from at least
18 three agencies within the Department of Health
19 and Human Services, including the Centers for
20 Medicare & Medicaid Services, at least one of
21 whom shall meet the criteria under this section.

22 (D) OMB ROLE.—The Director of the Of-
23 fice of Management and Budget shall facilitate
24 the timely resolution of Governmentwide and
25 multiagency issues to help the Council achieve

1 consensus recommendations described under
2 this section.

3 (E) NON-FEDERAL COMPOSITION.—The
4 Comptroller General of the United States may
5 designate up to 6 Council designees—

6 (i) who have relevant subject matter
7 expertise, including expertise implementing
8 and evaluating transformative initiatives
9 that harness data and conduct evaluations
10 to improve the impact and cost-effective-
11 ness of Federal Government services; and

12 (ii) that each represent—

13 (I) State, local, and Tribal health
14 and human services agencies;

15 (II) public housing authorities or
16 State housing finance agencies;

17 (III) State and local government
18 budget offices;

19 (IV) State Medicaid agencies; or

20 (V) national consumer advocacy
21 organizations.

22 (F) CHAIR.—

23 (i) IN GENERAL.—The Secretary shall
24 select the Chair of the Council from among
25 the members of the Council.

1 (ii) INITIATING GUIDANCE.—The
2 Chair, on behalf of the Council, shall iden-
3 tify and invite individuals from diverse en-
4 tities to provide the Council with advice
5 and information pertaining to addressing
6 social determinants of health, including—

7 (I) individuals from State and
8 local government health and human
9 services agencies;

10 (II) individuals from State Med-
11 icaid agencies;

12 (III) individuals from State and
13 local government budget offices;

14 (IV) individuals from public
15 housing authorities or State housing
16 finance agencies;

17 (V) individuals from nonprofit or-
18 ganizations, small businesses, and
19 philanthropic organizations;

20 (VI) advocates;

21 (VII) researchers; and

22 (VIII) any other individuals the
23 Chair determines to be appropriate.

24 (3) DUTIES.—The duties of the Council are—

1 (A) to make recommendations to the Sec-
2 retary and the Administrator regarding the cri-
3 teria for making awards under this section;

4 (B) to identify Federal authorities and op-
5 portunities for use by States or local govern-
6 ments to improve coordination of funding and
7 administration of Federal programs, the bene-
8 ficiaries of whom include individuals, and which
9 may be unknown or underutilized and to make
10 information on such authorities and opportuni-
11 ties publicly available;

12 (C) to provide targeted technical assistance
13 to States developing a social determinants ac-
14 celerator plan under this section, including
15 identifying potential statutory or regulatory
16 pathways for implementation of the plan and
17 assisting in identifying potential sources of
18 funding to implement the plan;

19 (D) to report to Congress annually on the
20 subjects set forth in this section;

21 (E) to develop and disseminate evaluation
22 guidelines and standards that can be used to
23 reliably assess the impact of an intervention or
24 approach that may be implemented pursuant to
25 this Act on outcomes, cost-effectiveness of, and

1 return on investment from Federal, State, local,
2 and Tribal governments, and to facilitate tech-
3 nical assistance, where needed, to help to im-
4 prove State and local evaluation designs and
5 implementation;

6 (F) to seek feedback from State, local, and
7 Tribal governments, including through an an-
8 nual survey by an independent third party, on
9 how to improve the technical assistance the
10 Council provides to better equip State, local,
11 and Tribal governments to coordinate health
12 and social service programs;

13 (G) to solicit applications for grants under
14 this section; and

15 (H) to coordinate with other cross-agency
16 initiatives focused on improving the health and
17 well-being of low-income and at-risk populations
18 in order to prevent unnecessary duplication be-
19 tween agency initiatives.

20 (4) SCHEDULE.—Not later than 60 days after
21 the date of the enactment of this Act, the Council
22 shall convene to develop a schedule and plan for car-
23 rying out the duties described in this section, includ-
24 ing solicitation of applications for the grants under
25 this section.

1 (5) REPORT TO CONGRESS.—The Council shall
2 submit an annual report to Congress, which shall in-
3 clude—

4 (A) a list of the Council members;

5 (B) activities and expenditures of the
6 Council;

7 (C) summaries of the interventions and ap-
8 proaches that will be supported by State, local,
9 and Tribal governments that received a grant
10 under this section, including—

11 (i) the best practices and evidence-
12 based approaches such governments plan
13 to employ to achieve the purposes listed in
14 this section; and

15 (ii) a description of how the practices
16 and approaches will impact the outcomes,
17 cost-effectiveness of, and return on invest-
18 ment from, Federal, State, local, and Trib-
19 al governments with respect to such pur-
20 poses;

21 (D) the feedback received from State and
22 local governments on ways to improve the tech-
23 nical assistance of the Council, including find-
24 ings from a third-party survey and actions the

1 Council plans to take in response to such feed-
2 back; and

3 (E) the major statutory, regulatory, and
4 administrative challenges identified by State,
5 local, and Tribal governments that received a
6 grant under subsection (d), and the actions that
7 Federal agencies are taking to address such
8 challenges.

9 (6) FACA APPLICABILITY.—The Federal Advi-
10 sory Committee Act (5 U.S.C. App.) shall not apply
11 to the Council.

12 (7) COUNCIL PROCEDURES.—The Secretary, in
13 consultation with the Comptroller General of the
14 United States and the Director of the Office of Man-
15 agement and Budget, shall establish procedures for
16 the Council to—

17 (A) ensure that adequate resources are
18 available to effectively execute the responsibil-
19 ities of the Council;

20 (B) effectively coordinate with other rel-
21 evant advisory bodies and working groups to
22 avoid unnecessary duplication;

23 (C) create transparency to the public and
24 Congress with regard to Council membership,
25 costs, and activities, including through use of

1 modern technology and social media to dissemi-
2 nate information; and

3 (D) avoid conflicts of interest that would
4 jeopardize the ability of the Council to make de-
5 cisions and provide recommendations.

6 (d) SOCIAL DETERMINANTS ACCELERATOR GRANTS
7 TO STATES OR LOCAL GOVERNMENTS.—

8 (1) GRANTS TO STATES, LOCAL GOVERNMENTS,
9 AND TRIBES.—Not later than 180 days after the
10 date of the enactment of this Act, the Administrator,
11 in consultation with the Secretary and the Council,
12 shall award on a competitive basis not more than 25
13 grants to eligible applicants described in this section,
14 for the development of social determinants accel-
15 erator plans, as described in this section.

16 (2) ELIGIBLE APPLICANT.—An eligible appli-
17 cant described in this section is a State, local, or
18 Tribal health or human services agency that—

19 (A) demonstrates the support of relevant
20 parties across relevant State, local, or Tribal ju-
21 risdictions; and

22 (B) in the case of an applicant that is a
23 local government agency, provides to the Sec-
24 retary a letter of support from the lead State

1 health or human services agency for the State
2 in which the local government is located.

3 (3) AMOUNT OF GRANT.—The Administrator,
4 in coordination with the Council, shall determine the
5 total amount that the Administrator will make avail-
6 able to each grantee under this section.

7 (4) APPLICATION.—An eligible applicant seek-
8 ing a grant under this section shall include in the
9 application the following information:

10 (A) The target population (or populations)
11 that would benefit from implementation of the
12 social determinants accelerator plan proposed to
13 be developed by the applicant.

14 (B) A description of the objective or objec-
15 tives and outcome goals of such proposed plan,
16 which shall include at least one health outcome
17 and at least one other important social out-
18 come.

19 (C) The sources and scope of inefficiencies
20 that, if addressed by the plan, could result in
21 improved cost-effectiveness of or return on in-
22 vestment from Federal, State, local, and Tribal
23 governments.

1 (D) A description of potential interventions
2 that could be designed or enabled using such
3 proposed plan.

4 (E) The State, local, Tribal, academic,
5 nonprofit, community-based organizations, and
6 other private sector partners that would partici-
7 pate in the development of the proposed plan
8 and subsequent implementation of programs or
9 initiatives included in such proposed plan.

10 (F) Such other information as the Admin-
11 istrator, in consultation with the Secretary and
12 the Council, determines necessary to achieve the
13 purposes of this Act.

14 (5) USE OF FUNDS.—A recipient of a grant
15 under this section may use funds received through
16 the grant for the following purposes:

17 (A) To convene and coordinate with rel-
18 evant government entities and other stake-
19 holders across sectors to assist in the develop-
20 ment of a social determinant accelerator plan.

21 (B) To identify populations of individuals
22 receiving medical assistance under a State plan
23 (or a waiver of such plan) under title XIX of
24 the Social Security Act (42 U.S.C. 1396 et
25 seq.) who may benefit from the proposed ap-

1 proaches to improving the health and well-being
2 of such individuals through the implementation
3 of the proposed social determinants accelerator
4 plan.

5 (C) To engage qualified research experts to
6 advise on relevant research and to design a pro-
7 posed evaluation plan, in accordance with the
8 standards and guidelines issued by the Admin-
9 istrator.

10 (D) To collaborate with the Council to sup-
11 port the development of social determinants ac-
12 celerator plans.

13 (E) To prepare and submit a final social
14 determinants accelerator plan to the Council.

15 (6) CONTENTS OF PLANS.—A social deter-
16 minant accelerator plan developed under this section
17 shall include the following:

18 (A) A description of the target population
19 (or populations) that would benefit from imple-
20 mentation of the social determinants accelerator
21 plan, including an analysis describing the pro-
22 jected impact on the well-being of individuals
23 described in paragraph (5)(B).

24 (B) A description of the interventions or
25 approaches designed under the social deter-

1 minants accelerator plan and the evidence for
2 selecting such interventions or approaches.

3 (C) The objectives and outcome goals of
4 such interventions or approaches, including at
5 least one health outcome and at least one other
6 important social outcome.

7 (D) A plan for accessing and linking rel-
8 evant data to enable coordinated benefits and
9 services for the jurisdictions described in this
10 section and an evaluation of the proposed inter-
11 ventions and approaches.

12 (E) A description of the State, local, Trib-
13 al, academic, nonprofit, or community-based or-
14 ganizations, or any other private sector organi-
15 zations that would participate in implementing
16 the proposed interventions or approaches, and
17 the role each would play to contribute to the
18 success of the proposed interventions or ap-
19 proaches.

20 (F) The identification of the funding
21 sources that would be used to finance the pro-
22 posed interventions or approaches.

23 (G) A description of any financial incen-
24 tives that may be provided, including outcome-
25 focused contracting approaches to encourage

1 service providers and other partners to improve
2 outcomes of, cost-effectiveness of, and return on
3 investment from, Federal, State, local, or Tribal
4 government spending.

5 (H) The identification of the applicable
6 Federal, State, local, or Tribal statutory and
7 regulatory authorities, including waiver authori-
8 ties, to be leveraged to implement the proposed
9 interventions or approaches.

10 (I) A description of potential consider-
11 ations that would enhance the impact,
12 scalability, or sustainability of the proposed
13 interventions or approaches and the actions the
14 grant awardee would take to address such con-
15 siderations.

16 (J) A proposed evaluation plan, to be car-
17 ried out by an independent evaluator, to meas-
18 ure the impact of the proposed interventions or
19 approaches on the outcomes of, cost-effective-
20 ness of, and return on investment from, Fed-
21 eral, State, local, and Tribal governments.

22 (K) Precautions for ensuring that vulner-
23 able populations will not be denied access to
24 Medicaid or other essential services as a result
25 of implementing the proposed plan.

1 (e) FUNDING.—

2 (1) IN GENERAL.—Out of any money in the
3 Treasury not otherwise appropriated, there is appro-
4 priated to carry out this Act \$25,000,000, of which
5 up to \$5,000,000 may be used to carry out this Act,
6 to remain available for obligation until the date that
7 is 5 years after the date of enactment of this Act.

8 (2) RESERVATION OF FUNDS.—

9 (A) IN GENERAL.—Of the funds made
10 available under paragraph (1), the Secretary
11 shall reserve not less than 20 percent to award
12 grants to eligible applicants for the development
13 of social determinants accelerator plans under
14 this section intended to serve rural populations.

15 (B) EXCEPTION.—In the case of a fiscal
16 year for which the Secretary determines that
17 there are not sufficient eligible applicants to
18 award up to 25 grants under section 4 that are
19 intended to serve rural populations and the Sec-
20 retary cannot satisfy the 20-percent require-
21 ment, the Secretary may reserve an amount
22 that is less than 20 percent of amounts made
23 available under paragraph (1) to award grants
24 for such purpose.

1 (3) RULE OF CONSTRUCTION.—Nothing in this
2 Act shall prevent Federal agencies represented on
3 the Council from contributing additional funding
4 from other sources to support activities to improve
5 the effectiveness of the Council.

6 **SEC. 1010. CORRECTING HURTFUL AND ALIENATING**
7 **NAMES IN GOVERNMENT EXPRESSION**
8 **(CHANGE).**

9 (a) SHORT TITLE.—This section may be cited as the
10 “Correcting Hurtful and Alienating Names in Government
11 Expression (CHANGE) Act”.

12 (b) MODERNIZATION OF LANGUAGE REFERRING TO
13 INDIVIDUALS WHO ARE NOT CITIZENS OR NATIONALS OF
14 THE UNITED STATES.—An Executive agency (as defined
15 in section 105 of title 5, United States Code) shall not
16 use the following terms in any proposed or final rule, regu-
17 lation, interpretation, publication, other document, dis-
18 play, or sign issued by the agency after the date of the
19 enactment of this Act, except to the extent that the term
20 is used in quoting or reproducing text written by a source
21 other than an officer (as defined in section 2104 of title
22 5, United States Code) or employee (as defined in section
23 2105 of title 5, United States Code) of the agency:

1 (1) The term “alien”, when used to refer to an
2 individual who is not a citizen or national of the
3 United States.

4 (2) The term “illegal alien” when used to refer
5 to an individual who is unlawfully present in the
6 United States or who lacks a lawful immigration
7 status in the United States.

8 (c) UNIFORM DEFINITION.—

9 (1) IN GENERAL.—Chapter 1 of title 1, United
10 States Code, is amended by adding at the end the
11 following:

12 **“§ 9. Definition of ‘foreign national’**

13 “In determining the meaning of any Act of Congress,
14 or of any ruling, regulation, or interpretation of various
15 administrative bureaus and agencies of the United States,
16 the term ‘foreign national’ means any individual other
17 than an individual—

18 “(1) who is a citizen of the United States; or

19 “(2) though not a citizen of the United States,
20 who owes permanent allegiance to the United
21 States.”.

22 (2) TECHNICAL AMENDMENT.—The table of
23 sections for chapter 1 of title 1, United States Code,
24 is amended by adding at the end the following:

“9. Definition of ‘foreign national’.”.

25 (d) REFERENCES.—

1 (1) IN GENERAL.—Any reference in any Fed-
2 eral statute, rule, regulation, Executive order, publi-
3 cation, or other document of the United States—

4 (A) to the term “alien”, when used to refer
5 to an individual who is not a citizen or national
6 of the United States, is deemed to refer to the
7 term “foreign national”; and

8 (B) to the term “illegal alien”, when used
9 to refer to an individual who is unlawfully
10 present in the United States or who lacks a
11 lawful immigration status in the United States,
12 is deemed to refer to the term “undocumented
13 foreign national”.

14 (2) CONFORMING AMENDMENTS.—

15 (A) Section 421(5)(A)(ii)(II) of the Con-
16 gressional Budget and Impoundment Control
17 Act of 1974 (2 U.S.C. 658(5)(A)(ii)(II)) is
18 amended by striking “illegal aliens” and insert-
19 ing “undocumented foreign nationals”.

20 (B) Section 432(e) of the Homeland Secu-
21 rity Act of 2002 (6 U.S.C. 240(e)) is amended
22 by striking “illegal alien” and inserting “un-
23 documented foreign national”.

24 (C) Section 439 of the Antiterrorism and
25 Effective Death Penalty Act of 1996 (8 U.S.C.

1 1252c) is amended in the section heading by
2 striking “**ILLEGAL ALIENS**” and inserting
3 “**UNDOCUMENTED FOREIGN NATIONALS**”.

4 (D) Section 280(b)(3)(A)(iii) of the Immi-
5 gration and Nationality Act (8 U.S.C.
6 1330(b)(3)(A)(iii)) is amended by striking “ille-
7 gal aliens” and inserting “undocumented for-
8 eign nationals”.

9 (E) Section 286(r)(3)(ii) of the Immigra-
10 tion and Nationality Act (8 U.S.C.
11 1356(r)(3)(ii)) is amended by striking “illegal
12 aliens” and inserting “undocumented foreign
13 nationals”.

14 (F) Section 501 of the Immigration Re-
15 form and Control Act of 1986 (8 U.S.C. 1365)
16 is amended—

17 (i) in the section heading, by striking
18 “**ILLEGAL ALIENS**” and inserting “**UN-**
19 **DOCUMENTED FOREIGN NATIONALS**”;

20 (ii) in the subsection heading for sub-
21 section (b), by striking “**ILLEGAL ALIENS**”
22 and inserting “**UNDOCUMENTED FOREIGN**
23 **NATIONALS**”; and

1 (iii) by striking “illegal alien” each
2 place such term appears and inserting
3 “undocumented foreign national”.

4 (G) Section 332 of the Omnibus Consoli-
5 dated Appropriations Act, 1997 (8 U.S.C.
6 1366) is amended by striking “illegal aliens”
7 each place such term appears and inserting
8 “undocumented foreign nationals”.

9 (H) Section 411(d) of the Personal Re-
10 sponsibility and Work Opportunity Reconcili-
11 ation Act of 1996 (8 U.S.C. 1621(d)) is amend-
12 ed in the subsection heading by striking “ILLE-
13 GAL ALIENS” and inserting “UNDOCUMENTED
14 FOREIGN NATIONALS”.

15 (I) Section 106(e) of the Public Works
16 Employment Act of 1976 (42 U.S.C. 6705(e))
17 is amended in the subsection heading by strik-
18 ing “ILLEGAL ALIENS” and inserting “UN-
19 DOCUMENTED FOREIGN NATIONALS”.

20 (J) Section 40125(a)(2) of title 49, United
21 States Code, is amended by striking “illegal
22 aliens” and inserting “undocumented foreign
23 nationals”.

1 **Subtitle B—Gun Violence**

2 **SEC. 1011. FINDINGS.**

3 Congress finds as follows:

4 (1) On average, 86 Americans are killed by
5 guns each day.

6 (2) An estimated 39,773 people were killed by
7 guns in 2017, of which two-thirds committed suicide.

8 (3) Gun violence disproportionately affects com-
9 munities of color, especially African Americans (who
10 comprise around 14 percent of the United States
11 population but account for more than half the coun-
12 try’s gun homicide victims).

13 (4) On average, there is more than one mass
14 shooting each day in the United States.

15 **SEC. 1012. REAFFIRMING RESEARCH AUTHORITY OF THE**
16 **CENTERS FOR DISEASE CONTROL AND PRE-**
17 **VENTION.**

18 (a) **IN GENERAL.**—Section 391 of the Public Health
19 Service Act (42 U.S.C. 280b) is amended—

20 (1) in subsection (a)(1), by striking “research
21 relating to the causes, mechanisms, prevention, diag-
22 nosis, treatment of injuries, and rehabilitation from
23 injuries;” and inserting: “research, including data
24 collection, relating to—

1 “(A) the causes, mechanisms, prevention,
2 diagnosis, and treatment of injuries, including
3 with respect to gun violence; and

4 “(B) rehabilitation from such injuries;”;
5 and

6 (2) by adding at the end the following new sub-
7 section:

8 “(c) **NO ADVOCACY OR PROMOTION OF GUN CON-**
9 **TROL.**—Nothing in this section shall be construed to—

10 “(1) authorize the Secretary to give assistance,
11 make grants, or enter into cooperative agreements or
12 contracts for the purpose of advocating or promoting
13 gun control; or

14 “(2) permit a recipient of any assistance, grant,
15 cooperative agreement, or contract under this section
16 to use such assistance, grant, agreement, or contract
17 for the purpose of advocating or promoting gun con-
18 trol.”.

19 **SEC. 1013. NATIONAL VIOLENT DEATH REPORTING SYSTEM.**

20 The Secretary of Health and Human Services, acting
21 through the Director of the Centers for Disease Control
22 and Prevention, shall improve, particularly through the in-
23 clusion of additional States, the National Violent Death
24 Reporting System, as authorized by sections 301(a) and
25 391(a) of the Public Service Health Act (42 U.S.C.

1 241(a), 280(b)). Participation in the system by the States
2 shall be voluntary.

3 **SEC. 1014. REPORT ON EFFECTS OF GUN VIOLENCE ON**
4 **PUBLIC HEALTH.**

5 Not later than one year after the date of the enact-
6 ment of this Act, and annually thereafter, the Surgeon
7 General shall submit to Congress a report on the effects
8 on public health, including mental health, of gun violence
9 in the United States during the preceding year, and the
10 status of actions taken to address such effects.

11 **SEC. 1015. REPORT ON EFFECTS OF GUN VIOLENCE ON**
12 **MENTAL HEALTH IN MINORITY COMMU-**
13 **NITIES.**

14 Not later than one year after the date of the enact-
15 ment of this Act, the Deputy Assistant Secretary for Mi-
16 nority Health in the Office of the Secretary of Health and
17 Human Services shall submit to the Congress a report on
18 the effects of gun violence on public health, including men-
19 tal health, in minority communities in the United States,
20 and the status of actions taken to address such effects.

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