

113TH CONGRESS
2D SESSION

H. R. 5294

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

IN THE HOUSE OF REPRESENTATIVES

JULY 30, 2014

Ms. ROYBAL-ALLARD (for herself, Ms. LEE of California, Mrs. CHRISTENSEN, Ms. BORDALLO, Ms. BROWN of Florida, Mr. BUTTERFIELD, Ms. CHU, Ms. CLARKE of New York, Mr. CÁRDENAS, Mr. CARSON of Indiana, Ms. CASTOR of Florida, Mr. CONYERS, Mr. CROWLEY, Mr. CUMMINGS, Mr. DANNY K. DAVIS of Illinois, Ms. DEGETTE, Ms. DELAURO, Ms. EDWARDS, Mr. ELLISON, Mr. FALEOMAVAEGA, Mr. FARR, Mr. FATTAH, Ms. FUDGE, Mr. GARCIA, Mr. GRIJALVA, Ms. MICHELLE LUJAN GRISHAM of New Mexico, Mr. GUTIÉRREZ, Ms. HAHN, Mr. HINOJOSA, Mr. HONDA, Ms. JACKSON LEE, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSON of Georgia, Mr. LEWIS, Ms. LOFGREN, Mrs. LOWEY, Mr. BEN RAY LUJÁN of New Mexico, Ms. MATSUI, Ms. MCCOLLUM, Mr. MCGOVERN, Mrs. NEGRETE MCLEOD, Mr. MEEKS, Ms. MENG, Mrs. NAPOLITANO, Ms. NORTON, Mr. PASTOR of Arizona, Mr. PIERLUISI, Mr. RANGEL, Mr. RICHMOND, Mr. RUSH, Mr. SABLAN, Ms. LINDA T. SÁNCHEZ of California, Ms. LORETTA SANCHEZ of California, Ms. SCHA-KOWSKY, Mr. SCHIFF, Mr. DAVID SCOTT of Georgia, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. SIRES, Ms. SLAUGHTER, Mr. TAKANO, Mr. TONKO, Mr. VARGAS, Mr. VELA, Ms. VELÁZQUEZ, and Ms. WATERS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Agriculture, Education and the Workforce, the Budget, Veterans' Affairs, Armed Services, the Judiciary, and Natural Resources, 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 2014”.

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. 101. Amendment to the Public Health Service Act.
- Sec. 102. Elimination of prerequisite of direct appropriations for data collection and analysis.
- Sec. 103. Collection of race and ethnicity data by the Social Security Administration.
- Sec. 104. Revision of HIPAA claims standards.
- Sec. 105. National Center for Health Statistics.
- Sec. 106. Oversampling of Asian-Americans, Native Hawaiians, or Pacific Islanders and other underrepresented groups in Federal health surveys.
- Sec. 107. Geo-access study.
- Sec. 108. Racial, ethnic, and primary language data collected by the Federal Government.
- Sec. 109. Data collection and analysis grants to minority-serving institutions.
- Sec. 110. Standards for measuring sexual orientation and gender identity in collection of health data.
- Sec. 111. Standards for measuring socioeconomic status in collection of health data.
- Sec. 112. Safety and effectiveness of drugs with respect to racial and ethnic background.
- Sec. 113. Improving health data regarding Native Hawaiians and other Pacific Islanders.
- Sec. 114. Clarification of simplified administrative reporting requirement.

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- Sec. 202. Amendment to the Public Health Service Act.
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- Sec. 205. Federal reimbursement for culturally and linguistically appropriate services under the Medicare, Medicaid, and State Children's Health Insurance Programs.
- Sec. 206. Increasing understanding of and improving health literacy.
- Sec. 207. Assurances for receiving Federal funds.
- Sec. 208. Report on Federal efforts to provide culturally and linguistically appropriate health care services.
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- Sec. 308. Rules for determination of full-time equivalent residents for cost-reporting periods.
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- Sec. 310. Loan forgiveness for mental and behavioral health social workers.
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- Sec. 403. Designation of health empowerment zones.
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- Sec. 711. Viral hepatitis and liver cancer control and prevention.

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- Sec. 721. Acquired bone marrow failure diseases.

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- Sec. 748. Minority AIDS initiative.
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- Sec. 756. National HIV/AIDS observance days.
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- Sec. 762. Support data system review and indicators for monitoring HIV care.
- Sec. 763. Transfer of funds for implementation of national HIV/AIDS strategy.
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- Sec. 800. Definitions.

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- Sec. 801. HRSA assistance to health centers for promotion of Health IT.
- Sec. 802. Assessment of impact of Health IT on racial and ethnic minority communities; outreach and adoption of Health IT in such communities.

Subtitle B—Modifications To Achieve Parity in Existing Programs

- Sec. 811. Extending funding to strengthen the Health IT infrastructure in racial and ethnic minority communities.
- Sec. 812. Prioritizing regional extension center assistance to racial and ethnic minority groups.
- Sec. 813. Extending competitive grants for the development of loan programs to facilitate adoption of certified EHR technology by providers serving racial and ethnic minority groups.
- Sec. 814. Authorization of appropriations.

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- Sec. 831. Data collection and assessments conducted in coordination with minority-serving institutions.
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- Sec. 841. Application of Medicare HITECH payments to hospitals in Puerto Rico.
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TITLE IX—ACCOUNTABILITY AND EVALUATION

- Sec. 901. Prohibition on discrimination in Federal assisted health care services and research programs on the basis of sex, race, color, national origin, marital status, familial status, sexual orientation, gender identity, or disability status.
- Sec. 902. Treatment of Medicare payments under title VI of the Civil Rights Act of 1964.

- Sec. 903. Accountability and transparency within the Department of Health and Human Services.
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- Sec. 1002. Findings.
- Sec. 1003. Health impact assessments.
- Sec. 1004. Implementation of recommendations by Environmental Protection Agency.
- Sec. 1005. Grant program to conduct environmental health improvement activities and to improve social determinants of health.
- Sec. 1006. Additional research on the relationship between the built environment and the health of community residents.
- Sec. 1007. Environment and public health restoration.
- Sec. 1008. GAO report on health effects of Deepwater Horizon oil rig explosion in the Gulf Coast.

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,

1 gender identity, socioeconomic status, or disability
2 status—that directly and indirectly affect the health,
3 health care, and wellness of individuals and commu-
4 nities.

5 (3) By 2020, the Nation will face a shortage of
6 health care providers and allied health workers and
7 this shortage disproportionately affects health pro-
8 fessional shortage areas where many racial and eth-
9 nic minority populations reside.

10 (4) All efforts to reduce health disparities and
11 barriers to quality health services require better and
12 more consistent data.

13 (5) A full range of culturally and linguistically
14 appropriate health care and public health services
15 must be available and accessible in every community.

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

19 (7) Efforts to improve minority health have
20 been limited by inadequate resources in funding,
21 staffing, stewardship, and accountability. Targeted
22 investments that are focused on disparities elimi-
23 nation must be made in providing care and services
24 that are community-based, including prevention and
25 policies addressing social determinants of health.

1 (8) In 2011, the Department of Health and
2 Human Services developed the HHS Action Plan to
3 Reduce Racial and Ethnic Health Disparities and
4 the National Stakeholder Strategy for Achieving
5 Health Equity, two strategic plans that represent
6 the country's first coordinated roadmap to reducing
7 health disparities. Along with the National Preven-
8 tion Strategy, Healthy People 2020, and the Na-
9 tional Health Care Quality Strategy, as well as crit-
10 ical resources such as the 2012 National Healthcare
11 Quality and Disparities Reports, these comprehen-
12 sive plans will work to increase the number of Amer-
13 icans who are healthy at every stage of life.

14 (9) The Department of Health and Human
15 Services also developed other strategic planning doc-
16 uments to combat disease disparities with a high im-
17 pact on minority populations including the National
18 HIV/AIDS Strategy, and the Action Plan for the
19 Prevention, Care and Treatment of Viral Hepatitis.

20 (10) The Patient Protection and Affordable
21 Care Act, as amended by the Health Care and Edu-
22 cation Reconciliation Act, represents the biggest ad-
23 vancement for minority health in the last 40 years.

1 **TITLE I—DATA COLLECTION**
2 **AND REPORTING**

3 **SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
4 **ACT.**

5 (a) **PURPOSE.**—It is the purpose of this section to
6 promote data collection, analysis, and reporting by race,
7 ethnicity, sex, primary language, sexual orientation, dis-
8 ability status, gender identity, and socioeconomic status
9 among federally supported health programs.

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

14 **“Subtitle B—Strengthening Data**
15 **Collection, Improving Data**
16 **Analysis, and Expanding Data**
17 **Reporting**

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

19 “(a) **REQUIREMENTS.**—

20 “(1) **IN GENERAL.**—Each health-related pro-
21 gram operated by or that receives funding or reim-
22 bursement, in whole or in part, either directly or in-
23 directly from the Department of Health and Human
24 Services shall—

1 “(A) require the collection, by the agency
2 or program involved, of data on the race, eth-
3 nicity, sex, primary language, sexual orienta-
4 tion, disability status, gender identity, and so-
5 cioeconomic status of each applicant for and re-
6 cipient of health-related assistance under such
7 program—

8 “(i) using, at a minimum, the stand-
9 ards for data collection on race, ethnicity,
10 sex, primary language, sexual orientation,
11 disability status, gender identity, and so-
12 cioeconomic status developed under section
13 3101;

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

19 “(iii) additionally referring, where
20 practicable, to the standards developed by
21 the Institute of Medicine in ‘Race, Eth-
22 nicity, and Language Data: Standardiza-
23 tion for Health Care Quality Improve-
24 ment’; and

1 “(iv) where practicable, through self-
2 reporting;

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

9 “(i) such data be collected from the
10 parent or legal guardian of such an appli-
11 cant or recipient; and

12 “(ii) the primary language of the par-
13 ent or legal guardian of such an applicant
14 or recipient be collected;

15 “(C) systematically analyze such data
16 using the smallest appropriate units of analysis
17 feasible to detect racial and ethnic disparities,
18 as well as disparities along the lines of primary
19 language, sex, disability status, sexual orienta-
20 tion, gender identity, and socioeconomic status
21 in health and health care, and report the results
22 of such analysis to the Secretary, the Director
23 of the Office for Civil Rights, each agency listed
24 in section 3101(c)(1), the Committee on
25 Health, Education, Labor, and Pensions and

1 the Committee on Finance of the Senate, and
2 the Committee on Energy and Commerce and
3 the Committee on Ways and Means of the
4 House of Representatives;

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

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

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

16 “(A) permit the use of information col-
17 lected under this subsection in a manner that
18 would adversely affect any individual providing
19 any such information; or

20 “(B) diminish existing or future require-
21 ments on health care providers to collect data.

22 “(3) NO COMPELLED DISCLOSURE OF DATA.—
23 This title does not authorize any health care pro-
24 vider, Federal official, or other entity to compel the
25 disclosure of any data collected under this title. The

1 disclosure of any such data by an individual pursu-
2 ant to this title shall be strictly voluntary.

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

7 “(1) under the same privacy protections as the
8 Secretary applies to other health data under the reg-
9 ulations promulgated under section 264(c) of the
10 Health Insurance Portability and Accountability Act
11 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
12 lating to the privacy of individually identifiable
13 health information and other protections; and

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

20 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
21 Secretary shall develop and implement a national plan to
22 ensure the collection of data in a culturally appropriate
23 and competent manner, to improve the collection, analysis,
24 and reporting of racial, ethnic, sex, primary language, sex-
25 ual orientation, disability status, gender identity, and so-

1 cioeconomic status data at the Federal, State, territorial,
2 tribal, and local levels, including data to be collected under
3 subsection (a), and to ensure that data collection activities
4 carried out under this section are in compliance with the
5 standards developed under section 3101. The Data Coun-
6 cil of the Department of Health and Human Services, in
7 consultation with the National Committee on Vital Health
8 Statistics, the Office of Minority Health, Office on Wom-
9 en’s Health, and other appropriate public and private enti-
10 ties, shall make recommendations to the Secretary con-
11 cerning the development, implementation, and revision of
12 the national plan. Such plan shall include recommenda-
13 tions on how to—

14 “(1) implement subsection (a) while minimizing
15 the cost and administrative burdens of data collec-
16 tion and reporting;

17 “(2) expand awareness among Federal agencies,
18 States, territories, Indian tribes, health providers,
19 health plans, health insurance issuers, and the gen-
20 eral public that data collection, analysis, and report-
21 ing by race, ethnicity, primary language, sexual ori-
22 entation, disability status, gender identity, and socio-
23 economic status is legal and necessary to assure eq-
24 uity and nondiscrimination in the quality of health
25 care services;

1 “(3) ensure that future patient record systems
2 have data code sets for racial, ethnic, primary lan-
3 guage, sexual orientation, disability status, gender
4 identity, and socioeconomic status identifiers and
5 that such identifiers can be retrieved from clinical
6 records, including records transmitted electronically;

7 “(4) improve health and health care data collec-
8 tion and analysis for more population groups if such
9 groups can be aggregated into the minimum race
10 and ethnicity categories, including exploring the fea-
11 sibility of enhancing collection efforts in States for
12 racial and ethnic groups that comprise a significant
13 proportion of the population of the State;

14 “(5) provide researchers with greater access to
15 racial, ethnic, primary language, sexual orientation,
16 disability status, gender identity, and socioeconomic
17 status data, subject to privacy and confidentiality
18 regulations; and

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

21 “(d) COMPLIANCE WITH STANDARDS.—Data col-
22 lected under subsection (a) shall be obtained, maintained,
23 and presented (including for reporting purposes) in ac-
24 cordance with the standards developed under section
25 3101.

1 “(e) TECHNICAL ASSISTANCE FOR THE COLLECTION
2 AND REPORTING OF DATA.—

3 “(1) IN GENERAL.—The Secretary may, either
4 directly or through grant or contract, provide tech-
5 nical assistance to enable a health care program or
6 an entity operating under such program to comply
7 with the requirements of this section.

8 “(2) TYPES OF ASSISTANCE.—Assistance pro-
9 vided under this subsection may include assistance
10 to—

11 “(A) enhance or upgrade computer tech-
12 nology that will facilitate racial, ethnic, primary
13 language, sexual orientation, disability status,
14 gender identity, and socioeconomic status data
15 collection and analysis;

16 “(B) improve methods for health data col-
17 lection and analysis, including additional popu-
18 lation groups if such groups can be aggregated
19 into the race and ethnicity categories outlined
20 by the standards developed under section 3101;

21 “(C) develop mechanisms for submitting
22 collected data subject to existing privacy and
23 confidentiality regulations; and

24 “(D) develop educational programs to in-
25 form health insurance issuers, health plans,

1 health providers, health-related agencies, and
2 the general public that data collection and re-
3 porting by race, ethnicity, primary language,
4 sexual orientation, disability status, gender
5 identity, and socioeconomic status are legal and
6 essential for eliminating health and health care
7 disparities.

8 “(f) ANALYSIS OF HEALTH DISPARITY DATA.—The
9 Secretary, acting through the Director of the Agency for
10 Healthcare Research and Quality and in coordination with
11 the Administrator of the Centers for Medicare & Medicaid
12 Services, shall provide technical assistance to agencies of
13 the Department of Health and Human Services in meeting
14 Federal standards for health disparity data collection and
15 for analysis of racial and ethnic disparities in health and
16 health care in public programs by—

17 “(1) identifying appropriate quality assurance
18 mechanisms to monitor for health disparities;

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

21 “(3) developing new quality measures relating
22 to racial and ethnic disparities and their overlap
23 with other disparity factors in health and health
24 care;

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

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

5 “(g) PRIMARY LANGUAGE.—References in this sec-
6 tion—

7 “(1) to primary language data, include spoken
8 and written primary language data; and

9 “(2) to primary language data collection activi-
10 ties, include identifying, collecting, storing, tracking,
11 and analyzing primary language data and informa-
12 tion on the methods used to meet the language ac-
13 cess needs of limited-English-proficient individuals.

14 “(h) DEFINITION.—In this section, the term ‘health-
15 related program’ mean a program—

16 “(1) under the Social Security Act (42 U.S.C.
17 301 et seq.) that pays for health care and services;
18 and

19 “(2) under this Act that provides Federal finan-
20 cial assistance for health care, biomedical research,
21 or health services research and or is designed to im-
22 prove the public’s health.

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

1 such sums as may be necessary for each of fiscal years
2 2015 through 2020.

3 **“SEC. 3432. PROVISIONS RELATING TO NATIVE AMERICANS.**

4 “(a) ESTABLISHMENT OF EPIDEMIOLOGY CEN-
5 TERS.—The Secretary shall establish an epidemiology cen-
6 ter in each service area to carry out the functions de-
7 scribed in subsection (b). Any new center established after
8 the date of the enactment of the Health Equity and Ac-
9 countability Act of 2014 may be operated under a grant
10 authorized by subsection (d), but funding under such a
11 grant shall not be divisible.

12 “(b) FUNCTIONS OF CENTERS.—In consultation with
13 and upon the request of Indian tribes, tribal organizations,
14 and urban Indian organizations, each service area epide-
15 miology center established under this subsection shall,
16 with respect to such service area—

17 “(1) collect data relating to, and monitor
18 progress made toward meeting, each of the health
19 status objectives of the service, the Indian tribes,
20 tribal organizations, and urban Indian organizations
21 in the service area;

22 “(2) evaluate existing delivery systems, data
23 systems, and other systems that impact the improve-
24 ment of Indian health;

1 “(3) assist Indian tribes, tribal organizations,
2 and urban Indian organizations in identifying their
3 highest priority health status objectives and the
4 services needed to achieve such objectives, based on
5 epidemiological data;

6 “(4) make recommendations for the targeting
7 of services needed by the populations served;

8 “(5) make recommendations to improve health
9 care delivery systems for Indians and urban Indians;

10 “(6) provide requested technical assistance to
11 Indian tribes, tribal organizations, and urban Indian
12 organizations in the development of local health
13 service priorities and incidence and prevalence rates
14 of disease and other illness in the community; and

15 “(7) provide disease surveillance and assist In-
16 dian tribes, tribal organizations, and urban Indian
17 organizations to promote public health.

18 “(c) TECHNICAL ASSISTANCE.—The Director of the
19 Centers for Disease Control and Prevention shall provide
20 technical assistance to the centers in carrying out the re-
21 quirements of this subsection.

22 “(d) GRANTS FOR STUDIES.—

23 “(1) IN GENERAL.—The Secretary may make
24 grants to Indian tribes, tribal organizations, urban
25 Indian organizations, and eligible intertribal con-

1 sortia to conduct epidemiological studies of Indian
2 communities.

3 “(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An
4 intertribal consortium is eligible to receive a grant
5 under this subsection if—

6 “(A) the intertribal consortium is incor-
7 porated for the primary purpose of improving
8 Indian health; and

9 “(B) the intertribal consortium is rep-
10 resentative of the Indian tribes or urban Indian
11 communities in which the intertribal consortium
12 is located.

13 “(3) APPLICATIONS.—An application for a
14 grant under this subsection shall be submitted in
15 such manner and at such time as the Secretary shall
16 prescribe.

17 “(4) REQUIREMENTS.—An applicant for a
18 grant under this subsection shall—

19 “(A) demonstrate the technical, adminis-
20 trative, and financial expertise necessary to
21 carry out the functions described in paragraph
22 (5);

23 “(B) consult and cooperate with providers
24 of related health and social services in order to
25 avoid duplication of existing services; and

1 “(C) demonstrate cooperation from Indian
2 tribes or urban Indian organizations in the area
3 to be served.

4 “(5) USE OF FUNDS.—A grant awarded under
5 paragraph (1) may be used—

6 “(A) to carry out the functions described
7 in subsection (b);

8 “(B) to provide information to and consult
9 with tribal leaders, urban Indian community
10 leaders, and related health staff on health care
11 and health service management issues; and

12 “(C) in collaboration with Indian tribes,
13 tribal organizations, and urban Indian commu-
14 nities, to provide the service with information
15 regarding ways to improve the health status of
16 Indians.

17 “(e) ACCESS TO INFORMATION.—An epidemiology
18 center operated by a grantee pursuant to a grant awarded
19 under subsection (d) shall be treated as a public health
20 authority for purposes of the Health Insurance Portability
21 and Accountability Act of 1996 (Public Law 104–191; 110
22 Stat. 2033), as such entities are defined in part 164.501
23 of title 45, Code of Federal Regulations (or a successor
24 regulation). The Secretary shall grant such grantees ac-
25 cess to and use of data, data sets, monitoring systems,

1 delivery systems, and other protected health information
2 in the possession of the Secretary.”.

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

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

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

9 (2) by redesignating subsection (i) as subsection
10 (h).

11 **SEC. 103. COLLECTION OF RACE AND ETHNICITY DATA BY**
12 **THE SOCIAL SECURITY ADMINISTRATION.**

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

16 **“SEC. 1150C. COLLECTION OF RACE AND ETHNICITY DATA**
17 **BY THE SOCIAL SECURITY ADMINISTRATION.**

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

21 “(1) require the collection of data on the race,
22 ethnicity, primary language, and disability status of
23 all applicants for Social Security account numbers or
24 benefits under title II or part A of title XVIII and
25 all individuals with respect to whom the Commis-

1 sioner maintains records of wages and self-employ-
2 ment income in accordance with reports received by
3 the Commissioner or the Secretary of the Treas-
4 ury—

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

9 “(B) where practicable, collecting data for
10 additional population groups if such groups can
11 be aggregated into the race and ethnicity cat-
12 egories outlined by the standards developed
13 under section 3101 of the Public Health Service
14 Act; and

15 “(C) additionally referring, where prac-
16 ticable, to the standards developed by the Insti-
17 tute of Medicine in ‘Race, Ethnicity, and Lan-
18 guage Data: Standardization for Health Care
19 Quality Improvement’ (released August 31,
20 2009);

21 “(2) with respect to the collection of the data
22 described in paragraph (1) for applicants who are
23 under 18 years of age or otherwise legally incapaci-
24 tated, require that—

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

3 “(B) the primary language of the parent
4 or legal guardian of such an applicant or recipi-
5 ent be used;

6 “(3) require that such data be uniformly ana-
7 lyzed and reported at least annually to the Commis-
8 sioner of Social Security;

9 “(4) be responsible for storing the data re-
10 ported under paragraph (3);

11 “(5) ensure transmission to the Centers for
12 Medicare & Medicaid Services and other Federal
13 health agencies;

14 “(6) provide such data to the Secretary on at
15 least an annual basis; and

16 “(7) ensure that the provision of assistance to
17 an applicant is not denied or otherwise adversely af-
18 fected because of the failure of the applicant to pro-
19 vide race, ethnicity, primary language, and disability
20 status data.

21 “(b) PROTECTION OF DATA.—The Commissioner of
22 Social Security shall ensure (through the promulgation of
23 regulations or otherwise) that all data collected pursuant
24 to subsection (a) are protected—

1 “(1) under the same privacy protections as the
2 Secretary applies to health data under the regula-
3 tions promulgated under section 264(c) of the
4 Health Insurance Portability and Accountability Act
5 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
6 lating to the privacy of individually identifiable
7 health information and other protections; and

8 “(2) from all inappropriate internal use by any
9 entity that collects, stores, or receives the data, in-
10 cluding use of such data in determinations of eligi-
11 bility (or continued eligibility) in health plans, and
12 from other inappropriate uses, as defined by the
13 Secretary.

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

19 “(d) TECHNICAL ASSISTANCE.—The Secretary may,
20 either directly or by grant or contract, provide technical
21 assistance to enable any health entity to comply with the
22 requirements of this section.

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

1 such sums as may be necessary for each of fiscal years
2 2015 through 2020.”.

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

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

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

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

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

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

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 “2020”;

11 (2) in paragraph (2), in the first sentence, by
12 striking “2003” and inserting “2020”; and

13 (3) in paragraph (3), by striking “2002” and
14 inserting “2020”.

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

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

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

5 “(a) NATIONAL STRATEGY.—

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

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

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

1 Native Hawaiians, or Pacific Islanders, and
2 other underrepresented populations; and

3 “(B) may solicit the participation of rep-
4 resentatives from other Federal departments
5 and agencies.

6 “(b) PROGRESS REPORT.—Not later than 2 years
7 after the date of the enactment of this section, the Sec-
8 retary shall submit to the Congress a progress report,
9 which shall include the national strategy described in sub-
10 section (a)(1).

11 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
12 carry out this section, there are authorized to be appro-
13 priated such sums as may be necessary for fiscal years
14 2015 through 2020.”.

15 **SEC. 107. GEO-ACCESS STUDY.**

16 The Administrator of the Substance Abuse and Men-
17 tal Health Services Administration shall—

18 (1) conduct a study to—

19 (A) determine which geographic areas of
20 the United States have shortages of specialty
21 mental health providers; and

22 (B) assess the preparedness of speciality
23 mental health providers to deliver culturally and
24 linguistically appropriate, affordable, and acces-
25 sible services; and

1 (2) submit a report to the Congress on the re-
2 sults of such study.

3 **SEC. 108. RACIAL, ETHNIC, AND PRIMARY LANGUAGE DATA**
4 **COLLECTED BY THE FEDERAL GOVERNMENT.**

5 (a) COLLECTION; SUBMISSION.—Not later than 90
6 days after the date of the enactment of this Act, and Jan-
7 uary 31 of each year thereafter, each department, agency,
8 and office of the Federal Government that has collected
9 racial, ethnic, or primary language data during the pre-
10 ceding calendar year shall submit such data to the Sec-
11 retary of Health and Human Services.

12 (b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
13 Not later than April 30, 2015, and each April 30 there-
14 after, the Secretary of Health and Human Services, acting
15 through the Director of the National Institute on Minority
16 Health and Health Disparities and the Deputy Assistant
17 Secretary for Minority Health, shall—

18 (1) collect and analyze the racial, ethnic, and
19 primary language data submitted under subsection
20 (a) for the preceding calendar year;

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

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

1 **SEC. 109. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**
 2 **NORITY-SERVING INSTITUTIONS.**

3 (a) **AUTHORITY.**—The Secretary of Health and
 4 Human Services, acting through the National Institute on
 5 Minority Health and Health Disparities and the Office of
 6 Minority Health, may award grants to access and analyze
 7 racial and ethnic, and where possible other health dis-
 8 parity data, to monitor and report on progress to reduce
 9 and eliminate disparities in health and health care.

10 (b) **ELIGIBLE ENTITY.**—In this section, the term “el-
 11 igible entity” means a historically Black college or univer-
 12 sity, an Hispanic-serving institution, a tribal college or
 13 university, or an Asian-American, Native American, or Pa-
 14 cific Islander-serving institution with an accredited public
 15 health, health policy, or health services research program.

16 **SEC. 110. STANDARDS FOR MEASURING SEXUAL ORIENTA-**
 17 **TION AND GENDER IDENTITY IN COLLECTION**
 18 **OF HEALTH DATA.**

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

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

24 (2) in paragraph (1)(C), by inserting “sexual
 25 orientation, gender identity,” before “and disability
 26 status”; and

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

4 **SEC. 111. STANDARDS FOR MEASURING SOCIOECONOMIC**
5 **STATUS IN COLLECTION OF HEALTH DATA.**

6 Section 3101(a) of the Public Health Service Act (42
7 U.S.C. 300kk(a)), as amended, is amended—

8 (1) in paragraph (1)(A), by inserting “socio-
9 economic status,” before “and disability status”;

10 (2) in paragraph (1)(C), by inserting “socio-
11 economic status,” before “and disability status”; and

12 (3) in paragraph (2)(B), by inserting “socio-
13 economic status,” before “and disability status”.

14 **SEC. 112. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
15 **RESPECT TO RACIAL AND ETHNIC BACK-**
16 **GROUND.**

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

20 **“SEC. 505F. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
21 **RESPECT TO RACIAL AND ETHNIC BACK-**
22 **GROUND.**

23 “(a) PREAPPROVAL STUDIES.—If there is evidence
24 that there may be a disparity on the basis of racial or

1 ethnic background as to the safety or effectiveness of a
2 drug, then—

3 “(1)(A) the investigations required under sec-
4 tion 505(b)(1)(A) shall include adequate and well-
5 controlled investigations of the disparity; or

6 “(B) the evidence required under section 351(a)
7 of the Public Health Service Act for approval of a
8 biologics license application for the drug shall in-
9 clude adequate and well-controlled investigations of
10 the disparity; and

11 “(2) if the investigations confirm that there is
12 a disparity, the labeling of the drug shall include ap-
13 propriate information about the disparity.

14 “(b) POSTMARKET STUDIES.—

15 “(1) IN GENERAL.—If there is evidence that
16 there may be a disparity on the basis of racial or
17 ethnic background as to the safety or effectiveness
18 of a drug for which there is an approved application
19 under section 505 or a license under section 351 of
20 the Public Health Service Act, the Secretary may by
21 order require the holder of the approved application
22 or license to conduct, by a date specified by the Sec-
23 retary, postmarketing studies to investigate the dis-
24 parity.

1 “(2) LABELING.—If the Secretary determines
2 that the postmarket studies confirm that there is a
3 disparity described in paragraph (1), the labeling of
4 the drug shall include appropriate information about
5 the disparity.

6 “(3) STUDY DESIGN.—The Secretary may
7 specify all aspects of study design, including the
8 number of studies and study participants, and the
9 other demographic characteristics of study partici-
10 pants included, in the order requiring postmarket
11 studies of the drug.

12 “(4) MODIFICATIONS OF STUDY DESIGN.—The
13 Secretary may by order modify any aspect of the
14 study design as necessary after issuing an order
15 under paragraph (1).

16 “(5) STUDY RESULTS.—The results from stud-
17 ies required under paragraph (1) shall be submitted
18 to the Secretary as supplements to the drug applica-
19 tion or biological license application.

20 “(c) DISPARITY.—The term ‘evidence that there may
21 be a disparity on the basis of racial or ethnic background
22 for adult and pediatric populations as to the safety or ef-
23 fectiveness of a drug’ includes—

24 “(1) evidence that there is a disparity on the
25 basis of racial or ethnic background as to safety or

1 effectiveness of a drug in the same chemical class as
2 the drug;

3 “(2) evidence that there is a disparity on the
4 basis of racial or ethnic background in the way the
5 drug is metabolized; and

6 “(3) other evidence as the Secretary may deter-
7 mine.

8 “(d) APPLICATIONS UNDER SECTIONS 505(b)(2)
9 AND 505(j).—

10 “(1) IN GENERAL.—A drug for which an appli-
11 cation has been submitted or approved under section
12 505(j) shall not be considered ineligible for approval
13 under that section or misbranded under section 502
14 on the basis that the labeling of the drug omits in-
15 formation relating to a disparity on the basis of ra-
16 cial or ethnic background as to the safety or effec-
17 tiveness of the drug, whether derived from investiga-
18 tions or studies required under this section or de-
19 rived from other sources, when the omitted informa-
20 tion is protected by patent or by exclusivity under
21 clause (iii) or (iv) of section 505(j)(5)(B).

22 “(2) LABELING.—Notwithstanding clauses (iii)
23 and (iv) of section 505(j)(5)(B), the Secretary may
24 require that the labeling of a drug approved under
25 section 505(j) that omits information relating to a

1 disparity on the basis of racial or ethnic background
 2 as to the safety or effectiveness of the drug include
 3 a statement of any appropriate contraindications,
 4 warnings, or precautions related to the disparity
 5 that the Secretary considers necessary.”.

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

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

14 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
 15 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h)
 16 is amended by adding after “are required” the following:
 17 “, including supplements required under section 505F”.

18 **SEC. 113. IMPROVING HEALTH DATA REGARDING NATIVE**

19 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

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

23 **“SEC. 317V. NATIVE HAWAIIAN AND OTHER PACIFIC IS-**

24 **LANDER HEALTH DATA.**

25 “(a) DEFINITIONS.—In this section:

1 “(1) COMMUNITY GROUP.—The term ‘commu-
2 nity group’ means a group of NHOPI who are orga-
3 nized at the community level, and may include a
4 church group, social service group, national advocacy
5 organization, or cultural group.

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

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

16 “(4) GOVERNMENT REPRESENTATIVES.—The
17 term ‘government representatives’ means representa-
18 tives from Hawaii, American Samoa, the Common-
19 wealth of the Northern Mariana Islands, the Fed-
20 erated States of Micronesia, Guam, the Republic of
21 Palau, and the Republic of the Marshall Islands.

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 2014, 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 2014.

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 2014, the Secretary shall submit to
23 Congress a progress report, which shall include the na-
24 tional strategy described in subsection (b)(1).

25 “(e) STUDY AND REPORT BY THE IOM.—

1 “(1) IN GENERAL.—The Secretary shall enter
2 into an agreement with the Institute of Medicine to
3 conduct a study, with input from stakeholders in in-
4 sular areas, on the following:

5 “(A) The standards and definitions of
6 health care applied to health care systems in in-
7 sular areas and the appropriateness of such
8 standards and definitions.

9 “(B) The status and performance of health
10 care systems in insular areas, evaluated based
11 upon standards and definitions, as the Sec-
12 retary determines.

13 “(C) The effectiveness of donor aid in ad-
14 dressing health care needs and priorities in in-
15 sular areas.

16 “(D) The progress toward implementation
17 of recommendations of the Committee on
18 Health Care Services in the United States—As-
19 sociated Pacific Basin of the Institute of Medi-
20 cine that are set forth in the 1998 report, ‘Pa-
21 cific Partnerships for Health: Charting a New
22 Course for the 21st Century’.

23 “(2) REPORT.—An agreement described in
24 paragraph (1) shall require the Institute of Medicine
25 to submit to the Secretary and to Congress, not

1 later than 2 years after the date of the enactment
2 of the Health Equity and Accountability Act of
3 2014, a report containing a description of the results
4 of the study conducted under paragraph (1), includ-
5 ing the conclusions and recommendations of the In-
6 stitute of Medicine for each of the items described
7 in subparagraphs (A) through (D) of such para-
8 graph.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
10 carry out this section, there are authorized to be appro-
11 priated such sums as may be necessary for fiscal years
12 2015 through 2020.”.

13 **SEC. 114. CLARIFICATION OF SIMPLIFIED ADMINISTRATIVE**
14 **REPORTING REQUIREMENT.**

15 Section 11(a) of the Food and Nutrition Act of 2008
16 (7 U.S.C. 2020(a)) is amended by adding at the end the
17 following:

18 “(5) SIMPLIFIED ADMINISTRATIVE REPORTING
19 REQUIREMENT.—The administrative notification re-
20 quirement under section 421(e)(2) of the Personal
21 Responsibility and Work Opportunity Reconciliation
22 Act of 1996 (8 U.S.C. 1631(e)(2)) shall be satisfied
23 by the submission by an agency of a report on the
24 aggregate number of exceptions granted under such
25 section by such agency in each year.”.

1 **TITLE II—CULTURALLY AND LIN-**
2 **GUISTICALLY APPROPRIATE**
3 **HEALTH CARE**

4 **SEC. 201. DEFINITIONS.**

5 In this title, the definitions contained in section 3400
6 of the Public Health Service Act, as added by section 202,
7 shall apply.

8 **SEC. 202. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
9 **ACT.**

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

11 (1) Effective communication is essential to
12 meaningful access to quality physical and mental
13 health care.

14 (2) Research indicates that the lack of appro-
15 priate language services creates language barriers
16 that result in increased risk of misdiagnosis, ineffec-
17 tive treatment plans and poor health outcomes for
18 limited-English-proficient individuals and individuals
19 with communication disabilities such as hearing, vi-
20 sion, or print impairments.

21 (3) The number of limited-English-speaking
22 residents in the United States who speak English
23 less than very well and, therefore, cannot effectively
24 communicate with health and social service providers
25 continues to increase significantly.

1 (4) The responsibility to fund language services
2 in the provision of health care and health-care-re-
3 lated services to limited-English-proficient individ-
4 uals and individuals with communication disabilities
5 such as hearing, vision, or print impairments is a so-
6 cietal one that cannot fairly be visited solely upon
7 the health care, public health, or social services com-
8 munity.

9 (5) Title VI of the Civil Rights Act of 1964
10 prohibits discrimination based on the grounds of
11 race, color, or national origin by any entity receiving
12 Federal financial assistance. In order to avoid dis-
13 crimination on the grounds of national origin, all
14 programs or activities administered by the Depart-
15 ment must take adequate steps to ensure that their
16 policies and procedures do not deny or have the ef-
17 fect of denying limited-English-proficient individuals
18 with equal access to benefits and services for which
19 such persons qualify.

20 (6) Linguistic diversity in the health care and
21 health-care-related-services workforce is important
22 for providing all patients the environment most con-
23 ducive to positive health outcomes.

24 (7) All members of the health care and health-
25 care-related-services community should continue to

1 educate their staff and constituents about limited-
 2 English-proficient and disability communication
 3 issues and help them identify resources to improve
 4 access to quality care for limited-English-proficient
 5 individuals and individuals with communication dis-
 6 abilities such as hearing, vision, or print impair-
 7 ments.

8 (8) Access to English as a second language and
 9 sign language instructions is an important mecha-
 10 nism for ensuring effective communication and elimi-
 11 nating the language barriers that impede access to
 12 health care.

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

15 (b) AMENDMENT.—The Public Health Service Act
 16 (42 U.S.C. 201 et seq.) is amended by adding at the end
 17 the following:

18 **“TITLE XXXIV—CULTURALLY**
 19 **AND LINGUISTICALLY APPRO-**
 20 **PRIATE HEALTH CARE**

21 **“SEC. 3400. DEFINITIONS.**

22 “In this title:

23 “(1) BILINGUAL.—The term ‘bilingual’ with re-
 24 spect to an individual means a person who has suffi-
 25 cient degree of proficiency in two languages.

1 “(2) COMMUNITY HEALTH WORKER.—The term
2 ‘community health worker’ includes a community
3 health advocate, a lay health educator, a community
4 health representative, a peer health promoter, a
5 community health outreach worker, and in Spanish,
6 promotores de salud.

7 “(3) COMPETENT INTERPRETER SERVICES.—
8 The term ‘competent interpreter services’ means a
9 translanguage rendition of a spoken or signed mes-
10 sage in which the interpreter—

11 “(A) comprehends the source language and
12 can communicate comprehensively in the target
13 language to convey the meaning intended in the
14 source language; and

15 “(B) knows health and health-related ter-
16 minology and provides accurate interpretations
17 by choosing equivalent expressions that convey
18 the best matching and meaning to the source
19 language and capture, to the greatest possible
20 extent, all nuances intended in the source mes-
21 sage.

22 “(4) COMPETENT TRANSLATION SERVICES.—
23 The term ‘competent translation services’ means a
24 translanguage rendition of a written document in
25 which the translator—

1 “(A) comprehends the source language and
2 can write or sign comprehensively in the target
3 language to convey the meaning intended in the
4 source language; and

5 “(B) knows health and health-related ter-
6 minology and provides accurate translations by
7 choosing equivalent expressions that convey the
8 best matching and meaning to the source lan-
9 guage and capture, to the greatest possible ex-
10 tent, all nuances intended in the source docu-
11 ment.

12 “(5) CULTURAL COMPETENCE.—The term ‘cul-
13 tural competence’ means a set of congruent behav-
14 iors, attitudes, and policies that come together in a
15 system, agency, or among professionals that enables
16 effective work in cross-cultural situations. In the
17 preceding sentence—

18 “(A) the term ‘cultural’ refers to inte-
19 grated patterns of human behavior that include
20 the language, thoughts, communications, ac-
21 tions, customs, beliefs, values, and institutions
22 of racial, ethnic, religious, or social groups, in-
23 cluding lesbian, gay, bisexual, transgender, and
24 intersex individuals, and individuals with phys-
25 ical and mental disabilities; and

1 “(B) the term ‘competence’ implies having
2 the capacity to function effectively as an indi-
3 vidual and an organization within the context of
4 the cultural beliefs, behaviors, and needs pre-
5 sented by consumers and their communities.

6 “(6) EFFECTIVE COMMUNICATION.—The term
7 ‘effective communication’ means an exchange of in-
8 formation between the provider of health care or
9 health-care-related services and the recipient of such
10 services who is limited in English proficiency, or has
11 a communication impairment such as a hearing, vi-
12 sion, or learning impairment, that enables access,
13 understanding, and benefit from health care or
14 health-care-related services, and full participation in
15 the development of their treatment plan.

16 “(7) GRIEVANCE RESOLUTION PROCESS.—The
17 term ‘grievance resolution process’ means all aspects
18 of dispute resolution including filing complaints,
19 grievance and appeal procedures, and court action.

20 “(8) HEALTH CARE GROUP.—The term ‘health
21 care group’ means a group of physicians organized,
22 at least in part, for the purposes of providing physi-
23 cians’ services under the Medicaid, SCHIP, or Medi-
24 care programs and may include a hospital and any
25 other individual or entity furnishing services covered

1 under the Medicaid, SCHIP, or Medicare programs
2 that is affiliated with the health care group.

3 “(9) HEALTHCARE SERVICES.—The term
4 ‘health care services’ means services that address
5 physical as well as mental health conditions in all
6 care settings.

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

11 “(11) INDIAN TRIBE.—The term ‘Indian tribe’
12 means any Indian tribe, band, nation, or other orga-
13 nized group or community, including any Alaska Na-
14 tive village or group or regional or village corpora-
15 tion as defined in or established pursuant to the
16 Alaska Native Claims Settlement Act (85 Stat. 688)
17 (43 U.S.C. 1601 et seq.), which is recognized as eli-
18 gible for the special programs and services provided
19 by the United States to Indians because of their sta-
20 tus as Indians.

21 “(12) INTEGRATED HEALTH CARE DELIVERY
22 SYSTEM.—The term ‘integrated health care delivery
23 system’ means an interdisciplinary system that
24 brings together providers from the primary health,
25 mental health, substance use and related disciplines

1 to improve the health outcomes of an individual.
2 Providers may include but are not limited to hos-
3 pitals, health, mental health or substance use clinics
4 and providers, home health agencies, ambulatory
5 surgery centers, skilled nursing facilities, rehabilita-
6 tion centers, and employed, independent, or con-
7 tracted physicians.

8 “(13) INTERPRETING/INTERPRETATION.—The
9 terms ‘interpreting’ and ‘interpretation’ mean the
10 transmission of a spoken, written, or signed message
11 from one language or format into another, faithfully,
12 accurately, and objectively.

13 “(14) LANGUAGE ACCESS.—The term ‘language
14 access’ means the provision of language services to
15 an LEP individual or individual with communication
16 disabilities designed to enhance that individual’s ac-
17 cess to, understanding of, or benefit from health
18 care or health-care-related services.

19 “(15) LANGUAGE OR LANGUAGE ACCESS SERV-
20 ICES.—The term ‘language or language access serv-
21 ices’ means provision of health care services directly
22 in a non-English language, interpretation, trans-
23 lation, signage, video recording, and English or non-
24 English alternative formats.

1 “(16) LEP.—The term ‘LEP’ means limited-
2 English-proficient.

3 “(17) MEDICARE, MEDICAID, AND SCHIP.—The
4 terms ‘Medicare’, ‘Medicaid’, and ‘SCHIP’ mean the
5 respective programs under titles XVIII, XIX, and
6 XXI of the Social Security Act.

7 “(18) MINORITY.—

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

11 “(B) POPULATIONS.—The term ‘minority’,
12 with respect to populations, refers to racial and
13 ethnic minority groups.

14 “(19) MINORITY GROUP.—The term ‘minority
15 group’ has the meaning given the term ‘racial and
16 ethnic minority group’.

17 “(20) RACIAL AND ETHNIC MINORITY GROUP.—
18 The term ‘racial and ethnic minority group’ means
19 American Indians and Alaska Natives, African-
20 Americans (including Caribbean Blacks, Africans,
21 and other Blacks), Asian-Americans, Hispanics (in-
22 cluding Latinos), and Native Hawaiians and other
23 Pacific Islanders.

24 “(21) ONSITE INTERPRETATION.—The term
25 ‘onsite interpretation’ means a method of inter-

1 preting or interpretation for which the interpreter is
2 in the physical presence of the provider of health
3 care or health-care-related services and the recipient
4 of such services who is limited in English proficiency
5 or has a communication impairment such as hear-
6 ing, vision, or learning.

7 “(22) SECRETARY.—The term ‘Secretary’
8 means the Secretary of Health and Human Services.

9 “(23) SIGHT TRANSLATION.—The term ‘sight
10 translation’ means the transmission of a written
11 message in one language into a spoken or signed
12 message in another language, or an alternative for-
13 mat in English or another language.

14 “(24) STATE.—The term ‘State’ means each of
15 the several States, the District of Columbia, the
16 Commonwealth of Puerto Rico, the Indian tribes,
17 the United States Virgin Islands, Guam, American
18 Samoa, and the Commonwealth of the Northern
19 Mariana Islands.

20 “(25) TELEPHONIC INTERPRETATION.—The
21 term ‘telephonic interpretation’ (also known as over
22 the phone interpretation or OPI) means a method of
23 interpreting/interpretation for which the interpreter
24 is not in the physical presence of the provider of
25 health care or related services and the limited-

1 English-proficient recipient of such services but is
2 connected via telephone.

3 “(26) TRANSLATION.—The term ‘translation’
4 means the transmission of a written message in one
5 language into a written or signed message in an-
6 other language, and includes translation into an-
7 other language or alternative format, such as large
8 print font, Braille, audio recording, or CD.

9 “(27) VIDEO INTERPRETATION.—The term
10 ‘video interpretation’ means a method of inter-
11 preting/interpretation for which the interpreter is
12 not in the physical presence of the provider of health
13 care or related services and the limited-English-pro-
14 ficient recipient of such services but is connected via
15 a video hook-up that includes both audio and video
16 transmission.

17 “(28) VITAL DOCUMENT.—The term ‘vital doc-
18 ument’ includes but is not limited to applications for
19 government programs that provide health care serv-
20 ices, medical or financial consent forms, financial as-
21 sistance documents, letters containing important in-
22 formation regarding patient instructions (such as
23 prescriptions, referrals to other providers, and dis-
24 charge plans) and participation in a program (such
25 as a Medicaid managed care program), notices per-

1 taining to the reduction, denial, or termination of
2 services or benefits, notices of the right to appeal
3 such actions, and notices advising limited-English-
4 proficient individuals and individuals with commu-
5 nication disabilities of the availability of free lan-
6 guage services, alternative formats, and other out-
7 reach materials.

8 **“SEC. 3401. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
9 **UALS WITH LIMITED ENGLISH PROFICIENCY.**

10 “(a) PURPOSE.—As provided in Executive Order
11 13166, it is the purpose of this section—

12 “(1) to improve Federal agency performance re-
13 garding access to federally conducted and federally
14 assisted programs and activities for individuals who
15 are limited in their English proficiency;

16 “(2) to require each Federal agency to examine
17 the services it provides and develop and implement
18 a system by which limited-English-proficient individ-
19 uals can obtain cultural competence and meaningful
20 access to those services consistent with, and without
21 substantially burdening, the fundamental mission of
22 the agency;

23 “(3) to require each Federal agency to ensure
24 that recipients of Federal financial assistance pro-
25 vide cultural competence and meaningful access to

1 their limited-English-proficient applicants and bene-
2 ficiaries;

3 “(4) to ensure that recipients of Federal finan-
4 cial assistance take reasonable steps, consistent with
5 the guidelines set forth in the Limited English Pro-
6 ficient Guidance of the Department of Justice (as
7 issued on June 12, 2002), to ensure cultural com-
8 petence and meaningful access to their programs
9 and activities by limited-English-proficient individ-
10 uals; and

11 “(5) to ensure compliance with title VI of the
12 Civil Rights Act of 1964 and that health care pro-
13 viders and organizations do not discriminate in the
14 provision of services.

15 “(b) **FEDERALLY CONDUCTED PROGRAMS AND AC-**
16 **TIVITIES.—**

17 “(1) **IN GENERAL.—**Not later than 120 days
18 after the date of enactment of this title, each Fed-
19 eral agency that carries out health-care-related ac-
20 tivities shall prepare a plan to improve access cul-
21 tural competence to the federally conducted, health-
22 care-related programs and activities of the agency by
23 limited-English-proficient individuals. Not later than
24 one year after the date of enactment of this title,

1 each such Federal agency shall ensure that such
2 plan is fully implemented.

3 “(2) PLAN REQUIREMENT.—Each plan under
4 paragraph (1) shall include—

5 “(A) the steps the agency will take to en-
6 sure that limited-English-proficient individuals
7 have access to the agency’s federally conducted
8 health care and health-care-related programs
9 and activities;

10 “(B) the policies and procedures for identi-
11 fying, assessing, and meeting the language
12 needs and cultural competence needs of its lim-
13 ited-English-proficient beneficiaries served by
14 federally conducted programs and activities;

15 “(C) the steps the agency will take for its
16 federally conducted programs and activities to
17 improve cultural competence to provide a range
18 of language assistance options, notice to lim-
19 ited-English-proficient individuals of the right
20 to competent language services, periodic train-
21 ing of staff, monitoring and quality assessment
22 of the language services and, in appropriate cir-
23 cumstances, the translation of written mate-
24 rials;

1 “(D) the steps the agency will take to en-
2 sure that applications, forms, and other rel-
3 evant documents for its federally conducted pro-
4 grams and activities are competently translated
5 into the primary language of a limited-English-
6 proficient client where such materials are need-
7 ed to improve access to federally conducted and
8 federally assisted programs and activities for
9 such a limited-English-proficient individual;

10 “(E) the resources the agency will provide
11 to improve cultural competence to assist recipi-
12 ents of Federal funds to improve access to
13 health care or health-care-related programs and
14 activities for limited-English-proficient individ-
15 uals;

16 “(F) the resources the agency will provide
17 to ensure that competent language assistance is
18 provided to limited-English-proficient patients
19 by interpreters or trained bilingual staff; and

20 “(G) the resources the agency will provide
21 to ensure that family, particularly minor chil-
22 dren, and friends are not used to provide inter-
23 pretation services, except—

24 “(i) in the case of a medical emer-
25 gency where delay directly associated with

1 obtaining a competent interpreter would
2 jeopardize the health of the patient; or

3 “(ii) on request of the patient, who
4 has been informed in his or her preferred
5 language of the availability of free inter-
6 pretation services, if the health care serv-
7 ices provider has determined that the fam-
8 ily or friend can provide competent inter-
9 preter services as defined in section 3400.

10 “(3) SUBMISSION OF PLAN TO DOJ.—Each
11 agency that is required to prepare a plan under
12 paragraph (1) shall send a copy of such plan to the
13 Department of Justice, which shall serve as the cen-
14 tral repository of such plans.

15 “(4) RULE OF CONSTRUCTION.—Paragraph
16 (2)(G)(i) shall not be construed to mean that emer-
17 gency rooms or similar entities that regularly pro-
18 vide health care services in medical emergencies are
19 exempt from legal or regulatory requirements related
20 to competent interpreter services.

21 “(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVI-
22 TIES.—

23 “(1) IN GENERAL.—Not later than 120 days
24 after the date of enactment of this title, each Fed-
25 eral agency providing health-care-related Federal fi-

1 nancial assistance shall ensure that the guidance for
2 recipients of Federal financial assistance developed
3 by the agency to ensure compliance with title VI of
4 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
5 seq.) is specifically tailored to the recipients of such
6 assistance. Each agency shall send a copy of such
7 guidance to the Department of Justice which shall
8 serve as the central repository of the agency's plans.
9 After approval by the Department of Justice, each
10 agency shall publish its guidance document in the
11 Federal Register for public comment.

12 “(2) REQUIREMENTS.—The agency-specific
13 guidance developed under paragraph (1) shall take
14 into account the types of health care services pro-
15 vided by the recipients, the individuals served by the
16 recipients, and other factors set out in such stand-
17 ards.

18 “(3) EXISTING GUIDANCES.—A Federal agency
19 that has developed a guidance for purposes of title
20 VI of the Civil Rights Act of 1964 shall examine
21 such existing guidance, as well as the programs and
22 activities to which such guidance applies, to deter-
23 mine if modification of such guidance is necessary to
24 comply with this subsection.

1 “(4) CONSULTATION.—Each Federal agency
2 shall consult with the Department of Justice in es-
3 tablishing the guidances under this subsection.

4 “(d) CONSULTATIONS.—

5 “(1) IN GENERAL.—In carrying out this sec-
6 tion, each Federal agency that carries out health
7 care and health-care-related activities shall ensure
8 that stakeholders, such as limited-English-proficient
9 individuals and their representative organizations,
10 recipients of Federal assistance, and other appro-
11 priate individuals or entities, have an adequate op-
12 portunity to provide input with respect to the actions
13 of the agency.

14 “(2) EVALUATION.—Each Federal agency de-
15 scribed in paragraph (1) shall evaluate the—

16 “(A) particular needs of the limited-
17 English-proficient individuals served by the
18 agency;

19 “(B) particular needs of the limited-
20 English-proficient individuals served by the
21 agency’s recipients of Federal financial assist-
22 ance; and

23 “(C) burdens of compliance with the agen-
24 cy guidance and this section for the agency and
25 its recipients.

1 **“SEC. 3402. NATIONAL STANDARDS FOR CULTURALLY AND**
2 **LINGUISTICALLY APPROPRIATE SERVICES IN**
3 **HEALTH CARE.**

4 “(a) **APPLICABILITY.**—This section applies to any
5 health program or activity, any part of which is receiving
6 Federal financial assistance, including credits, subsidies,
7 or contracts of insurance, or any program or activity that
8 is administered by an executive agency or any entity estab-
9 lished under title I of the Patient Protection and Afford-
10 able Care Act (or amendments made thereby), as such
11 programs, activities, agencies, and entities are described
12 in section 1557(a) of the Patient Protection and Afford-
13 able Care Act.

14 “(b) **STANDARDS.**—The programs, activities, agen-
15 cies, and entities described in subsection (a) shall—

16 “(1) implement strategies to recruit, retain, and
17 promote individuals at all levels to maintain a di-
18 verse staff and leadership that can provide culturally
19 and linguistically appropriate health care to patient
20 populations of the service area of the programs, ac-
21 tivities, agencies, and entities;

22 “(2) educate and train governance, leadership,
23 and workforce at all levels and across all disciplines
24 of the programs, activities, agencies, and entities in
25 culturally and linguistically appropriate policies and
26 practices on an ongoing basis;

1 “(3) offer and provide language assistance, in-
2 cluding trained bilingual staff and interpreter serv-
3 ices, to individuals who have limited-English pro-
4 ficiency or other communication needs, at no cost to
5 them at all points of contact, and during all hours
6 of operation, to facilitate timely access to all health
7 care and services;

8 “(4) notify patients, in a culturally appropriate
9 manner, of their right to receive language assistance
10 services in their primary language, verbally and in
11 writing;

12 “(5) ensure the competence of language assist-
13 ance provided to limited-English-proficient patients
14 by interpreters and bilingual staff, and ensure that
15 family, particularly minor children, and friends are
16 not used to provide interpretation services—

17 “(A) except in case of emergency; or

18 “(B) except on request of the patient, who
19 has been informed in his or her preferred lan-
20 guage of the availability of free interpretation
21 services if the health care services provider has
22 determined that the family or friend can pro-
23 vide competent interpreter services as defined in
24 section 3400;

1 “(6) for each eligible LEP language group that
2 constitutes 5 percent or 500 individuals, whichever
3 is less, of the population of persons eligible to be
4 served or likely to be affected or encountered in the
5 service area of the organization, make available—

6 “(A) easily understood patient-related ma-
7 terials, including print and multimedia mate-
8 rials;

9 “(B) information or notices about termi-
10 nation of benefits; and

11 “(C) signage;

12 “(7) develop and implement clear goals, poli-
13 cies, operational plans, and management, account-
14 ability, and oversight mechanisms to provide cul-
15 turally and linguistically appropriate services and in-
16 fuse them throughout the organization’s planning
17 and operations;

18 “(8) conduct initial and ongoing organizational
19 assessments of culturally and linguistically appro-
20 priate services-related activities and integrate valid
21 linguistic, competence-related National Standards
22 for Culturally and Linguistically Appropriate Serv-
23 ices (CLAS) measures into the internal audits, per-
24 formance improvement programs, patient satisfac-
25 tion assessments, continuous quality improvement

1 activities, and outcomes-based evaluations of the or-
2 ganization and develop ways to standardize the as-
3 sessments;

4 “(9) ensure that, consistent with the privacy
5 protections provided for under the regulations pro-
6 mulgated under section 264(c) of the Health Insur-
7 ance Portability and Accountability Act of 1996,
8 data on an individual required to be collected pursu-
9 ant to section 3101, including the individual’s alter-
10 native format preferences and policy modification
11 needs, are—

12 “(A) collected in health records;

13 “(B) integrated into the organization’s
14 management information systems; and

15 “(C) periodically updated;

16 “(10) maintain a current demographic, cultural,
17 and epidemiological profile of the community, con-
18 duct regular assessments of community health assets
19 and needs, and use the results to accurately plan for
20 and implement services that respond to the cultural
21 and linguistic characteristics of the service area of
22 the organization;

23 “(11) develop participatory, collaborative part-
24 nerships with communities and utilize a variety of
25 formal and informal mechanisms to facilitate com-

1 community and patient involvement in designing, imple-
2 menting, and evaluating policies and practices to en-
3 sure culturally and linguistically appropriate service-
4 related activities;

5 “(12) ensure that conflict and grievance resolu-
6 tion processes are culturally and linguistically sen-
7 sitive and capable of identifying, preventing, and re-
8 solving cross-cultural conflicts or complaints by pa-
9 tients;

10 “(13) regularly make available to the public in-
11 formation about their progress and successful inno-
12 vations in implementing the standards under this
13 section and provide public notice in their commu-
14 nities about the availability of this information; and

15 “(14) if requested, regularly make available to
16 the head of each Federal entity from which Federal
17 funds are received, information about their progress
18 and successful innovations in implementing the
19 standards under this section as required by the head
20 of such entity.

21 **“SEC. 3403. ROBERT T. MATSUI CENTER FOR CULTURAL**
22 **AND LINGUISTIC COMPETENCE IN HEALTH**
23 **CARE.**

24 “(a) ESTABLISHMENT.—The Secretary, acting
25 through the Director of the Agency for Healthcare Re-

1 search and Quality, shall establish and support a center
2 to be known as the ‘Robert T. Matsui Center for Cultural
3 and Linguistic Competence in Health Care’ (referred to
4 in this section as the ‘Center’) to carry out the following
5 activities:

6 “(1) INTERPRETATION SERVICES.—The Center
7 shall provide resources via the Internet to identify
8 and link health care providers to competent inter-
9 preter and translation services.

10 “(2) TRANSLATION OF WRITTEN MATERIAL.—

11 “(A) The Center shall provide, directly or
12 through contract, vital documents from com-
13 petent translation services for providers of
14 health care and health-care-related services at
15 no cost to such providers. Materials may be
16 submitted for translation into non-English lan-
17 guages. Translation services shall be provided
18 in a timely and reasonable manner. The quality
19 of such translation services shall be monitored
20 and reported publicly.

21 “(B) For each form developed or revised
22 by the Secretary that will be used by LEP indi-
23 viduals in health care or health-care-related set-
24 tings, the Center shall translate the form, at a
25 minimum, into the top 15 non-English lan-

1 guages in the United States according to the
2 most recent data from the American Commu-
3 nity Survey or its replacement. The translation
4 must be completed within 45 days of the Sec-
5 retary receiving final approval of the form from
6 the Office of Management and Budget.

7 “(3) TOLL-FREE CUSTOMER SERVICE TELE-
8 PHONE NUMBER.—The Center shall provide,
9 through a toll-free number, a customer service line
10 for LEP individuals—

11 “(A) to obtain information about federally
12 conducted or funded health programs, including
13 Medicare, Medicaid, and SCHIP;

14 “(B) to obtain assistance with applying for
15 or accessing these programs and understanding
16 Federal notices written in English; and

17 “(C) to learn how to access language serv-
18 ices.

19 “(4) HEALTH INFORMATION CLEARING-
20 HOUSE.—

21 “(A) IN GENERAL.—The Center shall de-
22 velop and maintain an information clearing-
23 house to facilitate the provision of language
24 services by providers of health care and health-
25 care-related services to reduce medical errors,

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

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

18 “(i) Administrative and legal docu-
19 ments, including—

20 “(I) intake forms;

21 “(II) Medicare, Medicaid, and
22 SCHIP forms, including eligibility in-
23 formation;

24 “(III) forms informing patient of
25 HIPAA compliance and consent; and

1 “(IV) documents concerning in-
2 formed consent, advanced directives,
3 and waivers of rights.

4 “(ii) Clinical information, such as how
5 to take medications, how to prevent trans-
6 mission of a contagious disease, and other
7 prevention and treatment instructions.

8 “(iii) Public health, patient education,
9 and outreach materials, such as immuniza-
10 tion notices, health warnings, or screening
11 notices.

12 “(iv) Additional health or health-care-
13 related materials as determined appro-
14 priate by the Director of the Center.

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

17 “(i) ensure that the documents posted
18 in English and non-English languages are
19 culturally appropriate;

20 “(ii) allow public review of the docu-
21 ments before dissemination in order to en-
22 sure that the documents are understand-
23 able and culturally appropriate for the tar-
24 get populations;

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

3 “(iv) facilitate access to these docu-
4 ments;

5 “(v) provide technical assistance with
6 respect to the access and use of such infor-
7 mation; and

8 “(vi) carry out any other activities the
9 Secretary determines to be useful to fulfill
10 the purposes of the clearinghouse.

11 “(D) LANGUAGE ASSISTANCE PRO-
12 GRAMS.—The Center shall provide for the col-
13 lection and dissemination of information on cur-
14 rent examples of language assistance programs
15 and strategies to improve language services for
16 LEP individuals, including case studies using
17 de-identified patient information, program sum-
18 maries, and program evaluations.

19 “(E) CULTURAL AND LINGUISTIC COM-
20 PETENCE MATERIALS.—The Center shall pro-
21 vide information relating to culturally and lin-
22 guistically competent health care for minority
23 populations residing in the United States to all
24 health care providers and health-care-related

1 services at no cost. Such information shall in-
2 clude—

3 “(i) tenets of culturally and linguis-
4 tically competent care;

5 “(ii) cultural and linguistic com-
6 petence self-assessment tools;

7 “(iii) cultural and linguistic com-
8 petence training tools;

9 “(iv) strategic plans to increase cul-
10 tural and linguistic competence in different
11 types of providers of health care and
12 health-care-related services, including re-
13 gional collaborations among health care or-
14 ganizations; and

15 “(v) cultural and linguistic com-
16 petence information for educators, practi-
17 tioners, and researchers.

18 “(F) INFORMATION ABOUT PROGRESS.—

19 The Center shall regularly collect and make
20 publicly available information about the
21 progress of entities receiving grants under sec-
22 tion 3404 regarding successful innovations in
23 implementing the obligations under this sub-
24 section and provide public notice in the entities’

1 communities about the availability of this infor-
2 mation.

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

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

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

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

22 “(2) the value of using trained interpreters and
23 the risks associated with using family members,
24 friends, minors, and untrained bilingual staff;

1 “(3) funding sources for developing and imple-
2 menting language services; and

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

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—In ad-
6 dition to the amounts authorized under subsection
7 (e)(8)(F), there are authorized to be appropriated to carry
8 out this section such sums as may be necessary for each
9 of fiscal years 2015 through 2019.

10 **“SEC. 3404. INNOVATIONS IN CULTURAL AND LINGUISTIC**
11 **COMPETENCE GRANTS.**

12 “(a) IN GENERAL.—The Secretary, acting through
13 the Director of the Agency for Healthcare Research and
14 Quality, shall award grants to eligible entities to enable
15 such entities to design, implement, and evaluate innova-
16 tive, cost-effective programs to improve cultural com-
17 petence and language access in health care for individuals
18 with limited-English proficiency. The Director of the
19 Agency for Healthcare Research and Quality shall coordi-
20 nate with, and ensure the participation of, other agencies
21 including the Health Resources and Services Administra-
22 tion, the Center on Minority Health and Health Dispari-
23 ties at the National Institutes of Health, and the Office
24 of Minority Health, regarding the design and evaluation
25 of the grants program.

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

3 “(1) be—

4 “(A) a city, county, Indian tribe, State,
5 territory, or subdivision thereof;

6 “(B) an organization described in section
7 501(c)(3) of the Internal Revenue Code of 1986
8 and exempt from tax under section 501(a) of
9 such Code;

10 “(C) a community health, mental health,
11 or substance use center or clinic;

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

13 “(E) an integrated health care delivery
14 system;

15 “(F) a public hospital;

16 “(G) a health care group, university, or
17 college; or

18 “(H) other entity designated by the Sec-
19 retary; and

20 “(2) prepare and submit to the Secretary an
21 application, at such time, in such manner, and ac-
22 companied by such additional information as the
23 Secretary may require.

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

1 “(1) develop, implement, and evaluate models of
2 providing competent interpretation services through
3 onsite interpretation, telephonic interpretation, or
4 video interpretation;

5 “(2) implement strategies to recruit, retain, and
6 promote individuals at all levels of the organization
7 to maintain a diverse staff and leadership that can
8 promote and provide language services to patient
9 populations of the service area of the organization;

10 “(3) develop and maintain a needs assessment
11 that identifies the current demographic, cultural,
12 and epidemiological profile of the community to ac-
13 curately plan for and implement language services
14 needed in service area of the organization;

15 “(4) develop a strategic plan to implement lan-
16 guage services;

17 “(5) develop participatory, collaborative part-
18 nerships with communities encompassing the LEP
19 patient populations being served to gain input in de-
20 signing and implementing language services;

21 “(6) develop and implement grievance resolu-
22 tion processes that are culturally and linguistically
23 sensitive and capable of identifying, preventing, and
24 resolving complaints by LEP individuals; or

1 “(7) develop short-term medical mental health
2 interpretation training courses and incentives for bi-
3 lingual health care staff who are asked to interpret
4 in the workplace;

5 “(8) develop formal training programs, includ-
6 ing continued professional development and edu-
7 cation programs as well as supervision, for individ-
8 uals interested in becoming dedicated health care in-
9 terpreters and culturally competent providers;

10 “(9) provide staff language training instruction,
11 which shall include information on the practical limi-
12 tations of such instruction for non-native speakers;

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

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

18 “(12) develop, implement, and evaluate models
19 of improving cultural competence; and

20 “(13) ensure that, consistent with the privacy
21 protections provided for under the regulations pro-
22 mulgated under section 264(c) of the Health Insur-
23 ance Portability and Accountability Act of 1996 (42
24 U.S.C. 1320d–2 note) and any applicable State pri-
25 vacy laws, data on the individual patient or recipi-

1 ent’s race, ethnicity, and primary language are col-
2 lected (and periodically updated) in health records
3 and integrated into the organization’s information
4 management systems or any similar system used to
5 store and retrieve data.

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

11 “(e) EVALUATION.—

12 “(1) BY GRANTEES.—An entity that receives a
13 grant under this section shall submit to the Sec-
14 retary an evaluation that describes, in the manner
15 and to the extent required by the Secretary, the ac-
16 tivities carried out with funds received under the
17 grant, and how such activities improved access to
18 health and health-care-related services and the qual-
19 ity of health care for individuals with limited-English
20 proficiency. Such evaluation shall be collected and
21 disseminated through the Robert T. Matsui Center
22 for Cultural and Linguistic Competence in Health
23 Care established under section 3403. The Director
24 of the Agency for Healthcare Research and Quality
25 shall notify grantees of the availability of technical

1 assistance for the evaluation and provide such assist-
2 ance upon request.

3 “(2) BY SECRETARY.—The Director of the
4 Agency for Healthcare Research and Quality shall
5 evaluate or arrange with other individuals or organi-
6 zations to evaluate projects funded under this sec-
7 tion.

8 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to carry out this section,
10 \$5,000,000 for each of fiscal years 2015 through 2019.

11 **“SEC. 3405. RESEARCH ON CULTURAL AND LANGUAGE COM-
12 PETENCE.**

13 “(a) IN GENERAL.—The Secretary, acting through
14 the Director of the Agency for Healthcare Research and
15 Quality, shall expand research concerning language access
16 in the provision of health care.

17 “(b) ELIGIBILITY.—The Director of the Agency for
18 Healthcare Research and Quality may conduct the re-
19 search described in subsection (a) or enter into contracts
20 with other individuals or organizations to do so.

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

23 “(1) To identify the barriers to mental and be-
24 havioral services that are faced by LEP individuals.

1 “(2) To identify health care providers’ and
2 health administrators’ attitudes, knowledge, and
3 awareness of the barriers to quality health care serv-
4 ices that are faced by LEP individuals.

5 “(3) To identify optimal approaches for deliver-
6 ing language access.

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

9 “(A) the collection by providers of health
10 care and health-care-related services of data on
11 the race, ethnicity, and primary language of re-
12 cipients of such services, taking into account ex-
13 isting research conducted by the Government or
14 private sector;

15 “(B) the development and implementation
16 of data collection and reporting systems; and

17 “(C) effective privacy safeguards for col-
18 lected data.

19 “(5) To develop a minimum data collection set
20 for primary language.

21 “(6) To evaluate the most effective ways in
22 which the Department can create or coordinate, and
23 then subsidize or otherwise fund telephonic interpre-
24 tation providers for health care providers, taking
25 into consideration, among other factors, the flexi-

1 bility necessary for such a system to accommodate
2 variations in—

3 “(A) provider type;

4 “(B) languages needed and their frequency
5 of use;

6 “(C) type of encounter;

7 “(D) time of encounter, including regular
8 business hours and after hours; and

9 “(E) location of encounter.

10 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section
12 such sums as may be necessary for each of fiscal years
13 2015 through 2019.”.

14 **SEC. 203. PILOT PROGRAM FOR IMPROVEMENT AND DE-**
15 **VELOPMENT OF STATE MEDICAL INTER-**
16 **PRETING SERVICES.**

17 (a) GRANTS AUTHORIZED.—The Secretary shall
18 award one grant in accordance with this section to each
19 of three States to assist each such State in designing, im-
20 plementing, and evaluating a statewide program to provide
21 onsite interpreter services under Medicaid.

22 (b) GRANT PERIOD.—A grant awarded under this
23 section is authorized for a period of three fiscal years be-
24 ginning on October 1, 2014.

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

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

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

7 (3) that has a high growth rate of the popu-
8 lation of LEP individuals, as determined by the Sec-
9 retary; and

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

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

16 (1) ensure that all health care providers in the
17 State participating in the State plan under Medicaid
18 have access to onsite interpreter services, for the
19 purpose of enabling effective communication between
20 such providers and qualified LEP enrollees during
21 the furnishing of items and services and administra-
22 tive interactions;

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

24 (A) a statewide health care information
25 technology system that is designed to achieve

1 efficiencies and economies of scale with respect
2 to onsite interpreter services provided to health
3 care providers in the State participating in the
4 State plan under Medicaid; and

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

7 (i) procuring and scheduling inter-
8 preter services for qualified LEP enrollees;

9 (ii) procuring and scheduling inter-
10 preter services for LEP individuals seeking
11 to enroll in the State plan under Medicaid;

12 (iii) ensuring that interpreters receive
13 payment for interpreter services rendered
14 under the system; and

15 (iv) consulting regularly with organi-
16 zations representing consumers, inter-
17 preters, and health care providers; and

18 (3) develop mechanisms to establish, improve,
19 and strengthen the competency of the medical inter-
20 pretation workforce that serves qualified LEP enroll-
21 ees in the State, including a national certification
22 process that is valid, credible, and vendor-neutral.

23 (e) APPLICATION.—To receive a grant under this sec-
24 tion, a State shall submit an application at such time and

1 containing such information as the Secretary may require,
2 which shall include the following:

3 (1) A description of the language access needs
4 of individuals in the State enrolled in the State plan
5 under Medicaid.

6 (2) A description of the extent to which the
7 program will—

8 (A) use the grant funds for the purposes
9 described in subsection (d);

10 (B) meet the health care needs of rural
11 populations of the State; and

12 (C) collect information that accurately
13 tracks the language services requested by con-
14 sumers as compared to the language services
15 provided by health care providers in the State
16 participating in the State plan under Medicaid.

17 (3) A description of how the program will be
18 evaluated, including a proposal for collaboration with
19 organizations representing interpreters, consumers,
20 and LEP individuals.

21 (f) DEFINITIONS.—In this section:

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

24 (A) who is limited-English-proficient; and

1 (B) who is enrolled in a State plan under
2 Medicaid.

3 (2) STATE.—The term “State” has the mean-
4 ing given the term in section 1101(a)(1) of the So-
5 cial Security Act (42 U.S.C. 1301(a)(1)), for pur-
6 poses of title XIX of such Act.

7 (3) UNITED STATES.—The term “United
8 States” has the meaning given the term in section
9 1101(a)(2) of the Social Security Act (42 U.S.C.
10 1301(a)(2)), for purposes of title XIX of such Act.

11 (g) FUNDING.—

12 (1) AUTHORIZATION OF APPROPRIATIONS.—
13 There is authorized to be appropriated \$5,000,000
14 to carry out this section.

15 (2) AVAILABILITY OF FUNDS.—The funds au-
16 thorized by paragraph (1) shall be available without
17 fiscal year limitation.

18 (3) INCREASED FEDERAL FINANCIAL PARTICI-
19 PATION.—Section 1903(a)(2)(E) of the Social Secu-
20 rity Act (42 U.S.C. 1396b(a)(2)(E)), as amended by
21 section 205(d)(1) of this Act, is further amended by
22 inserting “(or, in the case of a State receiving a
23 grant under section 203 of the Health Equity and
24 Accountability Act of 2014, 100 percent for each

1 quarter occurring during the grant period)” after
2 “90 percent”.

3 (h) LIMITATION.—No Federal funds under this sec-
4 tion may be used to provide interpreter services from a
5 location outside the United States.

6 **SEC. 204. TRAINING TOMORROW'S DOCTORS FOR CUL-**
7 **TURALLY AND LINGUISTICALLY APPRO-**
8 **PRIATE CARE: GRADUATE MEDICAL EDU-**
9 **CATION.**

10 (a) DIRECT GRADUATE MEDICAL EDUCATION.—Sec-
11 tion 1886(h)(4) of the Social Security Act (42 U.S.C.
12 1395ww(h)(4)) is amended by adding at the end the fol-
13 lowing new subparagraph:

14 “(L) TREATMENT OF CULTURALLY COM-
15 PETENCY TRAINING.—In determining a hos-
16 pital’s number of full-time equivalent residents
17 for purposes of this subsection, all the time that
18 is spent by an intern or resident in an approved
19 medical residency training program for edu-
20 cation and training in cultural competency and
21 linguistically appropriate service delivery shall
22 be counted toward the determination of full-
23 time equivalency.”.

24 (b) INDIRECT MEDICAL EDUCATION.—Section
25 1886(d)(5)(B) of the Social Security Act (42 U.S.C.

1 1395ww(d)(5)(B)) is amended by adding at the end the
2 following new clause:

3 “(xii) The provisions of subparagraph (L)
4 of subsection (h)(4) shall apply under this sub-
5 paragraph in the same manner as they apply
6 under such subsection.”.

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

11 **SEC. 205. FEDERAL REIMBURSEMENT FOR CULTURALLY**
12 **AND LINGUISTICALLY APPROPRIATE SERV-**
13 **ICES UNDER THE MEDICARE, MEDICAID, AND**
14 **STATE CHILDREN’S HEALTH INSURANCE**
15 **PROGRAMS.**

16 (a) LANGUAGE ACCESS GRANTS FOR MEDICARE
17 PROVIDERS.—

18 (1) ESTABLISHMENT.—

19 (A) IN GENERAL.—Not later than 6
20 months after the date of the enactment of this
21 Act, the Secretary of Health and Human Serv-
22 ices, acting through the Centers for Medicare &
23 Medicaid Services and in consultation with the
24 Center for Medicare and Medicaid Innovation,
25 shall establish a demonstration program under

1 which the Secretary shall award grants to eligi-
2 ble Medicare service providers to improve com-
3 munication between such providers and limited-
4 English-proficient Medicare beneficiaries, in-
5 cluding beneficiaries who live in diverse and un-
6 derserved communities.

7 (B) APPLICATION OF INNOVATION
8 RULES.—The demonstration project under sub-
9 paragraph (A) shall be conducted in a manner
10 that is consistent with the applicable provisions
11 of subsections (b), (c), and (d) of section 1115A
12 of the Social Security Act (42 U.S.C. 1315a).

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

16 (D) GRANT PERIOD.—Except as provided
17 under paragraph (2)(D), each grant awarded
18 under this subsection shall be for a 3-year pe-
19 riod.

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

23 (A) MEDICARE PROVIDER.—The entity
24 must be—

1 (i) a provider of services under part A
2 of title XVIII of the Social Security Act;

3 (ii) a provider of services under part
4 B of such title;

5 (iii) a Medicare Advantage organiza-
6 tion offering a Medicare Advantage plan
7 under part C of such title; or

8 (iv) a PDP sponsor offering a pre-
9 scription drug plan under part D of such
10 title.

11 (B) UNDERSERVED COMMUNITIES.—The
12 entity must serve a community that, with re-
13 spect to necessary language services for improv-
14 ing access and utilization of health care among
15 limited-English-proficient individuals, is
16 disproportionately underserved.

17 (C) APPLICATION.—The entity must pre-
18 pare and submit to the Secretary an applica-
19 tion, at such time, in such manner, and accom-
20 panied by such additional information as the
21 Secretary may require.

22 (D) REPORTING.—In the case of a grantee
23 that received a grant under this subsection in
24 a previous year, such grantee is only eligible for
25 continued payments under a grant under this

1 subsection if the grantee met the reporting re-
2 quirements under paragraph (9) for such year.
3 If a grantee fails to meet the requirement of
4 such paragraph for the first year of a grant, the
5 Secretary may terminate the grant and solicit
6 applications from new grantees to participate in
7 the demonstration program.

8 (3) DISTRIBUTION.—To the extent feasible, the
9 Secretary shall award—

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

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

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

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

18 (4) CONSIDERATIONS IN AWARDING GRANTS.—

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

22 (i) The grantees provide many dif-
23 ferent types of language services.

24 (ii) The grantees serve Medicare bene-
25 ficiaries who speak different languages,

1 and who, as a population, have differing
2 needs for language services.

3 (iii) The grantees serve Medicare
4 beneficiaries in both urban and rural set-
5 tings.

6 (iv) The grantees serve Medicare
7 beneficiaries in at least two geographic re-
8 gions, as defined by the Secretary.

9 (v) The grantees serve Medicare bene-
10 ficiaries in at least two large metropolitan
11 statistical areas with racial, ethnic, and
12 economically diverse populations.

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

18 (i) a community organization; or
19 (ii) a consortia of community organi-
20 zations, State agencies, and local agencies,
21 that has experience in providing language serv-
22 ices.

23 (5) USE OF FUNDS FOR COMPETENT LANGUAGE
24 SERVICES.—

1 (A) IN GENERAL.—Subject to subpara-
2 graph (E), a grantee may only use grant funds
3 received under this subsection to pay for the
4 provision of competent language services to
5 Medicare beneficiaries who are limited-English-
6 proficient.

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

10 (i) interpreter and translation services
11 that—

12 (I) subject to the exceptions
13 under subparagraph (C)—

14 (aa) if the grantee operates
15 in a State that has statewide
16 health care interpreter standards,
17 meet the State standards cur-
18 rently in effect; or

19 (bb) if the grantee operates
20 in a State that does not have
21 statewide health care interpreter
22 standards, utilizes competent in-
23 terpreters who follow the Na-
24 tional Council on Interpreting in

1 Health Care’s Code of Ethics and
2 Standards of Practice; and

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

6 (aa) onsite interpretation;

7 (bb) telephonic interpreta-
8 tion; or

9 (cc) video interpretation;

10 and

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

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

18 (i) in the case of a Medicare bene-
19 ficiary who is limited-English-proficient
20 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 Subparagraph (C)(ii) shall not be construed to
12 exempt emergency rooms or similar entities
13 that regularly provide health care services in
14 medical emergencies to limited-English-pro-
15 ficient patients from any applicable legal or reg-
16 ulatory requirements related to providing com-
17 petent interpreter and translation services with-
18 out undue 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 or a PDP
24 sponsor offering a prescription drug plan under
25 part D of such title, such entity must provide

1 at least 50 percent of the grant funds that the
2 entity receives under this subsection directly to
3 the entity's network providers (including all
4 health providers and pharmacists) for the pur-
5 pose of providing support for such providers to
6 provide competent language services to Medi-
7 care beneficiaries who are limited-English-pro-
8 ficient.

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

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

17 (A) IN GENERAL.—Payments to grantees
18 under this subsection shall be calculated based
19 on the estimated numbers of limited-English-
20 proficient Medicare beneficiaries in a grantee's
21 service area utilizing—

22 (i) data on the numbers of limited-
23 English-proficient individuals who speak
24 English less than “very well” from the
25 most recently available data from the Bu-

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

5 (ii) data provided by the grantee, if
6 the grantee routinely collects data on the
7 primary language of the Medicare bene-
8 ficiaries that the grantee serves and the
9 Secretary determines that the data is accu-
10 rate and shows a greater number of lim-
11 ited-English-proficient individuals than
12 would be estimated using the data under
13 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 with limited-English proficiency for all points of
13 contact between the patient and the grantee, in
14 a 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.—Limited-English-pro-
15 ficient Medicare beneficiaries shall not have to pay
16 cost-sharing or co-payments for competent language
17 services 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 limited-
3 English-proficient Medicare beneficiaries par-
4 ticipating in the project as compared to such
5 outcomes and costs for limited-English-pro-
6 ficient Medicare beneficiaries not participating,
7 based on the data provided under paragraph (9)
8 and any other information available to the Sec-
9 retary.

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

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

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

16 (iii) patient satisfaction;

17 (iv) health outcomes; and

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

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

1 other category as determined by the Secretary
2 to ensure the provision of high-quality interpre-
3 tation, translation, or other language services to
4 Medicare beneficiaries if such services are ex-
5 panded pursuant to subsection (c) of section
6 1907 of this Act.

7 (D) Recommendations, if any, regarding
8 the extension of such project to the entire Medi-
9 care program, subject to the provisions of sec-
10 tion 1115A(c) of the Social Security Act.

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

19 (b) LANGUAGE SERVICES UNDER THE MEDICARE
20 PROGRAM.—

21 (1) INCLUSION AS RURAL HEALTH CLINIC
22 SERVICES.—Section 1861 of the Social Security Act
23 (42 U.S.C. 1395x) is amended—

24 (A) in subsection (aa)(1)—

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

3 (ii) in subparagraph (C), by inserting
4 “and” after the comma at the end; and

5 (iii) by inserting after subparagraph
6 (C) the following:

7 “(D) language services as defined in sub-
8 section (iii)(1),”; and

9 (B) by adding at the end the following new
10 subsection:

11 “Language Services and Related Terms

12 “(iii)(1) LANGUAGE SERVICES DEFINED.—The term
13 ‘language services’ has the same meaning given ‘language
14 or language access services’ in section 3400 of the Public
15 Health Service Act.

16 “(2) INTERPRETER SERVICES DEFINED.—For the
17 purposes of this subsection, the term ‘interpreter services’
18 has the meaning given ‘competent interpreter services’
19 under section 3400(3) of the Public Health Service Act.

20 “(3) INTERPRETER DEFINED.—The term ‘inter-
21 preter’—

22 “(A) means an individual—

23 “(i) who faithfully, accurately, and objec-
24 tively transmits a spoken message from one lan-
25 guage into another language; and

1 “(ii) who knows health and health-related
2 terminology in both languages; and

3 “(B) includes individuals who provide in-person,
4 telephonic, and video interpretation.

5 “(4) TRANSLATION DEFINED.—The term ‘trans-
6 lation’ means the transmission of a written message in one
7 language into a written message in another language that
8 retains the intended meaning of the original message.

9 “(5) LIMITED-ENGLISH-PROFICIENT AND LEP DE-
10 FINED.—The terms ‘limited-English-proficient’ and ‘LEP’
11 have the meaning given the term ‘limited english pro-
12 ficient’ under section 9101(25) of the Elementary and
13 Secondary Education Act of 1965, except that subpara-
14 graphs (A), (B), and (D) of such section not apply.”.

15 (2) COVERAGE.—Section 1832(a)(2) of such
16 Act (42 U.S.C. 1395k(a)(2)) is amended—

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

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

21 (C) by adding at the end of subparagraph
22 (J) the following:

23 “(K) language services (as defined in para-
24 graph (1) of section 1861(iii)) furnished by an

1 interpreter (as defined in paragraph (3) of such
2 section) or translator.”.

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

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

7 (B) by redesignating paragraph (9) as
8 paragraph (10); and

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

11 “(9) in the case of language services described
12 in section 1861(iii)(1), 100 percent of the reasonable
13 charges for such services, as determined in consulta-
14 tion with the Medicare Payment Advisory Commis-
15 sion; and”.

16 (4) WAIVER OF BUDGET NEUTRALITY.—For
17 the 3-year period beginning on the date of enact-
18 ment of this section, the budget neutrality provision
19 of section 1848(e)(2)(B)(ii) of the Social Security
20 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not
21 apply with respect to language services (as such
22 term is defined in section 1861(iii)(1) of such Act).

23 (c) MEDICARE PARTS C AND D.—

24 (1) IN GENERAL.—Medicare Advantage plans
25 under part C of the Social Security Act and pre-

1 scription drug plans under part D of such Act shall
2 comply with title VI of the Civil Rights Act of 1964
3 and section 1557 of the Patient Protection and Af-
4 fordable Care Act to provide effective language serv-
5 ices to enrollees of such plans.

6 (2) MEDICARE ADVANTAGE PLANS AND PRE-
7 SCRIPTION DRUG PLANS REPORTING REQUIRE-
8 MENT.—Section 1857(e) of the Social Security Act
9 (42 U.S.C. 1395w–27(e)) is amended by adding at
10 the end the following new paragraph:

11 “(5) REPORTING REQUIREMENTS RELATING TO
12 EFFECTIVE LANGUAGE SERVICES.—A contract under
13 this part shall require a Medicare Advantage organi-
14 zation (and, through application of section 1860D–
15 12(b)(3)(D), a contract under section 1860D–12
16 shall require a PDP sponsor) to annually submit
17 (for each year of the contract) a report that contains
18 information on the plan’s internal policies and proce-
19 dures related to recruitment and retention efforts di-
20 rected to workforce diversity and linguistically and
21 culturally appropriate provision of services in each of
22 the following contexts:

23 “(A) The collection of data in a manner
24 that meets the requirements of title I of the

1 Health Equity and Accountability Act of 2014,
2 regarding the enrollee population.

3 “(B) Education of staff and contractors
4 who have routine contact with enrollees regard-
5 ing the various needs of the diverse enrollee
6 population.

7 “(C) Evaluation of the health plan’s lan-
8 guage services programs and services with re-
9 spect to the plan’s enrollee population, such as
10 through analysis of complaints or satisfaction
11 survey results.

12 “(D) Methods by which the plan provides
13 to the Secretary information regarding the eth-
14 nic diversity of the plan’s enrollee population.

15 “(E) The periodic provision of educational
16 information to plan enrollees on the plan’s lan-
17 guage services and programs.”.

18 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID
19 AND CHIP.—

20 (1) PAYMENTS TO STATES.—Section
21 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
22 1396b(a)(2)(E)) is amended by—

23 (A) striking “75” and inserting “90”;

1 (B) striking “translation or interpretation
2 services” and inserting “language services”;
3 and

4 (C) striking “children of families” and in-
5 serting “individuals”.

6 (2) STATE PLAN REQUIREMENTS.—Section
7 1902(a)(10)(A) of the Social Security Act (42
8 U.S.C. 1396a(a)(10)(A)) is amended by striking
9 “and (28)” and inserting “(28), and (29)”.

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

13 (A) in paragraph (28), by striking “and”
14 at the end;

15 (B) by redesignating paragraph (29) as
16 paragraph (30); and

17 (C) by inserting after paragraph (28) the
18 following new paragraph:

19 “(29) language services, as such term is defined
20 in section 1861(iii)(1), provided in a timely manner
21 to limited-English-proficient individuals who need
22 such services; and”.

23 (4) USE OF DEDUCTIONS AND COST SHAR-
24 ING.—Section 1916(a)(2) of the Social Security Act
25 (42 U.S.C. 1396o(2)) is amended by—

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

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

5 (C) by adding at the end the following new
6 subparagraph:

7 “(F) language services described in section
8 1905(a)(29); and”.

9 (5) CHIP COVERAGE REQUIREMENTS.—Section
10 2103 of the Social Security Act (42 U.S.C. 1397cc)
11 is amended—

12 (A) in subsection (a), in the matter before
13 paragraph (1), by striking “and (7)” and in-
14 serting “(7), and (9)”; and

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

17 “(9) LANGUAGE SERVICES.—The child health
18 assistance provided to a targeted low-income child
19 shall include coverage of language services, as such
20 term is defined in section 1861(iii)(1), provided in a
21 timely manner to limited-English-proficient individ-
22 uals who need such services.”; and

23 (C) in subsection (e)(2)—

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

1 (ii) by inserting “, subsection (c)(9),”
2 after “subsection (c)(1)(C)”.

3 (6) DEFINITION OF CHILD HEALTH ASSIST-
4 ANCE.—Section 2110(a)(27) of the Social Security
5 Act (42 U.S.C. 1397jj) is amended by striking
6 “translation” and inserting “language services as
7 described in section 2103(c)(9)”.

8 (7) STATE DATA COLLECTION.—Pursuant to
9 the reporting requirement described in section
10 2107(b)(1) of the Social Security Act (42 U.S.C.
11 1397gg(b)(1)), the Secretary of Health and Human
12 Services shall require that States collect data on—

13 (A) the primary language of individuals re-
14 ceiving child health assistance under title XXI
15 of the Social Security Act; and

16 (B) in the case of such individuals who are
17 minors or incapacitated, the primary language
18 of the individual’s parent or guardian.

19 (8) CHIP PAYMENTS TO STATES.—Section
20 2105 of the Social Security Act (42 U.S.C.
21 1397ee(c)) is amended—

22 (A) in subsection (a)(1) by striking “75”
23 and inserting “90”; and

24 (B) in subsection (c)(2)(A), by inserting
25 before the period “, except that expenditures

1 pursuant to clause (iv) of subparagraph (D) of
2 such paragraph shall not count towards this
3 total”.

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

8 (1) PAYMENT OF COSTS.—

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

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

23 (C) RELATION TO MEDICAID DSH.—Pay-
24 ments under this subsection shall not offset or
25 reduce payments under section 1923 of the So-

1 cial Security Act, nor shall payments under
2 such section be considered when determining
3 uncompensated costs associated with the provi-
4 sion of language services.

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

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

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

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

19 (3) DATA COLLECTION INSTRUMENT.—For pur-
20 poses of this subsection, the Secretary shall create a
21 standard data collection instrument that is con-
22 sistent with any existing reporting requirements by
23 the Secretary or relevant accrediting organizations
24 regarding the number of individuals to whom lan-
25 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 of Health and Human Services shall establish
4 and distribute guidelines concerning the implementa-
5 tion of this subsection.

6 (5) REPORTING REQUIREMENTS.—

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

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

21 (6) DEFINITIONS.—In this subsection:

22 (A) ELIGIBLE COSTS.—The term “eligible
23 costs” means, with respect to an eligible entity
24 that provides language services to limited-
25 English-proficient individuals, the product of—

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

5 (ii) the number of limited-English-pro-
6 ficient individuals who are provided lan-
7 guage services by the entity and for whom
8 no reimbursement is available for such
9 services under the amendments made by
10 subsections (a), (b), (c), or (d) or by pri-
11 vate health insurance.

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) provide language services to at
2 least 8 percent of the entity’s total number
3 of patients, not later than 6 months after
4 the date of the enactment of the Act; and

5 (iii) prepare and submit an applica-
6 tion to the Secretary, at such time, in such
7 manner, and accompanied by such infor-
8 mation as the Secretary may require to as-
9 certain the entity’s eligibility for funding
10 under this subsection.

11 (C) LANGUAGE SERVICES.—The term
12 “language services” has the meaning given such
13 term in section 1861(iii)(1) of the Social Secu-
14 rity Act.

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

21 (g) EFFECTIVE DATE.—

22 (1) IN GENERAL.—Except as otherwise pro-
23 vided and subject to paragraph (2), the amendments
24 made by this section shall take effect on January 1,
25 2013.

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

20 **SEC. 206. INCREASING UNDERSTANDING OF AND IMPROV-**
21 **ING HEALTH LITERACY.**

22 (a) IN GENERAL.—The Secretary, acting through the
23 Director of the Agency for Healthcare Research and Qual-
24 ity and the Administrator of the Health Resources and
25 Services Administration, in consultation with the Director

1 of the National Institute on Minority Health and Health
2 Disparities and the Office of Minority Health, shall award
3 grants to eligible entities to improve health care for pa-
4 tient populations that have low functional health literacy.

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

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

10 (2) prepare and submit to the Secretary an ap-
11 plication at such time, in such manner, and con-
12 taining such information as the Secretary may re-
13 quire.

14 (c) USE OF FUNDS.—

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

19 (A) to define and increase the under-
20 standing of health literacy;

21 (B) to investigate the correlation between
22 low health literacy and health and health care;

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

1 (D) for any other activity determined ap-
2 propriate by the Director of the Agency.

3 (2) HEALTH RESOURCES AND SERVICES ADMIN-
4 STRATION.—Grants awarded under subsection (a)
5 through the Health Resources and Services Adminis-
6 tration shall be used to conduct demonstration
7 projects for interventions for patients with low
8 health literacy that may include—

9 (A) the development of new disease man-
10 agement programs for patients with low health
11 literacy;

12 (B) the tailoring of existing disease man-
13 agement programs addressing mental, physical,
14 oral, and behavioral health conditions for pa-
15 tients with low health literacy;

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

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

20 (E) the conduct of educational campaigns
21 for patients and providers about low health lit-
22 eracy; and

23 (F) other activities determined appropriate
24 by the Administrator of the Health Resources
25 and Services Administration.

1 (d) DEFINITIONS.—In this section, the term “low
2 health literacy” means the inability of an individual to ob-
3 tain, process, and understand basic health information
4 and services needed to make appropriate health decisions.

5 (e) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section,
7 such sums as may be necessary for each of fiscal years
8 2015 through 2019.

9 **SEC. 207. ASSURANCES FOR RECEIVING FEDERAL FUNDS.**

10 (a) IN GENERAL.—Any health program or activity,
11 any part of which is receiving Federal financial assistance,
12 including credits, subsidies, or contracts of insurance, and
13 any program or activity that is administered by an execu-
14 tive agency or any entity established under title I of the
15 Patient Protection and Affordable Care Act (or amend-
16 ments made thereby), as such programs, activities, agen-
17 cies, and entities are described in section 1557(a) of the
18 Patient Protection and Affordable Care Act (42 U.S.C.
19 18116), in order to ensure the right of LEP individuals
20 to receive access to quality health care, shall—

21 (1) ensure that appropriate clinical and support
22 staff receive ongoing education and training in lin-
23 guistically appropriate service delivery;

24 (2) offer and provide appropriate language serv-
25 ices at no additional charge to each patient with lim-

1 ited-English-proficiency at all points of contact, in a
2 timely manner during all hours of operation;

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

5 (4) utilize only competent interpreter or trans-
6 lation services, as defined in section 3400 of the
7 Public Health Service Act.

8 (b) EXEMPTIONS.—The requirements of subsection
9 (a)(4) shall not apply as follows:

10 (1) When a patient (who has been informed in
11 his or her primary language of the availability of
12 free interpreter and translation services) requests
13 the use of family, friends, or other persons untrained
14 in interpretation or translation if the following con-
15 ditions are met:

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

18 (B) The recipient informs the patient that
19 he or she has the option of having the recipient
20 provide an interpreter for him or her without
21 charge, or of using his or her own interpreter.

22 (C) The recipient informs the patient that
23 the recipient may not require an LEP person to
24 use a family member or friend as an inter-
25 preter.

1 (D) The recipient evaluates whether the
2 person the patient wishes to use as an inter-
3 preter is competent. If the recipient has reason
4 to believe that the interpreter is not competent,
5 the recipient provides the recipient's own inter-
6 preter to protect the recipient from liability if
7 the patient's interpreter is later found not com-
8 petent.

9 (E) If the recipient has reason to believe
10 that there is a conflict of interest between the
11 interpreter and patient, the recipient may not
12 use the patient's interpreter.

13 (F) The recipient has the patient sign a
14 waiver, witnessed by at least 1 individual not
15 related to the patient, that includes the infor-
16 mation stated in subparagraphs (A) through
17 (E) and is translated into the patient's lan-
18 guage.

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

24 (c) RULE OF CONSTRUCTION.—Subsection (b)(2)
25 shall not be construed to mean that emergency rooms or

1 similar entities that regularly provide health care services
2 in medical emergencies are exempt from legal or regu-
3 latory requirements related to competent interpreter serv-
4 ices.

5 **SEC. 208. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
6 **TURALLY AND LINGUISTICALLY APPRO-**
7 **PRIATE HEALTH CARE SERVICES.**

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

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

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

23 (3) recommendations on the development and
24 implementation of policies and practices by providers

1 of health care and health-care-related services for
2 limited-English-proficient individuals;

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

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

8 (b) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2015 through 2019.

12 **SEC. 209. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.**

13 (a) GRANTS AUTHORIZED.—The Secretary of Edu-
14 cation is authorized to provide grants to eligible entities
15 for the provision of English as a second language (here-
16 after referred to as “ESL”) instruction and shall deter-
17 mine, after consultation with appropriate stakeholders, the
18 mechanism for administering and distributing such
19 grants.

20 (b) ELIGIBLE ENTITY DEFINED.—For purposes of
21 this section, the term “eligible entity” means a State or
22 community-based organization that employs, and serves,
23 minority populations.

24 (c) APPLICATION.—An eligible entity may apply for
25 a grant under this section by submitting such information

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

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

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

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

16 (3) maintain current ESL instruction efforts by
17 using the additional funds to supplement rather
18 than supplant any funds expended for ESL instruc-
19 tion in the State as of January 1, 2015.

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

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

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

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

7 (B) the extent of waiting lists including
8 how many programs maintain waiting lists and,
9 for programs that do not have waiting lists, the
10 reasons why not;

11 (C) the availability of programs to geo-
12 graphically isolated communities;

13 (D) the impact of course enrollment poli-
14 cies, including open enrollment, on the avail-
15 ability of ESL instruction;

16 (E) the number individuals in the State
17 and each participating locality;

18 (F) the effectiveness of the instruction in
19 meeting the needs of individuals receiving in-
20 struction and those needing instruction;

21 (G) as assessment of the need for pro-
22 grams that integrate job training and ESL in-
23 struction, to assist individuals to obtain better
24 jobs; and

1 (H) the availability of ESL slots by State
2 and locality;

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

6 (4) within 1 year of the date of enactment of
7 this Act, issue a report to Congress that assesses the
8 information collected in paragraphs (1), (2), and (3)
9 and makes recommendations on steps that should be
10 taken to progressively realize the goal of making
11 ESL instruction available to all English language
12 learners seeking instruction.

13 (f) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to the Secretary of Edu-
15 cation for each of fiscal years 2015 through 2018
16 \$250,000,000 to carry out this section.

17 **SEC. 210. IMPLEMENTATION.**

18 (a) GENERAL PROVISIONS.—

19 (1) A State shall not be immune under the
20 Eleventh Amendment of the Constitution of the
21 United States from suit in Federal court for failing
22 to provide the language access funded pursuant to
23 this title.

24 (2) In a suit against a State for a violation of
25 this title, remedies (including remedies at both at

1 law and in equity) are available for such a violation
2 to the same extent as such remedies are available for
3 such a violation in the suit against any public or pri-
4 vate entity other than a State.

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

10 **SEC. 211. LANGUAGE ACCESS SERVICES.**

11 (a) **ESSENTIAL BENEFITS.**—Section 1302(b)(1) of
12 the Patient Protection and Affordable Care Act (42
13 U.S.C. 18022(b)(1)) is amended by adding at the end the
14 following:

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

17 (b) **EMPLOYER-SPONSORED MINIMUM ESSENTIAL**
18 **COVERAGE.**—Section 36B(c)(2)(C) of the Internal Rev-
19 enue Code of 1986 is amended by adding at the end the
20 following:

21 “(v) **COVERAGE MUST INCLUDE LAN-**
22 **GUAGE ACCESS AND SERVICES.**—Except as
23 provided in clause (iii), an employee shall
24 not be treated as eligible for minimum es-
25 sential coverage if such coverage consists

1 of an eligible employer-sponsored plan (as
2 defined in section 5000A(f)(2)) and the
3 plan does not provide coverage for lan-
4 guage access services, including oral inter-
5 pretation and written translations.”.

6 (c) QUALITY REPORTING.—Section 2717(a)(1) of the
7 Public Health Service Act (42 U.S.C. 300gg–17(a)(1)) is
8 amended—

9 (1) by striking “and” at the end of subpara-
10 graph (C);

11 (2) by striking the period at the end of sub-
12 paragraph (D) and inserting “; and”; and

13 (3) by adding at the end the following new sub-
14 paragraph:

15 “(E) reduce health disparities through the
16 provision of language access services, including
17 oral interpretation and written translations.”.

18 (d) REGULATIONS REGARDING INTERNAL CLAIMS
19 AND APPEALS AND EXTERNAL REVIEW PROCESSES FOR
20 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—
21 The Secretary of the Treasury, the Secretary of Labor,
22 and the Secretary of Health and Human Services shall
23 amend the regulations in section 54.9815–2719T(e) of
24 title 26, Code of Federal Regulations, section 2590.715–
25 2719(e) of title 29, Code of Federal Regulations, and sec-

1 tion 147.136(e) of title 45, Code of Federal Regulations,
2 respectively, to require group health plans and health in-
3 surance issuers offering group or individual health insur-
4 ance coverage to which such sections apply—

5 (1) to provide oral interpretation services with-
6 out any threshold requirements;

7 (2) to provide in the English versions of all no-
8 tices a statement prominently displayed in not less
9 than 15 non-English languages clearly indicating
10 how to access the language services provided by the
11 plan or issuer; and

12 (3) with respect to written translations of no-
13 tices, to apply a threshold that 5 percent of the pop-
14 ulation or at least 500 individuals per service area
15 are literate only in the same non-English language
16 in lieu of 10 percent or more residing in a county.

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

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

1 Exchange under title I of the Patient Protection and
2 Affordable Care Act;

3 (2) require navigators, certified application
4 counselors, and other enrollment assisters to collect
5 and report requests for language assistance; and

6 (3) require the Federal and State call centers
7 established pursuant to section 1311(d)(4)(b) of the
8 Patient Protection and Affordable Care Act (42
9 U.S.C. 18031(d)(4)(b)) to submit an annual report
10 documenting the number of language assistance re-
11 quests, the types of languages requested, the range
12 and average wait time for a consumer to speak with
13 an interpreter, and any steps the call center and lan-
14 guage line have taken to actively address some of
15 the consumer complaints.

16 (f) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to plan years beginning after the
18 date of the enactment of this Act.

19 **TITLE III—HEALTH WORKFORCE**
20 **DIVERSITY**

21 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

22 **ACT.**

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

1 **“Subtitle A—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 within the Health Re-
7 sources and Services Administration, shall award a grant
8 to an entity determined appropriate by the Secretary for
9 the establishment of a national working group on work-
10 force diversity.

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 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 Public Health Practice Program
2 Office—Office of Workforce Policy and Plan-
3 ning.

4 “(G) The National Institute on Minority
5 Health and Health Disparities.

6 “(H) The Agency for Healthcare Research
7 and Quality.

8 “(I) The Institute of Medicine Study Com-
9 mittee for the 2004 workforce diversity report.

10 “(J) The Indian Health Service.

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

13 “(L) Consumer organizations.

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

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

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

21 “(P) Private foundations that have spon-
22 sored workforce diversity 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)(8).

3 “(S) Other entities determined appropriate
4 by the Secretary.

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

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

13 “(1) Review current public and private health
14 workforce diversity initiatives.

15 “(2) Identify successful health workforce diver-
16 sity programs and practices.

17 “(3) Examine challenges relating to the devel-
18 opment and implementation of health workforce di-
19 versity initiatives.

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

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

1 “(6) Develop recommended standards for work-
2 force diversity that could be applicable to all health
3 professions programs and programs funded under
4 this Act.

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

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

10 “(9) Other activities determined appropriate by
11 the Secretary.

12 “(d) ANNUAL REPORT.—Not later than 1 year after
13 the establishment of the working group under subsection
14 (a), and annually thereafter, the working group shall pre-
15 pare and make available to the general public for com-
16 ment, an annual report on the activities of the working
17 group. Such report shall include the recommendations of
18 the working group for improving health workforce diver-
19 sity.

20 “(e) 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 2015 through 2020.

1 **“SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH**
2 **WORKFORCE DIVERSITY.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Deputy Assistant Secretary for Minority Health, and
5 in collaboration with the Bureau of Health Workforce
6 within the Health Resources and Services Administration,
7 the National Institute on Minority Health and Health Dis-
8 parities, shall establish a technical clearinghouse on health
9 workforce diversity within the Office of Minority Health
10 and coordinate current and future clearinghouses.

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

14 “(1) Information on the importance of health
15 workforce diversity.

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

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

21 “(4) Admissions policies that promote health
22 workforce diversity and are in compliance with Fed-
23 eral and State laws.

24 “(5) Retainment policies that promote comple-
25 tion of health profession degrees for underserved
26 populations.

1 “(1) be an educational institution or entity that
2 historically produces or trains meaningful numbers
3 of underrepresented minority health professionals,
4 including—

5 “(A) historically Black colleges and univer-
6 sities;

7 “(B) Hispanic-serving health professions
8 schools;

9 “(C) Hispanic-serving institutions;

10 “(D) tribal colleges and universities;

11 “(E) Asian-American, Native American,
12 and Pacific Islander-serving institutions;

13 “(F) institutions that have programs to re-
14 cruit and retain underrepresented minority
15 health professionals, in which a significant
16 number of the enrolled participants are under-
17 represented minorities;

18 “(G) health professional associations,
19 which may include underrepresented minority
20 health professional associations; and

21 “(H) institutions—

22 “(i) located in communities with pre-
23 dominantly underrepresented minority pop-
24 ulations;

1 “(ii) with whom partnerships have
2 been formed for the purpose of increasing
3 workforce diversity; and

4 “(iii) in which at least 20 percent of
5 the enrolled participants are underrep-
6 resented minorities; and

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

10 “(c) USE OF FUNDS.—Amounts received under a
11 grant under subsection (a) shall be used to expand existing
12 workforce diversity programs, implement new workforce
13 diversity programs, or evaluate existing or new workforce
14 diversity programs, including with respect to mental
15 health care professions. Such programs shall enhance di-
16 versity by considering minority status as part of an indi-
17 vidualized consideration of qualifications. Possible activi-
18 ties may include—

19 “(1) educational outreach programs relating to
20 opportunities in the health professions;

21 “(2) scholarship, fellowship, grant, loan repay-
22 ment, and loan cancellation programs;

23 “(3) postbaccalaureate programs;

1 “(4) academic enrichment programs, particu-
2 larly targeting those who would not be competitive
3 for health professions schools;

4 “(5) kindergarten through 12th grade and
5 other health pipeline programs;

6 “(6) mentoring programs;

7 “(7) internship or rotation programs involving
8 hospitals, health systems, health plans, and other
9 health entities;

10 “(8) community partnership development for
11 purposes relating to workforce diversity; or

12 “(9) leadership training.

13 “(d) REPORTS.—Not later than 1 year after receiving
14 a grant under this section, and annually for the term of
15 the grant, a grantee shall submit to the Secretary a report
16 that summarizes and evaluates all activities conducted
17 under the grant.

18 “(e) DEFINITION.—In this section, the term ‘Asian-
19 American, Native American, and Pacific Islander-serving
20 institutions’ has the same meaning as the term ‘Asian
21 American and Native American Pacific Islander-serving
22 institution’ as defined in section 371(c) of the Higher
23 Education Act of 1965 (20 U.S.C. 1067q(c)).

24 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
25 is authorized to be appropriated to carry out this section,

1 such sums as may be necessary for each of fiscal years
2 2015 through 2020.

3 **“SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND**
4 **RESEARCHERS.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Director of the National Institutes of Health, the Di-
7 rector of the Centers for Disease Control and Prevention,
8 the Commissioner of Food and Drugs, the Director of the
9 Agency for Healthcare Research and Quality, and the Ad-
10 ministrator of the Health Resources and Services Admin-
11 istration, shall award grants that expand existing opportu-
12 nities for scientists and researchers and promote the inclu-
13 sion of underrepresented minorities in the health profes-
14 sions.

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

24 “(c) DATA COLLECTION.—The head of each entity
25 within the Department of Health and Human Services

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

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

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

23 “(f) 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 2015 through 2020.

3 **“SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH**
4 **PROFESSIONALS.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Director of the Centers for Disease Control and Pre-
7 vention, the Administrator of the Substance Abuse and
8 Mental Health Services Administration, the Administrator
9 of the Health Resources and Services Administration, and
10 the Administrator of the Centers for Medicare & Medicaid
11 Services, shall establish a program to award grants to eli-
12 gible individuals for career support in nonresearch-related
13 health and wellness professions.

14 “(b) ELIGIBILITY.—To be eligible to receive a grant
15 under subsection (a), an individual shall—

16 “(1) be a student in a health professions school,
17 a graduate of such a school who is working in a
18 health profession, an individual working in a health
19 or wellness profession (including mental and behav-
20 ioral health), or a faculty member of such a school;
21 and

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

1 “(c) USE OF FUNDS.—An individual shall use
2 amounts received under a grant under this section to—

3 “(1) support the individual’s health activities or
4 projects that involve underserved communities, in-
5 cluding racial and ethnic minority communities;

6 “(2) support health-related career advancement
7 activities;

8 “(3) to pay, or as reimbursement for payments
9 of, student loans or training or credentialing costs
10 for individuals who are health professionals and are
11 focused on health issues affecting underserved com-
12 munities, including racial and ethnic minority com-
13 munities; and

14 “(4) to establish and promote leadership train-
15 ing programs to decrease health disparities and to
16 increase cultural competence with the goal of in-
17 creasing diversity in leadership positions.

18 “(d) DEFINITION.—In this section, the term ‘career
19 in nonresearch-related health and wellness professions’
20 means employment or intended employment in the field
21 of public health, health policy, health management, health
22 administration, medicine, nursing, pharmacy, psychology,
23 social work, psychiatry, other mental and behavioral
24 health, allied health, community health, social work, or

1 other fields determined appropriate by the Secretary,
2 other than in a position that involves research.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2015 through 2020.

7 **“SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
8 **VERSITY ON QUALITY.**

9 “(a) IN GENERAL.—The Director of the Agency for
10 Healthcare Research and Quality, in collaboration with
11 the Deputy Assistant Secretary for Minority Health and
12 the Director of the National Institute on Minority Health
13 and Health Disparities, shall award grants to eligible enti-
14 ties to expand research on the link between health work-
15 force diversity and quality health care.

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 research entity or other entity determined ap-
20 propriate by the Director; and

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

24 “(c) USE OF FUNDS.—Amounts received under a
25 grant awarded under subsection (a) shall be used to sup-

1 port research that investigates the effect of health work-
2 force diversity on—

3 “(1) language access;

4 “(2) cultural competence;

5 “(3) patient satisfaction;

6 “(4) timeliness of care;

7 “(5) safety of care;

8 “(6) effectiveness of care;

9 “(7) efficiency of care;

10 “(8) patient outcomes;

11 “(9) community engagement;

12 “(10) resource allocation;

13 “(11) organizational structure;

14 “(12) compliance of care; or

15 “(13) other topics determined appropriate by
16 the Director.

17 “(d) PRIORITY.—In awarding grants under sub-
18 section (a), the Director shall give individualized consider-
19 ation to all relevant aspects of the applicant’s background.
20 Consideration of prior research experience involving the
21 health of underserved communities shall be such a factor.

22 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
23 is authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2015 through 2020.

1 **“SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.**

2 “(a) ESTABLISHMENT.—The Secretary, acting
3 through the National Institute on Minority Health and
4 Health Disparities and in collaboration with the Office of
5 Minority Health, the Office for Civil Rights, the Centers
6 for Disease Control and Prevention, the Centers for Medi-
7 care & Medicaid Services, the Health Resources and Serv-
8 ices Administration, and other appropriate public and pri-
9 vate entities, shall establish and coordinate a health and
10 health care disparities education program to support, de-
11 velop, and implement educational initiatives and outreach
12 strategies that inform health care professionals and the
13 public about the existence of and methods to reduce racial
14 and ethnic disparities in health and health care.

15 “(b) ACTIVITIES.—The Secretary, through the edu-
16 cation program established under subsection (a), shall,
17 through the use of public awareness and outreach cam-
18 paigns targeting the general public and the medical com-
19 munity at large—

20 “(1) disseminate scientific evidence for the ex-
21 istence and extent of racial and ethnic disparities in
22 health care, including disparities that are not other-
23 wise attributable to known factors such as access to
24 care, patient preferences, or appropriateness of
25 intervention, as described in the 2002 Institute of
26 Medicine Report entitled ‘Unequal Treatment: Con-

1 fronting Racial and Ethnic Disparities in Health
2 Care’, as well as the impact of disparities related to
3 age, disability status, socioeconomic status, sex, gen-
4 der identity, and sexual orientation on racial and
5 ethnic minorities;

6 “(2) disseminate new research findings to
7 health care providers and patients to assist them in
8 understanding, reducing, and eliminating health and
9 health care disparities;

10 “(3) disseminate information about the impact
11 of linguistic and cultural barriers on health care
12 quality and the obligation of health providers who
13 receive Federal financial assistance to ensure that
14 people with limited-English proficiency have access
15 to language access services;

16 “(4) disseminate information about the impor-
17 tance and legality of racial, ethnic, disability status,
18 socioeconomic status, sex, gender identity, and sex-
19 ual orientation, and primary language data collec-
20 tion, analysis, and reporting;

21 “(5) design and implement specific educational
22 initiatives to health care providers relating to health
23 and health care disparities; and

24 “(6) assess the impact of the programs estab-
25 lished under this section in raising awareness of

1 health and health care disparities and providing in-
2 formation on available resources.

3 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2015 through 2020.”.

7 **SEC. 302. HISPANIC-SERVING HEALTH PROFESSIONS**
8 **SCHOOLS.**

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

12 **“SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS**
13 **SCHOOLS.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Administrator of the Health Resources and Services
16 Administration, shall award grants to Hispanic-serving
17 health professions schools for the purpose of carrying out
18 programs to recruit Hispanic individuals to enroll in and
19 graduate from such schools, which may include providing
20 scholarships and other financial assistance as appropriate.

21 “(b) ELIGIBILITY.—In subsection (a), the term ‘His-
22 panic-serving health professions school’ means an entity
23 that—

24 “(1) is a school or program under section
25 799B;

1 “(2) has an enrollment of full-time equivalent
2 students that is made up of at least 9 percent His-
3 panic students;

4 “(3) has been effective in carrying out pro-
5 grams to recruit Hispanic individuals to enroll in
6 and graduate from the school;

7 “(4) has been effective in recruiting and retain-
8 ing Hispanic faculty members;

9 “(5) has a significant number of graduates who
10 are providing health services to medically under-
11 served populations or to individuals in health profes-
12 sional shortage areas; and

13 “(6) is a Regional Hispanic Center of Excel-
14 lence.”.

15 **SEC. 303. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
16 **DISEASE CONTROL AND PREVENTION.**

17 Section 317F(c) of the Public Health Service Act (42
18 U.S.C. 247b-7(c)) is amended—

19 (1) by striking “and” after “1994,”; and

20 (2) by inserting before the period at the end the
21 following: “\$750,000 for fiscal year 2015, and such
22 sums as may be necessary for each of the fiscal
23 years 2016 through 2020”.

1 **SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
2 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
3 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

4 Part B of title VII of the Public Health Service Act
5 (42 U.S.C. 293 et seq.), as amended by section 302, is
6 further amended by adding at the end the following:

7 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
8 **GREE PROGRAMS.**

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

18 “(b) PRIORITY.—In awarding cooperative agreements
19 under this section, the Secretary shall give priority to any
20 school of public health or school of allied health that has
21 an established track record of serving medically under-
22 served communities.

23 “(c) REQUIREMENTS.—Recipients of cooperative
24 agreements under this section shall design and implement
25 an online degree program that meets the following restric-
26 tions:

1 “(1) Enrollment of individuals who have ob-
2 tained a secondary school diploma or its recognized
3 equivalent.

4 “(2) Maintaining a significant enrollment of
5 underrepresented minority or disadvantaged stu-
6 dents.

7 “(3) Achieving a high completion rate of en-
8 rolled underrepresented minority or disadvantaged
9 students.

10 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section
12 such sums as may be necessary for each of fiscal years
13 2015 through 2020.”.

14 **SEC. 305. SENSE OF CONGRESS ON THE MISSION OF THE**
15 **NATIONAL HEALTH CARE WORKFORCE COM-**
16 **MISSION.**

17 It is the sense of Congress that the National Health
18 Care Workforce Commission established by section 5101
19 of the Patient Protection and Affordable Care Act (42
20 U.S.C. 294q) should, in carrying out its assigned duties
21 under that section, give attention to the needs of racial
22 and ethnic minorities, individuals with lower socio-
23 economic status, individuals with mental, developmental,
24 and physical disabilities, lesbian, gay, bisexual, and

1 transgender populations, and individuals who are members
2 of multiple minority or special population groups.

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

4 Subtitle A 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 Administrator of the Health
10 Resources and Services Administration and the Director
11 of the Centers for Disease Control and Prevention, in col-
12 laboration with the Deputy Assistant Secretary for Minor-
13 ity Health, shall award grants to eligible entities to in-
14 crease awareness among postprimary and postsecondary
15 students 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.

1 “(14) Other professions deemed appropriate by
2 the Director of the Centers for Disease Control and
3 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.—The Secretary may approve sti-
19 pends under this section for individuals for any period of
20 education in student-enhancement programs (other than
21 regular courses) at health professions schools, programs,
22 or entities, except that such a stipend may not be provided
23 to an individual for more than 6 months, and such a sti-
24 pend may not exceed \$20 per day (notwithstanding any
25 other provision of law regarding the amount of stipends).

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2015 through 2020.

5 **“SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
6 **PROGRAM.**

7 “(a) IN GENERAL.—The Director of the Centers for
8 Disease Control and Prevention, in collaboration with the
9 Deputy Assistant Secretary for Minority Health, shall
10 award scholarships to postsecondary students who seek a
11 career in public health.

12 “(b) ELIGIBILITY.—To be eligible to receive a schol-
13 arship under subsection (a), an individual shall—

14 “(1) have interest, knowledge, or skill in public
15 health research or public health practice, or other
16 health professions as determined appropriate by the
17 Director of the Centers for Disease Control and Pre-
18 vention;

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

21 “(3) demonstrate promise for becoming a leader
22 in public health;

23 “(4) secure admission to a 4-year institution of
24 higher education;

25 “(5) comply with subsection (e); and

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

4 “(c) USE OF FUNDS.—Amounts received under an
5 award under subsection (a) shall be used to support oppor-
6 tunities for students to become public health professionals.

7 “(d) PRIORITY.—In awarding grants under sub-
8 section (a), the Director shall give priority to those stu-
9 dents that—

10 “(1) are from disadvantaged backgrounds;

11 “(2) have secured admissions to a minority-
12 serving institution; and

13 “(3) have identified a health professional as a
14 mentor at their school or institution and an aca-
15 demic advisor to assist in the completion of their
16 baccalaureate degree.

17 “(e) SCHOLARSHIPS.—The Secretary may approve
18 payment of scholarships under this section for such indi-
19 viduals for any period of education in student under-
20 graduate tenure, except that such a scholarship may not
21 be provided to an individual for more than 4 years, and
22 such scholarships may not exceed \$10,000 per academic
23 year (notwithstanding any other provision of law regard-
24 ing the amount of scholarship).

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2015 through 2020.

5 **“SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH**
6 **FELLOWSHIP PROGRAM.**

7 “(a) IN GENERAL.—The Director of the Centers for
8 Disease Control and Prevention, in collaboration with the
9 Deputy Assistant Secretary for Minority Health, the Ad-
10 ministrator of the Substance Abuse and Mental Health
11 Services Administration, and the Director of the Indian
12 Health Services, shall award research fellowships to post-
13 baccalaureate students to conduct research that will exam-
14 ine gender and health disparities and to pursue a career
15 in the health professions.

16 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
17 ship under subsection (a) an individual shall—

18 “(1) have experience in health research or pub-
19 lic health practice;

20 “(2) reside in a health professional shortage
21 area as determined by the Secretary;

22 “(3) have expressed an interest in the health
23 professions;

24 “(4) demonstrate promise for becoming a leader
25 in the field of women’s health;

1 “(5) secure admission to a health professions
2 school or graduate program with an emphasis in
3 gender studies;

4 “(6) comply with subsection (f); and

5 “(7) submit to the Secretary an application at
6 such time, in such manner, and containing such in-
7 formation as the Secretary may require.

8 “(c) USE OF FUNDS.—Amounts received under an
9 award under subsection (a) shall be used to support oppor-
10 tunities for students to become researchers and advance
11 the research base on the intersection between gender and
12 health.

13 “(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Director of the Centers for Disease Con-
15 trol and Prevention shall give priority to those applicants
16 that—

17 “(1) are from disadvantaged backgrounds; and

18 “(2) have identified a mentor and academic ad-
19 visor who will assist in the completion of their grad-
20 uate or professional degree and have secured a re-
21 search assistant position with a researcher working
22 in the area of gender and health.

23 “(e) FELLOWSHIPS.—The Director of the Centers for
24 Disease Control and Prevention may approve fellowships
25 for individuals under this section for any period of edu-

1 cation in the student’s graduate or health profession ten-
2 ure, except that such a fellowship may not be provided
3 to an individual for more than 3 years, and such a fellow-
4 ship may not exceed \$18,000 per academic year (notwith-
5 standing any other provision of law regarding the amount
6 of fellowship).

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
8 is authorized to be appropriated to carry out this section
9 such sums as may be necessary for each of fiscal years
10 2015 through 2020.

11 **“SEC. 3420A. PAUL DAVID WELLSTONE INTERNATIONAL**
12 **HEALTH FELLOWSHIP PROGRAM.**

13 “(a) IN GENERAL.—The Director of the Agency for
14 Healthcare Research and Quality, in collaboration with
15 the Deputy Assistant Secretary for Minority Health, shall
16 award research fellowships to college students or recent
17 graduates to advance their understanding of international
18 health.

19 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
20 ship under subsection (a) an individual shall—

21 “(1) have educational experience in the field of
22 international health;

23 “(2) reside in a health professional shortage
24 area as determined by the Secretary;

1 “(3) demonstrate promise for becoming a leader
2 in the field of international health;

3 “(4) be a college senior or recent graduate of
4 a four-year higher education institution;

5 “(5) comply with subsection (e); and

6 “(6) submit to the Secretary an application at
7 such time, in such manner, and containing such in-
8 formation as the Secretary may require.

9 “(c) USE OF FUNDS.—Amounts received under an
10 award under subsection (a) shall be used to support oppor-
11 tunities for students to become health professionals and
12 to advance their knowledge about international issues re-
13 lating to health care access and quality.

14 “(d) PRIORITY.—In awarding grants under sub-
15 section (a), the Director shall give priority to those appli-
16 cants that—

17 “(1) are from a disadvantaged background; and

18 “(2) have identified a mentor at a health pro-
19 fessions school or institution, an academic advisor to
20 assist in the completion of their graduate or profes-
21 sional degree, and an advisor from an international
22 health non-governmental organization, private volun-
23 teer organization, or other international institution
24 or program that focuses on increasing health care

1 access and quality for residents in developing coun-
2 tries.

3 “(e) FELLOWSHIPS.—The Secretary shall approve
4 fellowships for college seniors or recent graduates, except
5 that such a fellowship may not be provided to an indi-
6 vidual for more than 6 months, may not be awarded to
7 a graduate that has not been enrolled in school for more
8 than 1 year, and may not exceed \$4,000 per academic year
9 (notwithstanding any other provision of law regarding the
10 amount of fellowship).

11 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
12 is authorized to be appropriated to carry out this section,
13 such sums as may be necessary for each of fiscal years
14 2015 through 2020.

15 **“SEC. 3420B. EDWARD R. ROYBAL HEALTH SCHOLAR PRO-**
16 **GRAM.**

17 “(a) IN GENERAL.—The Director of the Agency for
18 Healthcare Research and Quality, the Director of the Cen-
19 ters for Medicare and Medicaid Services, and the Adminis-
20 trator for Health Resources and Services Administration,
21 in collaboration with the Deputy Assistant Secretary for
22 Minority Health, shall award grants to eligible entities to
23 expose entering graduate students to the health profes-
24 sions.

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

3 “(1) be a clinical, public health, or health serv-
4 ices organization, community-based, academic, or
5 nonprofit entity, or other entity determined appro-
6 priate by the Director of the Agency for Healthcare
7 Research and Quality;

8 “(2) serve in a health professional shortage
9 area as determined by the Secretary;

10 “(3) work with students obtaining a degree in
11 the health professions; and

12 “(4) submit to the Secretary an application at
13 such time, in such manner, and containing such in-
14 formation as the Secretary may require.

15 “(c) USE OF FUNDS.—Amounts received under a
16 grant awarded under subsection (a) shall be used to sup-
17 port opportunities that expose students to non-research-
18 based health professions, including—

19 “(1) public health policy;

20 “(2) health care and pharmaceutical policy;

21 “(3) health care administration and manage-
22 ment;

23 “(4) health economics; and

24 “(5) other professions determined appropriate
25 by the Director of the Agency for Healthcare Re-

1 search and Quality, the Director of the Centers for
2 Medicare and Medicaid Services, and the Adminis-
3 trator for Health Resources and Services Adminis-
4 tration.

5 “(d) PRIORITY.—In awarding grants under sub-
6 section (a), the Director of the Agency for Healthcare Re-
7 search and Quality shall give priority to those entities
8 that—

9 “(1) have experience with health disparity elimi-
10 nation programs;

11 “(2) facilitate training in the fields described in
12 subsection (c); and

13 “(3) provide counseling or other services de-
14 signed to assist such individuals in successfully com-
15 pleting their education at the postsecondary level.

16 “(e) STIPENDS.—The Secretary may approve the
17 payment of stipends for individuals under this section for
18 any period of education in student-enhancement programs
19 (other than regular courses) at health professions schools
20 or entities, except that such a stipend may not be provided
21 to an individual for more than 2 months, and such a sti-
22 pend may not exceed \$100 per day (notwithstanding any
23 other provision of law regarding the amount of stipends).

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

1 such sums as may be necessary for each of fiscal years
2 2015 through 2020.”.

3 **SEC. 307. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
4 **PROGRAM.**

5 Section 402E of the Higher Education Act of 1965
6 (20 U.S.C. 1070a–15) is amended by striking subsection
7 (g) and inserting the following:

8 “(g) **COLLABORATION IN HEALTH PROFESSION DI-**
9 **VERSITY TRAINING PROGRAMS.**—The Secretary shall co-
10 ordinate with the Secretary of Health and Human Serv-
11 ices to ensure that there is collaboration between the goals
12 of the program under this section and programs of the
13 Health Resources and Services Administration that pro-
14 mote health workforce diversity. The Secretary of Edu-
15 cation shall take such measures as may be necessary to
16 encourage students participating in projects assisted
17 under this section to consider health profession careers.

18 “(h) **FUNDING.**—From amounts appropriated pursu-
19 ant to the authority of section 402A(g), the Secretary
20 shall, to the extent practicable, allocate funds for projects
21 authorized by this section in an amount which is not less
22 than \$31,000,000 for each of the fiscal years 2015
23 through 2021.”.

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)) is
6 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 (L),
10 such rules”;

11 (2) in subparagraph (J), by striking “Such
12 rules” and inserting “Subject to subparagraph (L),
13 such rules”;

14 (3) in subparagraph (K), by striking “In deter-
15 mining” and inserting “Subject to subparagraph
16 (L), in determining”; and

17 (4) by adding at the end the following new sub-
18 paragraph:

19 “(L) For purposes of cost-reporting peri-
20 ods beginning on or after October 1, 2014, in
21 determining the hospital’s number of full-time
22 equivalent residents for purposes of this para-
23 graph, all the time spent by an intern or resi-
24 dent in an approved medical residency training
25 program shall be counted toward the determina-
26 tion of full-time equivalency if the hospital—

1 “(i) is recognized as a subsection (d)
2 hospital;

3 “(ii) is recognized as a subsection (d)
4 Puerto Rico hospital;

5 “(iii) is reimbursed under a reim-
6 bursement system authorized under section
7 1814(b)(3); or

8 “(iv) is a provider-based hospital out-
9 patient department.”.

10 (b) IME DETERMINATIONS.—Section
11 1886(d)(5)(B)(x) of the Social Security Act (42 U.S.C.
12 1395ww(d)(5)(B)(x)) is amended—

13 (1) in subclause (II), by striking “In deter-
14 mining” and inserting “Subject to subclause (x)(IV),
15 in determining”;

16 (2) in subclause (III), by striking “In deter-
17 mining” and inserting “Subject to subclause (x)(IV),
18 in determining”; and

19 (3) by adding at the end the following new sub-
20 clause:

21 “(IV) The provisions of subpara-
22 graph (L) of subsection (h)(4) shall
23 apply under this subparagraph in the
24 same manner as they apply under
25 such subsection.”.

1 **SEC. 309. DEVELOPING AND IMPLEMENTING STRATEGIES**
2 **FOR LOCAL HEALTH EQUITY.**

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

6 (1) in accordance with subsection (b), devel-
7 oping capacity—

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

10 (B) to serve as national models of driving
11 local health equity;

12 (2) in accordance with subsection (c), devel-
13 oping a strategic partnership with the community in
14 which the academic institution is located; and

15 (3) collecting data on, and periodically evalu-
16 ating, the effectiveness of the institution's programs
17 funded through this section to enable the institution
18 to adapt accordingly for maximum efficiency and
19 success.

20 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
21 HEALTH EQUITY.—As a condition on receipt of a grant
22 under subsection (a), an academic institution shall agree
23 to use the grant to build an evidence base for successful
24 strategies for increasing local health equity, and to serve
25 as a national model of driving local health equity, by sup-
26 porting—

1 (1) resources to strengthen institutional metrics
2 and capacity to execute institutionwide health work-
3 force goals that can serve as models for increasing
4 health equity in communities across the country;

5 (2) collaborations among a cohort of institu-
6 tions in implementing systemic change, partnership
7 development, and programmatic efforts supportive of
8 health equity goals across disciplines and popu-
9 lations; and

10 (3) enhanced or newly developed data systems
11 and research infrastructure capable of informing
12 current and future workforce efforts and building a
13 foundation for a broader research agenda targeting
14 urban health disparities.

15 (c) STRATEGIC PARTNERSHIPS.—As a condition on
16 receipt of a grant under subsection (a), an academic insti-
17 tution shall agree to use the grant to develop a strategic
18 partnership with the community in which the institution
19 is located for the purposes of—

20 (1) strengthening connections between the insti-
21 tution and the community—

22 (A) to improve evaluation of and address
23 the community’s health and health workforce
24 needs; and

1 (B) to engage the community in health
2 workforce development;

3 (2) developing, enhancing, or accelerating inno-
4 vative undergraduate and graduate programs in the
5 biomedical sciences and health professions; and

6 (3) strengthening pipeline programs in the bio-
7 medical sciences and health professions, including by
8 developing partnerships between institutions of high-
9 er education and elementary and secondary schools
10 to recruit the next generation of health professionals
11 earlier in the pipeline to a health care career.

12 **SEC. 310. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**
13 **IORAL HEALTH SOCIAL WORKERS.**

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

17 “(r) REPAYMENT PLAN FOR MENTAL AND BEHAV-
18 IORAL HEALTH SOCIAL WORKERS.—

19 “(1) IN GENERAL.—The Secretary shall cancel
20 the balance of interest and principal due on any eli-
21 gible Federal Direct Loan not in default for a bor-
22 rower who—

23 “(A) has made 120 monthly payments on
24 the eligible Federal Direct Loan after October

1 1, 2014, pursuant to any one or a combination
2 of the following—

3 “(i) payments under an income-based
4 repayment plan under section 493C;

5 “(ii) payments under a standard re-
6 payment plan under subsection (d)(1)(A),
7 based on a 10-year repayment period;

8 “(iii) monthly payments under a re-
9 payment plan under subsection (d)(1) or
10 (g) of not less than the monthly amount
11 calculated under subsection (d)(1)(A),
12 based on a 10-year repayment period; or

13 “(iv) payments under an income con-
14 tingent repayment plan under subsection
15 (d)(1)(D); and

16 “(B)(i) is employed as a mental health or
17 behavioral health social worker, as defined by
18 the Secretary by regulation, at the time of such
19 forgiveness; and

20 “(ii) has been employed as such a mental
21 health or behavioral health social worker during
22 the period in which the borrower makes each of
23 the 120 payments as described in subparagraph
24 (A).

1 “(2) LOAN CANCELLATION AMOUNT.—After the
2 conclusion of the employment period described in
3 paragraph (1), the Secretary shall cancel the obliga-
4 tion to repay the balance of principal and interest
5 due as of the time of such cancellation, on the eligi-
6 ble Federal Direct Loans made to the borrower
7 under this part.

8 “(3) INELIGIBILITY FOR DOUBLE BENEFITS.—
9 No borrower may, for the same employment as a
10 mental health or behavioral health social worker, re-
11 ceive a reduction of loan obligations under both this
12 subsection and section 455(m), 428J, 428K, 428L,
13 or 460.

14 “(4) DEFINITION OF ELIGIBLE FEDERAL DI-
15 RECT LOAN.—In this subsection, the term ‘eligible
16 Federal Direct Loan’ means a Federal Direct Staf-
17 ford Loan, Federal Direct PLUS Loan, Federal Di-
18 rect Unsubsidized Stafford Loan, or a Federal Di-
19 rect Consolidation Loan.”.

20 **SEC. 311. HEALTH PROFESSIONS WORKFORCE FUND.**

21 (a) PURPOSE.—It is the purpose of this section to
22 establish a Health Professions Workforce Fund to be ad-
23 ministered through the Health Resources and Services Ad-
24 ministration within the Department of Health and Human
25 Services to provide for expanded and sustained national

1 investment in the health professions and nursing work-
2 force development programs under title VII and title VIII
3 of the Public Health Service Act.

4 (b) ESTABLISHING THE HEALTH PROFESSIONS
5 WORKFORCE FUND.—There is authorized to be appro-
6 priated, and there is appropriated, out of any monies in
7 the Treasury not otherwise appropriated, to the Health
8 Professions Workforce Fund—

- 9 (1) \$355,000,000 for fiscal year 2015;
- 10 (2) \$375,000,000 for fiscal year 2016;
- 11 (3) \$392,000,000 for fiscal year 2017;
- 12 (4) \$412,000,000 for fiscal year 2018;
- 13 (5) \$432,000,000 for fiscal year 2019;
- 14 (6) \$454,000,000 for fiscal year 2020;
- 15 (7) \$476,000,000 for fiscal year 2021;
- 16 (8) \$500,000,000 for fiscal year 2022;
- 17 (9) \$525,000,000 for fiscal year 2023; and
- 18 (10) \$552,000,000 for fiscal year 2024.

19 (c) FUNDING.—

20 (1) For the purpose of carrying out health pro-
21 fessions education programs authorized under title
22 VII of the Public Health Service Act, in addition to
23 any other amounts authorized to be appropriated for
24 such purpose, there is authorized to be appropriated

1 out of any monies in the Health Professions Work-
2 force Fund, the following:

3 (A) \$240,000,000 for fiscal year 2015.

4 (B) \$253,000,000 for fiscal year 2016.

5 (C) \$265,000,000 for fiscal year 2017.

6 (D) \$278,000,000 for fiscal year 2018.

7 (E) \$292,000,000 for fiscal year 2019.

8 (F) \$307,000,000 for fiscal year 2020.

9 (G) \$322,000,000 for fiscal year 2021.

10 (H) \$338,000,000 for fiscal year 2022.

11 (I) \$355,000,000 for fiscal year 2023.

12 (J) \$373,000,000 for fiscal year 2024.

13 (2) For the purpose of carrying out nursing
14 workforce development programs authorized under
15 Title VIII of the Public Health Service Act, in addi-
16 tion to any other amounts authorized to be appro-
17 priated for such purpose, there is authorized to be
18 appropriated out of any monies in the Health Pro-
19 fessions Workforce Fund, the following:

20 (A) \$115,000,000 for fiscal year 2015.

21 (B) \$122,000,000 for fiscal year 2016.

22 (C) \$127,000,000 for fiscal year 2017.

23 (D) \$134,000,000 for fiscal year 2018.

24 (E) \$140,000,000 for fiscal year 2019.

25 (F) \$147,000,000 for fiscal year 2020.

1 (G) \$154,000,000 for fiscal year 2021.

2 (H) \$162,000,000 for fiscal year 2022.

3 (I) \$170,000,000 for fiscal year 2023.

4 (J) \$179,000,000 for fiscal year 2024.

5 **SEC. 312. FINDINGS; SENSE OF CONGRESS RELATING TO**
6 **GRADUATE MEDICAL EDUCATION.**

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

8 (1) Projections by the Association of American
9 Medical Colleges (AAMC) and other expert entities,
10 such as the Health Resources and Services Adminis-
11 tration (HRSA), have indicated a nationwide short-
12 age of up to 130,600 physicians, split evenly be-
13 tween primary care and specialists, by 2025.

14 (2) The coverage of an additional 25 million
15 uninsured Americans under the Patient Protection
16 and Affordable Care Act is expected to increase the
17 projected shortage by 25 percent.

18 (3) The United States Census projects that the
19 Nation's population will grow from 310 million in
20 2010 to 400 million in 2044, with the Nation be-
21 coming majority-minority in 2043, and the number
22 of Medicare beneficiaries increasing from 50.7 mil-
23 lion in 2012 to 90 million in 2045.

1 (4) One-third of currently practicing physicians
2 are over 55 years of age and likely to retire in the
3 next 20 years.

4 (5) A nationwide physician shortage will result
5 in many Americans waiting longer and traveling far-
6 ther for health care; seeking nonemergent care in
7 emergency departments; and delaying treatment
8 until their health care needs become more serious,
9 complex, and costly.

10 (6) Changing demographics (such as an aging
11 population), new health care delivery models (such
12 as medical homes), and other factors (such as dis-
13 aster preparedness) are contributing to a shortage of
14 both generalist and specialist physicians.

15 (7) These shortages will have the most severe
16 impact on vulnerable and underserved populations,
17 including racial/ethnic minorities and the approxi-
18 mately 20 percent of Americans who live in rural or
19 inner-city locations designated as health professional
20 shortage areas.

21 (8) United States medical schools have com-
22 mitted to and have initiated a 30 percent increase
23 in enrollment by 2017 to help reduce the Nation's
24 shortage of quality physicians.

1 (9) An increase in United States medical school
2 graduates must be accompanied by an increase of
3 4,000 graduate medical education (GME) training
4 positions each year.

5 (10) Graduate medical education programs and
6 teaching hospitals provide venues in which the next
7 generation of physicians learns to work collaboratively
8 with other physicians and health professionals, adopt more
9 efficient care delivery models (such as care coordination
10 and medical homes), incorporate health information technology
11 and electronic health records in every aspect of their work,
12 apply new methods of assuring quality and safety,
13 and participate in groundbreaking clinical and public
14 health research.
15

16 (11) The Medicare Program under title XVIII
17 of the Social Security Act (having more beneficiaries
18 than any other health care program), supports its
19 “fair share” of the costs associated with graduate
20 medical education (GME).

21 (12) In general, the level of support of graduate
22 medical education by the Medicare Program has
23 been capped since 1997 and has not been increased
24 to support the expansion of graduate medical edu-
25 cation programs needed to avert the projected physi-

1 cian shortage or to accommodate the increase in
2 United States medical school graduates.

3 (b) SENSE OF CONGRESS.—It is the sense of Con-
4 gress that eliminating the limit of the number of residency
5 positions that receive some level of Medicare support
6 under section 1886(h) of the Social Security Act (42
7 U.S.C. 1395ww(h)), also referred to as the Medical grad-
8 uate medical education cap, is critical to—

9 (1) ensuring an appropriate supply of physi-
10 cians to meet the Nation’s health care needs;

11 (2) facilitating equitable access for all who seek
12 health care; and

13 (3) mitigating disparities in health and health
14 care.

15 **SEC. 313. CAREER SUPPORT FOR SKILLED INTERNATION-**
16 **ALLY EDUCATED HEALTH PROFESSIONALS.**

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

18 (1) According to the Association of Schools of
19 Public Health, projections indicate a nationwide
20 shortage of up to 250,000 public health workers
21 needed by 2020.

22 (2) Similar trends are projected for other health
23 professions indicating shortages across disciplines,
24 including within the fields of nursing, dentistry,

1 pharmacy, mental and behavioral health, primary
2 care, and community and allied health.

3 (3) A nationwide health workforce shortage will
4 result in serious health threats and more severe and
5 costly health care needs, due to, in part, a delayed
6 response to food-borne outbreaks, emerging infec-
7 tious diseases, and natural disasters, fewer cancer
8 screenings and delayed treatment.

9 (4) Vulnerable and underserved populations and
10 health professional shortage areas will be most se-
11 verely impacted by the health workforce shortage.

12 (5) According to the Migration Policy Institute,
13 over 2 million college-educated immigrants in the
14 United States today are unemployed or under-
15 employed in low- or semi-skilled jobs that fail to
16 draw on their education and expertise.

17 (6) Approximately two out of every five inter-
18 nationally educated immigrants are unemployed or
19 underemployed.

20 (7) According to Drexel University Center for
21 Labor Markets and Policy, underemployment for
22 internationally educated immigrant women is 28 per-
23 cent higher than for their male counterparts.

24 (8) According to the Drexel University Center
25 for Labor Markets and Policy, the mean annual

1 earnings of underemployed immigrants were
2 \$32,000, or 43 percent less than U.S.-born college
3 graduates employed in the college labor market.

4 (9) According to Upwardly Global and the Wel-
5 come Back Initiative, with proper guidance and sup-
6 port underemployed skilled immigrants typically in-
7 crease their income by 215 percent to 900 percent.

8 (10) According to the Brookings Institution and
9 the Partnership for a New American Economy, im-
10 migrants working in the health workforce are, on av-
11 erage, better-educated than U.S.-born workers in the
12 health workforce.

13 (b) GRANTS TO ELIGIBLE ENTITIES.—

14 (1) AUTHORITY TO PROVIDE GRANTS.—The
15 Secretary of Health and Human Services, acting
16 through the Bureau of Health Workforce within the
17 Health Resources and Services Administration, the
18 National Institute on Minority Health and Health
19 Disparities, or the Office of Minority Health (in this
20 section referred to as the “Secretary”), may award
21 grants to eligible entities to carry out activities de-
22 scribed in subsection (c).

23 (2) ELIGIBILITY.—To be eligible to receive a
24 grant under this section, an entity shall—

1 (A) be a clinical, public health, or health
2 services organization, a community-based or
3 nonprofit entity, an academic institution, a
4 faith-based organization, a State, county, or
5 local government, a National Area Health Edu-
6 cation Center, or another entity determined ap-
7 propriate by the Secretary; and

8 (B) submit to the Secretary an application
9 at such time, in such manner, and containing
10 such information as the Secretary may require.

11 (c) AUTHORIZED ACTIVITIES.—A grant awarded
12 under this section shall be used—

13 (1) to provide services to assist unemployed and
14 underemployed skilled immigrants, residing in the
15 United States, who have legal, permanent work au-
16 thorization and who are internationally educated
17 health professions, enter into the American health
18 workforce with employment matching their health
19 professional skills and education, and advance in em-
20 ployment to positions that better match their health
21 professional education and expertise;

22 (2) to reduce disparities in incomes between
23 skilled health professional immigrants and other
24 workers in the health workforce;

1 (3) to reduce barriers to entry and advance-
2 ment in the health workforce for internationally edu-
3 cated skilled immigrants; and

4 (4) to educate employers regarding the abilities
5 and capacities of internationally educated health
6 professionals.

7 (d) DEFINITIONS.—In this section:

8 (1) The term “health professional” means an
9 individual trained for employment or intended em-
10 ployment in the field of public health, health man-
11 agement, dentistry, health administration, medicine,
12 nursing, pharmacy, psychology, social work, psychi-
13 atry, other mental and behavioral health, allied
14 health, community health, social work, or wellness
15 work, including fitness and nutrition, or other fields
16 as determined appropriate by the Secretary.

17 (2) The term “underemployed” means being
18 employed at less skilled tasks than an employee’s
19 training or abilities would otherwise permit.

20 (e) 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 2015 through 2019.

1 **TITLE IV—IMPROVEMENT OF**
2 **HEALTH CARE SERVICES**
3 **Subtitle A—Health Empowerment**
4 **Zones**

5 **SEC. 401. SHORT TITLE.**

6 This subtitle may be cited as the “Health Empower-
7 ment Zone Act of 2014”.

8 **SEC. 402. FINDINGS.**

9 The Congress finds the following:

10 (1) Numerous studies and reports, including
11 the 2012 National Healthcare Disparities Report of
12 the Administration on Healthcare Research and
13 Quality and the 2002 Unequal Treatment Report of
14 the Institute of Medicine, document the extensive-
15 ness to which health disparities exist across the
16 country.

17 (2) These studies have found that, on average,
18 racial and ethnic minorities are disproportionately
19 afflicted with chronic and acute conditions—such as
20 cancer, diabetes, musculoskeletal disease, obesity,
21 and hypertension—and suffer worse health out-
22 comes, worse health status, and higher mortality
23 rates than their White counterparts.

24 (3) Several recent studies also show that health
25 disparities are a function of not only access to health

1 care, but also the social determinants of health—in-
2 cluding the environment, the physical structure of
3 communities, nutrition and food options, educational
4 attainment, employment, race, ethnicity, geography,
5 and language preference—that directly and indi-
6 rectly affect the health, health care, and wellness of
7 individuals and communities.

8 (4) Integrally involving and fully supporting the
9 communities most affected by health inequities in
10 the assessment, planning, launch, and evaluation of
11 health disparity elimination efforts are among the
12 leading recommendations made to adequately ad-
13 dress and ultimately reduce health disparities.

14 (5) Recommendations also include supporting
15 the efforts of community stakeholders from a broad
16 cross section—including, but not limited to local
17 businesses, local departments of commerce, edu-
18 cation, labor, urban planning, and transportation,
19 and community-based and other nonprofit organiza-
20 tions—to find areas of common ground around
21 health disparity elimination and collaborate to im-
22 prove the overall health and wellness of a community
23 and its residents.

1 **SEC. 403. DESIGNATION OF HEALTH EMPOWERMENT**
2 **ZONES.**

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

6 (b) **ELIGIBILITY CRITERIA.**—

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

10 (A) demonstrates widespread public sup-
11 port from key individuals and entities in the eli-
12 gible area, including members of the target
13 community, State and local governments, non-
14 profit organizations, and community and indus-
15 try leaders, for designation of the eligible area
16 as a health empowerment zone; and

17 (B) includes representatives of—

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

23 (ii) organizations, facilities, and insti-
24 tutions that have a history of working
25 within and serving such communities.

1 (2) ELIGIBLE AREA.—An area is eligible to be
2 designated as a health empowerment zone under this
3 section if one or more communities in the area expe-
4 rience disproportionate disparities in health status
5 and health care. In determining whether a commu-
6 nity experiences such disparities, the Secretary shall
7 consider the data collected by the Department of
8 Health and Human Services focusing on the fol-
9 lowing areas:

10 (A) Access to affordable, high-quality
11 health services.

12 (B) The prevalence of disproportionate
13 rates of certain illnesses or diseases including
14 the following:

15 (i) Arthritis, osteoporosis, chronic
16 back conditions, and other musculoskeletal
17 diseases.

18 (ii) Cancer.

19 (iii) Chronic kidney disease.

20 (iv) Diabetes.

21 (v) Injury (intentional and uninten-
22 tional).

23 (vi) Violence (intimate and non-
24 intimate).

1 (vii) Maternal and paternal illnesses
2 and diseases.

3 (viii) Infant mortality.

4 (ix) Mental illness and other disabil-
5 ities.

6 (x) Substance abuse treatment and
7 prevention, including underage drinking.

8 (xi) Nutrition, obesity, and overweight
9 conditions.

10 (xii) Heart disease.

11 (xiii) Hypertension.

12 (xiv) Cerebrovascular disease or
13 stroke.

14 (xv) Tuberculosis.

15 (xvi) HIV/AIDS and other sexually
16 transmitted diseases.

17 (xvii) Viral hepatitis.

18 (xviii) Asthma.

19 (xix) Tooth decay and other oral
20 health issues.

21 (C) Within the target community, the his-
22 torical and persistent presence of conditions
23 that have been found to contribute to health
24 disparities including any such conditions re-
25 specting the following:

- 1 (i) Poverty.
- 2 (ii) Educational status and the quality
3 of community schools.
- 4 (iii) Income.
- 5 (iv) Access to high-quality affordable
6 health care.
- 7 (v) Work and work environment.
- 8 (vi) Environmental conditions in the
9 community, including with respect to clean
10 water, clean air, and the presence or ab-
11 sence of pollutants.
- 12 (vii) Language and English pro-
13 ficiency.
- 14 (viii) Access to affordable healthy
15 food.
- 16 (ix) Access to ethnically and culturally
17 diverse health and human service providers
18 and practitioners.
- 19 (x) Access to culturally and linguis-
20 tically competent health and human serv-
21 ices and health and human service pro-
22 viders.
- 23 (xi) Health-supporting infrastructure.
- 24 (xii) Health insurance that is ade-
25 quate and affordable.

1 (xiii) Race, racism, and bigotry (con-
2 scious and unconscious).

3 (xiv) Sexual orientation.

4 (xv) Health literacy.

5 (xvi) Place of residence (such as
6 urban areas, rural areas, and tribal res-
7 ervations).

8 (xvii) Stress.

9 (c) PROCEDURE.—

10 (1) REQUEST.—A request under subsection (a)
11 shall—

12 (A) describe the bounds of the area to be
13 designated as a health empowerment zone and
14 the process used to select those bounds;

15 (B) demonstrate that the partnership sub-
16 mitting the request is an eligible community
17 partnership described in subsection (b)(1);

18 (C) demonstrate that the area is an eligible
19 area described in subsection (b)(2);

20 (D) include a comprehensive assessment of
21 disparities in health status and health care ex-
22 perience by one or more communities in the
23 area;

24 (E) set forth—

1 (i) a vision and a set of values for the
2 area; and

3 (ii) a comprehensive and holistic set of
4 goals to be achieved in the area through
5 designation as a health empowerment zone;
6 and

7 (F) include a strategic plan and an action
8 plan for achieving the goals described in sub-
9 paragraph (E)(ii).

10 (2) APPROVAL.—Not later than 60 days after
11 the receipt of a request for designation of an area
12 as a health empowerment zone under this section,
13 the Secretary shall approve or disapprove the re-
14 quest.

15 (d) MINIMUM NUMBER.—The Secretary—

16 (1) shall designate not more than 110 health
17 empowerment zones under this section; and

18 (2) shall designate at least one health empower-
19 ment zone in each of the several States, the District
20 of Columbia, and each territory or possession of the
21 United States.

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

23 At the request of any organization or entity seeking
24 to submit a request under section 403(a), the Secretary

1 shall provide technical assistance, and may award a grant,
2 to assist such organization or entity—

3 (1) to form an eligible community partnership
4 described in section 403(b)(1);

5 (2) to complete a health assessment, including
6 an assessment of health disparities under section
7 403(c)(1)(D); or

8 (3) to prepare and submit a request, including
9 a strategic plan, in accordance with section 403.

10 **SEC. 405. BENEFITS OF DESIGNATION.**

11 (a) **PRIORITY.**—In awarding any competitive grant,
12 a Federal official shall give priority to any applicant
13 that—

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

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

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

20 (b) **GRANTS FOR INITIAL IMPLEMENTATION OF**
21 **STRATEGIC PLAN.**—

22 (1) **IN GENERAL.**—Upon designating an eligible
23 area as a health empowerment zone at the request
24 of an eligible community partnership, the Secretary
25 shall, subject to the availability of appropriations,

1 make a grant to the community partnership for im-
2 plementation of the strategic plan for such zone.

3 (2) GRANT PERIOD.—A grant under paragraph
4 (1) for a health empowerment zone shall be for a pe-
5 riod of 2 years and may be renewed, except that the
6 total period of grants under paragraph (1) for such
7 zone may not exceed 10 years.

8 (3) LIMITATION.—In awarding grants under
9 this subsection, the Secretary shall not give less pri-
10 ority to an applicant or reduce the amount of a
11 grant because the Secretary rendered technical as-
12 sistance or made a grant to the same applicant
13 under section 404.

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

19 **SEC. 406. DEFINITION.**

20 In this subtitle, the term “Secretary” means the Sec-
21 retary of Health and Human Services, acting through the
22 Administrator of the Health Resources and Services Ad-
23 ministration and the Deputy Assistant Secretary for Mi-
24 nority Health, and in cooperation with the Director of the
25 Office of Community Services and the Director of the Na-

1 tional Institute for Minority Health and Health Dispari-
2 ties.

3 **SEC. 407. AUTHORIZATION OF APPROPRIATIONS.**

4 To carry out this subtitle, there is authorized to be
5 appropriated \$100,000,000 for fiscal year 2015.

6 **Subtitle B—Other Improvements of**
7 **Health Care Services**

8 **CHAPTER 1—EXPANSION OF COVERAGE**

9 **SEC. 411. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

10 **ACT.**

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

14 **“Subtitle D—Reconstruction and**
15 **Improvement Grants for Public**
16 **Health Care Facilities Serving**
17 **Pacific Islanders and the Insu-**
18 **lar Areas**

19 **“SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
20 **INITIATIVES.**

21 “(a) IN GENERAL.—The Secretary, in collaboration
22 with the Administrator of the Health Resources and Serv-
23 ices Administration, the Director of the Agency for
24 Healthcare Research and Quality, and the Administrator
25 of the Centers for Medicare & Medicaid Services, shall

1 award grants to eligible entities for the conduct of dem-
2 onstration projects to improve the quality of and access
3 to health care.

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

6 “(1) be a health center, hospital, health plan,
7 health system, community clinic, or other health en-
8 tity determined appropriate by the Secretary—

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

12 “(B) that provides care or treatment for a
13 substantial number of patients who are unin-
14 sured, are receiving assistance under a State
15 program under title XIX of the Social Security
16 Act, or are members of vulnerable populations,
17 as determined by the Secretary; and

18 “(C)(i) with respect to which, not less than
19 50 percent of the entity’s patient population is
20 made up of racial and ethnic minorities; or

21 “(ii) that—

22 “(I) serves a disproportionate percent-
23 age of local, minority racial and ethnic pa-
24 tients, or that has a patient population, at

1 least 50 percent of which is limited-
2 English-proficient; 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 popu-
7 lation 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; and

5 “(D) coping with end-of-life issues.

6 “(e) COMMON DATA SYSTEMS.—The Secretary shall
7 provide financial and other technical assistance to grant-
8 ees under this section for the development of common data
9 systems.

10 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section
12 such sums as may be necessary for each of fiscal years
13 2015 through 2020.

14 **“SEC. 3452. CENTERS OF EXCELLENCE.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Administrator of the Health Resources and Services
17 Administration, shall designate centers of excellence at
18 public hospitals, and other health systems serving large
19 numbers of minority patients, that—

20 “(1) meet the requirements of section
21 3451(b)(1);

22 “(2) demonstrate excellence in providing care to
23 minority populations; and

24 “(3) demonstrate excellence in reducing dispari-
25 ties in health and health care.

1 “(b) REQUIREMENTS.—A hospital or health system
2 that serves as a center of excellence under subsection (a)
3 shall—

4 “(1) design, implement, and evaluate programs
5 and policies relating to the delivery of care in ra-
6 cially, ethnically, and linguistically diverse popu-
7 lations;

8 “(2) provide training and technical assistance
9 to other hospitals and health systems relating to the
10 provision of quality health care to minority popu-
11 lations; and

12 “(3) develop activities for graduate or con-
13 tinuing medical education that institutionalize a
14 focus on cultural competence training for health care
15 providers.

16 “(c) 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 2015 through 2020.

20 **“SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**
21 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
22 **ING PACIFIC ISLANDERS AND THE INSULAR**
23 **AREAS.**

24 “(a) IN GENERAL.—The Secretary shall provide di-
25 rect financial assistance to designated health care pro-

1 viders and community health centers in American Samoa,
2 Guam, the Commonwealth of the Northern Mariana Is-
3 lands, the United States Virgin Islands, Puerto Rico, and
4 Hawaii for the purposes of reconstructing and improving
5 health care facilities and services in a culturally competent
6 and sustainable manner.

7 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
8 nancial assistance under subsection (a), an entity shall be
9 a public health facility or community health center located
10 in American Samoa, Guam, the Commonwealth of the
11 Northern Mariana Islands, the United States Virgin Is-
12 lands, Puerto Rico, or Hawaii that—

13 “(1) is owned or operated by—

14 “(A) the Government of American Samoa,
15 Guam, the Commonwealth of the Northern
16 Mariana Islands, the United States Virgin Is-
17 lands, Puerto Rico, or Hawaii or a unit of local
18 government; or

19 “(B) a nonprofit organization; and

20 “(2)(A) provides care or treatment for a sub-
21 stantial number of patients who are uninsured, re-
22 ceiving assistance under a State program under a
23 title XVIII of the Social Security Act, or a State
24 program under title XIX of such Act, or who are

1 members of a vulnerable population, as determined
2 by the Secretary; or

3 “(B) serves a disproportionate percentage of
4 local, minority racial and ethnic patients.

5 “(c) REPORT.—Not later than 180 days after the
6 date of enactment of this title and annually thereafter, the
7 Secretary shall submit to the Congress and the President
8 a report that includes an assessment of health resources
9 and facilities serving populations in American Samoa,
10 Guam, the Commonwealth of the Northern Mariana Is-
11 lands, the United States Virgin Islands, Puerto Rico, and
12 Hawaii. In preparing such report, the Secretary shall—

13 “(1) consult with and obtain information on all
14 health care facilities needs from the entities de-
15 scribed in subsection (b);

16 “(2) include all amounts of Federal assistance
17 received by each entity in the preceding fiscal year;

18 “(3) review the total unmet needs of each juris-
19 diction for health care facilities, including needs for
20 renovation and expansion of existing facilities;

21 “(4) include a strategic plan for addressing the
22 needs of each jurisdiction identified in the report;
23 and

1 “(5) evaluate the effectiveness of the care pro-
2 vided by measuring patient outcomes and cost meas-
3 ures.

4 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as necessary
6 to carry out this section.”.

7 **SEC. 412. REMOVING CITIZENSHIP AND IMMIGRATION BAR-**
8 **RIERS TO ACCESS TO AFFORDABLE HEALTH**
9 **CARE UNDER THE 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 subparagraph
15 heading to read as follows: “SPECIAL RULE
16 FOR CERTAIN INDIVIDUALS INELIGIBLE
17 FOR MEDICAID 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) PREEXISTING CONDITION INSURANCE
2 PLAN.—Section 1101(d) of the Patient Protection
3 and Affordable Care Act (42 U.S.C. 18001(d)) is
4 amended by striking paragraph (1) and redesignig-
5 nating paragraphs (2) and (3) as paragraphs (1)
6 and (2), respectively.

7 (4) BASIC HEALTH PROGRAM ELIGIBILITY.—
8 Section 1331(e)(1)(B) of the Patient Protection and
9 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
10 amended by striking “lawfully present in the United
11 States,”.

12 (5) RESTRICTIONS ON FEDERAL PAYMENTS.—
13 Section 1412 of the Patient Protection and Afford-
14 able Care Act (42 U.S.C. 18082) is amended by
15 striking subsection (d).

16 (6) REQUIREMENT TO MAINTAIN MINIMUM ES-
17 SENTIAL COVERAGE.—Subsection (d) of section
18 5000A of the Internal Revenue Code of 1986 is
19 amended by striking paragraph (3) and by redesignig-
20 nating paragraph (4) as paragraph (3).

21 (b) CONFORMING AMENDMENT.—

22 (1) Section 1411(a) of the Patient Protection
23 and Affordable Care Act (42 U.S.C. 18081(a)) is
24 amended by striking paragraph (1) and redesignig-

1 nating paragraphs (2), (3), and (4) as paragraphs
2 (1), (2), and (3), respectively.

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

6 (A) in the subsection heading, by striking
7 “employers;” and all that follows through “resi-
8 dents”; and

9 (B) by striking paragraph (3).

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

11 (a) IN GENERAL.—The Secretary of Health and
12 Human Services (in this section referred to as the “Sec-
13 retary”) shall—

14 (1) conduct a study, in accordance with the
15 standards under section 3101 of the Public Health
16 Service Act (42 U.S.C. 300kk), on the demographic
17 characteristics of the population of individuals who
18 do not have health insurance coverage; and

19 (2) predict, based on such study, the demo-
20 graphic characteristics of the population of individ-
21 uals who would remain without health insurance cov-
22 erage after the end of open enrollment or any special
23 enrollment period.

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 report the demographic
8 characteristics under paragraphs (1) and (2) of sub-
9 section (a) on the basis of racial and ethnic group,
10 and shall stratify the reporting on each racial and
11 ethnic group by other demographic characteristics
12 that can impact access to health insurance coverage,
13 such as sexual orientation, gender identity, primary
14 language, disability status, sex, socioeconomic sta-
15 tus, age group, and citizenship and immigration sta-
16 tus, in a manner consistent with title I of this Act.

17 **SEC. 414. MEDICAID PAYMENT PARITY FOR THE TERRI-**
18 **TORIES.**

19 (a) ELIMINATION OF FUNDING LIMITATIONS FOR
20 PUERTO RICO, THE UNITED STATES VIRGIN ISLANDS,
21 GUAM, THE COMMONWEALTH OF THE NORTHERN MAR-
22 IANA ISLANDS, AND AMERICAN SAMOA.—

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

1 (A) in subsection (f), in the matter pre-
2 ceding paragraph (1), by striking “subsection
3 (g)” and inserting “subsections (g) and (h)”;

4 (B) in subsection (g)(2), in the matter pre-
5 ceding subparagraph (A)—

6 (i) by striking “Notwithstanding sub-
7 section (f) and subject to and” and insert-
8 ing “Notwithstanding subsection (f) and
9 subject to”; and

10 (ii) by striking “paragraphs (3) and
11 (5)” and inserting “, paragraphs (3) and
12 (5) of this subsection, and subsection (h)”.

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

15 “(h) SUNSET OF FUNDING LIMITATIONS FOR PUER-
16 TO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM,
17 THE COMMONWEALTH OF THE NORTHERN MARIANA IS-
18 LANDS, AND AMERICAN SAMOA.—Subsections (f) and (g)
19 shall not apply to Puerto Rico, the United States Virgin
20 Islands, Guam, the Commonwealth of the Northern Mar-
21 iana Islands, and American Samoa for any fiscal year
22 after fiscal year 2015.”.

23 (2) CONFORMING AMENDMENT.—Section
24 1903(u) of such Act (42 U.S.C. 1396c(u)) is amend-
25 ed by striking paragraph (4).

1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply beginning with fiscal
3 year 2016.

4 (b) PARITY IN FMAP.—

5 (1) IN GENERAL.—Section 1905(b) of such Act
6 (42 U.S.C. 1396d(b)) is amended by inserting after
7 “and American Samoa shall be 55 percent,” the fol-
8 lowing: “(except that, beginning with fiscal year
9 2018, the Federal medical assistance percentage for
10 Puerto Rico, the United States Virgin Islands,
11 Guam, the Commonwealth of the Northern Mariana
12 Islands, and American Samoa shall be the Federal
13 medical assistance percentage determined by the
14 Secretary in consultation (for the United States Vir-
15 gin Islands, Guam, the Commonwealth of the North-
16 ern Mariana Islands, and American Samoa) with the
17 Secretary of the Interior)”.

18 (2) 2-FISCAL-YEAR TRANSITION.—Notwith-
19 standing any other provision of law, during fiscal
20 years 2016 and 2017, the Federal medical assist-
21 ance percentage established under section 1905(b) of
22 the Social Security Act (42 U.S.C. 1396d(b)) for
23 Puerto Rico, the United States Virgin Islands,
24 Guam, the Commonwealth of the Northern Mariana
25 Islands, and American Samoa shall be the highest

1 such Federal medical assistance percentage applica-
2 ble to any of the 50 States or the District of Colum-
3 bia for the fiscal year involved.

4 (3) PER CAPITA INCOME DATA.—

5 (A) REPORT TO CONGRESS.—Not later
6 than October 1, 2016, the Secretary of Health
7 and Human Services shall submit to Congress
8 a report that describes the per capita income
9 data used to promulgate the Federal medical
10 assistance percentage in the territories and how
11 such data differ from the per capita income
12 data used to promulgate Federal medical assist-
13 ance percentages for the 50 States and the Dis-
14 trict of Columbia. The report should include
15 recommendations on how the Federal medical
16 assistance percentages can be calculated for the
17 territories to ensure parity with the 50 States
18 and the District of Columbia.

19 (B) APPLICATION.—Section 1101(a)(8)(B)
20 of the Social Security Act (42 U.S.C.
21 1308(a)(8)(B)) is amended—

22 (i) by striking “(other than Puerto
23 Rico, the United States Virgin Islands, and
24 Guam)” and inserting “(including Puerto
25 Rico, the United States Virgin Islands,

1 Guam, the Commonwealth of the Northern
2 Mariana Islands, and American Samoa)”;
3 and

4 (ii) by inserting “(or, if such satisfac-
5 tory data are not available in the case of
6 the United States Virgin Islands, Guam,
7 the Northern Mariana Islands, or Amer-
8 ican Samoa, satisfactory data available
9 from the Department of the Interior for
10 the same period, or if such satisfactory
11 data are not available in the case of Puerto
12 Rico, satisfactory data available from the
13 government of the Commonwealth of Puer-
14 to Rico for the same period)” after “De-
15 partment of Commerce”.

16 **SEC. 415. EXTENSION OF MEDICARE SECONDARY PAYER.**

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

20 (1) in the last sentence, by inserting “, and be-
21 fore January 1, 2015” after “prior to such date”);
22 and

23 (2) by adding at the end the following new sen-
24 tence: “Effective for items and services furnished on
25 or after January 1, 2015 (with respect to periods

1 beginning on or after the date that is 42 months
2 prior to such date), clauses (i) and (ii) shall be ap-
3 plied by substituting ‘42-month’ for ‘12-month’ each
4 place it appears in the first sentence.”.

5 (b) **EFFECTIVE DATE.**—The amendments made by
6 this section shall take effect on the date of enactment of
7 this Act. For purposes of determining an individual’s sta-
8 tus under section 1862(b)(1)(C) of the Social Security Act
9 (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection
10 (a), an individual who is within the coordinating period
11 as of the date of enactment of this Act shall have that
12 period extended to the full 42 months described in the last
13 sentence of such section, as added by the amendment
14 made by subsection (a)(2).

15 **SEC. 416. BORDER HEALTH GRANTS.**

16 (a) **ELIGIBLE ENTITY DEFINED.**—In this section,
17 the term “eligible entity” means a State, public institution
18 of higher education, local government, tribal government,
19 nonprofit health organization, community health center, or
20 community clinic receiving assistance under section 330
21 of the Public Health Service Act (42 U.S.C. 254b), that
22 is located in the border area.

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 abuse;

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 or
7 promotoras;

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 and
17 1397aa)); 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 2015, and such sums as may
4 be necessary for each succeeding fiscal year.

5 **SEC. 417. REMOVING MEDICARE BARRIER TO HEALTH**
6 **CARE.**

7 (a) PART A.—Section 1818(a)(3) of the Social Secu-
8 rity Act (42 U.S.C. 1395i–2(a)(3)) is amended by striking
9 “(B)” and all that follows through “under this section”
10 and inserting “(B) an individual who is lawfully present
11 in the United States”.

12 (b) PART B.—Section 1836(2) of the Social Security
13 Act (42 U.S.C. 1395o(2)) is amended by striking “(B)”
14 and all that follows through “under this part” and insert-
15 ing “(B) an individual who is lawfully present in the
16 United States”.

17 **SEC. 418. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
18 **PROVIDED BY URBAN INDIAN HEALTH CEN-**
19 **TERS.**

20 (a) IN GENERAL.—The third sentence of section
21 1905(b) of the Social Security Act (42 U.S.C. 1396(b)),
22 as amended by section 415(c), is further amended by in-
23 serting “or are received through a program operated by
24 an urban Indian organization through a grant or contract

1 under title V of such Act” after “(as defined in section
2 4 of the Indian Health Care Improvement Act)”.

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

6 **SEC. 419. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
7 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
8 **A FEDERALLY QUALIFIED HEALTH CENTER**
9 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
10 **TEM UNDER THE MEDICAID PROGRAM.**

11 (a) IN GENERAL.—The third sentence of section
12 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),
13 as amended by section 419, is amended by inserting “;
14 and, with respect to medical assistance provided to a Na-
15 tive Hawaiian (as defined in section 12(2) of the Native
16 Hawaiian Health Care Improvement Act) through a feder-
17 ally qualified health center or a Native Hawaiian health
18 care system (as defined in section 12(6) of such Act),
19 whether directly, by referral, or under contract or other
20 arrangement between such federally qualified health cen-
21 ter or Native Hawaiian health care system and another
22 health care provider” before the period.

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

1 **CHAPTER 2—EXPANSION OF ACCESS**

2 **SEC. 421. GRANTS FOR RACIAL AND ETHNIC APPROACHES**
3 **TO COMMUNITY HEALTH.**

4 (a) **PURPOSE.**—It is the purpose of this section to
5 provide for the awarding of grants to assist communities
6 in mobilizing and organizing resources in support of effec-
7 tive and sustainable programs that will reduce or eliminate
8 disparities in health and health care experienced by racial
9 and ethnic minority individuals.

10 (b) **AUTHORITY TO AWARD GRANTS.**—The Secretary
11 of Health and Human Services, acting through the Ad-
12 ministrator of the Health Resources and Services Admin-
13 istration, shall award grants to eligible entities to assist
14 in designing, implementing, and evaluating culturally and
15 linguistically appropriate, science-based, and community-
16 driven sustainable strategies to eliminate racial and ethnic
17 health and health care disparities.

18 (c) **ELIGIBLE ENTITIES.**—To be eligible to receive a
19 grant under this section, an entity shall—

20 (1) represent a coalition—

21 (A) whose principal purpose is to develop
22 and implement interventions to reduce or elimi-
23 nate a health or health care disparity in a tar-
24 geted racial or ethnic minority group in the
25 community served by the coalition; and

- 1 (B) that includes—
- 2 (i) members selected from among—
- 3 (I) public health departments;
- 4 (II) community-based organiza-
- 5 tions;
- 6 (III) university and research or-
- 7 ganizations;
- 8 (IV) American Indian tribal or-
- 9 ganizations, national American Indian
- 10 organizations, Indian Health Service,
- 11 or organizations serving Alaska Na-
- 12 tives; and
- 13 (V) interested public or private
- 14 health care providers or organizations
- 15 as deemed appropriate by the Sec-
- 16 retary; and
- 17 (ii) at least 1 member from a commu-
- 18 nity-based organization that represents the
- 19 targeted racial or ethnic minority group;
- 20 and
- 21 (2) submit to the Secretary an application at
- 22 such time, in such manner, and containing such in-
- 23 formation as the Secretary may require, which shall
- 24 include—

1 (A) a description of the targeted racial or
2 ethnic populations in the community to be
3 served under the grant;

4 (B) a description of at least 1 health dis-
5 parity that exists in the racial or ethnic tar-
6 geted populations, including health issues such
7 as infant mortality, breast and cervical cancer
8 screening and management, musculoskeletal
9 diseases and obesity, prostate cancer screening
10 and management, cardiovascular disease, diabe-
11 tes, child and adult immunization levels, or
12 other health priority areas as designated by the
13 Secretary; and

14 (C) a demonstration of a proven record of
15 accomplishment of the coalition members in
16 serving and working with the targeted commu-
17 nity.

18 (d) SUSTAINABILITY.—The Secretary shall give pri-
19 ority to an eligible entity under this section if the entity
20 agrees that, with respect to the costs to be incurred by
21 the entity in carrying out the activities for which the grant
22 was awarded, the entity (and each of the participating
23 partners in the coalition represented by the entity) will
24 maintain its expenditures of non-Federal funds for such
25 activities at a level that is not less than the level of such

1 expenditures during the fiscal year immediately preceding
2 the first fiscal year for which the grant is awarded.

3 (e) NONDUPLICATION.—Funds provided through this
4 grant program should supplement, not supplant, existing
5 Federal funding, and the funds should not be used to du-
6 plicate the activities of the other health disparity grant
7 programs in this Act.

8 (f) TECHNICAL ASSISTANCE.—The Secretary may,
9 either directly or by grant or contract, provide any entity
10 that receives a grant under this section with technical and
11 other nonfinancial assistance necessary to meet the re-
12 quirements of this section.

13 (g) DISSEMINATION.—The Secretary shall encourage
14 and enable grantees to share best practices, evaluation re-
15 sults, and reports with communities not affiliated with
16 grantees using the Internet, conferences, and other perti-
17 nent information regarding the projects funded by this
18 section, including the outreach efforts of the Office of Mi-
19 nority Health and Health Disparity Elimination and the
20 Centers for Disease Control and Prevention.

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

1 (i) DEFINITION.—In this section, the term “Sec-
2 retary” means the Secretary of Health and Human Serv-
3 ices.

4 (j) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as may be
6 necessary to carry out this section.

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

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

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

13 (A) in subparagraph (B)—

14 (i) by striking “owned and”; and

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

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

22 (2) EFFECTIVE DATE.—The amendments made
23 by this subsection shall apply to services furnished
24 on or after January 1, 2015.

1 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
2 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
3 REQUIREMENT.—

4 (1) IN GENERAL.—Section 1820(c)(2) of the
5 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
6 amended—

7 (A) in subparagraph (B)(iii), by striking
8 “provides not more than” and inserting “sub-
9 ject to subparagraph (F), provides not more
10 than”; and

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

13 “(F) ALTERNATIVE TO 25 INPATIENT BED
14 LIMIT REQUIREMENT.—

15 “(i) IN GENERAL.—A State may elect
16 to treat a facility, with respect to the des-
17 ignation of the facility for a cost-reporting
18 period, as satisfying the requirement of
19 subparagraph (B)(iii) relating to a max-
20 imum number of acute care inpatient beds
21 if the facility elects, in accordance with a
22 method specified by the Secretary and be-
23 fore the beginning of the cost reporting pe-
24 riod, to meet the requirement under clause
25 (ii).

1 “(ii) ALTERNATE REQUIREMENT.—

2 The requirement under this clause, with
3 respect to a facility and a cost-reporting
4 period, is that the total number of inpa-
5 tient bed days described in subparagraph
6 (B)(iii) during such period will not exceed
7 7,300. For purposes of this subparagraph,
8 an individual who is an inpatient in a bed
9 in the facility for a single day shall be
10 counted as one inpatient bed day.

11 “(iii) WITHDRAWAL OF ELECTION.—

12 The option described in clause (i) shall not
13 apply to a facility for a cost-reporting pe-
14 riod if the facility (for any two consecutive
15 cost-reporting periods during the previous
16 5 cost-reporting periods) was treated under
17 such option and had a total number of in-
18 patient bed days for each of such two cost-
19 reporting periods that exceeded the num-
20 ber specified in such clause.”.

21 (2) EFFECTIVE DATE.—The amendments made
22 by paragraph (1) shall apply to cost-reporting peri-
23 ods beginning on or after the date of the enactment
24 of this Act.

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

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

7 “Rural Community Hospital; Rural Community Hospital
8 Services

9 “(jjj)(1) The term ‘rural community hospital’ means
10 a hospital (as defined in subsection (e)) that—

11 “(A) is located in a rural area (as defined in
12 section 1886(d)(2)(D)) or treated as being so lo-
13 cated pursuant to section 1886(d)(8)(E);

14 “(B) subject to paragraph (2), has less than 51
15 acute care inpatient beds, as reported in its most re-
16 cent cost report;

17 “(C) makes available 24-hour emergency care
18 services;

19 “(D) subject to paragraph (3), has a provider
20 agreement in effect with the Secretary and is open
21 to the public as of January 1, 2010; and

22 “(E) applies to the Secretary for such designa-
23 tion.

24 “(2) For purposes of paragraph (1)(B), beds in a
25 psychiatric or rehabilitation unit of the hospital which is
26 a distinct part of the hospital shall not be counted.

1 “(3) Paragraph (1)(D) shall not be construed to pro-
2 hibit any of the following from qualifying as a rural com-
3 munity hospital:

4 “(A) A replacement facility (as defined by the
5 Secretary in regulations in effect on January 1,
6 2012) with the same service area (as defined by the
7 Secretary in regulations in effect on such date).

8 “(B) A facility obtaining a new provider num-
9 ber pursuant to a change of ownership.

10 “(C) A facility which has a binding written
11 agreement with an outside, unrelated party for the
12 construction, reconstruction, lease, rental, or financ-
13 ing of a building as of January 1, 2012.

14 “(4) Nothing in this subsection shall be construed as
15 prohibiting a critical access hospital from qualifying as a
16 rural community hospital if the critical access hospital
17 meets the conditions otherwise applicable to hospitals
18 under subsection (e) and section 1866.

19 “(5) Nothing in this subsection shall be construed as
20 prohibiting a rural community hospital participating in
21 the demonstration program under section 410A of the
22 Medicare Prescription Drug, Improvement, and Mod-
23 ernization Act of 2003 (Public Law 108–173; 117 Stat.
24 2313) from qualifying as a rural community hospital if
25 the rural community hospital meets the conditions other-

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

3 (b) PAYMENT.—

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

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

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

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

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

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

1 “(p) PAYMENT FOR OUTPATIENT SERVICES FUR-
2 NISHED IN RURAL COMMUNITY HOSPITALS.—The
3 amount of payment under this part for outpatient services
4 furnished in a rural community hospital is, at the election
5 of the hospital in the application referred to in section
6 1861(jjj)(1)(E)—

7 “(1) 101 percent of the reasonable costs of pro-
8 viding such services, without regard to the amount
9 of the customary or other charge and any limitation
10 under section 1861(v)(1)(U), or

11 “(2) the amount of payment provided for under
12 the prospective payment system for covered OPD
13 services under section 1833(t).”.

14 (3) EXEMPTION FROM 30-PERCENT REDUCTION
15 IN REIMBURSEMENT FOR BAD DEBT.—Section
16 1861(v)(1)(T) of such Act (42 U.S.C.
17 1395x(v)(1)(T)) is amended by inserting “(other
18 than for a rural community hospital)” after “In de-
19 termining such reasonable costs for hospitals”.

20 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
21 SERVICES.—Section 1834(p) of such Act (as added by
22 subsection (b)(2)) is amended—

23 (1) by redesignating paragraphs (1) and (2) as
24 subparagraphs (A) and (B), respectively;

25 (2) by inserting “(1)” after “(p)”; and

1 (3) by adding at the end the following:

2 “(2) The amounts of beneficiary cost-sharing for out-
3 patient services furnished in a rural community hospital
4 under this part shall be as follows:

5 “(A) For items and services that would have
6 been paid under section 1833(t) if provided by a
7 hospital, the amount of cost-sharing determined
8 under paragraph (8) of such section.

9 “(B) For items and services that would have
10 been paid under section 1833(h) if furnished by a
11 provider or supplier, no cost-sharing shall apply.

12 “(C) For all other items and services, the
13 amount of cost-sharing that would apply to the item
14 or service under the methodology that would be used
15 to determine payment for such item or service if pro-
16 vided by a physician, provider, or supplier, as the
17 case may be.”.

18 (d) CONFORMING AMENDMENTS.—

19 (1) PART A PAYMENT.—Section 1814(b) of
20 such Act (42 U.S.C. 1395f(b)) is amended in the
21 matter preceding paragraph (1) by inserting “other
22 than inpatient hospital services furnished by a rural
23 community hospital,” after “critical access hospital
24 services,”.

1 (2) PART B PAYMENT.—Section 1833(a) of
2 such Act (42 U.S.C. 1395l(a)), as amended by sec-
3 tion 203(b)(2), is amended—

4 (A) in paragraph (2), in the matter before
5 subparagraph (A), by striking “and (I)” and in-
6 serting “(I), and (K)”;

7 (B) by striking “and” at the end of para-
8 graph (9);

9 (C) by striking the period at the end of
10 paragraph (10) and inserting “; and”; and

11 (D) by adding at the end the following:

12 “(11) in the case of outpatient services fur-
13 nished by a rural community hospital, the amounts
14 described in section 1834(p).”.

15 (3) TECHNICAL AMENDMENTS.—

16 (A) CONSULTATION WITH STATE AGEN-
17 CIES.—Section 1863 of such Act (42 U.S.C.
18 1395z) is amended by striking “and (dd)(2)”
19 and inserting “(dd)(2), (mm)(1), and (jjj)(1)”.

20 (B) PROVIDER AGREEMENTS.—Section
21 1866(a)(2)(A) of such Act (42 U.S.C.
22 1395cc(a)(2)(A)) is amended by inserting “sec-
23 tion 1834(p)(2),” after “section 1833(b),”.

1 (e) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to items and services furnished on
3 or after October 1, 2014.

4 **SEC. 424. MEDICARE REMOTE MONITORING PILOT**
5 **PROJECTS.**

6 (a) PILOT PROJECTS.—

7 (1) IN GENERAL.—Not later than 9 months
8 after the date of enactment of this Act, the Sec-
9 retary of Health and Human Services (in this sec-
10 tion referred to as the “Secretary”) shall conduct
11 pilot projects under title XVIII of the Social Secu-
12 rity Act for the purpose of providing incentives to
13 home health agencies to utilize home monitoring and
14 communications technologies that—

15 (A) enhance health outcomes for Medicare
16 beneficiaries; and

17 (B) reduce expenditures under such title.

18 (2) SITE REQUIREMENTS.—

19 (A) URBAN AND RURAL.—The Secretary
20 shall conduct the pilot projects under this sec-
21 tion in both urban and rural areas.

22 (B) SITE IN A SMALL STATE.—The Sec-
23 retary shall conduct at least 3 of the pilot
24 projects in a State with a population of less
25 than 1,000,000.

1 (3) DEFINITION OF HOME HEALTH AGENCY.—

2 In this section, the term “home health agency” has
3 the meaning given that term in section 1861(o) of
4 the Social Security Act (42 U.S.C. 1395x(o)).

5 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
6 OF PROJECTS.—The Secretary shall specify the criteria
7 for identifying those Medicare beneficiaries who shall be
8 considered within the scope of the pilot projects under this
9 section for purposes of the application of subsection (c)
10 and for the assessment of the effectiveness of the home
11 health agency in achieving the objectives of this section.
12 Such criteria may provide for the inclusion in the projects
13 of Medicare beneficiaries who begin receiving home health
14 services under title XVIII of the Social Security Act after
15 the date of the implementation of the projects.

16 (c) INCENTIVES.—

17 (1) PERFORMANCE TARGETS.—The Secretary
18 shall establish for each home health agency partici-
19 pating in a pilot project under this section a per-
20 formance target using one of the following meth-
21 odologies, as determined appropriate by the Sec-
22 retary:

23 (A) ADJUSTED HISTORICAL PERFORMANCE
24 TARGET.—The Secretary shall establish for the
25 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 for Medicare
5 beneficiaries determined to be within the
6 scope of the pilot project in a base period
7 determined by the Secretary; and

8 (ii) an annual per capita expenditure
9 target for such beneficiaries, reflecting the
10 base expenditure amount adjusted for risk
11 and adjusted growth rates.

12 (B) COMPARATIVE PERFORMANCE TAR-
13 GET.—The Secretary shall establish for the
14 agency a comparative performance target equal
15 to the average total payments under such parts
16 A and B during the pilot project for comparable
17 individuals in the same geographic area that
18 are not determined to be within the scope of the
19 pilot project.

20 (2) INCENTIVE.—Subject to paragraph (3), the
21 Secretary shall pay to each participating home care
22 agency an incentive payment for each year under the
23 pilot project equal to a portion of the Medicare sav-
24 ings realized for such year relative to the perform-
25 ance target under paragraph (1).

1 (3) LIMITATION ON EXPENDITURES.—The Sec-
2 retary shall limit incentive payments under this sec-
3 tion in order to ensure that the aggregate expendi-
4 tures under title XVIII of the Social Security Act
5 (including incentive payments under this subsection)
6 do not exceed the amount that the Secretary esti-
7 mates would have been expended if the pilot projects
8 under this section had not been implemented.

9 (d) WAIVER AUTHORITY.—The Secretary may waive
10 such provisions of titles XI and XVIII of the Social Secu-
11 rity Act as the Secretary determines to be appropriate for
12 the conduct of the pilot projects under this section.

13 (e) REPORT TO CONGRESS.—Not later than 5 years
14 after the date that the first pilot project under this section
15 is implemented, the Secretary shall submit to Congress a
16 report on the pilot projects. Such report shall contain a
17 detailed description of issues related to the expansion of
18 the projects under subsection (f) and recommendations for
19 such legislation and administrative actions as the Sec-
20 retary considers appropriate.

21 (f) EXPANSION.—If the Secretary determines that
22 any of the pilot projects under this section enhance health
23 outcomes for Medicare beneficiaries and reduce expendi-
24 tures under title XVIII of the Social Security Act, the Sec-

1 retary may initiate comparable projects in additional
2 areas.

3 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
4 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
5 tive payment under this section—

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

10 (2) shall have no effect on the amount of such
11 payments.

12 **SEC. 425. RURAL HEALTH QUALITY ADVISORY COMMISSION**
13 **AND DEMONSTRATION PROJECTS.**

14 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
15 SION.—

16 (1) ESTABLISHMENT.—Not later than 6
17 months after the date of the enactment of this sec-
18 tion, the Secretary of Health and Human Services
19 (in this section referred to as the “Secretary”) shall
20 establish a commission to be known as the Rural
21 Health Quality Advisory Commission (in this section
22 referred to as the “Commission”).

23 (2) DUTIES OF COMMISSION.—

24 (A) NATIONAL PLAN.—The Commission
25 shall develop, coordinate, and facilitate imple-

1 mentation of a national plan for rural health
2 quality improvement. The national plan shall—

3 (i) identify objectives for rural health
4 quality improvement;

5 (ii) identify strategies to eliminate
6 known gaps in rural health system capacity
7 and improve rural health quality; and

8 (iii) provide for Federal programs to
9 identify opportunities for strengthening
10 and aligning policies and programs to im-
11 prove rural health quality.

12 (B) DEMONSTRATION PROJECTS.—The
13 Commission shall design demonstration projects
14 to test alternative models for rural health qual-
15 ity improvement, including with respect to both
16 personal and population health.

17 (C) MONITORING.—The Commission shall
18 monitor progress toward the objectives identi-
19 fied pursuant to paragraph (1)(A).

20 (3) MEMBERSHIP.—

21 (A) NUMBER.—The Commission shall be
22 composed of 11 members appointed by the Sec-
23 retary.

24 (B) SELECTION.—The Secretary shall se-
25 lect the members of the Commission from

1 among individuals with significant rural health
2 care and health care quality expertise, including
3 expertise in clinical health care, health care
4 quality research, population or public health, or
5 purchaser organizations.

6 (4) CONTRACTING AUTHORITY.—Subject to the
7 availability of funds, the Commission may enter into
8 contracts and make other arrangements, as may be
9 necessary to carry out the duties described in para-
10 graph (2).

11 (5) STAFF.—Upon the request of the Commis-
12 sion, the Secretary may detail, on a reimbursable
13 basis, any of the personnel of the Office of Rural
14 Health Policy of the Health Resources and Services
15 Administration, the Agency for Healthcare Quality
16 and Research, or the Centers for Medicare & Med-
17 icaid Services to the Commission to assist in car-
18 rying out this subsection.

19 (6) REPORTS TO CONGRESS.—Not later than 1
20 year after the establishment of the Commission, and
21 annually thereafter, the Commission shall submit a
22 report to the Congress on rural health quality. Each
23 such report shall include the following:

1 (A) An inventory of relevant programs and
2 recommendations for improved coordination and
3 integration of policy and programs.

4 (B) An assessment of achievement of the
5 objectives identified in the national plan devel-
6 oped under paragraph (2) and recommenda-
7 tions for realizing such objectives.

8 (C) Recommendations on Federal legisla-
9 tion, regulations, or administrative policies to
10 enhance rural health quality and outcomes.

11 (b) RURAL HEALTH QUALITY DEMONSTRATION
12 PROJECTS.—

13 (1) IN GENERAL.—Not later than 270 days
14 after the date of the enactment of this section, the
15 Secretary, in consultation with the Rural Health
16 Quality Advisory Commission, the Office of Rural
17 Health Policy of the Health Resources and Services
18 Administration, the Agency for Healthcare Research
19 and Quality, and the Centers for Medicare & Med-
20 icaid Services, shall make grants to eligible entities
21 for 5 demonstration projects to implement and
22 evaluate methods for improving the quality of health
23 care in rural communities. Each such demonstration
24 project shall include—

25 (A) alternative community models that—

1 (i) will achieve greater integration of
2 personal and population health services;
3 and

4 (ii) address safety, effectiveness,
5 patient- or community-centeredness, timeli-
6 ness, efficiency, and equity (the 6 aims
7 identified by the Institute of Medicine of
8 the National Academies in its report enti-
9 tled “Crossing the Quality Chasm: A New
10 Health System for the 21st Century” re-
11 leased on March 1, 2001);

12 (B) innovative approaches to the financing
13 and delivery of health services to achieve rural
14 health quality goals; and

15 (C) development of quality improvement
16 support structures to assist rural health sys-
17 tems and professionals (such as workforce sup-
18 port structures, quality monitoring and report-
19 ing, clinical care protocols, and information
20 technology applications).

21 (2) ELIGIBLE ENTITIES.—In this subsection,
22 the term “eligible entity” means a consortium
23 that—

24 (A) shall include—

1 (i) at least one health care provider or
2 health care delivery system located in a
3 rural area; and

4 (ii) at least one organization rep-
5 resenting multiple community stakeholders;
6 and

7 (B) may include other partners such as
8 rural research centers.

9 (3) CONSULTATION.—In developing the pro-
10 gram for awarding grants under this subsection, the
11 Secretary shall consult with the Administrator of the
12 Agency for Healthcare Research and Quality, rural
13 health care providers, rural health care researchers,
14 and private and nonprofit groups (including national
15 associations) which are undertaking similar efforts.

16 (4) EXPEDITED WAIVERS.—The Secretary shall
17 expedite the processing of any waiver that—

18 (A) is authorized under title XVIII or XIX
19 of the Social Security Act (42 U.S.C. 1395 et
20 seq.); and

21 (B) is necessary to carry out a demonstra-
22 tion project under this subsection.

23 (5) DEMONSTRATION PROJECT SITES.—The
24 Secretary shall ensure that the 5 demonstration
25 projects funded under this subsection are conducted

1 at a variety of sites representing the diversity of
2 rural communities in the Nation.

3 (6) DURATION.—Each demonstration project
4 under this subsection shall be for a period of 4
5 years.

6 (7) INDEPENDENT EVALUATION.—The Sec-
7 retary shall enter into an arrangement with an enti-
8 ty that has experience working directly with rural
9 health systems for the conduct of an independent
10 evaluation of the program carried out under this
11 subsection.

12 (8) REPORT.—Not later than 1 year after the
13 conclusion of all of the demonstration projects fund-
14 ed under this subsection, the Secretary shall submit
15 a report to the Congress on the results of such
16 projects. The report shall include—

17 (A) an evaluation of patient access to care,
18 patient outcomes, and an analysis of the cost
19 effectiveness of each such project; and

20 (B) recommendations on Federal legisla-
21 tion, regulations, or administrative policies to
22 enhance rural health quality and outcomes.

23 (c) APPROPRIATION.—

24 (1) IN GENERAL.—Out of funds in the Treas-
25 ury not otherwise appropriated, there are appro-

1 priated to the Secretary to carry out this section
2 \$30,000,000 for the period of fiscal years 2015
3 through 2019.

4 (2) AVAILABILITY.—

5 (A) IN GENERAL.—Funds appropriated
6 under paragraph (1) shall remain available for
7 expenditure through fiscal year 2019.

8 (B) REPORT.—For purposes of carrying
9 out subsection (b)(8), funds appropriated under
10 paragraph (1) shall remain available for ex-
11 penditure through fiscal year 2020.

12 (3) RESERVATION.—Of the amount appro-
13 priated under paragraph (1), the Secretary shall re-
14 serve—

15 (A) \$5,000,000 to carry out subsection (a);

16 and

17 (B) \$25,000,000 to carry out subsection

18 (b), of which—

19 (i) 2 percent shall be for the provision
20 of technical assistance to grant recipients;
21 and

22 (ii) 5 percent shall be for independent
23 evaluation under subsection (b)(7).

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

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

4 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
5 **RURAL HEALTH NETWORK DEVELOPMENT,**
6 **DELTA RURAL DISPARITIES AND HEALTH**
7 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
8 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
9 **MENT GRANT PROGRAMS.**

10 “(a) PURPOSE.—The purpose of this section is to
11 provide for grants—

12 “(1) under subsection (b), to promote rural
13 health care services outreach;

14 “(2) under subsection (c), to provide for the
15 planning and implementation of integrated health
16 care networks in rural areas;

17 “(3) under subsection (d), to assist rural com-
18 munities in the Delta Region to reduce health dis-
19 parities and to promote and enhance health system
20 development; and

21 “(4) under subsection (e), to provide for the
22 planning and implementation of small rural health
23 care provider quality improvement activities.

24 “(b) RURAL HEALTH CARE SERVICES OUTREACH
25 GRANTS.—

1 “(1) GRANTS.—The Director of the Office of
2 Rural Health Policy of the Health Resources and
3 Services Administration may award grants to eligible
4 entities to promote rural health care services out-
5 reach by expanding the delivery of health care serv-
6 ices to include new and enhanced services in rural
7 areas. The Director may award the grants for peri-
8 ods of not more than 3 years.

9 “(2) ELIGIBILITY.—To be eligible to receive a
10 grant under this subsection for a project, an enti-
11 ty—

12 “(A) shall be a rural public or rural non-
13 profit private entity, a facility that qualifies as
14 a rural health clinic under title XVIII of the
15 Social Security Act, a public or nonprofit entity
16 existing exclusively to provide services to mi-
17 grant and seasonal farm workers in rural areas,
18 or a tribal government whose grant-funded ac-
19 tivities will be conducted within federally recog-
20 nized tribal areas;

21 “(B) shall represent a consortium com-
22 posed of members—

23 “(i) that include 3 or more independ-
24 ently owned health care entities; and

1 “(ii) that may be nonprofit or for-
2 profit entities; and

3 “(C) shall not previously have received a
4 grant under this subsection for the same or a
5 similar project, unless the entity is proposing to
6 expand the scope of the project or the area that
7 will be served through the project.

8 “(3) APPLICATIONS.—To be eligible to receive a
9 grant under this subsection, an eligible entity shall
10 prepare and submit to the Director an application at
11 such time, in such manner, and containing such in-
12 formation as the Director may require, including—

13 “(A) a description of the project that the
14 eligible entity will carry out using the funds
15 provided under the grant;

16 “(B) a description of the manner in which
17 the project funded under the grant will meet
18 the health care needs of rural populations in
19 the local community or region to be served;

20 “(C) a plan for quantifying how health
21 care needs will be met through identification of
22 the target population and benchmarks of service
23 delivery or health status, such as—

1 “(i) quantifiable measurements of
2 health status improvement for projects fo-
3 cusing on health promotion; or

4 “(ii) benchmarks of increased access
5 to primary care, including tracking factors
6 such as the number and type of primary
7 care visits, identification of a medical
8 home, or other general measures of such
9 access;

10 “(D) a description of how the local com-
11 munity or region to be served will be involved
12 in the development and ongoing operations of
13 the project;

14 “(E) a plan for sustaining the project after
15 Federal support for the project has ended;

16 “(F) a description of how the project will
17 be evaluated;

18 “(G) the administrative capacity to submit
19 annual performance data electronically as speci-
20 fied by the Director; and

21 “(H) other such information as the Direc-
22 tor determines to be appropriate.

23 “(c) RURAL HEALTH NETWORK DEVELOPMENT
24 GRANTS.—

25 “(1) GRANTS.—

1 “(A) IN GENERAL.—The Director may
2 award rural health network development grants
3 to eligible entities to promote, through planning
4 and implementation, the development of inte-
5 grated health care networks that have combined
6 the functions of the entities participating in the
7 networks in order to—

8 “(i) achieve efficiencies and economies
9 of scale;

10 “(ii) expand access to, coordinate, and
11 improve the quality of the health care de-
12 livery system through development of orga-
13 nizational efficiencies;

14 “(iii) implement health information
15 technology to achieve efficiencies, reduce
16 medical errors, and improve quality;

17 “(iv) coordinate care and manage
18 chronic illness; and

19 “(v) strengthen the rural health care
20 system as a whole in such a manner as to
21 show a quantifiable return on investment
22 to the participants in the network.

23 “(B) GRANT PERIODS.—The Director may
24 award such a rural health network development
25 grant—

1 “(i) for a period of 3 years for imple-
2 mentation activities; or

3 “(ii) for a period of 1 year for plan-
4 ning activities to assist in the initial devel-
5 opment of an integrated health care net-
6 work, if the proposed participants in the
7 network do not have a history of collabo-
8 rative efforts and a 3-year grant would be
9 inappropriate.

10 “(2) ELIGIBILITY.—To be eligible to receive a
11 grant under this subsection, an entity—

12 “(A) shall be a rural public or rural non-
13 profit private entity, a facility that qualifies as
14 a rural health clinic under title XVIII of the
15 Social Security Act, a public or nonprofit entity
16 existing exclusively to provide services to mi-
17 grant and seasonal farm workers in rural areas,
18 or a tribal government whose grant-funded ac-
19 tivities will be conducted within federally recog-
20 nized tribal areas;

21 “(B) shall represent a network composed
22 of participants—

23 “(i) that include 3 or more independ-
24 ently owned health care entities; and

1 “(ii) that may be nonprofit or for-
2 profit entities; and

3 “(C) shall not previously have received a
4 grant under this subsection (other than a 1-
5 year grant for planning activities) for the same
6 or a similar project.

7 “(3) APPLICATIONS.—To be eligible to receive a
8 grant under this subsection, an eligible entity, in
9 consultation with the appropriate State office of
10 rural health or another appropriate State entity,
11 shall prepare and submit to the Director an applica-
12 tion at such time, in such manner, and containing
13 such information as the Director may require, in-
14 cluding—

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—

22 “(i) the history of collaborative activi-
23 ties carried out by the participants in the
24 network;

1 “(ii) the degree to which the partici-
2 pants are ready to integrate their func-
3 tions; and

4 “(iii) how the local community or re-
5 gion to be served will benefit from and be
6 involved in the activities carried out by the
7 network;

8 “(D) a description of how the local com-
9 munity or region to be served will experience in-
10 creased access to quality health care services
11 across the continuum of care as a result of the
12 integration activities carried out by the net-
13 work, including a description of—

14 “(i) return on investment for the com-
15 munity and the network members; and

16 “(ii) other quantifiable performance
17 measures that show the benefit of the net-
18 work activities;

19 “(E) a plan for sustaining the project after
20 Federal support for the project has ended;

21 “(F) a description of how the project will
22 be evaluated;

23 “(G) the administrative capacity to submit
24 annual performance data electronically as speci-
25 fied by the Director; and

1 “(H) other such information as the Direc-
2 tor determines to be appropriate.

3 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
4 TEMS DEVELOPMENT GRANTS.—

5 “(1) GRANTS.—The Director may award grants
6 to eligible entities to support reduction of health dis-
7 parities, improve access to health care, and enhance
8 rural health system development in the Delta Re-
9 gion.

10 “(2) ELIGIBILITY.—To be eligible to receive a
11 grant under this subsection, an entity shall be a
12 rural public or rural nonprofit private entity, a facil-
13 ity that qualifies as a rural health clinic under title
14 XVIII of the Social Security Act, a public or non-
15 profit entity existing exclusively to provide services
16 to migrant and seasonal farm workers in rural
17 areas, or a tribal government whose grant-funded
18 activities will be conducted within federally recog-
19 nized tribal areas.

20 “(3) APPLICATIONS.—To be eligible to receive a
21 grant under this subsection, an eligible entity shall
22 prepare and submit to the Director an application at
23 such time, in such manner, and containing such in-
24 formation as the Director may require, including—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) an explanation of the reasons why
5 Federal assistance is required to carry out the
6 project;

7 “(C) a description of the manner in which
8 the project funded under the grant will meet
9 the health care needs of the Delta Region;

10 “(D) a description of how the local com-
11 munity or region to be served will experience in-
12 creased access to quality health care services as
13 a result of the activities carried out by the enti-
14 ty;

15 “(E) a description of how health dispari-
16 ties will be reduced or the health system will be
17 improved;

18 “(F) a plan for sustaining the project after
19 Federal support for the project has ended;

20 “(G) a description of how the project will
21 be evaluated including process and outcome
22 measures related to the quality of care provided
23 or how the health care system improves its per-
24 formance;

1 “(H) a description of how the grantee will
2 develop an advisory group made up of rep-
3 resentatives of the communities to be served to
4 provide guidance to the grantee to best meet
5 community need; and

6 “(I) other such information as the Director
7 determines to be appropriate.

8 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
9 ITY IMPROVEMENT GRANTS.—

10 “(1) GRANTS.—The Director may award grants
11 to provide for the planning and implementation of
12 small rural health care provider quality improvement
13 activities. The Director may award the grants for
14 periods of 1 to 3 years.

15 “(2) ELIGIBILITY.—To be eligible for a grant
16 under this subsection, an entity—

17 “(A) shall be—

18 “(i) a rural public or rural nonprofit
19 private health care provider or provider of
20 health care services, such as a rural health
21 clinic; or

22 “(ii) another rural provider or net-
23 work of small rural providers identified by
24 the Director as a key source of local care;
25 and

1 “(B) shall not previously have received a
2 grant under this subsection for the same or a
3 similar project.

4 “(3) PREFERENCE.—In awarding grants under
5 this subsection, the Director shall give preference to
6 facilities that qualify as rural health clinics under
7 title XVIII of the Social Security Act.

8 “(4) APPLICATIONS.—To be eligible to receive a
9 grant under this subsection, an eligible entity shall
10 prepare and submit to the Director an application at
11 such time, in such manner, and containing such in-
12 formation as the Director may require, including—

13 “(A) a description of the project that the
14 eligible entity will carry out using the funds
15 provided under the grant;

16 “(B) an explanation of the reasons why
17 Federal assistance is required to carry out the
18 project;

19 “(C) a description of the manner in which
20 the project funded under the grant will assure
21 continuous quality improvement in the provision
22 of services by the entity;

23 “(D) a description of how the local com-
24 munity or region to be served will experience in-
25 creased access to quality health care services as

1 a result of the activities carried out by the enti-
2 ty;

3 “(E) a plan for sustaining the project after
4 Federal support for the project has ended;

5 “(F) a description of how the project will
6 be evaluated including process and outcome
7 measures related to the quality of care pro-
8 vided; and

9 “(G) other such information as the Direc-
10 tor determines to be appropriate.

11 “(f) GENERAL REQUIREMENTS.—

12 “(1) PROHIBITED USES OF FUNDS.—An entity
13 that receives a grant under this section may not use
14 funds provided through the grant—

15 “(A) to build or acquire real property; or

16 “(B) for construction.

17 “(2) COORDINATION WITH OTHER AGENCIES.—

18 The Director shall coordinate activities carried out
19 under grant programs described in this section, to
20 the extent practicable, with Federal and State agen-
21 cies and nonprofit organizations that are operating
22 similar grant programs, to maximize the effect of
23 public dollars in funding meritorious proposals.

24 “(g) REPORT.—Not later than September 30, 2016,
25 the Secretary shall prepare and submit to the appropriate

1 committees of Congress a report on the progress and ac-
2 complishments of the grant programs described in sub-
3 sections (b), (c), (d), and (e).

4 “(h) DEFINITIONS.—In this section:

5 “(1) The term ‘Delta Region’ has the meaning
6 given to the term ‘region’ in section 382A of the
7 Consolidated Farm and Rural Development Act (7
8 U.S.C. 2009aa).

9 “(2) The term ‘Director’ means the Director of
10 the Office of Rural Health Policy of the Health Re-
11 sources and Services Administration.

12 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 \$40,000,000 for fiscal year 2015, and such sums as may
15 be necessary for each of fiscal years 2016 through 2019.”.

16 **SEC. 427. COMMUNITY HEALTH CENTER COLLABORATIVE**
17 **ACCESS EXPANSION.**

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

21 “(t) MISCELLANEOUS PROVISIONS.—

22 “(1) RULE OF CONSTRUCTION WITH RESPECT
23 TO RURAL HEALTH CLINICS.—Nothing in this sec-
24 tion shall be construed to prevent a community
25 health center from contracting with a federally cer-

1 tified rural health clinic (as defined by section
2 1861(aa)(2) of the Social Security Act) for the deliv-
3 ery of primary health care and other mental, dental,
4 and physical health services that are available at the
5 rural health clinic to individuals who would other-
6 wise be eligible for free or reduced cost care if that
7 individual were able to obtain that care at the com-
8 munity health center. Such services may be limited
9 in scope to those primary health care and other
10 mental, dental, and physical health services available
11 in that rural health clinic.

12 “(2) ENABLING SERVICES.—To the extent pos-
13 sible, enabling services such as transportation and
14 translation assistance shall be provided by rural
15 health clinics described in paragraph (1).

16 “(3) ASSURANCES.—In order for a rural health
17 clinic to receive funds under this section through a
18 contract with a community health center for the de-
19 livery of primary health care and other services de-
20 scribed in paragraph (1), such rural health clinic
21 shall establish policies to ensure—

22 “(A) nondiscrimination based upon the
23 ability of a patient to pay;

24 “(B) the establishment of a sliding fee
25 scale for low-income patients; and

1 “(C) any such services should be subject to
2 full reimbursement according to the Prospective
3 Payment System scale.”.

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

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

14 (b) **DEFINITIONS.**—In subsection (a):

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

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

23 (3) **MEDICARE PROGRAM.**—The term “Medicare
24 Program” means the program of health insurance
25 administered by the Secretary of Health and Human

1 Services under title XVIII of the Social Security Act
2 (42 U.S.C. 1395 et seq.).

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

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

7 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

8 “(1) DETERMINATION BY THE DIRECTOR.—

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

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

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

1 budgetary outyears and a description of the
2 basis for such conclusions; and

3 “(B) may prepare a budget projection that
4 includes some or all of the budgetary outyears,
5 notwithstanding the time periods for projections
6 described in subsection (e) and sections 308,
7 402, and 424.

8 “(3) DEFINITIONS.—As used in this sub-
9 section—

10 “(A) the term ‘preventive health’ means an
11 action that focuses on the health of the public,
12 individuals, and defined populations in order to
13 protect, promote, and maintain health, wellness,
14 and functional ability, and prevent disease, dis-
15 ability, and premature death that is dem-
16 onstrated by credible and publicly available epi-
17 demiological projection models, incorporating
18 clinical trials or observational studies in hu-
19 mans, to avoid future health care costs; and

20 “(B) the term ‘budgetary outyears’ means
21 the 2 consecutive 10-year periods beginning
22 with the first fiscal year that is 10 years after
23 the budget year provided for in the most re-
24 cently agreed to concurrent resolution on the
25 budget.”.

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

2 It is the sense of the Congress that—

3 (1) the maintenance of effort provisions added
4 to sections 1902 and 2105(d) of the Social Security
5 Act by sections 2001(b) and 2101(b) of the Patient
6 Protection and Affordable Care Act were written to
7 maintain the eligibility standards for the Medicaid
8 program under title XIX of the Social Security Act
9 and Children’s Health Insurance Program under
10 title XXI of such Act until the American Health
11 Benefit Exchanges in the States are fully oper-
12 ational;

13 (2) it is imperative that the maintenance of ef-
14 fort provisions are enforced to the strict standard in-
15 tended by the Congress;

16 (3) waiving the maintenance of effort provisions
17 should not be permitted, except in the case of a re-
18 quest for a waiver that meets the explicit non-
19 application requirements;

20 (4) the maintenance of effort provisions ensure
21 the continued success of the Medicaid program and
22 Children’s Health Insurance Program and were writ-
23 ten deliberately to specifically protect vulnerable and
24 disabled individuals, children, and senior citizens,
25 many of whom are also members of communities of
26 color; and

1 (5) the maintenance of effort provisions must
2 be strictly enforced and proposals to weaken the
3 maintenance of effort provisions must not be consid-
4 ered.

5 **SEC. 431. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
6 **TION EVIDENCING CITIZENSHIP OR NATION-**
7 **ALITY UNDER THE MEDICAID PROGRAM.**

8 (a) REPEAL.—Subsections (i)(22) and (x) of section
9 1903 of the Social Security Act (42 U.S.C. 1396b) are
10 each repealed.

11 (b) CONFORMING AMENDMENTS.—

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

14 (A) by amending paragraph (46) of sub-
15 section (a) to read as follows:

16 “(46) provide that information is requested and
17 exchanged for purposes of income and eligibility
18 verification in accordance with a State system which
19 meets the requirements of section 1137 of this
20 Act;”;

21 (B) in subsection (e)(13)(A)(i)—

22 (i) in the matter preceding subclause
23 (I), by striking “sections 1902(a)(46)(B)
24 and 1137(d)” and inserting “section
25 1137(d)”; and

1 (ii) in subclause (IV), by striking
2 “1902(a)(46)(B) or”; and
3 (C) by striking subsection (ee).

4 (2) Section 1903 of the Social Security Act (42
5 U.S.C. 1396b) is amended—

6 (A) in subsection (i), by redesignating
7 paragraphs (23) through (26) as paragraphs
8 (22) through (25), respectively; and

9 (B) by redesignating subsections (y) and
10 (z) as subsections (x) and (y), respectively.

11 (3) Subsection (c) of section 6036 of the Deficit
12 Reduction Act of 2005 (42 U.S.C. 1396b note) is re-
13 pealed.

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

17 **SEC. 432. OFFICE OF MINORITY HEALTH IN VETERANS**

18 **HEALTH ADMINISTRATION OF DEPARTMENT**

19 **OF VETERANS AFFAIRS.**

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

23 **“§ 7310. Office of Minority Health**

24 “(a) ESTABLISHMENT.—There is established in the
25 Department within the Office of the Under Secretary for

1 Health an office to be known as the ‘Office of Minority
2 Health’ (in this section referred to as the ‘Office’).

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

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

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

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

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

24 “(4) To develop mechanisms that support bet-
25 ter health care information dissemination, education,

1 prevention, and services delivery to veterans from
2 disadvantaged backgrounds, including veterans who
3 are members of a racial or ethnic minority group.

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

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

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

1 “(8) To perform such other functions and du-
2 ties as the Secretary or the Under Secretary for
3 Health considers appropriate.

4 “(d) DEFINITIONS.—In this section:

5 “(1) The term ‘racial or ethnic minority group’
6 means the following:

7 “(A) American Indians (including Alaska
8 Natives, Eskimos, and Aleuts).

9 “(B) Asian-Americans.

10 “(C) Native Hawaiians and other Pacific
11 Islanders.

12 “(D) Blacks.

13 “(E) Hispanics.

14 “(2) The term ‘Hispanic’ means individuals
15 whose origin is Mexican, Puerto Rican, Cuban, Cen-
16 tral or South American, or any other Spanish-speak-
17 ing country.”.

18 (b) CLERICAL AMENDMENT.—The table of sections
19 at the beginning of such chapter is amended by inserting
20 after the item relating to section 7309 the following new
21 item:

 “7310. Office of Minority Health.”.

22 **SEC. 433. INDIAN DEFINED IN PPACA.**

23 (a) DEFINITION OF INDIAN.—Section 1304 of the
24 Patient Protection and Affordable Care Act (42 U.S.C.
25 18024) is amended by adding at the end the following:

1 “(f) INDIAN.—

2 “(1) IN GENERAL.—In this title, the term ‘In-
3 dian’ means any individual—

4 “(A) described in paragraph (13) or (28)
5 of section 4 of the Indian Health Care Improve-
6 ment Act (25 U.S.C. 1603);

7 “(B) who is eligible for health services pro-
8 vided by the Indian Health Service under sec-
9 tion 809 of the Indian Health Care Improve-
10 ment Act (25 U.S.C. 1679);

11 “(C) who is of Indian descent and belongs
12 to the Indian community served by the local fa-
13 cilities and program of the Indian Health Serv-
14 ice; or

15 “(D) who is described in paragraph (2).

16 “(2) INCLUDED INDIVIDUALS.—The following
17 individuals shall be considered to be an ‘Indian’:

18 “(A) A member of a federally recognized
19 Indian tribe.

20 “(B) A resident of an urban center who
21 meets 1 or more of the following 4 criteria:

22 “(i) Membership in a tribe, band, or
23 other organized group of Indians, including
24 those tribes, bands, or groups terminated
25 since 1940 and those recognized as of the

1 date of enactment of the Health Equity
2 and Accountability Act of 2014 or later by
3 the State in which they reside, or being a
4 descendant, in the first or second degree,
5 of any such member.

6 “(ii) Is an Eskimo or Aleut or other
7 Alaska Native.

8 “(iii) Is considered by the Secretary of
9 the Interior to be an Indian for any pur-
10 pose.

11 “(iv) Is determined to be an Indian
12 under regulations promulgated by the Sec-
13 retary.

14 “(C) An individual who is considered by
15 the Secretary of the Interior to be an Indian for
16 any purpose.

17 “(D) An individual who is considered by
18 the Secretary to be an Indian for purposes of
19 eligibility for Indian health care services, includ-
20 ing as a California Indian, Eskimo, Aleut, or
21 other Alaska Native.”.

22 (b) CONFORMING AMENDMENTS.—

23 (1) AFFORDABLE CHOICES HEALTH BENEFIT
24 PLANS.—Section 1311(c)(6)(D) of the Patient Pro-
25 tection and Affordable Care Act (42 U.S.C.

1 18031(c)(6)(D)) is amended by striking “section 4
2 of the Indian Health Care Improvement Act” and
3 inserting “section 1304(f)”.

4 (2) REDUCED COST-SHARING FOR INDIVIDUALS
5 ENROLLING IN QUALIFIED HEALTH PLANS.—Section
6 1402(d) of the Patient Protection and Affordable
7 Care Act (42 U.S.C. 18071(d)) is amended—

8 (A) in paragraph (1), in the matter pre-
9 ceeding subparagraph (A), by striking “section
10 4(d) of the Indian Self-Determination and Edu-
11 cation Assistance Act (25 U.S.C. 450b(d))” and
12 inserting “section 1304(f)”; and

13 (B) in paragraph (2), in the matter pre-
14 ceeding subparagraph (A), by striking “(as so
15 defined)” and inserting “(as defined in section
16 1304(f))”.

17 (3) EXEMPTION FROM PENALTY FOR NOT
18 MAINTAINING MINIMUM ESSENTIAL COVERAGE.—
19 Section 5000A(e) of the Internal Revenue Code of
20 1986 is amended by striking paragraph (3) and in-
21 serting the following:

22 “(3) INDIANS.—Any applicable individual who
23 is an Indian (as defined in section 1304(f) of the
24 Patient Protection and Affordable Care Act).”.

1 **SEC. 434. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
2 **ACCESS FOR LOW-INCOME PATIENTS.**

3 (a) IN GENERAL.—Not later than January 1, 2016,
4 the Comptroller General of the United States shall con-
5 duct a study on how certain amendments made by the Pa-
6 tient Protection and Affordable Care Act (Public Law
7 111–148) to titles XVIII and XIX of the Social Security
8 Act affect the timely access to health care services for low-
9 income patients. Such study shall—

10 (1) evaluate and examine whether States elect-
11 ing to make medical assistance available under sec-
12 tion 1902(a)(10)(A)(i)(VIII) of the Social Security
13 Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including
14 States making such an election through a waiver of
15 the State plan) to individuals described in such sec-
16 tion mitigates the need for payments to dispropor-
17 tionate share hospitals under section 1886(d)(5)(F)
18 of the Social Security Act (42 U.S.C.
19 1395ww(d)(5)(F)) and section 1923 of such Act (42
20 U.S.C. 1396r–4), including the impact of such
21 States electing to make medical assistance available
22 to such individuals on—

23 (A) the number of individuals in the
24 United States who are without health insurance
25 and the distribution of such individuals in rela-

1 tion to areas primarily served by dispropor-
2 tionate share hospitals; and

3 (B) the low-income utilization rate of such
4 hospitals and the resulting fiscal sustainability
5 of such hospitals;

6 (2) evaluate the appropriate level and distribu-
7 tion of such payments among disproportionate hos-
8 pitals for purposes of—

9 (A) sufficiently accounting for the level of
10 uncompensated care provided by such hospitals
11 to low-income patients; and

12 (B) providing timely access to health serv-
13 ices for individuals in medically underserved
14 areas; and

15 (3) assess, with respect to disproportionate hos-
16 pitals—

17 (A) the role played by such hospitals in
18 providing critical access to emergency, inpa-
19 tient, and outpatient health services, as well as
20 the location of such hospitals in relation to
21 medically underserved areas; and

22 (B) the extent to which such hospitals sat-
23 isfy the requirements established for charitable
24 hospital organizations under section 501(r) of
25 the Internal Revenue Code of 1986 with respect

1 to community health needs assessments, finan-
2 cial assistance policy requirements, limitations
3 on charges, and billing and collection require-
4 ments.

5 (b) REPORTS.—

6 (1) REPORT TO CONGRESS.—Not later than
7 180 days after the date on which the study under
8 subsection (a) is completed, the Comptroller General
9 of the United States shall submit to the Committee
10 on Energy and Commerce of the House of Rep-
11 resentatives and the Committee on Health, Edu-
12 cation, Labor, and Pensions of the Senate a report
13 that contains—

14 (A) the results of the study;

15 (B) recommendations to Congress for any
16 legislative changes to the payments to dis-
17 proportionate share hospitals under section
18 1886(d)(5)(F) of the Social Security Act (42
19 U.S.C. 1395ww(d)(5)(F)) and section 1923 of
20 such Act (42 U.S.C. 1396r-4) that are needed
21 to ensure access to health services for low-in-
22 come patients that—

23 (i) are based on the number of indi-
24 viduals without health insurance, the
25 amount of uncompensated care provided by

1 such hospitals, and the impact of reduced
2 payments levels on low-income commu-
3 nities; and

4 (ii) takes into account any reports
5 submitted by the Secretary of the Treas-
6 ury, in consultation with the Secretary of
7 Health and Human Services, to Congres-
8 sional committees regarding the costs in-
9 curred by charitable hospital organizations
10 for charity care, bad debt, nonreimbursed
11 expenses for services provided to individ-
12 uals under the Medicare Program under
13 title XVIII of the Social Security Act and
14 the Medicaid Program under title XIX of
15 such Act, and any community benefit ac-
16 tivities provided by such organizations.

17 (2) REPORT TO THE SECRETARY OF HEALTH
18 AND HUMAN SERVICES.—Not later than 180 days
19 after the date on which the study under subsection
20 (a) is completed, the Comptroller General of the
21 United States shall submit to the Secretary of
22 Health and Human Services a report that con-
23 tains—

24 (A) the results of the study; and

1 (B) any recommendations for purposes of
2 assisting in the development of the methodology
3 for the adjustment of payments to dispro-
4 portionate share hospitals, as required under sec-
5 tion 1886(r) of the Social Security Act (42
6 U.S.C. 1395ww(r)) and the reduction of such
7 payments section 1923(f)(7) of such Act (42
8 U.S.C. 1396r-4(f)(7)), taking into account the
9 reports referred to in paragraph (1)(B)(ii).

10 **SEC. 435. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
11 **SERVICE.**

12 (a) REFERENCES.—Any reference in a law, regula-
13 tion, document, paper, or other record of the United
14 States to the Director of the Indian Health Service shall
15 be deemed to be a reference to the Assistant Secretary
16 of the Indian Health Service.

17 (b) EXECUTIVE SCHEDULE.—Section 5315 of title 5,
18 United States Code, is amended in the matter relating to
19 the Assistant Secretaries of Health and Human Services
20 by striking “(6)” and inserting “(7), 1 of whom shall be
21 the Assistant Secretary of the Indian Health Service”.

22 (c) CONFORMING AMENDMENT.—Section 5316 of
23 title 5, United States Code, is amended by striking “Direc-
24 tor, Indian Health Service, Department of Health and
25 Human Services.”.

1 **SEC. 436. REAUTHORIZATION OF THE NATIVE HAWAIIAN**
2 **HEALTH CARE IMPROVEMENT ACT.**

3 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
4 Section 6(h)(1) of the Native Hawaiian Health Care Im-
5 provement Act (42 U.S.C. 11705(h)(1)) is amended by
6 striking “may be necessary for fiscal years 1993 through
7 2019” and inserting “are necessary”.

8 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
9 LOKAHI.—Section 7(b) of the Native Hawaiian Health
10 Care Improvement Act (42 U.S.C. 11706(b)) is amended
11 by striking “may be necessary for fiscal years 1993
12 through 2019” and inserting “are necessary”.

13 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
14 Section 10(c) of the Native Hawaiian Health Care Im-
15 provement Act (42 U.S.C. 11709(c)) is amended by strik-
16 ing “may be necessary for fiscal years 1993 through
17 2019” and inserting “are necessary”.

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

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

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

1 **“SEC. 399Z-2. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
2 **HAVIORS IN WOMEN AND CHILDREN.**

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

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

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

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

25 “(3) to educate, guide, and provide experiential
26 learning opportunities that target risk factors that

1 impede achieving healthy behaviors and good health
2 outcomes, including—

3 “(A) poor nutrition;

4 “(B) physical inactivity;

5 “(C) being overweight or obese;

6 “(D) tobacco use;

7 “(E) alcohol and substance use;

8 “(F) injury and violence;

9 “(G) risky sexual behavior;

10 “(H) mental health problems;

11 “(I) musculoskeletal health and arthritis;

12 “(J) dental and oral health problems;

13 “(K) understanding informed consent; and

14 “(L) stigma;

15 “(4) to educate and guide regarding effective
16 strategies to promote positive health behaviors with-
17 in the family;

18 “(5) to promote community wellness and aware-
19 ness; and

20 “(6) to educate and refer target populations to
21 appropriate health care agencies and community-
22 based programs and organizations in order to in-
23 crease access to quality health care services, includ-
24 ing preventive health services.

25 “(c) APPLICATION.—

1 “(1) IN GENERAL.—Each eligible entity that
2 desires to receive a grant under subsection (a) shall
3 submit an application to the Secretary, at such time,
4 in such manner, and accompanied by such additional
5 information as the Secretary may require.

6 “(2) CONTENTS.—Each application submitted
7 pursuant to paragraph (1) shall—

8 “(A) describe the activities for which as-
9 sistance under this section is sought;

10 “(B) contain an assurance that, with re-
11 spect to each community health worker pro-
12 gram receiving funds under the grant awarded,
13 such program provides in-language training and
14 supervision to community health workers to en-
15 able such workers to provide authorized pro-
16 gram activities in (at least) the most commonly
17 used languages within a particular geographic
18 region;

19 “(C) contain an assurance that the appli-
20 cant will evaluate the effectiveness of commu-
21 nity health worker programs receiving funds
22 under the grant;

23 “(D) contain an assurance that each com-
24 munity health worker program receiving funds
25 under the grant will provide culturally com-

1 petent services in the linguistic context most
2 appropriate for the individuals served by the
3 program;

4 “(E) contain a plan to document and dis-
5 seminate project descriptions and results to
6 other States and organizations as identified by
7 the Secretary; and

8 “(F) describe plans to enhance the capac-
9 ity of individuals to utilize health services and
10 health-related social services under Federal,
11 State, and local programs by—

12 “(i) assisting individuals in estab-
13 lishing eligibility under the programs and
14 in receiving the services or other benefits
15 of the programs; and

16 “(ii) providing other services, as the
17 Secretary determines to be appropriate,
18 which may include transportation and
19 translation services.

20 “(d) PRIORITY.—In awarding grants under sub-
21 section (a), the Secretary shall give priority to those appli-
22 cants—

23 “(1) who propose to target geographic areas
24 that—

1 “(A)(i) have a high percentage of residents
2 who are uninsured or underinsured (if the tar-
3 geted geographic area is located in a State that
4 has elected to make medical assistance available
5 under section 1902(a)(10)(A)(i)(VIII) of the
6 Social Security Act to individuals described in
7 such section); or

8 “(ii) have a high percentage of under-
9 insured residents in a particular geographic
10 area (if the targeted geographic area is located
11 in a State that has not so elected); and

12 “(B) have a high percentage of families for
13 whom English is not their primary language or
14 including smaller limited-English-proficient
15 communities within the region that are not oth-
16 erwise reached by linguistically appropriate
17 health services;

18 “(2) with experience in providing health or
19 health-related social services to individuals who are
20 underserved with respect to such services; and

21 “(3) with documented community activity and
22 experience with community health workers.

23 “(e) COLLABORATION WITH ACADEMIC INSTITU-
24 TIONS.—The Secretary shall encourage community health
25 worker programs receiving funds under this section to col-

1 laborate with academic institutions, including minority-
2 serving institutions. Nothing in this section shall be con-
3 strued to require such collaboration.

4 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
5 NESS.—The Secretary shall establish guidelines for ensur-
6 ing the quality of the training and supervision of commu-
7 nity health workers under the programs funded under this
8 section and for ensuring the cost effectiveness of such pro-
9 grams.

10 “(g) MONITORING.—The Secretary shall monitor
11 community health worker programs identified in approved
12 applications and shall determine whether such programs
13 are in compliance with the guidelines established under
14 subsection (f).

15 “(h) TECHNICAL ASSISTANCE.—The Secretary may
16 provide technical assistance to community health worker
17 programs identified in approved applications with respect
18 to planning, developing, and operating programs under the
19 grant.

20 “(i) REPORT TO CONGRESS.—

21 “(1) IN GENERAL.—Not later than 4 years
22 after the date on which the Secretary first awards
23 grants under subsection (a), the Secretary shall sub-
24 mit to Congress a report regarding the grant
25 project.

1 “(2) CONTENTS.—The report required under
2 paragraph (1) shall include the following:

3 “(A) A description of the programs for
4 which grant funds were used.

5 “(B) The number of individuals served.

6 “(C) An evaluation of—

7 “(i) the effectiveness of these pro-
8 grams;

9 “(ii) the cost of these programs; and

10 “(iii) the impact of the project on the
11 health outcomes of the community resi-
12 dents.

13 “(D) Recommendations for sustaining the
14 community health worker programs developed
15 or assisted under this section.

16 “(E) Recommendations regarding training
17 to enhance career opportunities for community
18 health workers.

19 “(j) DEFINITIONS.—In this section:

20 “(1) COMMUNITY HEALTH WORKER.—The term
21 ‘community health worker’ means an individual who
22 promotes health or nutrition within the community
23 in which the individual resides—

24 “(A) by serving as a liaison between com-
25 munities and health care agencies;

1 “(B) by providing guidance and social as-
2 sistance to community residents;

3 “(C) by enhancing community residents’
4 ability to effectively communicate with health
5 care providers;

6 “(D) by providing culturally and linguis-
7 tically appropriate health or nutrition edu-
8 cation;

9 “(E) by advocating for individual and com-
10 munity health, including dental, oral, mental,
11 and environmental health, or nutrition needs;

12 “(F) by taking into consideration the
13 needs of the communities served, including the
14 prevalence rates of risk factors that impede
15 achieving healthy behaviors and good health
16 outcomes among women and children, especially
17 among racial and ethnic minority women and
18 children; and

19 “(G) by providing referral and followup
20 services.

21 “(2) COMMUNITY SETTING.—The term ‘commu-
22 nity setting’ means a home or a community organi-
23 zation that serves a population.

24 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
25 tity’ means—

1 “(A) a unit of State, territorial, local, or
2 tribal government (including a federally recog-
3 nized tribe or Alaska Native village); or

4 “(B) a community-based organization.

5 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
6 The term ‘medically underserved community’ means
7 a community—

8 “(A) that has a substantial number of in-
9 dividuals who are members of a medically un-
10 derserved population, as defined by section
11 330(b)(3);

12 “(B) a significant portion of which is a
13 health professional shortage area as designated
14 under section 332; and

15 “(C) that includes populations that are lin-
16 guistically isolated, such as geographic areas
17 with a shortage of health professionals able to
18 provide linguistically appropriate services.

19 “(5) SUPPORT.—The term ‘support’ means the
20 provision of training, supervision, and materials
21 needed to effectively deliver the services described in
22 subsection (b), reimbursement for services, and
23 other benefits.

24 “(6) TARGET POPULATION.—The term ‘target
25 population’ means women of reproductive age, re-

1 regardless of their current childbearing status and
2 children under 21 years of age.

3 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 \$15,000,000 for each of fiscal years 2015 through 2019.”.

6 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
7 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
8 **NANT WOMEN, AND LAWFULLY PRESENT IN-**
9 **DIVIDUALS.**

10 (a) MEDICAID.—Section 1903(v) of the Social Secu-
11 rity Act (42 U.S.C. 1396b(v)) is amended by striking
12 paragraph (4) and inserting the following new paragraph:

13 “(4)(A) Notwithstanding sections 401(a),
14 402(b), 403, and 421 of the Personal Responsibility
15 and Work Opportunity Reconciliation Act of 1996
16 and paragraph (1), payment shall be made to a
17 State under this section for medical assistance fur-
18 nished to an alien under this title (including an alien
19 described in such paragraph) who meets any of the
20 following conditions:

21 “(i) The alien is otherwise eligible for such
22 assistance under the State plan approved under
23 this title (other than the requirement of the re-
24 ceipt of aid or assistance under title IV, supple-
25 mental security income benefits under title

1 XVI, or a State supplementary payment) within
2 either or both of the following eligibility cat-
3 egories:

4 “(I) Children under 21 years of age,
5 including any optional targeted low-income
6 child (as such term is defined in section
7 1905(u)(2)(B)).

8 “(II) Pregnant women during preg-
9 nancy and during the 60-day period begin-
10 ning on the last day of the pregnancy.

11 “(ii) The alien is lawfully present in the
12 United States.

13 “(B) No debt shall accrue under an affidavit of
14 support against any sponsor of an alien who meets
15 the conditions specified in subparagraph (A) on the
16 basis of the provision of medical assistance to such
17 alien under this paragraph and the cost of such as-
18 sistance shall not be considered as an unreimbursed
19 cost.”.

20 (b) SCHIP.—Subparagraph (J) of section
21 2107(e)(1) of the Social Security Act (42 U.S.C.
22 1397gg(e)(1)) is amended to read as follows:

23 “(J) Paragraph (4) of section 1903(v) (re-
24 lating to coverage of categories of children,

1 pregnant women, and other lawfully present in-
2 dividuals).”.

3 (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-
4 withstanding sections 401(a), 402(a), and 403(a) of the
5 Personal Responsibility and Work Opportunity Reconcili-
6 ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))
7 and section 6(f) of the Food and Nutrition Act of 2008
8 (7 U.S.C. 2015(f)), persons who are lawfully present in
9 the United States shall be not be ineligible for benefits
10 under the supplemental nutrition assistance program on
11 the basis of their immigration status or date of entry into
12 the United States.

13 (d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—
14 Section of the 421(d)(3) of the Personal Responsibility
15 and Work Opportunity Reconciliation Act of 1996 (8
16 U.S.C. 1631(d)(3)) is amended by striking “to the extent
17 that a qualified alien is eligible under section
18 402(a)(2)(J)” and inserting, “to the extent that a child
19 is a member of a household under the supplemental nutri-
20 tion assistance program”.

21 (e) ENSURING PROPER SCREENING.—Section
22 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7
23 U.S.C. 2020(e)(2)(B)) is amended—

24 (1) by redesignating clauses (vi) and (vii) as
25 clauses (vii) and (viii); and

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

2 “(vi) shall provide a method for imple-
3 menting section 421 of the Personal Re-
4 sponsibility and Work Opportunity Rec-
5 onciliation Act of 1996 (8 U.S.C. 1631)
6 that does not require any unnecessary in-
7 formation from persons who may be ex-
8 empt from that provision;”.

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

10 Section 115 of the Personal Responsibility and Work
11 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
12 is amended—

13 (1) in subsection (a) by striking paragraph (2);

14 (2) in subsection (b) by striking paragraph (2);

15 and

16 (3) in subsection (e) by striking paragraph (2).

17 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
18 **AND AWARENESS.**

19 (a) IN GENERAL.—The Secretary shall establish and
20 implement a birth defects prevention and public awareness
21 program, consisting of the activities described in sub-
22 sections (c) and (d).

23 (b) DEFINITIONS.—In this section:

24 (1) The term “pregnancy and breastfeeding in-
25 formation services” includes only—

1 (A) information services to provide accu-
2 rate, evidence-based, clinical information re-
3 garding maternal exposures during pregnancy
4 that may be associated with birth defects or
5 other health risks, such as exposures to medica-
6 tions, chemicals, infections, foodborne patho-
7 gens, illnesses, nutrition, or lifestyle factors;

8 (B) information services to provide accu-
9 rate, evidence-based, clinical information re-
10 garding maternal exposures during breast-
11 feeding that may be associated with health risks
12 to a breast-fed infant, such as exposures to
13 medications, chemicals, infections, foodborne
14 pathogens, illnesses, nutrition, or lifestyle fac-
15 tors;

16 (C) the provision of accurate, evidence-
17 based information weighing risks of exposures
18 during breastfeeding against the benefits of
19 breastfeeding; and

20 (D) the provision of information described
21 in subparagraph (A), (B), or (C) through coun-
22 selors, Web sites, fact sheets, telephonic or elec-
23 tronic communication, community outreach ef-
24 forts, or other appropriate means.

1 (2) The term “Secretary” means the Secretary
2 of Health and Human Services, acting through the
3 Director of the Centers for Disease Control and Pre-
4 vention.

5 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
6 subsection (a), the Secretary shall conduct or support a
7 nationwide media campaign to increase awareness among
8 health care providers and at-risk populations about preg-
9 nancy and breastfeeding information services.

10 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
11 INFORMATION SERVICES.—

12 (1) IN GENERAL.—In carrying out subsection
13 (a), the Secretary shall award grants to State or re-
14 gional agencies or organizations for any of the fol-
15 lowing:

16 (A) INFORMATION SERVICES.—The provi-
17 sion of, or campaigns to increase awareness
18 about, pregnancy and breastfeeding information
19 services.

20 (B) SURVEILLANCE AND RESEARCH.—The
21 conduct or support of—

22 (i) surveillance of or research on—

23 (I) maternal exposures and ma-
24 ternal health conditions that may in-
25 fluence the risk of birth defects, pre-

1 maturity, or other adverse pregnancy
2 outcomes; and

3 (II) maternal exposures that may
4 influence health risks to a breastfed
5 infant; or

6 (ii) networking to facilitate surveil-
7 lance or research described in this sub-
8 paragraph.

9 (2) PREFERENCE FOR CERTAIN STATES.—The
10 Secretary, in making any grant under this sub-
11 section, shall give preference to States, otherwise
12 equally qualified, that have or had a pregnancy and
13 breastfeeding information service in place on or after
14 January 1, 2006.

15 (3) MATCHING FUNDS.—The Secretary may
16 only award a grant under this subsection to a State
17 or regional agency or organization that agrees, with
18 respect to the costs to be incurred in carrying out
19 the grant activities, to make available (directly or
20 through donations from public or private entities)
21 non-Federal funds toward such costs in an amount
22 equal to not less than 25 percent of the amount of
23 the grant.

24 (4) COORDINATION.—The Secretary shall en-
25 sure that activities funded through a grant under

1 this subsection are coordinated, to the maximum ex-
2 tent practicable, with other birth defects prevention
3 and environmental health activities of the Federal
4 Government, including with respect to pediatric envi-
5 ronmental health specialty units and children’s envi-
6 ronmental health centers.

7 (e) EVALUATION.—In furtherance of the program
8 under subsection (a), the Secretary shall provide for an
9 evaluation of pregnancy and breastfeeding information
10 services to identify efficient and effective models of—

11 (1) providing information;

12 (2) raising awareness and increasing knowledge
13 about birth defects prevention measures and tar-
14 geting education to at-risk groups;

15 (3) modifying risk behaviors; or

16 (4) other outcome measures as determined ap-
17 propriate by the Secretary.

18 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 \$5,000,000 for fiscal year 2015, \$6,000,000 for fiscal year
21 2016, \$7,000,000 for fiscal year 2017, \$8,000,000 for fis-
22 cal year 2018, and \$9,000,000 for fiscal year 2019.

1 **SEC. 505. UNIFORM STATE MATERNAL MORTALITY REVIEW**
2 **COMMITTEES ON PREGNANCY-RELATED**
3 **DEATHS.**

4 (a) IN GENERAL.—Title V of the Social Security Act
5 (42 U.S.C. 701 et seq.) is amended by adding at the end
6 the following new section:

7 **“SEC. 514. UNIFORM STATE MATERNAL MORTALITY RE-**
8 **VIEW COMMITTEES ON PREGNANCY-RE-**
9 **LATED DEATHS.**

10 “(a) GRANTS.—

11 “(1) IN GENERAL.—Notwithstanding any other
12 provision of this title, for each of fiscal years 2015
13 through 2021, in addition to payments from allot-
14 ments for States under section 502 for such year,
15 the Secretary shall, subject to paragraph (3) and in
16 accordance with the criteria established under para-
17 graph (2), award grants to States to—

18 “(A) carry out the activities described in
19 subsection (b)(1);

20 “(B) establish a State maternal mortality
21 review committee, in accordance with subsection
22 (b)(2), to carry out the activities described in
23 subsection (b)(2)(A), and to establish the proc-
24 esses described in subsection (b)(1);

25 “(C) ensure the State department of
26 health carries out the applicable activities de-

1 scribed in subsection (b)(3), with respect to
2 pregnancy-related deaths occurring within the
3 State during such fiscal year;

4 “(D) implement and use the comprehensive
5 case abstraction form developed under sub-
6 section (c), in accordance with such subsection;
7 and

8 “(E) provide for public disclosure of infor-
9 mation, in accordance with subsection (e).

10 “(2) CRITERIA.—The Secretary shall establish
11 criteria for determining eligibility for and the
12 amount of a grant awarded to a State under para-
13 graph (1). Such criteria shall provide that in the
14 case of a State that receives such a grant for a fiscal
15 year and is determined by the Secretary to have not
16 used such grant in accordance with this section,
17 such State shall not be eligible for such a grant for
18 any subsequent fiscal year.

19 “(3) AUTHORIZATION OF APPROPRIATIONS.—
20 For purposes of carrying out the grant program
21 under this section, including for administrative pur-
22 poses, there is authorized to be appropriated
23 \$10,000,000 for each of fiscal years 2015 through
24 2021.

25 “(b) PREGNANCY-RELATED DEATH REVIEW.—

1 “(1) REVIEW OF PREGNANCY-RELATED DEATH
2 AND PREGNANCY-ASSOCIATED DEATH CASES.—For
3 purposes of subsection (a), with respect to a State
4 that receives a grant under subsection (a), the fol-
5 lowing shall apply:

6 “(A) MANDATORY REPORTING OF PREG-
7 NANCY-RELATED DEATHS.—

8 “(i) IN GENERAL.—The State shall,
9 through the State maternal mortality re-
10 view committee, develop a process, sepa-
11 rate from any reporting process established
12 by the State department of health prior to
13 the date of the enactment of this section,
14 that provides for mandatory and confiden-
15 tial case reporting by individuals and enti-
16 ties described in clause (ii) of pregnancy-
17 related deaths to the State department of
18 health.

19 “(ii) INDIVIDUALS AND ENTITIES DE-
20 SCRIBED.—Individuals and entities de-
21 scribed in this clause include each of the
22 following:

23 “(I) Health care providers.

24 “(II) Medical examiners.

25 “(III) Medical coroners.

1 “(IV) Hospitals.

2 “(V) Free-standing birth centers.

3 “(VI) Federally qualified health
4 centers.

5 “(VII) Other health care facili-
6 ties.

7 “(VIII) Any other individuals re-
8 sponsible for completing death certifi-
9 cates.

10 “(IX) Any other appropriate in-
11 dividuals or entities specified by the
12 Secretary.

13 “(B) VOLUNTARY REPORTING OF PREG-
14 NANCY-RELATED AND PREGNANCY-ASSOCIATED
15 DEATHS.—

16 “(i) The State shall, through the
17 State maternal mortality review committee,
18 develop a process for and encourage, sepa-
19 rate from any reporting process established
20 by the State department of health prior to
21 the date of the enactment of this section,
22 voluntary and confidential case reporting
23 by individuals described in clause (ii) of
24 pregnancy-associated deaths to the State
25 department of health.

1 “(ii) The State shall, through the
2 State maternal mortality review committee,
3 develop a process for voluntary and con-
4 fidential reporting by family members of
5 the deceased and by other individuals on
6 possible pregnancy-related and pregnancy-
7 associated deaths to the State department
8 of health. Such process shall include—

9 “(I) making publicly available on
10 the Internet Web site of the State de-
11 partment of health a telephone num-
12 ber, Internet Web link, and email ad-
13 dress for such reporting; and

14 “(II) publicizing to local profes-
15 sional organizations, community orga-
16 nizations, and social services agencies
17 the availability of the telephone num-
18 ber, Internet Web link, and email ad-
19 dress made available under subclause
20 (I).

21 “(C) DEVELOPMENT OF CASE-FINDING.—

22 The State, through the vital statistics unit of
23 the State, shall annually identify pregnancy-re-
24 lated and pregnancy-associated deaths occur-

1 ring in such State during the year involved
2 by—

3 “(i) matching all death records, with
4 respect to such year, for women of child-
5 bearing age to live birth certificates and in-
6 fant death certificates to identify deaths of
7 women that occurred during pregnancy
8 and within one year after the end of a
9 pregnancy;

10 “(ii) identifying deaths reported dur-
11 ing such year as having an underlying or
12 contributing cause of death related to
13 pregnancy, regardless of the time that has
14 passed between the end of the pregnancy
15 and the death;

16 “(iii) collecting data from medical ex-
17 aminer and coroner reports; and

18 “(iv) any other methods the States
19 may devise to identify maternal deaths,
20 such as through review of a random sam-
21 ple of reported deaths of women of child-
22 bearing age to ascertain cases of preg-
23 nancy-related and pregnancy-associated
24 deaths that are not discernable from a re-
25 view of death certificates alone.

1 When feasible and for purposes of effectively
2 collecting and obtaining data on pregnancy-re-
3 lated and pregnancy-associated deaths, the
4 State shall adopt the most recent standardized
5 birth and death certificates, as issued by the
6 National Center for Vital Health Statistics, in-
7 cluding the recommended checkbox section for
8 pregnancy on the death certificates.

9 “(D) CASE INVESTIGATION AND DEVELOP-
10 MENT OF CASE SUMMARIES.—Following receipt
11 of reports by the State department of health
12 pursuant to subparagraph (A) or (B) and col-
13 lection by the vital statistics unit of the State
14 of possible cases of pregnancy-related and preg-
15 nancy-associated deaths pursuant to subpara-
16 graph (C), the State, through the State mater-
17 nal mortality review committee established
18 under subsection (a), shall investigate each
19 case, utilizing the case abstraction form de-
20 scribed in subsection (c), and prepare de-identi-
21 fied case summaries, which shall be reviewed by
22 the committee and included in applicable re-
23 ports. For purposes of subsection (a), under the
24 processes established under subparagraphs (A),
25 (B), and (C), a State department of health or

1 vital statistics unit of a State shall provide to
2 the State maternal mortality review committee
3 access to information collected pursuant to such
4 subparagraphs as necessary to carry out this
5 subparagraph. Data and information collected
6 for the case summary and review are for pur-
7 poses of public health activities, in accordance
8 with HIPAA privacy and security law (as de-
9 fined in section 3009(a)(2) of the Public Health
10 Service Act). Such case investigations shall in-
11 clude data and information obtained through—

12 “(i) medical examiner and autopsy re-
13 ports of the woman involved;

14 “(ii) medical records of the woman,
15 including such records related to health
16 care prior to pregnancy, prenatal and post-
17 natal care, labor and delivery care, emer-
18 gency room care, hospital discharge
19 records including immunization status and
20 screening status for prevalent diseases, and
21 any care delivered up until the time of
22 death of the woman for purposes of public
23 health activities, in accordance with
24 HIPAA privacy and security law (as de-

1 fined in section 3009(a)(2) of the Public
2 Health Service Act);

3 “(iii) oral and written interviews of in-
4 dividuals directly involved in the maternal
5 care of the woman during and immediately
6 following the pregnancy of the woman, in-
7 cluding health care, mental health, and so-
8 cial service providers in-language when
9 possible, as applicable;

10 “(iv) optional oral or written inter-
11 views of the family of the woman;

12 “(v) socioeconomic and other relevant
13 background information about the woman;

14 “(vi) information collected in subpara-
15 graph (C)(i); and

16 “(vii) other information on the cause
17 of death of the woman, such as social serv-
18 ices and child welfare reports, including ex-
19 periences with intimate partner violence.

20 “(2) STATE MATERNAL MORTALITY REVIEW
21 COMMITTEES.—

22 “(A) DUTIES.—

23 “(i) REQUIRED COMMITTEE ACTIVI-
24 TIES.—For purposes of subsection (a), a
25 maternal mortality review committee estab-

1 lished by a State pursuant to a grant
2 under such subsection shall carry out the
3 following pregnancy-related death and
4 pregnancy-associated death review activi-
5 ties and shall include all information rel-
6 evant to the death involved on the case ab-
7 straction form developed under subsection
8 (d):

9 “(I) With respect to a case of
10 pregnancy-related or pregnancy-asso-
11 ciated death of a woman, review the
12 case summaries prepared under sub-
13 paragraphs (A), (B), (C), and (D) of
14 paragraph (1).

15 “(II) Review aggregate statistical
16 reports developed by the vital statis-
17 tics unit of the State under paragraph
18 (1)(C) regarding pregnancy-related
19 and pregnancy-associated deaths to
20 identify trends, patterns, and dispari-
21 ties in adverse outcomes and address
22 medical, nonmedical, and system-re-
23 lated factors that may have contrib-
24 uted to such pregnancy-related and

1 pregnancy-associated deaths and dis-
2 parities.

3 “(III) Develop recommendations,
4 based on the review of the case sum-
5 maries under paragraph (1)(D) and
6 aggregate statistical reports under
7 subclause (II), to improve maternal
8 care, social and health services, and
9 public health policy and institutions,
10 including with respect to improving
11 access to maternal care, improving the
12 availability of social services, and
13 eliminating disparities in maternal
14 care and outcomes.

15 “(ii) OPTIONAL COMMITTEE ACTIVI-
16 TIES.—For purposes of subsection (a), a
17 maternal mortality review committee estab-
18 lished by a State under such subsection
19 may present findings and recommendations
20 regarding a specific case or set of cir-
21 cumstances directly to a health care facil-
22 ity or its local or State professional organi-
23 zation for the purpose of instituting policy
24 changes, educational activities, or other-

1 wise improving the quality of care provided
2 by the facilities.

3 “(B) COMPOSITION OF MATERNAL MOR-
4 TALITY REVIEW COMMITTEES.—

5 “(i) IN GENERAL.—Each State mater-
6 nal mortality review committee established
7 pursuant to a grant under subsection (a)
8 shall be multidisciplinary, consisting of
9 health care, behavioral health, and social
10 service providers, public health officials,
11 other persons with professional expertise
12 on maternal health and mortality, and pa-
13 tient and community advocates who rep-
14 resent those communities within such State
15 that are the most affected by maternal
16 mortality. Membership on such a com-
17 mittee of a State shall be reviewed annu-
18 ally by the State department of health to
19 ensure that membership representation re-
20 quirements are being fulfilled in accord-
21 ance with this paragraph.

22 “(ii) REQUIRED MEMBERSHIP.—Each
23 such review committee shall include—

24 “(I) representatives from medical
25 specialties providing care to pregnant

1 and postpartum patients, including
2 obstetricians (including generalists
3 and maternal fetal medicine special-
4 ists), and family practice physicians;

5 “(II) representatives from mid-
6 wifery specialties (including certified
7 professional midwives and certified
8 midwives);

9 “(III) advanced practice nurses;

10 “(IV) hospital-based nurses;

11 “(V) representatives of the State
12 department of health maternal and
13 child health department;

14 “(VI) social service providers or
15 social workers;

16 “(VII) the chief medical exam-
17 iners or designees;

18 “(VIII) facility representatives,
19 such as from hospitals or free-stand-
20 ing birth centers; and

21 “(IX) community or patient ad-
22 vocates who represent those commu-
23 nities within the State that are the
24 most affected by maternal mortality.

1 “(iii) ADDITIONAL MEMBERS.—Each
2 such review committee may also include
3 representatives from other relevant aca-
4 demic, health, social service, or policy pro-
5 fessions, or community organizations, on
6 an ongoing basis, or as needed, as deter-
7 mined beneficial by the review committee,
8 including—

- 9 “(I) anesthesiologists;
10 “(II) emergency physicians;
11 “(III) pathologists;
12 “(IV) epidemiologists or biostat-
13 isticians;
14 “(V) intensivists;
15 “(VI) orthopedic surgeons and/or
16 orthopedic physicians;
17 “(VII) vital statistics officers;
18 “(VIII) nutritionists;
19 “(IX) mental health profes-
20 sionals;
21 “(X) substance abuse treatment
22 specialists;
23 “(XI) representatives of relevant
24 advocacy groups;
25 “(XII) academics;

1 “(XIII) representatives of bene-
2 ficiaries of the State plan under the
3 Medicaid Program under title XIX;

4 “(XIV) paramedics;

5 “(XV) lawyers;

6 “(XVI) risk management special-
7 ists;

8 “(XVII) representatives of the
9 departments of health or public health
10 of major cities in the State involved;
11 and

12 “(XVIII) policymakers.

13 “(iv) DIVERSE COMMUNITY MEMBER-
14 SHIP.—The composition of such a com-
15 mittee, with respect to a State, shall in-
16 clude—

17 “(I) representatives from diverse
18 communities, particularly those com-
19 munities within such State most se-
20 verely affected by pregnancy-related
21 deaths or pregnancy-associated deaths
22 and by a lack of access to relevant
23 maternal care services, from commu-
24 nity maternal child health organiza-

1 tions, and from minority advocacy
2 groups;

3 “(II) members, including health
4 care providers, from different geo-
5 graphic regions in the State, including
6 any rural, urban, and tribal areas;
7 and

8 “(III) health care and social serv-
9 ice providers who work in commu-
10 nities that are diverse with regard to
11 race, ethnicity, immigration status, in-
12 digenous status, and English pro-
13 ficiency.

14 “(v) MATERNAL MORTALITY REVIEW
15 STAFF.—Staff of each such review com-
16 mittee shall include—

17 “(I) vital health statisticians, ma-
18 ternal child health statisticians, or
19 epidemiologists;

20 “(II) a coordinator of the State
21 maternal mortality review committee,
22 to be designated by the State; and

23 “(III) administrative staff.

24 “(C) OPTION FOR STATES TO FORM RE-
25 GIONAL MATERNAL MORTALITY REVIEWS.—

1 States with a low rate of occurrence of preg-
2 nancy-associated or pregnancy-related deaths
3 may choose to partner with one or more neigh-
4 boring States to fulfill the activities described in
5 paragraph (1)(C). In such a case, with respect
6 to States in such a partnership, any require-
7 ment under this section relating to the report-
8 ing of information related to such activities
9 shall be deemed to be fulfilled by each such
10 State if a single such report is submitted for
11 the partnership.

12 “(3) STATE DEPARTMENT OF HEALTH ACTIVI-
13 TIES.—For purposes of subsection (a), a State de-
14 partment of health of a State receiving a grant
15 under such subsection shall—

16 “(A) in consultation with the maternal
17 mortality review committee of the State and in
18 conjunction with relevant professional organiza-
19 tions, develop a plan for ongoing health care
20 provider education, based on the findings and
21 recommendations of the committee, in order to
22 improve the quality of maternal care; and

23 “(B) take steps to widely disseminate the
24 findings and recommendations of the State ma-
25 ternal mortality review committees of the State

1 and to implement the recommendations of such
2 committee.

3 “(c) CASE ABSTRACTION FORM.—

4 “(1) DEVELOPMENT.—The Director of the Cen-
5 ters for Disease Control and Prevention shall de-
6 velop a uniform, comprehensive case abstraction
7 form and make such form available to States for
8 State maternal mortality review committees for use
9 by such committees in order to—

10 “(A) ensure that the cases and information
11 collected and reviewed by such committees can
12 be pooled for review by the Department of
13 Health and Human Services and its agencies;
14 and

15 “(B) preserve the uniformity of the infor-
16 mation and its use for Federal public health
17 purposes.

18 “(2) PERMISSIBLE STATE MODIFICATION.—
19 Each State may modify the form developed under
20 paragraph (1) for implementation and use by such
21 State or by the State maternal mortality review com-
22 mittee of such State by including on such form addi-
23 tional information to be collected, but may not alter
24 the standard questions on such form, in order to en-

1 sure that the information can be collected and re-
2 viewed centrally at the Federal level.

3 “(d) TREATMENT AS PUBLIC HEALTH AUTHORITY
4 FOR PURPOSES OF HIPAA.—For purposes of applying
5 HIPAA privacy and security law (as defined in section
6 3009(a)(2) of the Public Health Service Act), a State ma-
7 ternal mortality review committee of a State established
8 pursuant to this section to carry out activities described
9 in subsection (b)(2)(A) shall be deemed to be a public
10 health authority described in section 164.501 (and ref-
11 erenced in section 164.512(b)(1)(i)) of title 45, Code of
12 Federal Regulations (or any successor regulation), car-
13 rying out public health activities and purposes described
14 in such section 164.512(b)(1)(i) (or any such successor
15 regulation).

16 “(e) PUBLIC DISCLOSURE OF INFORMATION.—

17 “(1) IN GENERAL.—For fiscal year 2015 or a
18 subsequent fiscal year, each State receiving a grant
19 under this section for such year shall, subject to
20 paragraph (3), provide for the public disclosure, and
21 submission to the information clearinghouse estab-
22 lished under paragraph (2), of the information in-
23 cluded in the report of the State under section
24 506(a)(2)(F) for such year (relating to the findings
25 for such year of the State maternal mortality review

1 committee established by the State under this sec-
2 tion).

3 “(2) INFORMATION CLEARINGHOUSE.—The
4 Secretary of Health and Human Services shall es-
5 tablish an information clearinghouse, that shall be
6 administered by the Director of the Centers for Dis-
7 ease Control and Prevention, that will maintain find-
8 ings and recommendations submitted pursuant to
9 paragraph (1) and provide such findings and rec-
10 ommendations for public review and research pur-
11 poses by State health departments, maternal mor-
12 tality review committees, and health providers and
13 institutions.

14 “(3) CONFIDENTIALITY OF INFORMATION.—In
15 no case shall any individually identifiable health in-
16 formation be provided to the public, or submitted to
17 the information clearinghouse, under paragraph (1).

18 “(f) CONFIDENTIALITY OF REVIEW COMMITTEE
19 PROCEEDINGS.—

20 “(1) IN GENERAL.—All proceedings and activi-
21 ties of a State maternal mortality review committee
22 under this section, opinions of members of such a
23 committee formed as a result of such proceedings
24 and activities, and records obtained, created, or
25 maintained pursuant to this section, including

1 records of interviews, written reports, and state-
2 ments procured by the Department of Health and
3 Human Services or by any other person, agency, or
4 organization acting jointly with the Department, in
5 connection with morbidity and mortality reviews
6 under this section, shall be confidential, and not sub-
7 ject to discovery, subpoena, or introduction into evi-
8 dence in any civil, criminal, legislative, or other pro-
9 ceeding. Such records shall not be open to public in-
10 spection.

11 “(2) TESTIMONY OF MEMBERS OF COM-
12 MITTEE.—

13 “(A) IN GENERAL.—Members of a State
14 maternal mortality review committee under this
15 section may not be questioned in any civil,
16 criminal, legislative, or other proceeding regard-
17 ing information presented in, or opinions
18 formed as a result of, a meeting or communica-
19 tion of the committee.

20 “(B) CLARIFICATION.—Nothing in this
21 subsection shall be construed to prevent a mem-
22 ber of such a committee from testifying regard-
23 ing information that was obtained independent
24 of such member’s participation on the com-
25 mittee, or that is public information.

1 “(3) AVAILABILITY OF INFORMATION FOR RE-
2 SEARCH PURPOSES.—Nothing in this subsection
3 shall prohibit the publishing by such a committee or
4 the Department of Health and Human Services of
5 statistical compilations and research reports that—

6 “(A) are based on confidential information,
7 relating to morbidity and mortality review; and

8 “(B) do not contain identifying informa-
9 tion or any other information that could be
10 used to ultimately identify the individuals con-
11 cerned.

12 “(g) DEFINITIONS.—For purposes of this section:

13 “(1) The term ‘pregnancy-associated death’
14 means the death of a woman while pregnant or dur-
15 ing the one-year period following the date of the end
16 of pregnancy, irrespective of the cause of such death.

17 “(2) The term ‘pregnancy-related death’ means
18 the death of a woman while pregnant or during the
19 one-year period following the date of the end of
20 pregnancy, irrespective of the duration or site of the
21 pregnancy, from any cause related to or aggravated
22 by the pregnancy or its management, but not from
23 any accidental or incidental cause.

1 “(3) The term ‘woman of childbearing age’
2 means a woman who is at least 10 years of age and
3 not more than 54 years of age.”.

4 (b) INCLUSION OF FINDINGS OF REVIEW COMMIT-
5 TEES IN REQUIRED REPORTS.—

6 (1) STATE TRIENNIAL REPORTS.—Paragraph
7 (2) of section 506(a) of such Act (42 U.S.C. 706(a))
8 is amended by inserting after subparagraph (E) the
9 following new subparagraph:

10 “(F) In the case of a State receiving a
11 grant under section 514, beginning for the first
12 fiscal year beginning after 3 years after the
13 date of establishment of the State maternal
14 mortality review committee established by the
15 State pursuant to such grant and once every 3
16 years thereafter, information containing the
17 findings and recommendations of such com-
18 mittee and information on the implementation
19 of such recommendations during the period in-
20 volved.”.

21 (2) ANNUAL REPORTS TO CONGRESS.—Para-
22 graph (3) of such section is amended—

23 (A) in subparagraph (D), at the end, by
24 striking “and”;

1 (B) in subparagraph (E), at the end, by
2 striking the period and inserting “; and”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(F) For fiscal year 2015 and each subse-
6 quent fiscal year, taking into account the find-
7 ings, recommendations, and implementation in-
8 formation submitted by States pursuant to
9 paragraph (2)(F), on the status of pregnancy-
10 related deaths and pregnancy-associated deaths
11 in the United States and including rec-
12 ommendations on methods to prevent such
13 deaths in the United States.”.

14 **SEC. 506. ELIMINATING DISPARITIES IN MATERNITY**
15 **HEALTH OUTCOMES.**

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

19 **“SEC. 317W. ELIMINATING DISPARITIES IN MATERNITY**
20 **HEALTH OUTCOMES.**

21 “(a) IN GENERAL.—The Secretary (in consultation
22 with the Deputy Assistant Secretary for Minority Health,
23 the Director of the National Institutes of Health, the Di-
24 rector of the Centers for Disease Control and Prevention,
25 the Administrator of the Centers for Medicare & Medicaid

1 Services, and the Administrator of the Agency for
2 Healthcare Research & Quality, and in consultation with
3 relevant national stakeholder organizations such as na-
4 tional medical specialty organizations, national maternal
5 child health organizations, national groups that represent
6 minority populations, and national health disparity organi-
7 zations) shall carry out the following activities to eliminate
8 disparities in maternal health outcomes:

9 “(1) Conduct research into the determinants
10 and the distribution of disparities in maternal care,
11 health risks, and health outcomes, and improve the
12 capacity of the performance measurement infrastruc-
13 ture to measure such disparities.

14 “(2) Expand access to services that have been
15 demonstrated to improve the quality and outcomes
16 of maternity care for vulnerable populations.

17 “(3) Establish a demonstration project to com-
18 pare the effectiveness of interventions to reduce dis-
19 parities in maternity services and outcomes, and im-
20 plement and assess effective interventions.

21 “(b) SCOPE AND SELECTION OF STATES FOR DEM-
22 ONSTRATION PROJECT.—The demonstration project
23 under subsection (a)(3) shall be conducted in no more
24 than 8 States, which shall be selected by the Secretary
25 based on—

1 “(1) applications submitted by States, which
2 specify which regions and populations the State in-
3 volved will serve under the demonstration project;

4 “(2) criteria designed by the Secretary to en-
5 sure that, as a whole, the demonstration project is,
6 to the greatest extent possible, representative of the
7 demographic and geographic composition of commu-
8 nities most affected by disparities;

9 “(3) criteria designed by the Secretary to en-
10 sure that a variety of types of models are tested
11 through the demonstration project and that such
12 models include interventions that have an existing
13 evidence base for effectiveness; and

14 “(4) criteria designed by the Secretary to as-
15 sure that the demonstration projects and models will
16 be carried out in consultation with local and regional
17 provider organizations, such as community health
18 centers, hospital systems, and medical societies rep-
19 resenting providers of maternity services.

20 “(c) DURATION OF DEMONSTRATION PROJECT.—
21 The demonstration project under subsection (a)(3) shall
22 begin on January 1, 2015, and end on December 31,
23 2019.

24 “(d) GRANTS FOR EVALUATION AND MONITORING.—
25 The Secretary may make grants to States and health care

1 providers participating in the demonstration project under
2 subsection (a)(3) for the purpose of collecting data nec-
3 essary for the evaluation and monitoring of such project.

4 “(e) REPORTS.—

5 “(1) STATE REPORTS.—Each State that par-
6 ticipates in the demonstration project under sub-
7 section (a)(3) shall report to the Secretary, in a
8 time, form, and manner specified by the Secretary,
9 the data necessary to—

10 “(A) monitor the—

11 “(i) outcomes of the project;

12 “(ii) costs of the project; and

13 “(iii) quality of maternity care pro-
14 vided under the project; and

15 “(B) evaluate the rationale for the selec-
16 tion of the items and services included in any
17 bundled payment made by the State under the
18 project.

19 “(2) FINAL REPORT.—Not later than December
20 31, 2020, the Secretary shall submit to Congress a
21 report on the results of the demonstration project
22 under subsection (a)(3).”.

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 com-
11 petent public health awareness and education campaign
12 to provide information that is focused on decreasing the
13 risk factors for sudden unexpected infant death and sud-
14 den unexplained death in childhood, including educating
15 individuals about safe sleep environments, sleep positions,
16 and reducing exposure to smoking during pregnancy and
17 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 2015 through 2019.

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 following
5 new part:

6 **“PART W—YOUTH PREGNANCY PREVENTION**
7 **PROGRAMS**

8 **“SEC. 39900. PURPOSE.**

9 “It is the purpose of this part to develop and carry
10 out research and demonstration projects on new and exist-
11 ing program interventions to provide youth in communities
12 at disproportionate risk for unintended teen pregnancy
13 (particularly youth in racial or ethnic minority or immi-
14 grant communities, youth in the foster care system, youth
15 in the juvenile justice system, rural youth, and LGBT
16 youth) the information and skills needed to prevent unin-
17 tended teenage pregnancies, build healthy relationships,
18 and improve overall health and well-being.

19 **“SEC. 39900-1. LIMITATION.**

20 “No Federal funds provided under this Act may be
21 used for health education programs or media awareness
22 campaigns that—

23 “(1) deliberately withhold life-saving informa-
24 tion about the human immunodeficiency virus
25 (HIV);

1 “(2) undermine young people’s confidence in
2 the effectiveness of contraception;

3 “(3) are medically inaccurate or have been sci-
4 entifically shown to be ineffective;

5 “(4) promote gender, racial, or ethnic stereo-
6 types;

7 “(5) are insensitive and unresponsive to the
8 needs of sexually active youth or LGBT youth;

9 “(6) are inconsistent with the ethical impera-
10 tives of medicine and public health; or

11 “(7) stigmatize and shame youth who are par-
12 enting or choose to parent.

13 **“SEC. 39900-2. DEMONSTRATION GRANTS TO REDUCE UN-
14 INTENDED TEENAGE PREGNANCIES.**

15 “(a) IN GENERAL.—The Secretary shall award com-
16 petitive grants to eligible entities for establishing or ex-
17 panding programs to provide youth in communities at dis-
18 proportionate risk for unintended teen pregnancy (particu-
19 larly youth in racial or ethnic minority or immigrant com-
20 munities, youth in the foster care system, youth in the
21 juvenile justice system, rural youth, and LGBT youth) the
22 information and skills needed to prevent unintended teen-
23 age pregnancy and develop healthy relationships.

24 “(b) PRIORITY.—In awarding grants under this sec-
25 tion, the Secretary shall give priority to applicants—

1 “(1) proposing to carry out projects in commu-
2 nities at disproportionate risk for unintended teen
3 pregnancy (particularly youth in racial or ethnic mi-
4 nority or immigrant communities, youth in the foster
5 care system, youth in the juvenile justice system,
6 rural youth, and LGBT youth);

7 “(2) that have a demonstrated history of effec-
8 tively working with such targeted communities;

9 “(3) that have a demonstrated history of engag-
10 ing in a meaningful and significant partnership with
11 such targeted communities; or

12 “(4) that have an integrated approach that also
13 promotes the skills necessary to build healthy rela-
14 tionships and recognize abusive or unhealthy behav-
15 iors.

16 “(c) PROGRAM SETTINGS.—Programs funded
17 through a grant under subsection (a) shall be provided—

18 “(1) through classroom-based settings, such as
19 school health education, humanities, language arts,
20 or family and consumer science education; after-
21 school programs; community-based programs; work-
22 force development programs; and health care set-
23 tings, including community health centers; or

1 “(2) in collaboration with systems that serve
2 large numbers of at-risk youth such as juvenile jus-
3 tice or foster care systems.

4 “(d) PROJECT REQUIREMENTS.—As a condition of
5 receipt of a grant under this section, an entity shall agree
6 that, with respect to information and skills provided
7 through the grant—

8 “(1) such information and skills will be—

9 “(A) age-appropriate;

10 “(B) evidence-based or evidence-informed;

11 “(C) provided in accordance with section
12 39900–6(b); and

13 “(D) culturally sensitive and relevant to
14 the target populations; and

15 “(2) any information provided about contracep-
16 tives shall include the health benefits and side ef-
17 fects of all contraceptives and barrier methods.

18 “(e) EVALUATION.—Of the total amount made avail-
19 able to carry out this section for a fiscal year, the Sec-
20 retary, acting through the Director of the Centers for Dis-
21 ease Control and Prevention and other agencies as appro-
22 priate, shall allot up to 10 percent of such amount to carry
23 out a rigorous, independent evaluation to determine the
24 extent and the effectiveness of activities funded through
25 this section during such fiscal year in changing attitudes

1 and behavior of teenagers with respect to healthy relation-
2 ships and childbearing.

3 “(f) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGA-
4 NIZATIONS.—Of the total amount made available to carry
5 out this section for a fiscal year, the Secretary shall re-
6 serve 5 percent of such amount to award grants under
7 this section to Indian tribes and tribal organizations in
8 such manner, and subject to such requirements, as the
9 Secretary, in consultation with Indian tribes and tribal or-
10 ganizations, determines appropriate.

11 “(g) ELIGIBLE ENTITY DEFINED.—

12 “(1) IN GENERAL.—In this section, the term
13 ‘eligible entity’ means a State, local, or tribal agen-
14 cy; a school or postsecondary institution; an after-
15 school program; a nonprofit organization; or a com-
16 munity or faith-based organization.

17 “(2) PREVENTING EXCLUSION OF SMALLER
18 COMMUNITY-BASED ORGANIZATIONS.—In carrying
19 out this section, the Secretary shall ensure that the
20 amounts and requirements of grants provided under
21 this section do not preclude receipt of such grants
22 by community-based organizations with a dem-
23 onstrated history of effectively working with adoles-
24 cents in racial or ethnic minority or immigrant com-

1 communities or engaged in meaningful and significant
2 partnership with such communities.

3 **“SEC. 39900–3. MULTIMEDIA CAMPAIGNS TO REDUCE UNIN-**
4 **TENDED TEENAGE PREGNANCIES.**

5 “(a) IN GENERAL.—The Secretary shall award com-
6 petitive grants to public and private entities to carry out
7 multimedia campaigns to provide public education and in-
8 crease public awareness regarding unintended teenage
9 pregnancy and related social and emotional issues, such
10 as violence prevention.

11 “(b) PRIORITY.—In awarding grants under this sec-
12 tion, the Secretary shall give priority to applicants pro-
13 posing to carry out campaigns developed for communities
14 at disproportionate risk for unintended teen pregnancy
15 (particularly youth in racial or ethnic minority or immi-
16 grant communities, youth in the foster care system, youth
17 in the juvenile justice system, rural youth, and LGBT
18 youth).

19 “(c) INFORMATION TO BE PROVIDED.—As a condi-
20 tion of receipt of a grant under this section, an entity shall
21 agree to use the grant to carry out multimedia campaigns
22 described in subsection (a) that—

23 “(1) at a minimum, shall provide information
24 on—

1 “(A) the prevention of unintended teenage
2 pregnancy; and

3 “(B) healthy relationship development; and

4 “(2) may provide information on the prevention
5 of dating violence and sexual assault.

6 **“SEC. 39900-4. RESEARCH ON REDUCING UNINTENDED**
7 **TEENAGE PREGNANCIES AND TEENAGE DAT-**
8 **ING VIOLENCE AND IMPROVING HEALTHY**
9 **RELATIONSHIPS.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Director of the Centers for Disease Control and Pre-
12 vention, shall make grants to public and private entities
13 to conduct, support, or coordinate research on unintended
14 teenage pregnancy, dating violence, and healthy relation-
15 ships among racial or ethnic minority or immigrant com-
16 munities that—

17 “(1) improves data collection on—

18 “(A) sexual and reproductive health, in-
19 cluding unintended teenage pregnancies and
20 births, among all minority communities and
21 subpopulations in which such data are not col-
22 lected, including American Indian and Alaska
23 Native youth;

1 “(B) sexual behavior, reproductive and sex-
2 ual coercion, and teenage contraceptive use pat-
3 terns at the State level, as appropriate;

4 “(C) unintended teenage pregnancies
5 among youth in and aging out of foster care or
6 juvenile justice systems and the underlying fac-
7 tors that lead to unintended teenage pregnancy
8 among youth in foster care or juvenile justice
9 systems; and

10 “(D) sexual and reproductive health, in-
11 cluding teenage pregnancies and births, sexual
12 behavior, reproductive and sexual coercion, and
13 teenage contraceptive use among—

14 “(i) LGBT youth; and

15 “(ii) rural youth;

16 “(2) investigates—

17 “(A) the variance in the rates of unin-
18 tended teenage pregnancy by—

19 “(i) racial and ethnic group (such as
20 Hispanic, Asian-American, African-Amer-
21 ican, Pacific Islander, American Indian,
22 and Alaska Native); and

23 “(ii) socioeconomic status, based on
24 the income of the family and education at-
25 tainment;

1 “(B) factors affecting the risk for youth of
2 unintended teenage pregnancy or dating vio-
3 lence, including the physical and social environ-
4 ment, level of acculturation, access to health
5 care, aspirations for the future, and history of
6 physical or sexual violence or abuse;

7 “(C) the role that violence and abuse play
8 in teenage sex, pregnancy, and childbearing;

9 “(D) strategies to address the dispro-
10 portionate rates of unintended teenage pregnancies
11 and dating violence in racial or ethnic minority
12 or immigrant communities;

13 “(E) how effective interventions can be
14 replicated or adapted in other settings to serve
15 racial or ethnic minority or immigrant commu-
16 nities in a culturally appropriate manner; and

17 “(F) the effectiveness of media campaigns
18 in addressing healthy relationship development,
19 dating violence prevention, and unintended
20 teenage pregnancy; and

21 “(3) tests research-based strategies for address-
22 ing high rates of unintended teenage pregnancy
23 through programs that emphasize healthy relation-
24 ships and violence prevention.

1 “(b) PRIORITY.—In carrying out this section, the
2 Secretary shall give priority to research that incor-
3 porates—

4 “(1) interdisciplinary approaches;

5 “(2) a strong emphasis on community-based
6 participatory research; or

7 “(3) translational research.

8 **“SEC. 39900-5. HHS ADOLESCENT HEALTH WORK GROUP.**

9 “(a) PURPOSE.—Not later than 30 days after the
10 date of the enactment of this part, the Secretary shall di-
11 rect the interagency adolescent health workgroup within
12 the Office of Adolescent Health of the Department of
13 Health and Human Services to—

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

19 “(2) with respect to including such strategies,
20 consult, to the greatest extent possible, with the
21 Federal Interagency Workgroup on Teen Dating Vi-
22 olence formed under the leadership of the National
23 Institute of Justice of the Department of Justice.

1 “(b) REPORT REQUIREMENT.—The Secretary,
2 through the Office of Adolescent Health, shall periodically
3 submit to Congress a report that—

4 “(1) includes a review of the evidence-based
5 programs on preventing unintended teenage preg-
6 nancy, which are carried out and identified by the
7 Office; and

8 “(2) identifies the programs of the Department
9 of Health and Human Services that include teenage
10 dating violence prevention and the promotion of
11 healthy teenage relationships as part of a strategy to
12 prevent unintended teenage pregnancy.

13 **“SEC. 39900-6. GENERAL GRANT PROVISIONS.**

14 “(a) APPLICATIONS.—To seek a grant under this
15 part, an entity shall submit an application to the Secretary
16 in such form, in such manner, and containing such agree-
17 ments, assurances, and information as the Secretary may
18 require.

19 “(b) ADDITIONAL REQUIREMENTS.—A grant may be
20 made under this part only if the applicant involved agrees
21 that information, activities, and services provided under
22 the grant—

23 “(1) will be evidence-based or evidence-in-
24 formed;

1 “(2) will be factually and medically accurate
2 and complete; and

3 “(3) if directed to a particular population
4 group, will be provided in an appropriate language
5 and cultural context.

6 “(c) TRAINING AND TECHNICAL ASSISTANCE.—

7 “(1) IN GENERAL.—Of the total amount made
8 available to carry out this part for a fiscal year, the
9 Secretary shall use 10 percent to provide, directly or
10 through a competitive grant process, training and
11 technical assistance to the grant recipients under
12 this part, including by disseminating research and
13 information regarding effective and promising prac-
14 tices, providing consultation and resources on a
15 broad array of teenage and unintended pregnancy
16 and violence prevention strategies, and developing
17 resources and materials.

18 “(2) COLLABORATION.—In carrying out this
19 subsection, the Secretary shall collaborate with enti-
20 ties that have expertise in the prevention of teenage
21 pregnancy, healthy relationship development, minor-
22 ity health and health disparities, and violence pre-
23 vention.

24 **“SEC. 39900-7. DEFINITIONS.**

25 “‘In this part:

1 “(1) MEDICALLY ACCURATE AND COMPLETE.—

2 The term ‘medically accurate and complete’ means,
3 with respect to information, activities, or services,
4 verified or supported by the weight of research con-
5 ducted in compliance with accepted scientific meth-
6 ods and—

7 “(A) published in peer-reviewed journals,
8 where applicable; or

9 “(B) comprising information that leading
10 professional organizations and agencies with
11 relevant expertise in the field recognize as accu-
12 rate, objective, and complete.

13 “(2) LGBT YOUTH.—The term ‘LGBT youth’
14 means lesbian, gay, bisexual, and transgender youth.

15 “(3) RACIAL OR ETHNIC MINORITY OR IMMI-
16 GRANT COMMUNITIES.—The term ‘racial or ethnic
17 minority or immigrant communities’ means commu-
18 nities with a substantial number of residents who
19 are members of racial or ethnic minority groups or
20 who are immigrants.

21 “(4) REPRODUCTIVE AND SEXUAL COERCION.—

22 The term ‘reproductive and sexual coercion’—

23 “(A) means, with respect to a person, coer-
24 cive behavior that interferes with the ability of
25 such person to control the reproductive deci-

1 sionmaking of such person, such as inten-
2 tionally exposing such person to sexually trans-
3 mitted infections; in the case such person is a
4 female, attempting to impregnate such person
5 against her will; intentionally interfering with
6 the person’s birth control; or threatening or act-
7 ing violent if the person does not comply with
8 the perpetrator’s wishes regarding contracep-
9 tion or the decision whether to terminate or
10 continue a pregnancy; and

11 “(B) includes a range of behaviors that a
12 partner may use related to sexual decision-mak-
13 ing to pressure or coerce a person to have sex
14 without using physical force, such as repeatedly
15 pressuring a partner to have sex when he or she
16 does not want to; threatening to end a relation-
17 ship if a person does not have sex; and threat-
18 ening retaliation if notified of a positive sexu-
19 ally transmitted disease test result.

20 “(5) YOUTH.—The term ‘youth’ means individ-
21 uals who are 11 to 19 years of age.

22 **“SEC. 39900-8. REPORTS.**

23 “(a) REPORT ON USE OF FUNDS.—Not later than
24 1 year after the date of the enactment of this part, the

1 Secretary shall submit to Congress a report on the use
2 of funds provided pursuant to this part.

3 “(b) REPORT ON IMPACT OF PROGRAMS.—Not later
4 than March 1, 2019, the Secretary shall submit to Con-
5 gress a report on the impact of the programs under this
6 part on reducing unintended teenage pregnancies.

7 **“SEC. 39900–9. AUTHORIZATION OF APPROPRIATIONS.**

8 “(a) IN GENERAL.—There are authorized to be ap-
9 propriated to carry out this part such sums as may be
10 necessary for each of the fiscal years 2015 through 2019.

11 “(b) AVAILABILITY.—Amounts appropriated pursu-
12 ant to subsection (a)—

13 “(1) are authorized to remain available until ex-
14 pended; and

15 “(2) are in addition to amounts otherwise made
16 available for such purposes.”

17 **SEC. 509. GESTATIONAL DIABETES.**

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

21 **“SEC. 317H–1. GESTATIONAL DIABETES.**

22 “(a) UNDERSTANDING AND MONITORING GESTA-
23 TIONAL DIABETES.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Director of the Centers for Disease

1 Control and Prevention, in consultation with the Di-
2 abetes Mellitus Interagency Coordinating Committee
3 established under section 429 and representatives of
4 appropriate national health organizations, shall de-
5 velop a multisite gestational diabetes research
6 project within the diabetes program of the Centers
7 for Disease Control and Prevention to expand and
8 enhance surveillance data and public health research
9 on gestational diabetes.

10 “(2) AREAS TO BE ADDRESSED.—The research
11 project developed under paragraph (1) shall ad-
12 dress—

13 “(A) procedures to establish accurate and
14 efficient systems for the collection of gestational
15 diabetes data within each State and common-
16 wealth, territory, or possession of the United
17 States;

18 “(B) the progress of collaborative activities
19 with the National Vital Statistics System, the
20 National Center for Health Statistics, and
21 State health departments with respect to the
22 standard birth certificate, in order to improve
23 surveillance of gestational diabetes;

24 “(C) postpartum methods of tracking
25 women with gestational diabetes after delivery

1 as well as targeted interventions proven to
2 lower the incidence of type 2 diabetes in that
3 population;

4 “(D) variations in the distribution of diag-
5 nosed and undiagnosed gestational diabetes,
6 and of impaired fasting glucose tolerance and
7 impaired fasting glucose, within and among
8 groups of women; and

9 “(E) factors and culturally sensitive inter-
10 ventions that influence risks and reduce the in-
11 cidence of gestational diabetes and related com-
12 plications during childbirth, including cultural,
13 behavioral, racial, ethnic, geographic, demo-
14 graphic, socioeconomic, and genetic factors.

15 “(3) REPORT.—Not later than 2 years after the
16 date of the enactment of this section, and annually
17 thereafter, the Secretary shall generate a report on
18 the findings and recommendations of the research
19 project including prevalence of gestational diabetes
20 in the multisite area and disseminate the report to
21 the appropriate Federal and non-Federal agencies.

22 “(b) EXPANSION OF GESTATIONAL DIABETES RE-
23 SEARCH.—

1 “(1) IN GENERAL.—The Secretary shall expand
2 and intensify public health research regarding gesta-
3 tional diabetes. Such research may include—

4 “(A) developing and testing novel ap-
5 proaches for improving postpartum diabetes
6 testing or screening and for preventing type 2
7 diabetes in women with a history of gestational
8 diabetes; and

9 “(B) conducting public health research to
10 further understanding of the epidemiologic,
11 socioenvironmental, behavioral, translation, and
12 biomedical factors and health systems that in-
13 fluence the risk of gestational diabetes and the
14 development of type 2 diabetes in women with
15 a history of gestational diabetes.

16 “(2) 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 2015 through 2019.

20 “(c) DEMONSTRATION GRANTS TO LOWER THE
21 RATE OF GESTATIONAL DIABETES.—

22 “(1) IN GENERAL.—The Secretary, acting
23 through the Director of the Centers for Disease
24 Control and Prevention, shall award grants, on a
25 competitive basis, to eligible entities for demonstra-

1 tion projects that implement evidence-based inter-
2 ventions to reduce the incidence of gestational diabe-
3 tes, the recurrence of gestational diabetes in subse-
4 quent pregnancies, and the development of type 2 di-
5 abetes in women with a history of gestational diabe-
6 tes.

7 “(2) PRIORITY.—In making grants under this
8 subsection, the Secretary shall give priority to
9 projects focusing on—

10 “(A) helping women who have 1 or more
11 risk factors for developing gestational diabetes;

12 “(B) working with women with a history of
13 gestational diabetes during a previous preg-
14 nancy;

15 “(C) providing postpartum care for women
16 with gestational diabetes;

17 “(D) tracking cases where women with a
18 history of gestational diabetes developed type 2
19 diabetes;

20 “(E) educating mothers with a history of
21 gestational diabetes about the increased risk of
22 their child developing diabetes;

23 “(F) working to prevent gestational diabe-
24 tes and prevent or delay the development of

1 type 2 diabetes in women with a history of ges-
2 tational diabetes; and

3 “(G) achieving outcomes designed to assess
4 the efficacy and cost-effectiveness of interven-
5 tions that can inform decisions on long-term
6 sustainability, including third-party reimburse-
7 ment.

8 “(3) APPLICATION.—An eligible entity desiring
9 to receive a grant under this subsection shall submit
10 to the Secretary—

11 “(A) an application at such time, in such
12 manner, and containing such information as the
13 Secretary may require; and

14 “(B) a plan to—

15 “(i) lower the rate of gestational dia-
16 betes during pregnancy; or

17 “(ii) develop methods of tracking
18 women with a history of gestational diabe-
19 tes and develop effective interventions to
20 lower the incidence of the recurrence of
21 gestational diabetes in subsequent preg-
22 nancies and the development of type 2 dia-
23 betes.

24 “(4) USES OF FUNDS.—An eligible entity re-
25 ceiving a grant under this subsection shall use the

1 grant funds to carry out demonstration projects de-
2 scribed in paragraph (1), including—

3 “(A) expanding community-based health
4 promotion education, activities, and incentives
5 focused on the prevention of gestational diabe-
6 tes and development of type 2 diabetes in
7 women with a history of gestational diabetes;

8 “(B) aiding State- and tribal-based diabe-
9 tes prevention and control programs to collect,
10 analyze, disseminate, and report surveillance
11 data on women with, and at risk for, gesta-
12 tional diabetes, the recurrence of gestational di-
13 abetes in subsequent pregnancies, and, for
14 women with a history of gestational diabetes,
15 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 women with a history of
25 gestational diabetes, and its complications

1 in the practice settings of the health care
2 providers.

3 “(5) REPORT.—Not later than 4 years after the
4 date of the enactment of this section, the Secretary
5 shall prepare and submit to the Congress a report
6 concerning the results of the demonstration projects
7 conducted through the grants awarded under this
8 subsection.

9 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
10 this subsection, the term ‘eligible entity’ means a
11 nonprofit organization (such as a nonprofit academic
12 center or community health center) or a State, trib-
13 al, or local health agency.

14 “(7) AUTHORIZATION OF APPROPRIATIONS.—
15 There is authorized to be appropriated to carry out
16 this subsection \$5,000,000 for each of fiscal years
17 2015 through 2019.

18 “(d) POSTPARTUM FOLLOWUP REGARDING GESTA-
19 TIONAL DIABETES.—The Secretary, acting through the
20 Director of the Centers for Disease Control and Preven-
21 tion, shall work with the State- and tribal-based diabetes
22 prevention and control programs assisted by the Centers
23 to encourage postpartum followup after gestational diabe-
24 tes, as medically appropriate, for the purpose of reducing
25 the incidence of gestational diabetes, the recurrence of

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

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

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

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

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

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

24 (b) EMERGENCY CONTRACEPTION INFORMATION
25 PROGRAM FOR HEALTH CARE PROVIDERS.—

1 (1) IN GENERAL.—The Secretary, acting
2 through the Administrator of the Health Resources
3 and Services Administration and in consultation
4 with major medical and public health organizations,
5 shall develop and disseminate to health care pro-
6 viders information on emergency contraception.

7 (2) INFORMATION.—The information dissemi-
8 nated under paragraph (1) shall include, at a min-
9 imum—

10 (A) information describing the use, safety,
11 efficacy, and availability of emergency contra-
12 ception;

13 (B) a recommendation regarding the use of
14 such contraception in appropriate cases; and

15 (C) information explaining how to obtain
16 copies of the information developed under sub-
17 section (a) for distribution to the patients of
18 the providers.

19 (c) DEFINITIONS.—In this section:

20 (1) EMERGENCY CONTRACEPTION.—The term
21 “emergency contraception” means a drug or device
22 (as the terms are defined in section 201 of the Fed-
23 eral Food, Drug, and Cosmetic Act (21 U.S.C. 321))
24 or a drug regimen that—

25 (A) is used postcoitally;

1 (B) prevents pregnancy primarily by pre-
2 venting or delaying ovulation, and does not ter-
3 minate an established pregnancy; and

4 (C) is approved by the Food and Drug Ad-
5 ministration.

6 (2) HEALTH CARE PROVIDER.—The term
7 “health care provider” means an individual who is li-
8 censed or certified under State law to provide health
9 care services and who is operating within the scope
10 of such license. Such term shall include a phar-
11 macist.

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

16 (4) SECRETARY.—The term “Secretary” means
17 the Secretary of Health and Human Services.

18 (d) 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 the fiscal years
21 2015 through 2019.

22 **SEC. 511. SUPPORTING HEALTHY ADOLESCENT DEVELOP-**
23 **MENT.**

24 (a) IN GENERAL.—The Secretary may award a grant
25 to each eligible State to conduct programs of sex education

1 described in subsection (b), including education on both
2 abstinence and contraception for the prevention of teenage
3 pregnancy and sexually transmitted diseases, including
4 HIV/AIDS and viral hepatitis.

5 (b) REQUIREMENTS FOR SEX EDUCATION PRO-
6 GRAMS.—A program of sex education described in this
7 subsection is a program that—

8 (1) is age appropriate and medically accurate;

9 (2) stresses the value of abstinence while not ig-
10 noring those young people who have been or are sex-
11 ually active;

12 (3) includes information providing a factual un-
13 derstanding of male and female reproductive anat-
14 omy;

15 (4) provides information about the health bene-
16 fits and side effects of contraceptive and barrier
17 methods used—

18 (A) as a means to prevent pregnancy; and

19 (B) to reduce the risk of contracting sexu-
20 ally transmitted disease, including HIV/AIDS
21 and viral hepatitis;

22 (5) encourages family communication between
23 parent and child about sexuality;

24 (6) cultivates a respectful dialogue about sexu-
25 ality, including sexual orientation and gender iden-

1 tity, and embraces the principles of nondiscrimina-
2 tion based on sexual orientation and gender identity;

3 (7) counters the perpetuation of narrow gender
4 roles, including the sexualization of female children,
5 adolescents, and adults;

6 (8) teaches young people the skills to make re-
7 sponsible decisions about sexuality, including how to
8 avoid unwanted verbal, physical, and sexual ad-
9 vances and how to avoid making verbal, physical,
10 and sexual advances that are not wanted by the
11 other party;

12 (9) develops healthy relationships, including the
13 prevention of dating and sexual violence;

14 (10) teaches young people how alcohol and drug
15 use can affect responsible decisionmaking; and

16 (11) does not teach or promote religion.

17 (c) **ADDITIONAL ACTIVITIES.**—In carrying out a pro-
18 gram of sex education, a State may expend grant funds
19 awarded under subsection (a) to carry out educational and
20 motivational activities that help young people—

21 (1) gain knowledge about the physical, emo-
22 tional, biological, and hormonal changes of adoles-
23 cence and subsequent stages of human maturation;

24 (2) develop the knowledge and skills nec-
25 essary—

1 (A) to ensure and protect their sexual and
2 reproductive health from unintended pregnancy
3 and sexually transmitted disease, including
4 HIV/AIDS, throughout their lifespan;

5 (B) to be aware that certain racial and
6 ethnic groups are more affected by certain sex-
7 ually transmitted diseases; and

8 (C) to receive the education to prevent fur-
9 ther transmission;

10 (3) gain knowledge about the specific involve-
11 ment and responsibility of each individual in sexual
12 decisionmaking;

13 (4) develop healthy attitudes and values about
14 adolescent growth and development, body image,
15 gender roles, racial and ethnic diversity, sexual ori-
16 entation and gender identity, and other subjects;

17 (5) develop and practice healthy life skills in-
18 cluding goal-setting, decisionmaking, negotiation,
19 communication, and stress management; and

20 (6) promote self-esteem and positive inter-
21 personal skills focusing on relationship dynamics, in-
22 cluding friendships, dating, romantic involvement,
23 marriage, and family interactions.

24 (d) MATCHING FUNDS.—The Secretary may not
25 make payments to a State under this section in an amount

1 exceeding Federal medical assistance percentage for such
2 State (as such term is defined in section 1905(b) of the
3 Social Security Act (42 U.S.C. 1396d(b))) of the costs of
4 the programs conducted by the State under this section.

5 (e) EVALUATION OF PROGRAMS.—

6 (1) IN GENERAL.—For the purpose of evalu-
7 ating the effectiveness of programs of sex education
8 carried out with a grant under this section, evalua-
9 tions shall be carried out in accordance with para-
10 graphs (2) and (3).

11 (2) NATIONAL EVALUATION.—

12 (A) METHOD.—The Secretary shall pro-
13 vide for a national evaluation of a representa-
14 tive sample of programs of sex education car-
15 ried out with grants under this section to deter-
16 mine—

17 (i) the effectiveness of such programs
18 in helping to delay the initiation of sexual
19 intercourse and other high-risk behaviors;

20 (ii) the effectiveness of such programs
21 in preventing adolescent pregnancy;

22 (iii) the effectiveness of such pro-
23 grams in preventing sexually transmitted
24 disease, including HIV/AIDS and viral
25 hepatitis;

1 (iv) the effectiveness of such programs
2 in increasing contraceptive knowledge and
3 contraceptive behaviors when sexual inter-
4 course occurs; and

5 (v) a list of best practices that—

6 (I) is based upon essential pro-
7 grammatic components of evaluated
8 programs that have led to success de-
9 scribed in clauses (i) through (iv); and

10 (II) documents the racial and
11 ethnic minority populations that are
12 recipients of grant funds under this
13 section or are served by programs of
14 sex education funded under this sec-
15 tion.

16 (B) GRANT CONDITION.—A condition for
17 the receipt of a grant to a State under this sec-
18 tion is that the State cooperate with the evalua-
19 tion under subparagraph (A).

20 (C) REPORT.—The Secretary shall submit
21 to the Congress—

22 (i) not later than the end of each fis-
23 cal year during the 5-year period beginning
24 with fiscal year 2015, an interim report on

1 the national evaluation under subpara-
2 graph (A); and

3 (ii) not later than March 31, 2020, a
4 final report providing the results of such
5 national evaluation.

6 (3) INDIVIDUAL STATE EVALUATIONS.—A con-
7 dition for the receipt of a grant under this section
8 is that the State evaluate the programs of sex edu-
9 cation funded through such grant in accordance with
10 the following requirements:

11 (A) The evaluation will be conducted by an
12 external, independent entity.

13 (B) The purposes of the evaluation will be
14 the determination of—

15 (i) the effectiveness of such programs
16 in helping to delay the initiation of sexual
17 intercourse and other high-risk behaviors;

18 (ii) the effectiveness of such programs
19 in preventing adolescent pregnancy;

20 (iii) the effectiveness of such pro-
21 grams in preventing sexually transmitted
22 disease, including HIV/AIDS; and

23 (iv) the effectiveness of such programs
24 in increasing contraceptive and barrier

1 method knowledge and contraceptive be-
2 haviors when sexual intercourse occurs.

3 (f) LIMITATIONS ON USE OF FUNDS.—

4 (1) LIMITATIONS ON SECRETARY.—Of the
5 amounts appropriated for a fiscal year for purposes
6 of this section, the Secretary may not use more
7 than—

8 (A) 7 percent of such amounts for admin-
9 istrative expenses related to carrying out this
10 section for that fiscal year; and

11 (B) 10 percent of such amounts for the
12 national evaluation under subsection (e)(2).

13 (2) LIMITATIONS TO STATES.—Of amounts pro-
14 vided to an eligible State under this subsection, the
15 State may not use more than 10 percent of the
16 grant to conduct any evaluation under subsection
17 (e)(3).

18 (g) NONDISCRIMINATION REQUIRED.—Programs
19 funded under this section shall not discriminate on the
20 basis of sex, race, ethnicity, national origin, disability, reli-
21 gion, marital status, familial status, sexual orientation, or
22 gender identity. Nothing in this section shall be construed
23 to invalidate or limit rights, remedies, procedures, or legal
24 standards available to victims of discrimination under any
25 other Federal law or any law of a State or a political sub-

1 division of a State, including title VI of the Civil Rights
2 Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the
3 Education Amendments of 1972 (20 U.S.C. 1681 et seq.),
4 section 504 of the Rehabilitation Act of 1973 (29 U.S.C.
5 794), and the Americans with Disabilities Act of 1990 (42
6 U.S.C. 12101 et seq.).

7 (h) DEFINITIONS.—For purposes of this section:

8 (1) The term “age appropriate” means, with re-
9 spect to topics, messages, and teaching methods,
10 those suitable to particular ages or age groups of
11 children, adolescents, and adults, based on devel-
12 oping cognitive, emotional, and behavioral capacity
13 typical for the age or age group.

14 (2) The term “eligible State” means a State
15 that submits to the Secretary an application for a
16 grant under this section that is in such form, is
17 made in such manner, and contains such agree-
18 ments, assurances, and information as the Secretary
19 determines to be necessary to carry out this section.

20 (3) The term “HIV/AIDS” means the human
21 immunodeficiency virus, and includes acquired im-
22 mune deficiency syndrome.

23 (4) The term “medically accurate”, with respect
24 to information, means information that is supported
25 by research, recognized as accurate and objective by

1 leading medical, psychological, psychiatric, and pub-
2 lic health organizations and agencies, and, published
3 in journals that are peer reviewed.

4 (5) The term “State” means the 50 States, the
5 District of Columbia, the Commonwealth of Puerto
6 Rico, the Commonwealth of the Northern Mariana
7 Islands, American Samoa, Guam, the United States
8 Virgin Islands, and any other territory or possession
9 of the United States.

10 (i) AUTHORIZATION OF APPROPRIATIONS.—For the
11 purpose of carrying out this section, there is authorized
12 to be appropriated \$50,000,000 for each of the fiscal years
13 2015 through 2019.

14 **SEC. 512. COMPASSIONATE ASSISTANCE FOR RAPE EMER-**
15 **GENCIES.**

16 (a) MEDICARE.—

17 (1) LIMITATION ON PAYMENT.—Section
18 1866(a)(1) of the Social Security Act (42 U.S.C.
19 1395cc(a)(1)) is amended—

20 (A) by striking “and” at the end of sub-
21 paragraph (V);

22 (B) in the subparagraph (W) added by sec-
23 tion 3005(1)(C) of Public Law 111–148—

24 (i) by striking the period at the end
25 and inserting a comma;

1 (ii) by moving the indentation 2 ems
2 to the left; and

3 (iii) by moving such subparagraph to
4 immediately follow subparagraph (V);

5 (C) in the subparagraph (W) added by sec-
6 tion 6406(b)(3) of Public Law 111–148—

7 (i) by striking the period at the end
8 and inserting “, and”;

9 (ii) by moving the indentation 2 ems
10 to the left;

11 (iii) by redesignating such subpara-
12 graph as subparagraph (X); and

13 (iv) by moving such subparagraph to
14 immediately follow subparagraph (W), as
15 moved under paragraph (2)(C); and

16 (D) by inserting after the subparagraph
17 (X), as redesignated and moved under para-
18 graph (3), the following:

19 “(Y) in the case of a hospital or critical ac-
20 cess hospital, to adopt and enforce a policy to
21 ensure compliance with the requirements of
22 subsection (l) and to meet the requirements of
23 such subsection.”.

24 (2) ASSISTANCE TO VICTIMS.—Section 1866 of
25 the Social Security Act (42 U.S.C. 1395cc) is

1 amended by adding at the end the following new
2 subsection:

3 “(1) COMPASSIONATE ASSISTANCE FOR RAPE EMER-
4 GENCIES.—

5 “(1) IN GENERAL.—For purposes of section
6 1866(a)(1)(Y), a hospital meets the requirements of
7 this subsection if the hospital provides each of the
8 services described in paragraph (2) to each female
9 individual, whether or not eligible for benefits under
10 this title or under any other form of health insur-
11 ance. who comes to the hospital on or after January
12 1, 2015, and—

13 “(A) who states to hospital personnel that
14 she is a victim of sexual assault;

15 “(B) who is accompanied by an individual
16 who states to hospital personnel that the female
17 individual is a victim of sexual assault; or

18 “(C) whom hospital personnel, during the
19 course of treatment and care for the female in-
20 dividual, have reason to believe is a victim of
21 sexual assault.

22 “(2) REQUIRED SERVICES DESCRIBED.—For
23 purposes of paragraph (1), the services described in
24 this subparagraph are the following:

1 “(A) Provision of medically and factually
2 accurate and unbiased written and oral infor-
3 mation about emergency contraception that—

4 “(i) is written in clear and concise
5 language;

6 “(ii) is readily comprehensible;

7 “(iii) includes an explanation that—

8 “(I) emergency contraception has
9 been approved by the Food and Drug
10 Administration as an over-the-counter
11 medication for female individuals, and
12 is a safe and effective way to prevent
13 pregnancy after unprotected inter-
14 course or contraceptive failure if
15 taken in a timely manner;

16 “(II) emergency contraception is
17 more effective the sooner it is taken;
18 and

19 “(III) emergency contraception
20 does not cause an abortion and cannot
21 interrupt an established pregnancy;

22 “(iv) meets such conditions regarding
23 the provision of such information in lan-
24 guages other than English as the Secretary
25 may establish; and

1 “(v) is provided without regard to the
2 ability of the individual or her family to
3 pay costs associated with the provision of
4 such information to the individual.

5 “(B) Prompt offer to provide emergency
6 contraception to the individual, and in the case
7 that the individual accepts such offer, prompt
8 provision of such contraception to such indi-
9 vidual without regard to the inability of the in-
10 dividual or her family to pay costs associated
11 with the offer and provision of such contracep-
12 tion.

13 “(3) DEFINITIONS.—For purposes of this para-
14 graph:

15 “(A) The term ‘emergency contraception’
16 means a drug or device (as such terms are de-
17 fined in section 201 of the Federal Food, Drug,
18 and Cosmetic Act (21 U.S.C. 321)) or a drug
19 regimen that—

20 “(i) is used postcoitally;

21 “(ii) prevents pregnancy primarily by
22 preventing or delaying ovulation, and does
23 not terminate an established pregnancy;
24 and

1 “(iii) is approved by the Food and
2 Drug Administration.

3 “(B) The term ‘hospital’ includes a critical
4 access hospital, as defined in section
5 1861(mm)(1).

6 “(C) The term ‘sexual assault’ means co-
7 itus in which the individual involved does not
8 consent or lacks the legal capacity to consent.”.

9 (b) **LIMITATION ON PAYMENT UNDER MEDICAID.**—
10 Section 1903(i) of the Social Security Act (42 U.S.C.
11 1396b(i)) is amended by inserting after paragraph (11)
12 the following new paragraph:

13 “(12) with respect to any amount expended for
14 care or services furnished under the plan by a hos-
15 pital on or after January 1, 2015, unless such hos-
16 pital meets the requirements specified in section
17 1866(l) for purposes of title XVIII.”.

18 **SEC. 513. ACCESS TO BIRTH CONTROL DUTIES OF PHAR-**
19 **MACIES TO ENSURE PROVISION OF FDA-AP-**
20 **PROVED CONTRACEPTION.**

21 Part B of title II of the Public Health Service Act
22 (42 U.S.C. 238 et seq.) is amended by adding at the end
23 the following:

1 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
2 **OF FDA-APPROVED CONTRACEPTION.**

3 “(a) IN GENERAL.—Subject to subsection (c), a
4 pharmacy that receives Food and Drug Administration-
5 approved drugs or devices in interstate commerce shall
6 maintain compliance with the following:

7 “(1) If a customer requests a contraceptive that
8 is in stock, the pharmacy shall ensure that the con-
9 traceptive is provided to the customer without delay.

10 “(2) If a customer requests a contraceptive that
11 is not in stock and the pharmacy in the normal
12 course of business stocks contraception, the phar-
13 macy shall immediately inform the customer that the
14 contraceptive is not in stock and without delay offer
15 the customer the following options:

16 “(A) If the customer prefers to obtain the
17 contraceptive 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 in
22 stock; and

23 “(ii) refer the customer or transfer
24 the prescription to that pharmacy.

25 “(B) If the customer prefers for the phar-
26 macy to order the contraceptive, the pharmacy

1 shall obtain the contraceptive under the phar-
2 macy's standard procedure for expedited order-
3 ing of medication and notify the customer when
4 the contraceptive arrives.

5 “(3) The pharmacy shall ensure that its em-
6 ployees do not—

7 “(A) intimidate, threaten, or harass cus-
8 tomers in the delivery of services relating to a
9 request for contraception;

10 “(B) interfere with or obstruct the delivery
11 of services relating to a request for contracep-
12 tion;

13 “(C) intentionally misrepresent or deceive
14 customers about the availability of contracep-
15 tion or its mechanism of action;

16 “(D) breach medical confidentiality with
17 respect to a request for contraception or threat-
18 en to breach such confidentiality; or

19 “(E) refuse to return a valid, lawful pre-
20 scription for contraception upon customer re-
21 quest.

22 “(b) CONTRACEPTIVES NOT ORDINARILY
23 STOCKED.—Nothing in subsection (a)(2) shall be con-
24 strued to require any pharmacy to comply with such sub-

1 section if the pharmacy does not ordinarily stock contra-
2 ceptives in the normal course of business.

3 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
4 MACY PRACTICE.—This section does not prohibit a phar-
5 macy from refusing to provide a contraceptive to a cus-
6 tomer in accordance with any of the following:

7 “(1) If it is unlawful to dispense the contracep-
8 tive to the customer without a valid, lawful prescrip-
9 tion and no such prescription is presented.

10 “(2) If the customer is unable to pay for the
11 contraceptive.

12 “(3) If the employee of the pharmacy refuses to
13 provide the contraceptive on the basis of a profes-
14 sional clinical judgment.

15 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
16 tion shall be construed to invalidate or limit rights, rem-
17 edies, procedures, or legal standards under title VII of the
18 Civil Rights Act of 1964.

19 “(e) PREEMPTION.—This section does not preempt
20 any provision of State law or any professional obligation
21 made applicable by a State board or other entity respon-
22 sible for licensing or discipline of pharmacies or phar-
23 macists, to the extent that such State law or professional
24 obligation provides protections for customers that are
25 greater than the protections provided by this section.

1 “(f) ENFORCEMENT.—

2 “(1) CIVIL PENALTY.—A pharmacy that vio-
3 lates a requirement of subsection (a) is liable to the
4 United States for a civil penalty in an amount not
5 exceeding \$1,000 per day of violation, not to exceed
6 \$100,000 for all violations adjudicated in a single
7 proceeding.

8 “(2) PRIVATE CAUSE OF ACTION.—Any person
9 aggrieved as a result of a violation of a requirement
10 of subsection (a) may, in any court of competent ju-
11 risdiction, commence a civil action against the phar-
12 macy involved to obtain appropriate relief, including
13 actual and punitive damages, injunctive relief, and a
14 reasonable attorney’s fee and cost.

15 “(3) LIMITATIONS.—A civil action under para-
16 graph (1) or (2) may not be commenced against a
17 pharmacy after the expiration of the 5-year period
18 beginning on the date on which the pharmacy alleg-
19 edly engaged in the violation involved.

20 “(g) DEFINITIONS.—In this section:

21 “(1) The term ‘contraception’ or ‘contraceptive’
22 means any drug or device approved by the Food and
23 Drug Administration to prevent pregnancy.

1 “(2) The term ‘employee’ means a person hired,
2 by contract or any other form of an agreement, by
3 a pharmacy.

4 “(3) The term ‘pharmacy’ means an entity
5 that—

6 “(A) is authorized by a State to engage in
7 the business of selling prescription drugs at re-
8 tail; and

9 “(B) employs one or more employees.

10 “(4) The term ‘product’ means a Food and
11 Drug Administration-approved drug or device.

12 “(5) The term ‘professional clinical judgment’
13 means the use of professional knowledge and skills
14 to form a clinical judgment, in accordance with pre-
15 vailing medical standards.

16 “(6) The term ‘without delay’, with respect to
17 a pharmacy providing, providing a referral for, or
18 ordering contraception, or transferring the prescrip-
19 tion for contraception, means within the usual and
20 customary timeframe at the pharmacy for providing,
21 providing a referral for, or ordering other products,
22 or transferring the prescription for other products,
23 respectively.

24 “(h) EFFECTIVE DATE.—This section shall take ef-
25 fect on the 31st day after the date of the enactment of

1 this section, without regard to whether the Secretary has
2 issued any guidance or final rule regarding this section.”.

3 **SEC. 514. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
4 **WOMEN’S HEALTH.**

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

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

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

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

13 “(8) facilitate policymakers, health system lead-
14 ers and providers, consumers, and other stake-
15 holders in understanding optimal maternity care and
16 support for the provision of such care, including the
17 priorities of—

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

22 “(B) using obstetric interventions only
23 when such interventions are supported by
24 strong, high-quality evidence, and minimizing
25 overuse of maternity practices that have been

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

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

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

24 “(E) a shared understanding of the results
25 of the best available research comparing hos-

1 pital, birth center, and planned home births, in-
 2 cluding information about each setting’s safety,
 3 satisfaction, outcomes, and costs; and

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

11 **SEC. 515. INTERAGENCY COORDINATING COMMITTEE ON**
 12 **THE PROMOTION OF OPTIMAL MATERNITY**
 13 **OUTCOMES.**

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

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

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

1 Committee on the Promotion of Optimal Maternity Out-
2 comes (referred to in this subsection as the ‘ICCPOM’).

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

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

22 “(d) DUTIES.—The ICCPOM shall guide policy and
23 program development across the Federal Government with
24 respect to promotion of optimal maternity care, provided,
25 however, that nothing in this section shall be construed

1 as transferring regulatory or program authority from an
2 agency to the ICCPOM.

3 “(e) CONSULTATIONS.—The ICCPOM shall actively
4 seek the input of, and shall consult with, all appropriate
5 and interested stakeholders, including State health depart-
6 ments, public health research and interest groups, founda-
7 tions, childbearing women and their advocates, and mater-
8 nity care professional associations and organizations, re-
9 flecting racially, ethnically, demographically, and geo-
10 graphically diverse communities.

11 “(f) ANNUAL REPORT.—

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

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

24 “(B) all programs and policies of Federal
25 agencies (including the Medicare Program

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

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

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

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

22 “(2) CERTAIN INFORMATION.—Each report
23 under paragraph (1) shall include information
24 (disaggregated by race, ethnicity, and indigenous

1 status, as applicable) on the following rates and
2 costs by State:

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

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

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

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

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

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

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

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

22 “(i) uncomplicated vaginal birth;

23 “(ii) complicated vaginal birth;

24 “(iii) uncomplicated cesarean birth;

25 and

1 “(iv) complicated cesarean birth.

2 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
3 is authorized to be appropriated, in addition to such
4 amounts authorized to be appropriated under section
5 229(e), to carry out this section \$1,000,000 for each of
6 the fiscal years 2015 through 2019.”.

7 (b) CONFORMING AMENDMENTS.—

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

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

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

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

17 “(9) establish the Interagency Coordinating
18 Committee on the Promotion of Optimal Maternity
19 Outcomes in accordance with section 229A.”.

20 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
21 tion 229(d) of such Act (42 U.S.C. 237a(d)) is
22 amended by inserting “(other than under subsection
23 (b)(9))” after “under this section”.

1 **SEC. 516. CONSUMER EDUCATION CAMPAIGN.**

2 Section 229 of the Public Health Service Act (42
3 U.S.C. 237a), as amended, is further amended in sub-
4 section (b)—

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

7 (2) in paragraph (9), at the end, by striking the
8 period and inserting “; and”; and

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

11 “(10) not later than one year after the date of
12 the enactment of the Health Equity and Account-
13 ability Act of 2014, develop and implement a 4-year
14 culturally and linguistically appropriate multimedia
15 consumer education campaign that is designed to
16 promote understanding and acceptance of evidence-
17 based maternity practices and models of care for op-
18 timal maternity outcomes among women of child-
19 bearing ages and families of such women and that—

20 “(A) highlights the importance of pro-
21 tecting, promoting, and supporting the innate
22 capacities of childbearing women and their
23 newborns for childbirth, breastfeeding, and at-
24 tachment;

25 “(B) promotes understanding of the impor-
26 tance of using obstetric interventions when

1 medically necessary and when supported by
2 strong, high-quality evidence;

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

12 “(D) emphasizes the noninvasive maternity
13 practices that have strong proven correlation or
14 may be associated with considerable improve-
15 ment in outcomes with no detrimental side ef-
16 fects, and are significantly underused in the
17 United States, including smoking cessation pro-
18 grams in pregnancy, group model prenatal care,
19 continuous labor support, nonsupine positions
20 for birth, and external version to turn breech
21 babies at term;

22 “(E) educates consumers about the quali-
23 fications of licensed providers of maternity care
24 and the best evidence about their safety, satis-
25 faction, outcomes, and costs;

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

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

14 “(H) is pilot tested for consumer com-
15 prehension, cultural sensitivity, and acceptance
16 of the messages across geographically, racially,
17 ethnically, and linguistically diverse popu-
18 lations.”.

19 **SEC. 517. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
20 **VIEWS FOR CARE OF CHILDBEARING WOMEN**
21 **AND NEWBORNS.**

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

1 (1) make publicly available an online biblio-
2 graphic database identifying systematic reviews, in-
3 cluding an explanation of the level and quality of
4 evidence, for care of childbearing women and
5 newborns; and

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

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

12 (1) scientific peer-reviewed journals;

13 (2) databases, including Cochrane Database of
14 Systematic Reviews, Clinical Evidence, and Data-
15 base of Abstracts of Reviews of Effects; and

16 (3) Internet Web sites of agencies and organi-
17 zations throughout the world that produce such sys-
18 tematic reviews.

19 (c) FEATURES.—The database shall—

20 (1) provide bibliographic citations for each
21 record within the database, and for each such cita-
22 tion include an explanation of the level and quality
23 of evidence;

24 (2) include abstracts, as available;

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

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

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

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

12 (7) offer to users periodic electronic notification
13 of database updates relating to users' topics of inter-
14 est.

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

21 (e) CONSULTATION.—For purposes of developing the
22 database under this section and maintaining and updating
23 such database, the Secretary of Health and Human Serv-
24 ices shall convene and consult with an advisory committee
25 composed of relevant stakeholders, including—

1 (1) Federal Medicaid administrators and State
2 agencies administering State plans under title XIX
3 of the Social Security Act pursuant to section
4 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

5 (2) providers of maternity and newborn care
6 from both academic and community-based settings,
7 including obstetrician-gynecologists, family physi-
8 cians, certified nurse midwives, certified midwives,
9 certified professional midwives, physician assistants,
10 perinatal nurses, pediatricians, and nurse practi-
11 tioners;

12 (3) maternal-fetal medicine specialists;

13 (4) neonatologists;

14 (5) childbearing women and advocates for such
15 women, including childbirth educators certified by a
16 nationally accredited program, representing commu-
17 nities that are diverse in terms of race, ethnicity, in-
18 digenous status, and geographic area;

19 (6) employers and purchasers;

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

22 (8) journalists; and

23 (9) bibliographic informatics specialists.

24 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
25 authorized to be appropriated \$2,500,000 for each of the

1 fiscal years 2015 through 2017 for the purpose of devel-
2 oping the database and such sums as may be necessary
3 for each subsequent fiscal year for updating the database
4 and providing outreach and notification to users, as de-
5 scribed in this section.

6 **SEC. 518. MATERNITY CARE HEALTH PROFESSIONAL**
7 **SHORTAGE AREAS.**

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

11 “(k)(1) The Secretary, acting through the Adminis-
12 trator of the Health Resources and Services Administra-
13 tion, shall designate maternity care health professional
14 shortage areas in the States, publish a descriptive list of
15 the area’s population groups, medical facilities, and other
16 public facilities so designated, and at least annually review
17 and, as necessary, revise such designations.

18 “(2) For purposes of paragraph (1), a complete de-
19 scriptive list shall be published in the Federal Register not
20 later than one year after the date of the enactment of the
21 Health Equity and Accountability Act of 2014 and annu-
22 ally thereafter.

23 “(3) The provisions of subsections (b), (c), (e), (f),
24 (g), (h), (i), and (j) (other than (j)(1)(B)) of this section
25 shall apply to the designation of a maternity care health

1 professional shortage area in a similar manner and extent
2 as such provisions apply to the designation of health pro-
3 fessional shortage areas, except in applying subsection
4 (b)(3), the reference in such subsection to ‘physicians’
5 shall be deemed to be a reference to nationally certified
6 and State licensed obstetricians, family practice physicians
7 who practice full-scope maternity care, certified nurse
8 midwives, certified midwives, certified professional mid-
9 wives, and physician’s assistants who practice full scope
10 maternity care.

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

13 “(A) an area in an urban or rural area (which
14 need not conform to the geographic boundaries of a
15 political subdivision and which is a rational area for
16 the delivery of health services) which the Secretary
17 determines has a shortage of providers of maternity
18 care health services including those referenced in
19 paragraph (3) or an urban or rural area that the
20 Secretary determines has lost a significant number
21 of such providers during the 10-year period begin-
22 ning with 2004 or has no obstetrical providers li-
23 censed to provide operative obstetrical services;

24 “(B) an area in an urban or rural area (which
25 need not conform to the geographic boundaries of a

1 political subdivision and which is a rational area for
2 the delivery of health services) which the Secretary
3 determines has a shortage of hospital or labor and
4 delivery units, hospital birth center units, or free-
5 standing birth centers or an area that lost a signifi-
6 cant number of these units during the 10-year pe-
7 riod beginning with 2004; or

8 “(C) a population group which the Secretary
9 determines has such a shortage of providers or fa-
10 cilities.”.

11 **SEC. 519. EXPANSION OF CDC PREVENTION RESEARCH**
12 **CENTERS PROGRAM TO INCLUDE CENTERS**
13 **ON OPTIMAL MATERNITY OUTCOMES.**

14 (a) **IN GENERAL.**—Not later than one year after the
15 date of the enactment of this Act, the Secretary of Health
16 and Human Services, shall support the establishment of
17 additional Prevention Research Centers under the Preven-
18 tion Research Center Program administered by the Cen-
19 ters for Disease Control and Prevention. Such additional
20 centers shall each be known as a Center for Excellence
21 on Optimal Maternity Outcomes.

22 (b) **RESEARCH.**—Each Center for Excellence on Opti-
23 mal Maternity Outcomes shall—

24 (1) conduct at least one focused program of re-
25 search to improve maternity outcomes, including the

1 reduction of cesarean birth rates, elective inductions,
2 prematurity rates, and low birth weight rates within
3 an underserved population that has a disproportion-
4 ately large burden of suboptimal maternity out-
5 comes, including maternal mortality and morbidity,
6 infant mortality, prematurity, or low birth weight;

7 (2) work with partners on special interest
8 projects, as specified by the Centers for Disease
9 Control and Prevention and other relevant agencies
10 within the Department of Health and Human Serv-
11 ices, and on projects funded by other sources; and

12 (3) involve a minimum of two distinct birth set-
13 ting models, such as a hospital labor and delivery
14 model and freestanding birth center model; or a hos-
15 pital labor and delivery model and planned home
16 birth model.

17 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
18 for Excellence on Optimal Maternity Outcomes shall in-
19 clude the following interdisciplinary providers of maternity
20 care:

21 (1) Obstetrician-gynecologists.

22 (2) At least two of the following providers:

23 (A) Family practice physicians.

24 (B) Nurse practitioners.

25 (C) Physician assistants.

1 (D) Certified professional midwives.

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

6 (1) Mental health.

7 (2) Doula labor support.

8 (3) Nutrition education.

9 (4) Childbirth education.

10 (5) Social work.

11 (6) Physical therapy or occupation therapy.

12 (7) Substance abuse services.

13 (8) Home visiting.

14 (e) COORDINATION.—The programs of research at
15 each of the two Centers of Excellence on Optimal Mater-
16 nity Outcomes shall compliment and not replicate the
17 work of the other.

18 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
19 authorized to be appropriated to carry out this section
20 \$2,000,000 for each of the fiscal years 2015 through
21 2019.

1 **SEC. 520. EXPANDING MODELS ALLOWED TO BE TESTED BY**
2 **CENTER FOR MEDICARE AND MEDICAID IN-**
3 **NOVATION TO INCLUDE MATERNITY CARE**
4 **MODELS.**

5 Section 1115A(b)(2)(B) of the Social Security Act
6 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
7 end the following new clause:

8 “(xxi) Promoting evidence-based mod-
9 els of care that have been associated with
10 reductions in maternal and infant health
11 disparities, including incorporating the use
12 of doula and promotoras support for preg-
13 nant and childbearing women into evi-
14 dence-based models of prenatal care, labor
15 and delivery, and postpartum care, and
16 supporting the appropriate use of out-of-
17 hospital birth models, including births at
18 home and in freestanding birth centers.”.

19 **SEC. 521. DEVELOPMENT OF INTERPROFESSIONAL MATER-**
20 **NITY CARE EDUCATIONAL MODELS AND**
21 **TOOLS.**

22 (a) IN GENERAL.—Not later than 6 months after the
23 date of the enactment of this Act, the Secretary of Health
24 and Human Services, acting in conjunction with the Ad-
25 ministrator of Health Resources and Services Administra-
26 tion, shall convene, for a 1-year period, an Interprofes-

1 sional Maternity Provider Education Commission to dis-
2 cuss and make recommendations for—

3 (1) a consensus standard physiologic maternity
4 care curriculum that takes into account the core
5 competencies for basic midwifery practice such as
6 those developed by the American College of Nurse
7 Midwives and the North American Registry of Mid-
8 wives, and the educational objectives for physicians
9 practicing in obstetrics and gynecology as deter-
10 mined by the Council on Resident Education in Ob-
11 stetrics and Gynecology;

12 (2) suggestions for multidisciplinary use of the
13 consensus physiologic curriculum;

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

18 (4) pilot demonstrations of interprofessional
19 educational models.

20 (b) PARTICIPANTS.—The Commission shall include
21 maternity care educators, curriculum developers, service
22 leaders, certification leaders, and accreditation leaders
23 from the various professions that provide maternity care
24 in this country. Such professions shall include obstetrician
25 gynecologists, certified nurse midwives or certified mid-

1 wives, family practice physicians, nurse practitioners, phy-
2 sician assistants, certified professional midwives, and
3 perinatal nurses. Additionally, the Commission shall in-
4 clude representation from maternity care consumer advo-
5 cates.

6 (c) CURRICULUM.—The consensus standard physio-
7 logic maternity care curriculum described in subsection
8 (a)(1) shall—

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

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

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

15 (4) incorporate recommendations to ensure re-
16 spectful, safe, and seamless consultation, referral,
17 transport, and transfer of care when necessary; and

18 (5) include cultural sensitivity and strategies to
19 decrease disparities in maternity outcomes.

20 (d) REPORT.—Not later than 6 months after the final
21 meeting of the Commission, the Secretary of Health and
22 Human Services shall—

23 (1) submit to Congress a report containing the
24 recommendations made by the Commission under
25 this section; and

1 (2) make such report publicly available.

2 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
3 authorized to be appropriated to carry out this section
4 \$1,000,000 for each of the fiscal years 2015 and 2016,
5 and such sums as are necessary for each of the fiscal years
6 2017 through 2019.

7 **SEC. 522. INCLUDING WITHIN INPATIENT HOSPITAL SERV-**
8 **ICES UNDER MEDICARE SERVICES FUR-**
9 **NISHED BY CERTAIN STUDENTS, INTERNS,**
10 **AND RESIDENTS SUPERVISED BY CERTIFIED**
11 **NURSE MIDWIVES.**

12 (a) IN GENERAL.—Section 1861(b) of the Social Se-
13 curity Act (42 U.S.C. 1395x(b)) is amended—

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

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

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

3 “(8) a certified nurse-midwife where the hos-
4 pital has a teaching program approved as specified
5 in paragraph (6), if (A) the hospital elects to receive
6 any payment due under this title for reasonable
7 costs of such services, and (B) all certified nurse-
8 midwives in such hospital agree not to bill charges
9 for professional services rendered in such hospital to
10 individuals covered under the insurance program es-
11 tablished by this title.”.

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

15 **SEC. 523. GRANTS TO PROFESSIONAL ORGANIZATIONS TO**
16 **INCREASE DIVERSITY IN MATERNITY CARE**
17 **PROFESSIONALS.**

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

23 (1) for fiscal year 2015, planning grants de-
24 scribed in subsection (b); and

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

3 (b) PLANNING GRANTS.—

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

6 (A) To collect data and identify any work-
7 force disparities, with respect to a health pro-
8 fession, at each of the following areas along the
9 health professional continuum:

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

14 (ii) Entrance into the training pro-
15 gram for the profession.

16 (iii) Graduation from such training
17 program.

18 (iv) Entrance into practice.

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

21 (B) To develop one or more strategies to
22 address the workforce disparities within the
23 health profession, as identified under (and in
24 response to the findings pursuant to) subpara-
25 graph (A).

1 (2) APPLICATION.—To be eligible to receive a
2 grant under this subsection, an eligible health pro-
3 fessional organization shall submit to the Secretary
4 of Health and Human Services an application in
5 such form and manner and containing such informa-
6 tion as specified by the Secretary.

7 (3) AMOUNT.—Each grant awarded under this
8 subsection shall be for an amount not to exceed
9 \$300,000.

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

13 (A) information on the extent and distribu-
14 tion of workforce disparities identified through
15 the grant; and

16 (B) reasonable objectives and strategies
17 developed to address such disparities within a
18 5-, 10-, and 25-year period.

19 (c) IMPLEMENTATION GRANTS.—

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

24 (2) APPLICATION.—To be eligible to receive a
25 grant under this subsection, an eligible health pro-

1 fessional organization shall submit to the Secretary
2 of Health and Human Services an application in
3 such form and manner as specified by the Secretary.
4 Each such application shall contain information on
5 the capability of the organization to carry out a
6 strategy described in paragraph (1), involvement of
7 partners or coalitions, plans for developing sustain-
8 ability of the efforts after the culmination of the
9 grant cycle, and any other information specified by
10 the Secretary.

11 (3) AMOUNT.—Each grant awarded under this
12 subsection shall be for an amount not to exceed
13 \$500,000 each year during the 4-year period of the
14 grant.

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

1 activities carried out by the organization through the
2 grant and a detailed plan for continuation of out-
3 reach efforts.

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

13 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
14 authorized to be appropriated to carry out this section
15 \$2,000,000 for fiscal year 2015 and \$3,000,000 for each
16 of the fiscal years 2016 through 2019.

17 **TITLE VI—MENTAL HEALTH**

18 **SEC. 601. COVERAGE OF MARRIAGE AND FAMILY THERA-**
19 **PIST SERVICES, MENTAL HEALTH COUN-**
20 **SELOR SERVICES, AND SUBSTANCE ABUSE**
21 **COUNSELOR SERVICES UNDER PART B OF**
22 **THE MEDICARE PROGRAM.**

23 (a) COVERAGE OF SERVICES.—

1 (1) IN GENERAL.—Section 1861(s)(2) of the
2 Social Security Act (42 U.S.C. 1395x(s)(2)) is
3 amended—

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

6 (B) in subparagraph (FF), by inserting
7 “and” at the end; and

8 (C) by adding at the end the following new
9 subparagraph:

10 “(GG) marriage and family therapist services
11 (as defined in subsection (kkk)(1)) and mental
12 health counselor services (as defined in subsection
13 (kkk)(3)) and substance abuse counselor services (as
14 defined in subsection (kkk)(5));”.

15 (2) DEFINITIONS.—Section 1861 of such Act
16 (42 U.S.C. 1395x), as amended by sections
17 202(b)(1)(A) and 423(a), is amended by adding at
18 the end the following new subsection:

19 “Marriage and Family Therapist Services; Marriage and
20 Family Therapist; Mental Health Counselor Serv-
21 ices; Mental Health Counselor

22 “(kkk)(1) The term ‘marriage and family therapist
23 services’ means services performed by a marriage and
24 family therapist (as defined in paragraph (2)) for the diag-
25 nosis and treatment of mental illnesses, which the mar-

1 riage and family therapist is legally authorized to perform
2 under State law (or the State regulatory mechanism pro-
3 vided by State law) of the State in which such services
4 are performed, as would otherwise be covered if furnished
5 by a physician or as an incident to a physician's profes-
6 sional service, but only if no facility or other provider
7 charges or is paid any amounts with respect to the fur-
8 nishing of such services.

9 “(2) The term ‘marriage and family therapist’ means
10 an individual who—

11 “(A) possesses a master’s or doctoral degree
12 which qualifies for licensure or certification as a
13 marriage and family therapist pursuant to State
14 law;

15 “(B) after obtaining such degree has performed
16 at least 2 years of clinical supervised experience in
17 marriage and family therapy; and

18 “(C) in the case of an individual performing
19 services in a State that provides for licensure or cer-
20 tification of marriage and family therapists, is li-
21 censed or certified as a marriage and family thera-
22 pist in such State.

23 “(3) The term ‘mental health counselor services’
24 means services performed by a mental health counselor (as
25 defined in paragraph (4)) for the diagnosis and treatment

1 of mental illnesses which the mental health counselor is
2 legally authorized to perform under State law (or the
3 State regulatory mechanism provided by the State law) of
4 the State in which such services are performed, as would
5 otherwise be covered if furnished by a physician or as inci-
6 dent to a physician's professional service, but only if no
7 facility or other provider charges or is paid any amounts
8 with respect to the furnishing of such services.

9 “(4) The term ‘mental health counselor’ means an
10 individual who—

11 “(A) possesses a master's or doctor's degree in
12 mental health counseling or a related field;

13 “(B) after obtaining such a degree has per-
14 formed at least 2 years of supervised mental health
15 counselor practice; and

16 “(C) in the case of an individual performing
17 services in a State that provides for licensure or cer-
18 tification of mental health counselors or professional
19 counselors, is licensed or certified as a mental health
20 counselor or professional counselor in such State.

21 “(5) The term ‘substance abuse counselor services’
22 means services performed by a substance abuse counselor
23 (as defined in paragraph (6)) for the diagnosis and treat-
24 ment of substance abuse and addiction which the sub-
25 stance abuse counselor is legally authorized to perform

1 under State law (or the State regulatory mechanism pro-
2 vided by the State law) of the State in which such services
3 are performed, as would otherwise be covered if furnished
4 by a physician or as incident to a physician’s professional
5 service, but only if no facility or other provider charges
6 or is paid any amounts with respect to the furnishing of
7 such services.

8 “(6) The term ‘substance abuse counselor’ means an
9 individual who—

10 “(A) has performed at least 2 years of super-
11 vised substance abuse counselor practice;

12 “(B) in the case of an individual performing
13 services in a State that provides for licensure or cer-
14 tification of substance abuse counselors or profes-
15 sional counselors, is licensed or certified as a sub-
16 stance abuse counselor or professional counselor in
17 such State; or

18 “(C) the individual is a drug and alcohol coun-
19 selor as defined in section 40.281 of title 49, Code
20 of Federal Regulations.”.

21 (3) PROVISION FOR PAYMENT UNDER PART
22 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.
23 1395k(a)(2)(B)) is amended by adding at the end
24 the following new clause:

1 “(v) marriage and family therapist
2 services, mental health counselor services,
3 and substance abuse counselor services;”.

4 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
5 of such Act (42 U.S.C. 1395l(a)(1)) is amended—

6 (A) by striking “and (Z)” and inserting
7 “(Z)”; and

8 (B) by inserting before the semicolon at
9 the end the following: “, and (AA) with respect
10 to marriage and family therapist services, men-
11 tal health counselor services, and substance
12 abuse counselor services under section
13 1861(s)(2)(GG), the amounts paid shall be 80
14 percent of the lesser of the actual charge for
15 the services or 75 percent of the amount deter-
16 mined for payment of a psychologist under sub-
17 paragraph (L)”.

18 (5) EXCLUSION OF MARRIAGE AND FAMILY
19 THERAPIST SERVICES AND MENTAL HEALTH COUN-
20 SELOR SERVICES FROM SKILLED NURSING FACILITY
21 PROSPECTIVE PAYMENT SYSTEM.—Section
22 1888(e)(2)(A)(ii) of such Act (42 U.S.C.
23 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
24 riage and family therapist services (as defined in
25 section 1861(kkk)(1)), mental health counselor serv-

1 ices (as defined in section 1861(kkk)(3)),” after
2 “qualified psychologist services,”.

3 (6) INCLUSION OF MARRIAGE AND FAMILY
4 THERAPISTS, MENTAL HEALTH COUNSELORS, AND
5 SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS
6 FOR ASSIGNMENT OF CLAIMS.—Section
7 1842(b)(18)(C) of such Act (42 U.S.C.
8 1395u(b)(18)(C)) is amended by adding at the end
9 the following new clauses:

10 “(vii) A marriage and family therapist (as de-
11 fined in section 1861(kkk)(2)).

12 “(viii) A mental health counselor (as defined in
13 section 1861(kkk)(4)).

14 “(ix) A substance abuse counselor (as defined
15 in section 1861 (kkk)(6)).”.

16 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
17 ICES PROVIDED IN CERTAIN SETTINGS.—

18 (1) RURAL HEALTH CLINICS AND FEDERALLY
19 QUALIFIED HEALTH CENTERS.—Section
20 1861(aa)(1)(B) of the Social Security Act (42
21 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
22 by a clinical social worker (as defined in subsection
23 (hh)(1)),” and inserting “, by a clinical social worker
24 (as defined in subsection (hh)(1)), by a marriage
25 and family therapist (as defined in subsection

1 (kkk)(2)), or by a mental health counselor (as de-
2 fined in subsection (kkk)(4)), or by a substance
3 abuse counselor (as defined in section 1861
4 (kkk)(6)).”.

5 (2) HOSPICE PROGRAMS.—Section
6 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C.
7 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or
8 one marriage and family therapist (as defined in
9 subsection (kkk)(2))” after “social worker”.

10 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
11 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-
12 HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the So-
13 cial Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended
14 by inserting “marriage and family therapist (as defined
15 in subsection (kkk)(2)),” after “social worker,”.

16 (d) EFFECTIVE DATE.—The amendments made by
17 this section shall apply with respect to services furnished
18 on or after January 1, 2015.

19 **SEC. 602. MINORITY FELLOWSHIP PROGRAM.**

20 Title V of the Public Health Service Act is amended
21 by inserting after section 506B of such Act (42 U.S.C.
22 290aa–5b) the following:

23 **“SEC. 506C. MINORITY FELLOWSHIP PROGRAM.**

24 “(a) FELLOWSHIPS.—The Administrator shall main-
25 tain a program, to be known as the Minority Fellowship

1 Program, under which the Administrator awards grants
2 or contracts to national associations or other appropriate
3 entities for the financial support of graduate students,
4 postdoctoral fellows, and residents in the professions of
5 psychology, psychiatry, social work, psychiatric advance-
6 practice nursing, marriage and family therapy, and profes-
7 sional counseling to students who demonstrate a commit-
8 ment to clinical or research careers focused on racial and
9 ethnic minority populations.

10 “(b) **TERM OF FINANCIAL SUPPORT.**—Financial sup-
11 port provided to an individual pursuant to subsection (a)
12 shall be for a term of not more than 12 months and may
13 be renewed thereafter.

14 “(c) **AUTHORIZATION OF APPROPRIATIONS.**—To
15 carry out this section, there is authorized to be appro-
16 priated \$10,000,000 for each of fiscal years 2015 through
17 2019.”.

18 **SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION**
19 **PROGRAM.**

20 Part D of title V of the Public Health Service Act
21 (42 U.S.C. 290dd et seq.) is amended by adding at the
22 end the following:

1 **“SEC. 544. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
2 **PROVISION OF BEHAVIORAL HEALTH CARE**
3 **IN PRIMARY CARE SETTINGS.**

4 “(a) GRANTS.—The Secretary, acting through the
5 Deputy Assistant Secretary for Minority Health, shall
6 award grants to eligible entities for the purpose of pro-
7 viding technical assistance and training regarding the ef-
8 fective development and implementation of integrated
9 interprofessional health care teams that provide behavioral
10 health care.

11 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
12 a grant under this section, an entity shall be a federally
13 qualified health center (as defined in section 1861(aa) of
14 the Social Security Act) serving a high proportion of indi-
15 viduals from racial and ethnic minority groups (as defined
16 in section 1707(g)).

17 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
18 carry out this section, there is authorized to be appro-
19 priated \$20,000,000 for each of fiscal years 2014 through
20 2016.”.

21 **SEC. 604. ADDRESSING RACIAL AND ETHNIC MINORITY**
22 **MENTAL HEALTH DISPARITIES RESEARCH**
23 **GAPS.**

24 Not later than 6 months after the date of the enact-
25 ment of this Act, the Director of the National Institute
26 on Minority Health and Health Disparities shall enter into

1 an arrangement with the Institute of Medicine (or, if the
2 Institute declines to enter into such an arrangement, an-
3 other appropriate entity)—

4 (1) to conduct a study with respect to mental
5 and behavioral health disparities in racial and ethnic
6 minority groups (as defined in section 1707(g) of
7 the Public Health Service Act (42 U.S.C. 300u-
8 6(g)); and

9 (2) to submit to the Congress a report on the
10 results of such study, including—

11 (A) a compilation of information on the dy-
12 namics of mental disorders in such racial and
13 ethnic minority groups;

14 (B) an identification of gaps in knowledge
15 and research needs; and

16 (C) recommendations for an interprofes-
17 sional research agenda at the National Insti-
18 tutes of Health aimed at reducing and ulti-
19 mately eliminating mental and behavioral health
20 disparities in such racial and ethnic minority
21 groups.

1 **SEC. 605. HEALTH PROFESSIONS COMPETENCIES TO AD-**
2 **DRESS RACIAL AND ETHNIC MINORITY MEN-**
3 **TAL HEALTH DISPARITIES.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services, acting through the Administrator of the
6 Substance Abuse and Mental Health Services Administra-
7 tion, shall award grants to qualified national organizations
8 for the purpose of developing, and disseminating to health
9 professional educational programs, curricula or core com-
10 petencies addressing mental health disparities among ra-
11 cial and ethnic minority groups.

12 (b) USE OF FUNDS.—Organizations receiving funds
13 under subsection (a) shall use the funds to develop and
14 disseminate curricula or core competencies, as described
15 in such subsection, for use in the training of students in
16 the professions of social work, psychology, psychiatry,
17 marriage and family therapy, mental health counseling,
18 and substance abuse counseling.

19 (c) ALLOWABLE ACTIVITIES.—Organizations receiv-
20 ing funds under subsection (a) may use the funds to en-
21 gage in the following activities related to the development
22 and dissemination of curricula or core competencies:

23 (1) Formation of committees or working groups
24 comprised of experts from accredited health profes-
25 sions schools to identify core competencies relating

1 to mental health disparities among racial and ethnic
2 minority groups.

3 (2) Planning of workshops in national fora to
4 allow for public input into the educational needs as-
5 sociated with mental health disparities among racial
6 and ethnic minority groups.

7 (3) Dissemination and promotion of the use of
8 curricula or core competencies in undergraduate and
9 graduate health professions training programs na-
10 tionwide.

11 (d) DEFINITIONS.—In this section:

12 (1) The term “qualified national organization”
13 means a national organization that focuses on the
14 education of students in programs of social work,
15 psychology, psychiatry, and marriage and family
16 therapy.

17 (2) The term “racial and ethnic minority
18 group” has the meaning given to such term in sec-
19 tion 1707(g) of the Public Health Service Act (42
20 U.S.C. 300u–6(g)).

21 (e) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 such sums as may be necessary for each of fiscal years
24 2014 through 2018.

1 **TITLE VII—ADDRESSING HIGH**
2 **IMPACT MINORITY DISEASES**
3 **Subtitle A—Cancer**

4 **SEC. 701. LUNG CANCER MORTALITY REDUCTION.**

5 (a) **SHORT TITLE.**—This section may be cited as the
6 “Lung Cancer Mortality Reduction Act of 2014”.

7 (b) **FINDINGS.**—Congress makes the following find-
8 ings:

9 (1) Lung cancer is the leading cause of cancer
10 death for both men and women, accounting for 28
11 percent of all cancer deaths.

12 (2) Lung cancer kills more people annually
13 than breast cancer, prostate cancer, colon cancer,
14 liver cancer, melanoma, and kidney cancer combined.

15 (3) Since the National Cancer Act of 1971
16 (Public Law 92–218; 85 Stat. 778), coordinated and
17 comprehensive research has raised the 5-year sur-
18 vival rates for breast cancer to 88 percent, for pros-
19 tate cancer to 99 percent, and for colon cancer to
20 64 percent.

21 (4) However, the 5-year survival rate for lung
22 cancer is still only 15 percent and a similar coordi-
23 nated and comprehensive research effort is required
24 to achieve increases in lung cancer survivability
25 rates.

1 (5) Sixty percent of lung cancer cases are now
2 diagnosed nonsmokers or former smokers.

3 (6) Two-thirds of nonsmokers diagnosed with
4 lung cancer are women.

5 (7) Certain minority populations, such as Afri-
6 can-American males, have disproportionately high
7 rates of lung cancer incidence and mortality, not-
8 withstanding their similar smoking rate.

9 (8) Members of the baby boomer generation are
10 entering their sixties, the most common age at which
11 people develop lung cancer.

12 (9) Tobacco addiction and exposure to other
13 lung cancer carcinogens such as Agent Orange and
14 other herbicides and battlefield emissions are serious
15 problems among military personnel and war vet-
16 erans.

17 (10) Significant and rapid improvements in
18 lung cancer mortality can be expected through great-
19 er use and access to lung cancer screening tests for
20 at-risk individuals.

21 (11) Additional strategies are necessary to fur-
22 ther enhance the existing tests and therapies avail-
23 able to diagnose and treat lung cancer in the future.

24 (12) The August 2001 Report of the Lung
25 Cancer Progress Review Group of the National Can-

1 cer Institute stated that funding for lung cancer re-
2 search was “far below the levels characterized for
3 other common malignancies and far out of propor-
4 tion to its massive health impact”.

5 (13) The Report of the Lung Cancer Progress
6 Review Group identified as its “highest priority” the
7 creation of integrated, multidisciplinary, multi-insti-
8 tutional research consortia organized around the
9 problem of lung cancer rather than around specific
10 research disciplines.

11 (14) The United States must enhance its re-
12 sponse to the issues raised in the Report of the
13 Lung Cancer Progress Review Group, and this can
14 be accomplished through the establishment of a co-
15 ordinated effort designed to reduce the lung cancer
16 mortality rate by 50 percent by 2015 and targeted
17 funding to support this coordinated effort.

18 (c) SENSE OF CONGRESS CONCERNING INVESTMENT
19 IN LUNG CANCER RESEARCH.—It is the sense of the Con-
20 gress that—

21 (1) lung cancer mortality reduction should be
22 made a national public health priority; and

23 (2) a comprehensive mortality reduction pro-
24 gram coordinated by the Secretary of Health and

1 Human Services is justified and necessary to ade-
2 quately address and reduce lung cancer mortality.

3 (d) LUNG CANCER MORTALITY REDUCTION PRO-
4 GRAM.—

5 (1) IN GENERAL.—Subpart 1 of part C of title
6 IV of the Public Health Service Act (42 U.S.C. 285
7 et seq.) is amended by adding at the end the fol-
8 lowing:

9 **“SEC. 417H. LUNG CANCER MORTALITY REDUCTION PRO-**
10 **GRAM.**

11 “(a) IN GENERAL.—Not later than 6 months after
12 the date of the enactment of this section, the Secretary,
13 in consultation with the Secretary of Defense, the Sec-
14 retary of Veterans Affairs, the Director of the National
15 Institutes of Health, the Director of the Centers for Dis-
16 ease Control and Prevention, the Commissioner of Food
17 and Drugs, the Administrator of the Centers for Medicare
18 & Medicaid Services, the Director of the National Institute
19 on Minority Health and Health Disparities, and other
20 members of the Lung Cancer Advisory Board established
21 under section 701 of the Health Equity and Accountability
22 Act of 2014, shall implement a comprehensive program,
23 to be known as the Lung Cancer Mortality Reduction Pro-
24 gram, to achieve a reduction of at least 25 percent in the
25 mortality rate of lung cancer by 2020.

1 “(b) REQUIREMENTS.—The Program shall include at
2 least the following:

3 “(1) With respect to the National Institutes of
4 Health—

5 “(A) a strategic review and prioritization
6 by the National Cancer Institute of research
7 grants to achieve the goal of the Lung Cancer
8 Mortality Reduction Program in reducing lung
9 cancer mortality;

10 “(B) the provision of funds to enable the
11 Airway Biology and Disease Branch of the Na-
12 tional Heart, Lung, and Blood Institute to ex-
13 pand its research programs to include pre-
14 dispositions to lung cancer, the interrelationship
15 between lung cancer and other pulmonary and
16 cardiac disease, and the diagnosis and treat-
17 ment of these interrelationships;

18 “(C) the provision of funds to enable the
19 National Institute of Biomedical Imaging and
20 Bioengineering to expedite the development of
21 computer-assisted diagnostic, surgical, treat-
22 ment, and drug-testing innovations to reduce
23 lung cancer mortality, such as through expan-
24 sion of the Institute’s Quantum Grant Program
25 and Image-Guided Interventions programs; and

1 “(D) the provision of funds to enable the
2 National Institute of Environmental Health
3 Sciences to implement research programs rel-
4 ative to the lung cancer incidence.

5 “(2) With respect to the Food and Drug Ad-
6 ministration—

7 “(A) activities under section 530 of the
8 Federal Food, Drug, and Cosmetic Act; and

9 “(B) activities under section 561 of the
10 Federal Food, Drug, and Cosmetic Act to ex-
11 pand access to investigational drugs and devices
12 for the diagnosis, monitoring, or treatment of
13 lung cancer.

14 “(3) With respect to the Centers for Disease
15 Control and Prevention, the establishment of an
16 early disease research and management program
17 under section 1511.

18 “(4) With respect to the Agency for Healthcare
19 Research and Quality, the conduct of a biannual re-
20 view of lung cancer screening, diagnostic, and treat-
21 ment protocols, and the issuance of updated guide-
22 lines.

23 “(5) The cooperation and coordination of all
24 minority and health disparity programs within the
25 Department of Health and Human Services to en-

1 sure that all aspects of the Lung Cancer Mortality
2 Reduction Program under this section adequately
3 address the burden of lung cancer on minority and
4 rural populations.

5 “(6) The cooperation and coordination of all to-
6 bacco control and cessation programs within agen-
7 cies of the Department of Health and Human Serv-
8 ices to achieve the goals of the Lung Cancer Mor-
9 tality Reduction Program under this section with
10 particular emphasis on the coordination of drug and
11 other cessation treatments with early detection pro-
12 tocols.”.

13 (2) FEDERAL FOOD, DRUG, AND COSMETIC
14 ACT.—Subchapter B of chapter V of the Federal
15 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
16 seq.) is amended by adding at the end the following:

17 “DRUGS RELATING TO LUNG CANCER

18 “SEC. 530. (a) IN GENERAL.—The provisions of this
19 subchapter shall apply to a drug described in subsection
20 (b) to the same extent and in the same manner as such
21 provisions apply to a drug for a rare disease or condition.

22 “(b) QUALIFIED DRUGS.—A drug described in this
23 subsection is—

24 “(1) a chemoprevention drug for precancerous
25 conditions of the lung;

1 “(2) a drug for targeted therapeutic treat-
2 ments, including any vaccine, for lung cancer; and

3 “(3) a drug to curtail or prevent nicotine addic-
4 tion.

5 “(c) BOARD.—The Board established under the
6 Health Equity and Accountability Act of 2014 shall mon-
7 itor the program implemented under this section.”.

8 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
9 tion 561(e) of the Federal Food, Drug, and Cos-
10 metic Act (21 U.S.C. 360bbb(e)) is amended by in-
11 serting before the period the following: “and shall
12 include expanding access to drugs under section
13 530, with substantial consideration being given to
14 whether the totality of information available to the
15 Secretary regarding the safety and effectiveness of
16 an investigational drug, as compared to the risk of
17 morbidity and death from the disease, indicates that
18 a patient may obtain more benefit than risk if treat-
19 ed with the drug”.

20 (4) CDC.—Title XV of the Public Health Serv-
21 ice Act (42 U.S.C. 300k et seq.) is amended by add-
22 ing at the end the following:

1 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
2 **PROGRAM.**

3 “The Secretary shall establish and implement an
4 early disease research and management program targeted
5 at the high incidence and mortality rates of lung cancer
6 among minority and low-income populations.”.

7 (e) DEPARTMENT OF DEFENSE AND THE DEPART-
8 MENT OF VETERANS AFFAIRS.—The Secretary of Defense
9 and the Secretary of Veterans Affairs shall coordinate
10 with the Secretary of Health and Human Services—

11 (1) in the development of the Lung Cancer
12 Mortality Reduction Program under section 417H;

13 (2) in the implementation within the Depart-
14 ment of Defense and the Department of Veterans
15 Affairs of an early detection and disease manage-
16 ment research program for military personnel and
17 veterans whose smoking history and exposure to car-
18 cinogens during active duty service has increased
19 their risk for lung cancer; and

20 (3) in the implementation of coordinated care
21 programs for military personnel and veterans diag-
22 nosed with lung cancer.

23 (f) LUNG CANCER ADVISORY BOARD.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services shall convene a Lung Cancer Advi-

1 sory Board (referred to in this section as the
2 “Board”)—

3 (A) to monitor the programs established
4 under this section (and the amendments made
5 by this section); and

6 (B) to provide annual reports to the Con-
7 gress concerning benchmarks, expenditures,
8 lung cancer statistics, and the public health im-
9 pact of such programs.

10 (2) COMPOSITION.—The Board shall be com-
11 posed of—

12 (A) the Secretary of Health and Human
13 Services;

14 (B) the Secretary of Defense;

15 (C) the Secretary of Veterans Affairs; and

16 (D) two representatives each from the
17 fields of clinical medicine focused on lung can-
18 cer, lung cancer research, imaging, drug devel-
19 opment, and lung cancer advocacy, to be ap-
20 pointed by the Secretary of Health and Human
21 Services.

22 (g) AUTHORIZATION OF APPROPRIATIONS.—

23 (1) IN GENERAL.—To carry out this section
24 (and the amendments made by this section), there
25 are authorized to be appropriated such sums as may

1 be necessary for each of fiscal years 2015 through
2 2019.

3 (2) LUNG CANCER MORTALITY REDUCTION PRO-
4 GRAM.—Of the amounts authorized to be appro-
5 priated by subsection (a), there are authorized to be
6 appropriated—

7 (A) \$25,000,000 for fiscal year 2015, and
8 such sums as may be necessary for each of fis-
9 cal years 2016 through 2019, for the activities
10 described in section 417H(b)(1)(B) of the Pub-
11 lic Health Service Act, as added by subsection
12 (d)(1);

13 (B) \$25,000,000 for fiscal year 2015, and
14 such sums as may be necessary for each of fis-
15 cal years 2016 through 2019, for the activities
16 described in section 417H(b)(1)(C) of such Act;

17 (C) \$10,000,000 for fiscal year 2015, and
18 such sums as may be necessary for each of fis-
19 cal years 2016 through 2019, for the activities
20 described in section 417H(b)(1)(D) of such Act;
21 and

22 (D) \$15,000,000 for fiscal year 2015, and
23 such sums as may be necessary for each of fis-
24 cal years 2016 through 2019, for the activities
25 described in section 417H(b)(3) of such 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 2014” 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 2010, more than 217,730 new patients
13 were diagnosed with prostate cancer and more than
14 32,000 men died from this disease.

15 (3) Roughly 2,000,000 Americans are living
16 with a diagnosis of prostate cancer and its con-
17 sequences.

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, namely African-
25 Americans have prostate cancer mortality rates that
26 are more 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 For example, it is not fully understood how much of
17 known disparities are attributable to disease eti-
18 ology, access to care, or education and awareness in
19 the community.

20 (10) Causes of prostate cancer are not known.
21 There is not good information regarding how to dif-
22 ferentiate accurately, early on, between aggressive
23 and indolent forms of the disease. As a result, there
24 is significant overtreatment in prostate cancer.
25 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 (roughly 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 as one of eight high-volume, high-cost
12 areas in the Resource Utilization Report Program
13 authorized by Congress under the Medicare Im-
14 provements for Patients and Providers Act of 2008.

15 (12) Prostate cancer research and health care
16 programs across Federal agencies should be coordi-
17 nated to improve accountability and actively encour-
18 age the translation of research into practice, to iden-
19 tify and implement best practices, in order to foster
20 an integrated and consistent focus on effective pre-
21 vention, diagnosis, and treatment of this disease.

22 (c) PROSTATE CANCER COORDINATION AND EDU-
23 CATION.—

24 (1) INTERAGENCY PROSTATE CANCER COORDI-
25 NATION AND EDUCATION TASK FORCE.—Not later

1 than 180 days after the date of the enactment of
2 this section, the Secretary of Veterans Affairs, in co-
3 operation with the Secretary of Defense and the Sec-
4 retary of Health and Human Services, shall estab-
5 lish an Interagency Prostate Cancer Coordination
6 and Education Task Force (in this section referred
7 to as the “Prostate Cancer Task Force”).

8 (2) DUTIES.—The Prostate Cancer Task Force
9 shall—

10 (A) develop a summary of advances in
11 prostate cancer research supported or con-
12 ducted by Federal agencies relevant to the diag-
13 nosis, prevention, and treatment of prostate
14 cancer, including psychosocial impairments re-
15 lated to prostate cancer treatment, and compile
16 a list of best practices that warrant broader
17 adoption in health care programs;

18 (B) consider establishing, and advocating
19 for, a guidance to enable physicians to allow
20 screening of men who are over age 74, on a
21 case-by-case basis, taking into account quality
22 of life and family history of prostate cancer;

23 (C) share and coordinate information on
24 Federal research and health care program ac-
25 tivities, including activities related to—

1 (i) determining how to improve re-
2 search and health care programs, including
3 psychosocial impairments related to pros-
4 tate cancer treatment;

5 (ii) identifying any gaps in the overall
6 research inventory and in health care pro-
7 grams;

8 (iii) identifying opportunities to pro-
9 mote translation of research into practice;
10 and

11 (iv) maximizing the effects of Federal
12 efforts by identifying opportunities for col-
13 laboration and leveraging of resources in
14 research and health care programs that
15 serve those susceptible to or diagnosed
16 with prostate cancer;

17 (D) develop a comprehensive interagency
18 strategy and advise relevant Federal agencies in
19 the solicitation of proposals for collaborative,
20 multidisciplinary research and health care pro-
21 grams, including proposals to evaluate factors
22 that may be related to the etiology of prostate
23 cancer, that would—

24 (i) result in innovative approaches to
25 study emerging scientific opportunities or

1 eliminate knowledge gaps in research to
2 improve the prostate cancer research port-
3 folio of the Federal Government;

4 (ii) outline key research questions,
5 methodologies, and knowledge gaps; and

6 (iii) ensure consistent action, as out-
7 lined by section 402(b) of the Public
8 Health Service Act;

9 (E) develop a coordinated message related
10 to screening and treatment for prostate cancer
11 to be reflected in educational and beneficiary
12 materials for Federal health programs as such
13 documents are updated; and

14 (F) not later than 2 years after the date
15 of the establishment of the Prostate Cancer
16 Task Force, submit to the Expert Advisory
17 Panel to be reviewed and returned within 30
18 days, and then within 90 days submitted to
19 Congress recommendations—

20 (i) regarding any appropriate changes
21 to research and health care programs, in-
22 cluding recommendations to improve the
23 research portfolio of the Department of
24 Veterans Affairs, Department of Defense,
25 National Institutes of Health, and other

1 Federal agencies to ensure that scientif-
2 ically based strategic planning is imple-
3 mented in support of research and health
4 care program priorities;

5 (ii) designed to ensure that the re-
6 search and health care programs and ac-
7 tivities of the Department of Veterans Af-
8 fairs, the Department of Defense, the De-
9 partment of Health and Human Services,
10 and other Federal agencies are free of un-
11 necessary duplication;

12 (iii) regarding public participation in
13 decisions relating to prostate cancer re-
14 search and health care programs to in-
15 crease the involvement of patient advo-
16 cates, community organizations, and med-
17 ical associations representing a broad geo-
18 graphical area;

19 (iv) on how to best disseminate infor-
20 mation on prostate cancer research and
21 progress achieved by health care programs;

22 (v) about how to expand partnerships
23 between public entities, including Federal
24 agencies, and private entities to encourage

1 collaborative, cross-cutting research and
2 health care delivery;

3 (vi) assessing any cost savings and ef-
4 ficiencies realized through the efforts iden-
5 tified and supported in this section and
6 recommending expansion of those efforts
7 that have proved most promising while also
8 ensuring against any conflicts in directives
9 from other congressional or statutory man-
10 dates or enabling statutes;

11 (vii) identifying key priority action
12 items from among the recommendations;
13 and

14 (viii) with respect to the level of fund-
15 ing needed by each agency to implement
16 the recommendations contained in the re-
17 port.

18 (3) MEMBERS OF THE PROSTATE CANCER TASK
19 FORCE.—The Prostate Cancer Task Force described
20 in subsection (a) shall be composed of representa-
21 tives from such Federal agencies, as each Secretary
22 determines necessary, to coordinate a uniform mes-
23 sage relating to prostate cancer screening and treat-
24 ment where appropriate, including representatives of
25 the following:

1 (A) The Department of Veterans Affairs,
2 including representatives of each relevant pro-
3 gram areas of the Department of Veterans Af-
4 fairs.

5 (B) The Prostate Cancer Research Pro-
6 gram of the Congressionally Directed Medical
7 Research Program of the Department of De-
8 fense.

9 (C) The Department of Health and
10 Human Services, including at a minimum rep-
11 resentatives of the following:

12 (i) The National Institutes of Health.

13 (ii) National research institutes and
14 centers, including the National Cancer In-
15 stitute, the National Institute of Allergy
16 and Infectious Diseases, and the Office of
17 Minority Health.

18 (iii) The Centers for Medicare & Med-
19 icaid Services.

20 (iv) The Food and Drug Administra-
21 tion.

22 (v) The Centers for Disease Control
23 and Prevention.

24 (vi) The Agency for Healthcare Re-
25 search and Quality.

1 (vii) The Health Resources and Serv-
2 ices Administration.

3 (4) APPOINTING EXPERT ADVISORY PANELS.—

4 The Prostate Cancer Task Force shall appoint ex-
5 pert advisory panels, as determined appropriate, to
6 provide input and concurrence from individuals and
7 organizations from the medical, prostate cancer pa-
8 tient and advocate, research, and delivery commu-
9 nities with expertise in prostate cancer diagnosis,
10 treatment, and research, including practicing urolo-
11 gists, primary care providers, and others and indi-
12 viduals with expertise in education and outreach to
13 underserved populations affected by prostate cancer.

14 (5) MEETINGS.—The Prostate Cancer Task
15 Force shall convene not less than twice a year, or
16 more frequently as the Secretary determines to be
17 appropriate.

18 (6) SUBMISSION OF RECOMMENDATIONS TO
19 CONGRESS.—The Secretary of Veterans Affairs shall
20 submit to Congress any recommendations submitted
21 to the Secretary under paragraph (2)(E).

22 (7) FEDERAL ADVISORY COMMITTEE ACT.—

23 (A) IN GENERAL.—Except as provided in
24 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 (8) SUNSET DATE.—The Prostate Cancer Task
8 Force shall terminate at the end of fiscal year 2019.

9 (d) PROSTATE CANCER RESEARCH.—

10 (1) RESEARCH COORDINATION.—The Secretary
11 of Veterans Affairs, in coordination with the Secre-
12 taries of Defense and of Health and Human Serv-
13 ices, shall establish and carry out a program to co-
14 ordinate and intensify prostate cancer research as
15 needed. Specifically, 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) better understand the etiology of the
24 disease (including an analysis of lifestyle factors
25 proven to be involved in higher rates of prostate

1 cancer, such as obesity and diet, and in dif-
2 ferent ethnic, racial, and socioeconomic groups,
3 such as the African-American, Latino or His-
4 panic, and American Indian populations and
5 men with a family history of prostate cancer) to
6 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 section.

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) needed outreach and educational
2 efforts to raise awareness in these commu-
3 nities; and

4 (iv) appropriate access and utilization
5 of imaging modalities.

6 (e) TELEHEALTH AND RURAL ACCESS PILOT
7 PROJECT.—

8 (1) IN GENERAL.—The Secretary of Veterans
9 Affairs, the Secretary of Defense, and the Secretary
10 of Health and Human Services (in this section re-
11 ferred to as the “Secretaries”) shall establish 4-year
12 telehealth pilot projects for the purpose of analyzing
13 the clinical outcomes and cost effectiveness associ-
14 ated with telehealth services in a variety of geo-
15 graphic areas that contain high proportions of medi-
16 cally underserved populations, including African-
17 Americans, Latino or Hispanic, American Indians/
18 Alaska Natives, and those in rural areas. Such
19 projects shall promote efficient use of specialist care
20 through better coordination of primary care and
21 physician extender teams in underserved areas and
22 more effectively employ tumor boards to better coun-
23 sel 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 in-
3 novative 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 12 months after
15 the 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 shall develop a national education campaign
24 for prostate cancer. Such campaign shall involve the
25 use of written educational materials and public serv-

1 ice announcements consistent with the findings of
2 the Prostate Cancer Task Force under subsection
3 (c), that are intended to encourage men to seek
4 prostate cancer screening when appropriate.

5 (2) RACIAL DISPARITIES AND THE POPULATION
6 OF MEN WITH A FAMILY HISTORY OF PROSTATE
7 CANCER.—In developing the national campaign
8 under paragraph (1), the Secretary shall ensure that
9 such educational materials and public service an-
10 nouncements are more readily available in commu-
11 nities experiencing racial disparities in the incidence
12 and mortality rates of prostate cancer and by men
13 of any race classification with a family history of
14 prostate cancer.

15 (3) GRANTS.—In carrying out the national
16 campaign under this section, the Secretary shall
17 award grants to nonprofit private entities to enable
18 such entities to test alternative outreach and edu-
19 cation strategies.

20 (g) AUTHORIZATION OF APPROPRIATIONS.—

21 (1) IN GENERAL.—There is authorized to be
22 appropriated to carry out this section for the period
23 of fiscal years 2015 through 2019 an amount equal
24 to the savings described in paragraph (2).

1 (2) CORRESPONDING REDUCTION.—The
2 amount authorized to be appropriated by provisions
3 of law other than this section for the period of fiscal
4 years 2015 through 2019 for Federal research and
5 health care program activities related to prostate
6 cancer is reduced by the amount of Federal savings
7 projected to be achieved over such period by imple-
8 mentation of subsection (c)(2)(C) of this section.

9 **SEC. 703. 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 2015, 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 such commonwealth or
23 territory for such fiscal year.”.

1 (2) TECHNICAL AMENDMENT.—Such section is
2 further amended by striking “(3), and (4)” and in-
3 sserting “(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
10 United States Virgin Islands, Guam, the Commonwealth
11 of the Northern Mariana Islands, or American Samoa in
12 a fiscal year, the Federal medical assistance percentage
13 is equal to the highest such percentage applied under such
14 clause for such fiscal year for any of the 50 States or the
15 District of Columbia that provides such medical assistance
16 for any portion of such fiscal 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 2014.

21 **SEC. 704. 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 (in this section referred to as the
3 “Secretary”) shall conduct demonstration projects
4 (in this section referred to as “demonstration
5 projects”) for the purpose of developing models and
6 evaluating methods that—

7 (A) improve the quality of items and serv-
8 ices provided to target individuals in order to
9 facilitate reduced disparities in early detection
10 and treatment of cancer;

11 (B) improve clinical outcomes, satisfaction,
12 quality of life, appropriate use of items and
13 services covered under the Medicare Program
14 under title XVIII of the Social Security Act (42
15 U.S.C. 1395 et seq.), and referral patterns with
16 respect to target individuals with cancer;

17 (C) eliminate disparities in the rate of pre-
18 ventive cancer screening measures, such as Pap
19 smears, prostate cancer screenings, colon cancer
20 screenings, breast cancer screenings, and com-
21 puted tomography (CT) scans, for lung cancer
22 among target individuals;

23 (D) promote collaboration with community-
24 based organizations to ensure cultural com-
25 petency of health care professionals and lin-

1 guistic access for 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 promotor, 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 nine
9 demonstration projects, including the following:

10 (A) Two projects, each of which shall tar-
11 get different ethnic subpopulations, for each of
12 the four following major racial and ethnic mi-
13 nority groups:

14 (i) American Indians and Alaska Na-
15 tives, Eskimos and Aleuts.

16 (ii) Asian-Americans.

17 (iii) Blacks/African-Americans.

18 (iv) Latinos or 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 each in a rural
24 area and inner-city area.

1 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
2 TION OF DEMONSTRATION PROJECT RESULTS.—If
3 the initial report under subsection (c) contains an
4 evaluation that demonstration projects—

5 (A) reduce expenditures under the Medi-
6 care Program under title XVIII of the Social
7 Security Act (42 U.S.C. 1395 et seq.); or

8 (B) do not increase expenditures under the
9 Medicare Program and reduce racial and ethnic
10 health disparities in the quality of health care
11 services provided to target individuals and in-
12 crease satisfaction of Medicare beneficiaries and
13 health care providers;

14 the Secretary shall continue the existing demonstra-
15 tion projects and may expand the number of dem-
16 onstration projects.

17 (c) REPORT TO CONGRESS.—

18 (1) IN GENERAL.—Not later than 2 years after
19 the date the Secretary implements the initial dem-
20 onstration projects, and biannually thereafter, the
21 Secretary shall submit to Congress a report regard-
22 ing the demonstration projects.

23 (2) CONTENTS OF REPORT.—Each report under
24 paragraph (1) shall include the following:

1 (A) A description of the demonstration
2 projects.

3 (B) An evaluation of—

4 (i) the cost effectiveness of the dem-
5 onstration projects;

6 (ii) the quality of the health care serv-
7 ices provided to target individuals under
8 the demonstration projects; and

9 (iii) beneficiary and health care pro-
10 vider satisfaction under the demonstration
11 projects.

12 (C) Any other information regarding the
13 demonstration projects that the Secretary de-
14 termines to be appropriate.

15 (d) WAIVER AUTHORITY.—The Secretary shall waive
16 compliance with the requirements of title XVIII of the So-
17 cial Security Act (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. 705. 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).

1 **Subtitle B—Viral Hepatitis and**
2 **Liver Cancer Control and Pre-**
3 **vention**

4 **SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL**
5 **AND PREVENTION.**

6 (a) **SHORT TITLE.**—This subtitle may be cited as the
7 “Viral Hepatitis and Liver Cancer Control and Prevention
8 Act of 2014”.

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

10 (1) Approximately 5,300,000 Americans are
11 chronically infected with the hepatitis B virus (re-
12 ferred to in this section as “HBV”), the hepatitis C
13 virus (referred to in this section as “HCV”), or
14 both.

15 (2) In the United States, chronic HBV and
16 HCV are the most common cause of liver cancer,
17 one of the most lethal and fastest growing cancers
18 in this country. It is the most common cause of
19 chronic liver disease, liver cirrhosis, and the most
20 common indication for liver transplantation. At least
21 15,000 deaths per year in the United States can be
22 attributed to chronic HBV and HCV. Chronic HCV
23 is also a leading cause of death in Americans living
24 with HIV/AIDS, many of those living with HIV/

1 AIDS are coinfecting with chronic HBV, chronic
2 HCV, or both.

3 (3) According to the Centers for Disease Con-
4 trol and Prevention (referred to in this section as
5 the “CDC”), approximately 2 percent of the popu-
6 lation of the United States is living with chronic
7 HBV, chronic HCV, or both. The CDC has recog-
8 nized HCV as the Nation’s most common chronic
9 bloodborne virus infection and HBV as the deadliest
10 vaccine-preventable disease.

11 (4) HBV is easily transmitted and is 100 times
12 more infectious than HIV. According to the CDC,
13 HBV is transmitted through contact with infectious
14 blood, semen, or other body fluids. HCV is trans-
15 mitted by contact with infectious blood, particularly
16 through percutaneous exposures (i.e. puncture
17 through the skin).

18 (5) The CDC conservatively estimates that in
19 2010 approximately 17,000 Americans were newly
20 infected with HCV and more than 35,000 Americans
21 were newly infected with HBV. These estimates
22 could be much higher due to many reasons, includ-
23 ing lack of screening education and awareness, and
24 perceived marginalization of the populations at risk.

1 (6) In 2012, CDC released new guidelines rec-
2 ommending every person born between 1945 and
3 1965 receive a one-time test. Among the estimated
4 102 million (1.6 million chronically HCV-infected)
5 eligible for screening, birth-cohort screening leads to
6 84,000 fewer cases of decompensated cirrhosis,
7 46,000 fewer cases of hepatocellular carcinoma,
8 10,000 fewer liver transplants, and 78,000 fewer
9 HCV-related deaths gained versus risk-based screen-
10 ing.

11 (7) In 2013, the United States Preventive Task
12 Force (USPSTF) issued a Grade B rating for
13 screening for the hepatitis C virus (HCV) infection
14 in persons at high risk for infection and adults born
15 between 1945 and 1965. In 2014, the USPSTF
16 issued a Grade B for screening for the hepatitis B
17 virus (HBV) in persons at high-risk of hepatitis B
18 infection. In 2009, the USPSTF issued a Grade A
19 for screening pregnant women for the hepatitis B
20 virus (HBV) during their first prenatal visit.

21 (8) There were 35 outbreaks (19 of HBV, 16
22 of HCV) reported to CDC for investigation from
23 2008 through 2012 related to health care acquired
24 infection of HBV and HCV, 33 of which occurred in

1 nonhospital settings. There were more than 99,975
2 patients potentially exposed to one of the viruses.

3 (9) Chronic HBV and chronic HCV usually do
4 not cause symptoms early in the course of the dis-
5 ease, but after many years of a clinically “silent”
6 phase, CDC estimates show more than 33 percent of
7 infected individuals will develop cirrhosis, end-stage
8 liver disease, or liver cancer. Since most individuals
9 with chronic HBV, HCV, or both are unaware of
10 their infection, they do not know to take precautions
11 to prevent the spread of their infection and can un-
12 knowingly exacerbate their own disease progression.

13 (10) HBV and HCV disproportionately affect
14 certain populations in the United States. Although
15 representing only 6 percent of the population, Asian-
16 Americans and Pacific Islanders account for over
17 half of the 1,400,000 domestic chronic HBV cases.
18 Baby boomers (those born between 1945 and 1965)
19 account for more than half of domestic chronic hepa-
20 titis C cases. In addition, African-Americans,
21 Latinos (Latinas), and American Indian/Native
22 Alaskans are among the groups which have dis-
23 proportionately high rates of HBV and/or HCV in-
24 fections in the United States.

1 (11) For both chronic HBV and chronic HCV,
2 behavioral changes can slow disease progression if
3 diagnosis is made early. Early diagnosis, which is
4 determined through simple blood tests, can reduce
5 the risk of transmission and disease progression
6 through education and vaccination of household
7 members and other susceptible persons at risk.

8 (12) Advancements have led to the development
9 of improved diagnostic tests for viral hepatitis.
10 These tests, including rapid, point of care testing
11 and others in development, can facilitate testing, no-
12 tification of results and post-test counseling, and re-
13 ferral to care at the time of the testing visit. In par-
14 ticular, these tests are also advantageous because
15 they can be used simultaneously with HIV rapid
16 testing for persons at risk for both HCV and HIV
17 infections.

18 (13) For those chronically infected with HBV
19 or HCV, regular monitoring can lead to the early de-
20 tection of liver cancer at a stage where a cure is still
21 possible. Liver cancer is the second deadliest cancer
22 in the United States; however, liver cancer has re-
23 ceived little funding for research, prevention, or
24 treatment.

1 (14) Treatment for chronic HCV can eradicate
2 the disease in approximately 75 percent of those cur-
3 rently treated. The treatment of chronic HBV can
4 effectively suppress viral replication in the over-
5 whelming majority (over 80 percent) of those treat-
6 ed, thereby reducing the risk of transmission and
7 progression to liver scarring or liver cancer, even
8 though a complete cure is much less common than
9 for HCV.

10 (15) To combat the viral hepatitis epidemic in
11 the United States, in May 2011, the Department of
12 Health and Human Services released “Combating
13 the Silent Epidemic of Viral Hepatitis: Action Plan
14 for the Prevention, Care & Treatment of Viral Hepa-
15 titis” (hereafter referred to as the HHS Action
16 Plan). The Institute of Medicine (IOM) of the Na-
17 tional Academies produced a 2010 report on the
18 Federal response to HBV and HCV titled: “Hepa-
19 titis and Liver Cancer: A National Strategy for Pre-
20 vention and Control of Hepatitis B and C”. These
21 recommendations and guidelines provide a frame-
22 work for HBV and HCV prevention, education, con-
23 trol, research, and medical management programs.

24 (16) The annual health care costs attributable
25 to HBV and HCV in the United States are signifi-

1 cant. For HBV, it is estimated to be approximately
2 \$2,500,000,000 (\$2,000 per infected person). In
3 2000, the lifetime cost of HBV—before the avail-
4 ability of most current therapies—was approxi-
5 mately \$80,000 per chronically infected person, to-
6 taling more than \$100,000,000,000. For HCV, med-
7 ical costs for patients are expected to increase from
8 \$30,000,000,000 in 2009 to over \$85,000,000,000
9 in 2024. Avoiding these costs by screening and diag-
10 nosing individuals earlier—and connecting them to
11 appropriate treatment and care, will save lives and
12 critical health care dollars. Currently, without a
13 comprehensive screening, testing, and diagnosis pro-
14 gram, most patients are diagnosed too late when
15 they need a liver transplant costing at least
16 \$314,000 for uncomplicated cases or when they have
17 liver cancer or end stage liver disease which costs
18 \$30,980 to \$110,576 per hospital admission. As
19 health care costs continue to grow, it is critical that
20 the Federal Government invests in effective mecha-
21 nisms to avoid documented cost drivers.

22 (17) According to the IOM report in 2010 (de-
23 scribed in paragraph (15)), chronic HBV and HCV
24 infections cause substantial morbidity and mortality
25 despite being preventable and treatable. Deficiencies

1 in the implementation of established guidelines for
2 the prevention, diagnosis, and medical management
3 of chronic HBV and HCV infections perpetuate per-
4 sonal and economic burdens. Existing grants are not
5 sufficient for the scale of the health burden pre-
6 sented by HBV and HCV.

7 (18) Screening and testing for HBV and HCV
8 is aligned with the Healthy People 2020 goal to in-
9 crease immunization rates and reduce preventable
10 infectious diseases. Awareness of disease and access
11 to prevention and treatment remain essential compo-
12 nents for reducing infectious disease transmission.

13 (19) Federal support is necessary to increase
14 knowledge and awareness of HBV and HCV and to
15 assist State and local prevention and control efforts
16 in reducing the morbidity and mortality of these
17 epidemics.

18 (20) The Secretary of Health and Human Serv-
19 ices has the discretion to carry out this Act directly
20 and through whichever of the agencies of the Public
21 Health Service the Secretary determines to be ap-
22 propriate, which may (in the Secretary's discretion)
23 include the Centers for Disease Control and Preven-
24 tion, the Health Resources and Services Administra-
25 tion, the Substance Abuse and Mental Health Serv-

1 ices Administration, the National Institutes of
2 Health (including the National Institute on Minority
3 Health and Health Disparities), and other agencies
4 of such Service.

5 (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B
6 AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,
7 AND MEDICAL MANAGEMENT PLAN.—Title III of the
8 Public Health Service Act (42 U.S.C. 241 et seq.) is
9 amended—

10 (1) by striking section 317N (42 U.S.C. 247b–
11 15); and

12 (2) by adding at the end the following:

13 **“PART W—BIENNIAL ASSESSMENT OF HHS HEPA-**
14 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
15 **CATION, RESEARCH, AND MEDICAL MANAGE-**
16 **MENT PLAN**

17 **“SEC. 399NN. BIENNIAL UPDATE OF THE PLAN.**

18 “(a) IN GENERAL.—The Secretary shall conduct a bi-
19 ennial assessment of the Secretary’s plan for the preven-
20 tion, control, and medical management of, and education
21 and research relating to, hepatitis B and hepatitis C, for
22 the purposes of—

23 “(1) incorporating into such plan new knowl-
24 edge or observations relating to hepatitis B and hep-
25 atitis C (such as knowledge and observations that

1 may be derived from clinical, laboratory, and epide-
2 miological research and disease detection, preven-
3 tion, and surveillance outcomes);

4 “(2) addressing gaps in the coverage or effec-
5 tiveness of the plan; and

6 “(3) evaluating and, if appropriate, updating
7 recommendations, guidelines, or educational mate-
8 rials of the Centers for Disease Control and Preven-
9 tion or the National Institutes of Health for health
10 care providers or the public on viral hepatitis in
11 order to be consistent with the plan.

12 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
13 Not later than October 1 of the first even-numbered year
14 beginning after the date of the enactment of this part,
15 and October 1 of each even-numbered year thereafter, the
16 Secretary shall publish in the Federal Register a notice
17 of the results of the assessments conducted under para-
18 graph (1). Such notice shall include—

19 “(1) a description of any revisions to the plan
20 referred to in subsection (a) as a result of the as-
21 sessment;

22 “(2) an explanation of the basis for any such
23 revisions, including the ways in which such revisions
24 can reasonably be expected to further promote the
25 original goals and objectives of the plan; and

1 “(3) in the case of a determination by the Sec-
2 retary that the plan does not need revision, an expla-
3 nation of the basis for such determination.

4 **“SEC. 399NN-1. ELEMENTS OF PROGRAM.**

5 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
6 Secretary, acting through the Director of the Centers for
7 Disease Control and Prevention, the Administrator of the
8 Health Resources and Services Administration, and the
9 Administrator of the Substance Abuse and Mental Health
10 Services Administration, and in accordance with the plan
11 referred to in section 399NN(a), shall implement pro-
12 grams to increase awareness and enhance knowledge and
13 understanding of hepatitis B and hepatitis C. Such pro-
14 grams shall include—

15 “(1) the conduct of culturally and language ap-
16 propriate health education in primary and secondary
17 schools, college campuses, public awareness cam-
18 paigns, and community outreach activities (especially
19 to the ethnic communities with high rates of chronic
20 hepatitis B and chronic hepatitis C and other high-
21 risk groups) to promote public awareness and knowl-
22 edge about the value of hepatitis A and hepatitis B
23 immunization, risk factors, the transmission and
24 prevention of hepatitis B and hepatitis C, the value
25 of screening for the early detection of hepatitis B

1 and hepatitis C, and options available for the treat-
2 ment of chronic hepatitis B and chronic hepatitis C;

3 “(2) the promotion of immunization programs
4 that increase awareness and access to hepatitis A
5 and hepatitis B vaccines for susceptible adults and
6 children;

7 “(3) the training of health care professionals
8 regarding the importance of vaccinating individuals
9 infected with hepatitis C and individuals who are at
10 risk for hepatitis C infection against hepatitis A and
11 hepatitis B;

12 “(4) the training of health care professionals
13 regarding the importance of vaccinating individuals
14 chronically infected with hepatitis B and individuals
15 who are at risk for chronic hepatitis B infection
16 against the hepatitis A virus;

17 “(5) the training of health care professionals
18 and health educators to make them aware of the
19 high rates of chronic hepatitis B and chronic hepa-
20 titis C in certain adult ethnic populations, and the
21 importance of prevention, detection, and medical
22 management of hepatitis B and hepatitis C and of
23 liver cancer screening;

24 “(6) the development and distribution of health
25 education curricula (including information relating

1 to the special needs of individuals infected with hep-
2 atitis B and hepatitis C, such as the importance of
3 prevention and early intervention, regular moni-
4 toring, the recognition of psychosocial needs, appro-
5 priate treatment, and liver cancer screening) for in-
6 dividuals providing hepatitis B and hepatitis C coun-
7 seling; and

8 “(7) support for the implementation curricula
9 described in paragraph (6) by State and local public
10 health agencies.

11 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
12 PROGRAMS.—

13 “(1) IN GENERAL.—The Secretary, acting
14 through the Director of the Centers for Disease
15 Control and Prevention, shall support the integra-
16 tion of activities described in paragraph (3) into ex-
17 isting clinical and public health programs at State,
18 local, territorial, and tribal levels (including commu-
19 nity health clinics, programs for the prevention and
20 treatment of HIV/AIDS, sexually transmitted dis-
21 eases, and substance abuse, and programs for indi-
22 viduals in correctional settings).

23 “(2) COORDINATION OF DEVELOPMENT OF
24 FEDERAL SCREENING GUIDELINES.—

1 “(A) REFERENCES.—For purposes of this
2 subsection, the term ‘CDC Director’ means the
3 Director of the Centers for Disease Control and
4 Prevention, and the term ‘AHRQ Director’
5 means the Director of the Agency for
6 Healthcare Research and Quality.

7 “(B) AGENCY FOR HEALTHCARE RE-
8 SEARCH AND QUALITY.—Due to the rapidly
9 evolving standard of care associated with diag-
10 nosing and treating viral hepatitis infection, the
11 AHRQ Director shall convene the Preventive
12 Services Task Force under section 915(a) of
13 the Public Health Service Act to review its rec-
14 ommendation for screening for HBV and HCV
15 infection every 3 years.

16 “(3) ACTIVITIES.—

17 “(A) VOLUNTARY TESTING PROGRAMS.—

18 “(i) IN GENERAL.—The Secretary
19 shall establish a mechanism by which to
20 support and promote the development of
21 State, local, territorial, and tribal vol-
22 untary hepatitis B and hepatitis C testing
23 programs to screen the high-prevalence
24 populations to aid in the early identifica-
25 tion of chronically infected individuals.

1 “(ii) CONFIDENTIALITY OF THE TEST
2 RESULTS.—The Secretary shall prohibit
3 the use of the results of a hepatitis B or
4 hepatitis C test conducted by a testing pro-
5 gram developed or supported under this
6 subparagraph for any of the following:

7 “(I) Issues relating to health in-
8 surance.

9 “(II) To screen or determine
10 suitability for employment.

11 “(III) To discharge a person
12 from employment.

13 “(B) COUNSELING REGARDING VIRAL HEP-
14 ATITIS.—The Secretary shall support State,
15 local, territorial, and tribal programs in a wide
16 variety of settings, including those providing
17 primary and specialty health care services in
18 nonprofit private and public sectors, to—

19 “(i) provide individuals with ongoing
20 risk factors for hepatitis B and hepatitis C
21 infection with client-centered education
22 and counseling which concentrates on—

23 “(I) promoting testing of individ-
24 uals that have been exposed to their

1 blood, family members, and their sex-
2 ual partners; and

3 “(II) changing behaviors that
4 place individuals at risk for infection;

5 “(ii) provide individuals chronically in-
6 fected with hepatitis B or hepatitis C with
7 education, health information, and coun-
8 seling to reduce their risk of—

9 “(I) dying from end-stage liver
10 disease and liver cancer; and

11 “(II) transmitting viral hepatitis
12 to others; and

13 “(iii) provide women chronically in-
14 fected with hepatitis B or hepatitis C who
15 are pregnant or of childbearing age with
16 culturally and language appropriate health
17 information, such as how to prevent hepa-
18 titis B perinatal infection, and to alleviate
19 fears associated with pregnancy or raising
20 a family.

21 “(C) IMMUNIZATION.—The Secretary shall
22 support State, local, territorial, and tribal ef-
23 forts to expand the current vaccination pro-
24 grams to protect every child in the country and
25 all susceptible adults, particularly those infected

1 with hepatitis C and high-prevalence ethnic
2 populations and other high-risk groups, from
3 the risks of acute and chronic hepatitis B infec-
4 tion by—

5 “(i) ensuring continued funding for
6 hepatitis B vaccination for all children 19
7 years of age or younger through the Vac-
8 cines for Children Program;

9 “(ii) ensuring that the recommenda-
10 tions of the Advisory Committee on Immu-
11 nization Practices are followed regarding
12 the birth dose of hepatitis B vaccinations
13 for newborns;

14 “(iii) requiring proof of hepatitis B
15 vaccination for entry into public or private
16 daycare, preschool, elementary school, sec-
17 ondary school, and institutions of higher
18 education;

19 “(iv) expanding the availability of
20 hepatitis B vaccination for all susceptible
21 adults to protect them from becoming
22 acutely or chronically infected, including
23 ethnic and other populations with high
24 prevalence rates of chronic hepatitis B in-
25 fection;

1 “(v) expanding the availability of hep-
2 atitis B vaccination for all susceptible
3 adults, particularly those in their reproduc-
4 tive age (women and men less than 45
5 years of age), to protect them from the
6 risk of hepatitis B infection;

7 “(vi) ensuring the vaccination of indi-
8 viduals infected, or at risk for infection,
9 with hepatitis C against hepatitis A, hepa-
10 titis B, and other infectious diseases, as
11 appropriate, for which such individuals
12 may be at increased risk; and

13 “(vii) ensuring the vaccination of indi-
14 viduals infected, or at risk for infection,
15 with hepatitis B against hepatitis A virus
16 and other infectious diseases, as appro-
17 priate, for which such individuals may be
18 at increased risk.

19 “(D) MEDICAL REFERRAL.—The Secretary
20 shall support State, local, territorial, and tribal
21 programs that support—

22 “(i) referral of persons chronically in-
23 fected with hepatitis B or hepatitis C—

24 “(I) for medical evaluation to de-
25 termine the appropriateness for

1 antiviral treatment to reduce the risk
2 of progression to cirrhosis and liver
3 cancer; and

4 “(II) for ongoing medical man-
5 agement including regular monitoring
6 of liver function and screening for
7 liver cancer; and

8 “(ii) referral of persons infected with
9 acute or chronic hepatitis B infection or
10 acute or chronic hepatitis C infection for
11 drug and alcohol abuse treatment where
12 appropriate.

13 “(4) INCREASED SUPPORT FOR ADULT VIRAL
14 HEPATITIS COORDINATORS.—The Secretary, acting
15 through the Director of the Centers for Disease
16 Control and Prevention, shall provide increased sup-
17 port to Adult Viral Hepatitis Coordinators in State,
18 local, territorial, and tribal health departments in
19 order to enhance the additional management, net-
20 working, and technical expertise needed to ensure
21 successful integration of hepatitis B and hepatitis C
22 prevention and control activities into existing public
23 health programs.

24 “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Director of the Centers for Disease
3 Control and Prevention, shall support the establish-
4 ment and maintenance of a national chronic and
5 acute hepatitis B and hepatitis C surveillance pro-
6 gram, in order to identify—

7 “(A) trends in the incidence of acute and
8 chronic hepatitis B and acute and chronic hepa-
9 titis C;

10 “(B) trends in the prevalence of acute and
11 chronic hepatitis B and acute and chronic hepa-
12 titis C infection among groups that may be dis-
13 proportionately affected; and

14 “(C) trends in liver cancer and end-stage
15 liver disease incidence and deaths, caused by
16 chronic hepatitis B and chronic hepatitis C in
17 the high-risk ethnic populations.

18 “(2) SEROPREVALENCE AND LIVER CANCER
19 STUDIES.—The Secretary, acting through the Direc-
20 tor of the Centers for Disease Control and Preven-
21 tion, shall prepare a report outlining the population-
22 based seroprevalence studies currently underway, fu-
23 ture planned studies, the criteria involved in deter-
24 mining which seroprevalence studies to conduct,
25 defer, or suspend, and the scope of those studies, the

1 economic and clinical impact of hepatitis B and hep-
2 atitis C, and the impact of chronic hepatitis B and
3 chronic hepatitis C infections on the quality of life.
4 Not later than one year after the date of the enact-
5 ment of this part, the Secretary shall submit the re-
6 port to the Committee on Energy and Commerce of
7 the House of Representatives and the Committee on
8 Health, Education, Labor, and Pensions of the Sen-
9 ate.

10 “(3) CONFIDENTIALITY.—The Secretary shall
11 not disclose any individually identifiable information
12 identified under paragraph (1) or derived through
13 studies under paragraph (2).

14 “(d) RESEARCH.—The Secretary, acting through the
15 Director of the Centers for Disease Control and Preven-
16 tion, the Director of the National Cancer Institute, and
17 the Director of the National Institutes of Health, shall—

18 “(1) conduct epidemiologic and community-
19 based research to develop, implement, and evaluate
20 best practices for hepatitis B and hepatitis C pre-
21 vention especially in the ethnic populations with high
22 rates of chronic hepatitis B and chronic hepatitis C
23 and other high-risk groups;

24 “(2) conduct research on hepatitis B and hepa-
25 titis C natural history, pathophysiology, improved

1 treatments and prevention (such as the hepatitis C
2 vaccine), and noninvasive tests that help to predict
3 the risk of progression to liver cirrhosis and liver
4 cancer;

5 “(3) conduct research that will lead to better
6 noninvasive or blood tests to screen for liver cancer,
7 and more effective treatments of liver cancer caused
8 by chronic hepatitis B and chronic hepatitis C; and

9 “(4) conduct research comparing the effective-
10 ness of screening, diagnostic, management, and
11 treatment approaches for chronic hepatitis B, chron-
12 ic hepatitis C, and liver cancer in the affected com-
13 munities.

14 “(e) UNDERSERVED AND DISPROPORTIONATELY AF-
15 FECTED POPULATIONS.—In carrying out this section, the
16 Secretary shall provide expanded support for individuals
17 with limited access to health education, testing, and health
18 care services and groups that may be disproportionately
19 affected by hepatitis B and hepatitis C.

20 “(f) EVALUATION OF PROGRAM.—The Secretary
21 shall develop benchmarks for evaluating the effectiveness
22 of the programs and activities conducted under this sec-
23 tion and make determinations as to whether such bench-
24 marks have been achieved.

1 **“SEC. 399NN-2. GRANTS.**

2 “(a) IN GENERAL.—The Secretary may award grants
3 to, or enter into contracts or cooperative agreements with,
4 States, political subdivisions of States, territories, Indian
5 tribes, or nonprofit entities that have special expertise re-
6 lating to hepatitis B, hepatitis C, or both, to carry out
7 activities under this part.

8 “(b) APPLICATION.—To be eligible for a grant, con-
9 tract, or cooperative agreement under subsection (a), an
10 entity shall prepare and submit to the Secretary an appli-
11 cation at such time, in such manner, and containing such
12 information as the Secretary may require.

13 **“SEC. 399NN-3. AUTHORIZATION OF APPROPRIATIONS.**

14 “There are authorized to be appropriated to carry out
15 this part \$90,000,000 for fiscal year 2015, \$90,000,000
16 for fiscal year 2016, \$110,000,000 for fiscal year 2017,
17 \$130,000,000 for fiscal year 2018, and \$150,000,000 for
18 fiscal year 2019.”.

19 (d) ENHANCING SAMHSA’S ROLE IN HEPATITIS AC-
20 TIVITIES.—Paragraph (6) of section 501(d) of the Public
21 Health Service Act (42 U.S.C. 290aa(d)) is amended by
22 striking “HIV or tuberculosis” and inserting “HIV, tuber-
23 culosis, or hepatitis”.

1 **Subtitle C—Acquired Bone Marrow**
2 **Failure Diseases**

3 **SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

4 (a) **SHORT TITLE.**—This subtitle may be cited as the
5 “Bone Marrow Failure Disease Research and Treatment
6 Act of 2014”.

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

8 (1) Between 20,000 and 30,000 Americans are
9 diagnosed each year with myelodysplastic syndromes,
10 aplastic anemia, paroxysmal nocturnal hemo-
11 globinuria, and other acquired bone marrow failure
12 diseases.

13 (2) Acquired bone marrow failure diseases have
14 a debilitating and often fatal impact on those diag-
15 nosed with these diseases.

16 (3) While some treatments for acquired bone
17 marrow failure diseases can prolong and improve the
18 quality of patients’ lives, there is no single cure for
19 these diseases.

20 (4) The prevalence of acquired bone marrow
21 failure diseases in the United States will continue to
22 grow as the general public ages.

23 (5) Evidence exists suggesting that acquired
24 bone marrow failure diseases occur more often in

1 minority populations, particularly in Asian-American
2 and Latino or Hispanic populations.

3 (6) The National Heart, Lung, and Blood Insti-
4 tute and the National Cancer Institute have con-
5 ducted important research into the causes of and
6 treatments for acquired bone marrow failure dis-
7 eases.

8 (7) The National Marrow Donor Program Reg-
9 istry has made significant contributions to the fight
10 against bone marrow failure diseases by connecting
11 millions of potential marrow donors with individuals
12 and families suffering from these conditions.

13 (8) Despite these advances, a more comprehen-
14 sive Federal strategic effort among numerous Fed-
15 eral agencies is needed to discover a cure for ac-
16 quired bone marrow failure disorders.

17 (9) Greater Federal surveillance of acquired
18 bone marrow failure diseases is needed to gain a bet-
19 ter understanding of the causes of acquired bone
20 marrow failure diseases.

21 (10) The Federal Government should increase
22 its research support for and engage with public and
23 private organizations in developing a comprehensive
24 approach to combat and cure acquired bone marrow
25 failure diseases.

1 (c) NATIONAL ACQUIRED BONE MARROW FAILURE
2 DISEASE REGISTRY.—Part B of the Public Health Service
3 Act (42 U.S.C. 311 et seq.) is amended by inserting after
4 section 317W, as added, the following:

5 **“SEC. 317X. NATIONAL ACQUIRED BONE MARROW FAILURE**
6 **DISEASE REGISTRY.**

7 “(a) ESTABLISHMENT OF REGISTRY.—

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 Director of the Cen-
11 ters for Disease Control and Prevention, shall—

12 “(A) develop a system to collect data on
13 acquired bone marrow failure diseases; and

14 “(B) establish and maintain a national and
15 publicly available registry, to be known as the
16 National Acquired Bone Marrow Failure Dis-
17 ease Registry, in accordance with paragraph
18 (3).

19 “(2) RECOMMENDATIONS OF ADVISORY COM-
20 MITTEE.—In carrying out this subsection, the Sec-
21 retary shall take into consideration the recommenda-
22 tions of the Advisory Committee on Acquired Bone
23 Marrow Failure Diseases established under sub-
24 section (b).

1 “(3) PURPOSES OF REGISTRY.—The National
2 Acquired Bone Marrow Failure Disease Registry—

3 “(A) shall identify the incidence and preva-
4 lence of acquired bone marrow failure diseases
5 in the United States;

6 “(B) shall be used to collect and store data
7 on acquired bone marrow failure diseases, in-
8 cluding data concerning—

9 “(i) the age, race or ethnicity, general
10 geographic location, sex, and family history
11 of individuals who are diagnosed with ac-
12 quired bone marrow failure diseases, and
13 any other characteristics of such individ-
14 uals determined appropriate by the Sec-
15 retary;

16 “(ii) the genetic and environmental
17 factors that may be associated with devel-
18 oping acquired bone marrow failure dis-
19 eases;

20 “(iii) treatment approaches for deal-
21 ing with acquired bone marrow failure dis-
22 eases;

23 “(iv) outcomes for individuals treated
24 for acquired bone marrow failure diseases,
25 including outcomes for recipients of stem

1 cell therapeutic products as contained in
2 the database established pursuant to sec-
3 tion 379A; and

4 “(v) any other factors pertaining to
5 acquired bone marrow failure diseases de-
6 termined appropriate by the Secretary; and

7 “(C) shall be made available—

8 “(i) to the general public; and

9 “(ii) to researchers to facilitate fur-
10 ther research into the causes of, and treat-
11 ments for, acquired bone marrow failure
12 diseases in accordance with standard prac-
13 tices of the Centers for Disease Control
14 and Preventions.

15 “(b) ADVISORY COMMITTEE.—

16 “(1) ESTABLISHMENT.—Not later than 6
17 months after the date of the enactment of this sec-
18 tion, the Secretary, acting through the Director of
19 the Centers for Disease Control and Prevention,
20 shall establish an advisory committee, to be known
21 as the Advisory Committee on Acquired Bone Mar-
22 row Failure Diseases.

23 “(2) MEMBERS.—The members of the Advisory
24 Committee on Acquired Bone Marrow Failure Dis-
25 eases shall be appointed by the Secretary, acting

1 through the Director of the Centers for Disease
2 Control and Prevention, and shall include at least
3 one representative from each of the following:

4 “(A) A national patient advocacy organiza-
5 tion with experience advocating on behalf of pa-
6 tients suffering from acquired bone marrow
7 failure diseases.

8 “(B) The National Institutes of Health, in-
9 cluding at least one representative from each
10 of—

11 “(i) the National Cancer Institute;

12 “(ii) the National Heart, Lung, and
13 Blood Institute; and

14 “(iii) the Office of Rare Diseases.

15 “(C) The Centers for Disease Control and
16 Prevention.

17 “(D) Clinicians with experience in—

18 “(i) diagnosing or treating acquired
19 bone marrow failure diseases; and

20 “(ii) medical data registries.

21 “(E) Epidemiologists who have experience
22 with data registries.

23 “(F) Publicly or privately funded research-
24 ers who have experience researching acquired
25 bone marrow failure diseases.

1 “(G) The entity operating the C.W. Bill
2 Young Cell Transplantation Program estab-
3 lished pursuant to section 379 and the entity
4 operating the C.W. Bill Young Cell Transplan-
5 tation Program Outcomes Database.

6 “(3) RESPONSIBILITIES.—The Advisory Com-
7 mittee on Acquired Bone Marrow Failure Diseases
8 shall provide recommendations to the Secretary on
9 the establishment and maintenance of the National
10 Acquired Bone Marrow Failure Disease Registry, in-
11 cluding recommendations on the collection, mainte-
12 nance, and dissemination of data.

13 “(4) PUBLIC AVAILABILITY.—The Secretary
14 shall make the recommendations of the Advisory
15 Committee on Acquired Bone Marrow Failure Dis-
16 ease publicly available.

17 “(c) GRANTS.—The Secretary, acting through the
18 Director of the Centers for Disease Control and Preven-
19 tion, may award grants to, and enter into contracts and
20 cooperative agreements with, public or private nonprofit
21 entities for the management of, as well as the collection,
22 analysis, and reporting of data to be included in, the Na-
23 tional Acquired Bone Marrow Failure Disease Registry.

24 “(d) DEFINITION.—In this section, the term ‘ac-
25 quired bone marrow failure disease’ means—

- 1 “(1) myelodysplastic syndromes (MDS);
2 “(2) aplastic anemia;
3 “(3) paroxysmal nocturnal hemoglobinuria
4 (PNH);
5 “(4) pure red cell aplasia;
6 “(5) acute myeloid leukemia that has pro-
7 gressed from myelodysplastic syndromes; or
8 “(6) large granular lymphocytic leukemia.

9 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
10 is authorized to be appropriated to carry out this section
11 \$3,000,000 for each of fiscal years 2015 through 2019.”.

12 (d) PILOT STUDIES THROUGH THE AGENCY FOR
13 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

14 (1) PILOT STUDIES.—The Secretary of Health
15 and Human Services, acting through the Adminis-
16 trator of the Agency for Toxic Substances and Dis-
17 ease Registry, shall conduct pilot studies to deter-
18 mine which environmental factors, including expo-
19 sure to toxins, may cause acquired bone marrow fail-
20 ure diseases.

21 (2) COLLABORATION WITH THE RADIATION IN-
22 JURY TREATMENT NETWORK.—In carrying out the
23 directives of this section, the Secretary may collabo-
24 rate with the Radiation Injury Treatment Network
25 of the C.W. Bill Young Cell Transplantation Pro-

1 gram established pursuant to section 379 of the
2 Public Health Service Act (42 U.S.C. 274j) to—

3 (A) augment data for the pilot studies au-
4 thorized by this section;

5 (B) access technical assistance that may be
6 provided by the Radiation Injury Treatment
7 Network; or

8 (C) perform joint research projects.

9 (3) AUTHORIZATION OF APPROPRIATIONS.—

10 There is authorized to be appropriated to carry out
11 this section \$1,000,000 for each of fiscal years 2015
12 through 2019.

13 (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
14 BONE MARROW FAILURE DISEASES.—Title XVII of the
15 Public Health Service Act (42 U.S.C. 300u et seq.) is
16 amended by inserting after section 1707A the following:

17 “MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE
18 MARROW FAILURE DISEASES

19 “SEC. 1707B. (a) INFORMATION AND REFERRAL
20 SERVICES.—

21 “(1) IN GENERAL.—Not later than 6 months
22 after the date of the enactment of this section, the
23 Secretary, acting through the Deputy Assistant Sec-
24 retary for Minority Health, shall establish and co-
25 ordinate outreach and informational programs tar-

1 geted to minority populations affected by acquired
2 bone marrow failure diseases.

3 “(2) PROGRAM REQUIREMENTS.—Minority-fo-
4 cused outreach and informational programs author-
5 ized by this section—

6 “(A) shall make information about treat-
7 ment options and clinical trials for acquired
8 bone marrow failure diseases publicly available,
9 and

10 “(B) shall provide referral services for
11 treatment options and clinical trials,
12 at the National Minority Health Resource Center
13 supported under section 1707(b)(8) (including by
14 means of the Center’s Web site, through appropriate
15 locations such as the Center’s knowledge center, and
16 through appropriate programs such as the Center’s
17 resource persons network) and through minority
18 health consultants located at each Department of
19 Health and Human Services regional office.

20 “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
21 ISLANDER OUTREACH.—

22 “(1) IN GENERAL.—The Secretary, acting
23 through the Deputy Assistant Secretary for Minority
24 Health, shall undertake a coordinated outreach ef-
25 fort to connect Hispanic, Asian-American, and Pa-

1 cific Islander communities with comprehensive serv-
2 ices focused on treatment of, and information about,
3 acquired bone marrow failure diseases.

4 “(2) COLLABORATION.—In carrying out this
5 subsection, the Secretary may collaborate with public
6 health agencies, nonprofit organizations, community
7 groups, and online entities to disseminate informa-
8 tion about treatment options and clinical trials for
9 acquired bone marrow failure diseases.

10 “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

11 “(1) IN GENERAL.—Not later than 6 months
12 after the date of the enactment of this section, the
13 Secretary, acting through the Deputy Assistant Sec-
14 retary for Minority Health, shall award grants to, or
15 enter into cooperative agreements with, entities to
16 perform research on acquired bone marrow failure
17 diseases.

18 “(2) REQUIREMENT.—Grants and cooperative
19 agreements authorized by this subsection shall be
20 awarded or entered into on a competitive, peer-re-
21 viewed basis.

22 “(3) SCOPE OF RESEARCH.—Research funded
23 under this section shall examine factors affecting the
24 incidence of acquired bone marrow failure diseases
25 in minority populations.

1 “(d) DEFINITION.—In this section, the term ‘ac-
2 quired bone marrow failure disease’ has the meaning given
3 to such term in section 317X(d).

4 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section
6 \$2,000,000 for each of fiscal years 2015 through 2019.”.

7 (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-
8 QUIRED BONE MARROW FAILURE DISEASES.—

9 (1) GRANTS.—The Secretary of Health and
10 Human Services, acting through the Director of the
11 Agency for Healthcare Research and Quality, shall
12 award grants to entities to improve diagnostic prac-
13 tices and quality of care with respect to patients
14 with acquired bone marrow failure diseases.

15 (2) AUTHORIZATION OF APPROPRIATIONS.—
16 There is authorized to be appropriated to carry out
17 this section \$2,000,000 for each of fiscal years 2015
18 through 2019.

19 (g) DEFINITION.—In this section, the term “acquired
20 bone marrow failure disease” means—

- 21 (1) myelodysplastic syndromes (MDS);
- 22 (2) aplastic anemia;
- 23 (3) paroxysmal nocturnal hemoglobinuria
24 (PNH);
- 25 (4) pure red cell aplasia;

1 (5) acute myeloid leukemia that progressed
2 from myelodysplastic syndromes; or

3 (6) large granular lymphocytic leukemia.

4 **Subtitle D—Cardiovascular Dis-**
5 **ease, Chronic Disease, and**
6 **Other Disease Issues**

7 **SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MI-**
8 **NORITY PATIENTS.**

9 (a) IN GENERAL.—The Secretary, acting through the
10 Director of the Agency for Healthcare Research and Qual-
11 ity, shall convene a series of meetings to develop guidelines
12 for disease screening for minority patient populations
13 which have a higher than average risk for many chronic
14 diseases and cancers.

15 (b) PARTICIPANTS.—In convening meetings under
16 subsection (a), the Secretary shall ensure that meeting
17 participants include representatives of—

18 (1) professional societies and associations;

19 (2) minority health organizations;

20 (3) health care researchers and providers, in-
21 cluding those with expertise in minority health;

22 (4) Federal health agencies, including the Of-
23 fice of Minority Health, the National Institute on
24 Minority Health and Health Disparities, and the
25 National Institutes of Health; and

1 (5) other experts determined appropriate by the
2 Secretary.

3 (c) DISEASES.—Screening guidelines for minority
4 populations shall be developed as appropriate under sub-
5 section (a) for—

6 (1) hypertension;

7 (2) hypercholesterolemia;

8 (3) diabetes;

9 (4) cardiovascular disease;

10 (5) cancers, including breast, prostate, colon,
11 cervical, and lung cancer;

12 (6) asthma;

13 (7) diabetes;

14 (8) kidney diseases;

15 (9) eye diseases and disorders, including glau-
16 coma;

17 (10) HIV/AIDS and sexually transmitted dis-
18 eases;

19 (11) uterine fibroids;

20 (12) autoimmune disease;

21 (13) mental health conditions;

22 (14) dental health conditions and oral diseases,
23 including oral cancer;

24 (15) environmental and related health illnesses
25 and conditions;

- 1 (16) Sickle cell disease;
- 2 (17) violence and injury prevention and control;
- 3 (18) genetic and related conditions;
- 4 (19) heart disease and stroke;
- 5 (20) tuberculosis;
- 6 (21) chronic obstructive pulmonary disease;
- 7 (22) musculoskeletal diseases, arthritis, and
- 8 obesity; and
- 9 (23) other diseases determined appropriate by
- 10 the Secretary.

11 (d) DISSEMINATION.—Not later than 24 months

12 after the date of enactment of this title, the Secretary

13 shall publish and disseminate to health care provider orga-

14 nizations the guidelines developed under subsection (a).

15 (e) 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 2015 through 2019.

19 **SEC. 732. CDC WISEWOMAN SCREENING PROGRAM.**

20 Section 1509 of the Public Health Service Act (42

21 U.S.C. 300n-4a) is amended—

22 (1) in subsection (a)—

23 (A) by striking the heading and inserting

24 “IN GENERAL.—”; and

1 (B) in the matter preceding paragraph (1),
2 by striking “may make grants” and all that fol-
3 lows through “purpose” and inserting the fol-
4 lowing: “may make grants to such States for
5 the purpose”; and

6 (2) in subsection (d)(1), by striking “there are
7 authorized” and all that follows through the period
8 and inserting “there are authorized to be appro-
9 priated \$23,000,000 for fiscal year 2015,
10 \$25,300,000 for fiscal year 2016, \$27,800,000 for
11 fiscal year 2017, \$30,800,000 for fiscal year 2018,
12 and \$34,000,000 for fiscal year 2019.”.

13 **SEC. 733. REPORT ON CARDIOVASCULAR CARE FOR WOMEN**
14 **AND MINORITIES.**

15 Part P of title III of the Public Health Service Act
16 (42 U.S.C. 280g et seq.) is amended by adding at the end
17 the following:

18 **“SEC. 399V-6. REPORT ON CARDIOVASCULAR CARE FOR**
19 **WOMEN AND MINORITIES.**

20 “Not later than September 30, 2015, and annually
21 thereafter, the Secretary shall prepare and submit to the
22 Congress a report on the quality of and access to care
23 for women and minorities with heart disease, stroke, and
24 other cardiovascular diseases. The report shall contain rec-
25 ommendations for eliminating disparities in, and improv-

1 ing the treatment of, heart disease, stroke, and other car-
2 diovascular diseases in women, racial and ethnic minori-
3 ties, those for whom English is not their primary lan-
4 guage, and individuals with disabilities.”.

5 **SEC. 734. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
6 **SATION SERVICES IN MEDICAID.**

7 (a) REQUIRING COVERAGE OF COUNSELING AND
8 PHARMACOTHERAPY FOR CESSATION OF TOBACCO
9 USE.—Section 1905 of the Social Security Act (42 U.S.C.
10 1396d) is amended—

11 (1) in subsection (a)(4)(D) is amended by strik-
12 ing “by pregnant women”; and

13 (2) in subsection (bb)—

14 (A) by striking “by pregnant women” each
15 place it appears;

16 (B) in paragraph (1), in the matter before
17 subparagraph (A), by inserting “by individuals”
18 before “who use tobacco”; and

19 (C) in paragraph (2)(A), by striking “with
20 respect to pregnant women”.

21 (b) EXCEPTION FROM OPTIONAL RESTRICTION
22 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
23 Section 1927(d)(2)(F) of the Social Security Act (42
24 U.S.C. 1396r–8(d)(2)(F)) is amended by striking “in the
25 case of pregnant women”.

1 (c) REMOVAL OF COST SHARING FOR COUNSELING
2 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
3 USE.—

4 (1) GENERAL COST SHARING LIMITATIONS.—
5 Section 1916 of the Social Security Act (42 U.S.C.
6 1396o) is amended—

7 (A) in subsections (a)(2)(B) and (b)(2)(B),
8 by striking “and counseling and
9 pharmacotherapy for cessation of tobacco use
10 by pregnant women (as defined in section
11 1905(bb)) and covered outpatient drugs (as de-
12 fined in subsection (k)(2) of section 1927 and
13 including nonprescription drugs described in
14 subsection (d)(2) of such section) that are pre-
15 scribed for purposes of promoting, and when
16 used to promote, tobacco cessation by pregnant
17 women in accordance with the Guideline re-
18 ferred to in section 1905(bb)(2)(A)” each place
19 it appears; and

20 (B) in each of subsections (a)(2)(D) and
21 (b)(2)(D) by inserting “and counseling and
22 pharmacotherapy for cessation of tobacco use
23 (as defined in section 1905(bb)) and covered
24 outpatient drugs (as defined in subsection
25 (k)(2) of section 1927 and including non-

1 prescription drugs described in subsection
2 (d)(2) of such section) that are prescribed for
3 purposes of promoting, and when used to pro-
4 mote, tobacco cessation in accordance with the
5 Guideline referred to in section
6 1905(bb)(2)(A),” after “section
7 1905(a)(4)(C),”.

8 (2) APPLICATION TO ALTERNATIVE COST SHAR-
9 ING.—Section 1916A(b)(3)(B) of such Act (42
10 U.S.C. 1396o–1(b)(3)(B)42 U.S.C. 1396o–
11 1(b)(3)(B)) is amended—

12 (A) in clause (iii), by striking “, and coun-
13 seling and pharmacotherapy for cessation of to-
14 bacco use by pregnant women (as defined in
15 section 1905(bb))”; and

16 (B) by adding at the end the following:

17 “(xi) Counseling and pharmacothe-
18 rapy for cessation of tobacco use (as defined
19 in section 1905(bb)) and covered out-
20 patient drugs (as defined in subsection
21 (k)(2) of section 1927 and including non-
22 prescription drugs described in subsection
23 (d)(2) of such section) that are prescribed
24 for purposes of promoting, and when used
25 to promote, tobacco cessation in accord-

1 ance with the Guideline referred to in sec-
2 tion 1905(bb)(2)(A).”.

3 (d) **EFFECTIVE DATE.**—The amendments made by
4 this section shall take effect on October 1, 2014.

5 **SEC. 735. CLINICAL RESEARCH FUNDING FOR ORAL**
6 **HEALTH.**

7 (a) **IN GENERAL.**—The Secretary of Health and
8 Human Services shall expand and intensify the conduct
9 and support of the research activities of the National In-
10 stitutes of Health and the National Institute of Dental
11 and Craniofacial Research to improve the oral health of
12 the population through the prevention and management
13 of oral diseases and conditions.

14 (b) **INCLUDED RESEARCH ACTIVITIES.**—Research
15 activities under subsection (a) shall include—

16 (1) comparative effectiveness research and clin-
17 ical disease management research addressing early
18 childhood caries and oral cancer; and

19 (2) awarding of grants and contracts to support
20 the training and development of health services re-
21 searchers, comparative effectiveness researchers, and
22 clinical researchers whose research improves the oral
23 health of the population.

1 **SEC. 736. PARTICIPATION BY MEDICAID BENEFICIARIES IN**
2 **APPROVED CLINICAL TRIALS.**

3 (a) IN GENERAL.—Title XIX of the Social Security
4 Act (42 U.S.C. 1396 et seq.) is amended by inserting after
5 section 1943 the following new section:

6 **“SEC. 1944. PARTICIPATION IN AN APPROVED CLINICAL**
7 **TRIAL.**

8 “(a) COVERAGE OF ROUTINE PATIENT COSTS ASSO-
9 CIATED WITH APPROVED CLINICAL TRIALS.—

10 “(1) INCLUSION.—Subject to paragraph (2),
11 routine patient costs shall include all items and serv-
12 ices consistent with the medical assistance provided
13 under the State plan that would otherwise be pro-
14 vided to the individual under such State plan if such
15 individual was not enrolled in an approved clinical
16 trial, including any items or services related to the
17 prevention, detection, and treatment of any medical
18 complications that arise as a result of participation
19 in the approved clinical trial.

20 “(2) EXCLUSION.—For purposes of paragraph
21 (1), routine patient costs does not include—

22 “(A) the investigational item, device, or
23 service itself;

24 “(B) items and services that are provided
25 solely to satisfy data collection and analysis

1 needs and that are not used in the direct clin-
2 ical management of the patient; or

3 “(C) a service that is clearly inconsistent
4 with widely accepted and established standards
5 of care for a particular diagnosis.

6 “(3) INFORMATION CONCERNING CLINICAL
7 TRIALS.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (B), the Secretary, in consultation with
10 relevant stakeholders, shall develop a single
11 standardized electronic form for use by the indi-
12 vidual or the referring health care provider to
13 submit to the State agency administering the
14 State plan in order to verify that the clinical
15 trial meets the conditions established for an ap-
16 proved clinical trial (as defined in subsection
17 (c)).

18 “(B) EXCLUDED INFORMATION.—For pur-
19 poses of subparagraph (A) or any such request
20 by the State agency for information regarding
21 a clinical trial, an individual or referring health
22 care provider shall not be required to submit—

23 “(i) the clinical protocol document for
24 the clinical trial; or

1 “(ii) subject to subparagraph (C), any
2 additional information other than such in-
3 formation as is required pursuant to the
4 form described in subparagraph (A).

5 “(C) OPTIONAL INFORMATION.—For pur-
6 poses of subparagraphs (A) and (B)(ii), the
7 form may include a requirement that the refer-
8 ring health care provider attest that the indi-
9 vidual is eligible to participate in the clinical
10 trial pursuant to the trial protocol and that
11 their participation in such trial would be appro-
12 priate.

13 “(D) REVIEW OF INFORMATION.—

14 “(i) IN GENERAL.—A State plan
15 under this title shall establish a process for
16 timely review by the State agency of the
17 form and information submitted pursuant
18 to subparagraph (A) and, not later than
19 48 hours after receipt of such form, con-
20 firmation that the information provided in
21 such form satisfies the requirements estab-
22 lished under such subparagraph, with such
23 process to include establishment and oper-
24 ation of a 24-hour, toll-free telephone num-

1 ber and e-mail address to provide for expedited communication.

2
3 “(ii) FAILURE TO RESPOND.—If an
4 individual or the referring health care provider does not receive a response or request for additional information from the
5 State agency following the 48-hour period
6 described in clause (i), the information
7 provided in the form may be presumed to
8 satisfy the requirements established under
9 this paragraph.
10
11

12 “(b) ENCOURAGEMENT OF PARTICIPATION IN APPROVED CLINICAL TRIALS.—

13
14 “(1) REASONABLY ACCESSIBLE PROVIDER.—
15 For purposes of participation in an approved clinical
16 trial by an individual eligible for medical assistance
17 under this title, the State agency administering the
18 State plan shall make reasonable efforts to ensure
19 that the individual is provided with access to a provider who is—
20

21 “(A) participating in the approved clinical
22 trial;

23 “(B) located not more than 25 miles from
24 the residence of the individual (or, if no such

1 provider is available, as close as possible to the
2 residence of the individual); and

3 “(C) a participating provider under the
4 State plan or has been deemed to be a partici-
5 pating provider under the State plan for pur-
6 poses of providing medical assistance to the in-
7 dividual during their participation in the ap-
8 proved clinical trial.

9 “(2) INFORMATIONAL MATERIALS.—The State
10 agency administering the plan approved under this
11 title shall develop informational materials and pro-
12 grams to encourage participating providers to make
13 appropriate referrals to physicians and other appro-
14 priate health care professionals who can provide in-
15 dividuals with access to approved clinical trials.

16 “(c) DEFINITION OF APPROVED CLINICAL TRIAL.—
17 The term ‘approved clinical trial’ has the same meaning
18 as provided under section 2709(d) of the Public Health
19 Service Act.”.

20 (b) CONFORMING AMENDMENT.—Section 1902(a) of
21 such Act (42 U.S.C. 1396a(a)) is amended by inserting
22 after paragraph (77) the following new paragraph:

23 “(78) provide that participation in an approved
24 clinical trial and coverage of routine patient costs
25 associated with such trial for an individual eligible

1 for medical assistance under this title is conducted
2 in accordance with the requirements under section
3 1944;”.

4 (c) EFFECTIVE DATE.—

5 (1) IN GENERAL.—Except as provided in para-
6 graph (2), the amendments made by this section
7 shall apply to calendar quarters beginning on or
8 after October 1, 2014.

9 (2) DELAY PERMITTED FOR STATE PLAN
10 AMENDMENT.—In the case of a State plan for med-
11 ical assistance under title XIX of the Social Security
12 Act which the Secretary of Health and Human Serv-
13 ices determines requires State legislation (other than
14 legislation appropriating funds) in order for the plan
15 to meet the additional requirements imposed by the
16 amendments made by this section, the State plan
17 shall not be regarded as failing to comply with the
18 requirements of such title solely on the basis of its
19 failure to meet these additional requirements before
20 the first day of the first calendar quarter beginning
21 after the close of the first regular session of the
22 State legislature that begins after the date of enact-
23 ment of this Act. For purposes of the previous sen-
24 tence, in the case of a State that has a 2-year legis-
25 lative session, each year of such session shall be

1 deemed to be a separate regular session of the State
2 legislature.

3 **Subtitle E—HIV/AIDS**

4 **SEC. 741. STATEMENT OF POLICY.**

5 It is the policy of the United States to achieve an
6 AIDS-free generation, and to—

7 (1) expand access to lifesaving antiretroviral
8 therapy for people living with HIV/AIDS and imme-
9 diately link people to continuous and coordinated
10 high-quality care when they learn they are infected
11 with HIV;

12 (2) expand targeted efforts to prevent HIV in-
13 fection using a combination of effective, evidence-
14 based approaches, including routine HIV screening,
15 and universal access to HIV prevention tools in the
16 communities where HIV/AIDS is most heavily con-
17 centrated, particularly communities of color;

18 (3) ensure laws, policies, and regulations do not
19 impede access to prevention, treatment, and care for
20 people living with HIV/AIDS or at risk for acquiring
21 HIV;

22 (4) accelerate research for more efficacious HIV
23 prevention and treatments tools, a cure, and a vac-
24 cine; and

1 (5) respect the human rights and dignity of
2 persons living with HIV/AIDS.

3 **SEC. 742. FINDINGS.**

4 The Congress finds the following:

5 (1) Over one million people are estimated to be
6 living with HIV in the United States according to
7 the Centers for Disease Control and Prevention, 18
8 percent of whom are unaware of their HIV-positive
9 status.

10 (2) Annually there are over 50,000 new HIV in-
11 fections and 20,000 deaths in people with an HIV
12 diagnoses in 50 States and 6 dependent areas of the
13 United States.

14 (3) The Centers for Disease Control and Pre-
15 vention estimates that in 2011 there were approxi-
16 mately 50,199 people newly diagnosed with HIV.
17 Though this number seems to be staying relatively
18 stable, the number of new infections is rapidly in-
19 creasing among certain populations especially among
20 young African-American men who have sex with men
21 (MSM) who, in 2010, accounted for 45 percent of
22 new HIV infections among black MSM and 55 per-
23 cent of HIV infections among young MSM overall.

24 (4) HIV disproportionately affects certain popu-
25 lations in the United States. Though African-Ameri-

1 cans represent less than 13 percent of the popu-
2 lation, African-Americans account for almost half
3 (44 percent) of all people living with HIV in the
4 United States. Men who have sex with men (MSM)
5 make up approximately 4 percent of the population,
6 but account for 63 percent of all new HIV infections
7 and are the only risk group in which HIV infections
8 continue to increase.

9 (5) Disparities exist among Latinos/Hispanics;
10 they make up 16 percent of US population and 22
11 percent of new infections (2011).

12 (6) Though American Indians/Alaska Natives
13 represent less than 2 percent of the total number of
14 HIV/AIDS cases, American Indians and Alaska Na-
15 tives rank fifth in rates of HIV/AIDS diagnosis, still
16 higher than their White counterparts.

17 (7) While Asian-Americans, Native Hawaiians,
18 and Pacific Islanders HIV/AIDS cases account for
19 approximately 1 percent of cases nationally, between
20 2010 and 2011, the rate of new HIV diagnoses in-
21 creased for Asian-Americans by 22 percent.

22 (8) The latest data from the CDC (2013) indi-
23 cate that women account for 1 in 5 (20 percent) new
24 HIV infections in the United States women of color,
25 particularly Black women, have been especially hard

1 hit and represent the majority of women living with
2 the disease and women newly infected. In addition,
3 Black women accounted for nearly two-thirds (64
4 percent) of all estimated new HIV infections among
5 women, while only accounting for 13 percent of the
6 female population; White women accounted for 18
7 percent and Latinas 15 percent of new infections.

8 (9) The history of HIV shows that culturally
9 relevant and gender-responsive supportive services,
10 including psychosocial support, treatment literacy,
11 case management, and transportation are necessary
12 strategies to reach and engage women and girls in
13 medical care.

14 (10) The limited data available on transgender
15 individuals point to a disproportionate burden of
16 HIV infection.

17 (11) Stigma and discrimination contribute to
18 these disparities.

19 (12) The Centers for Disease Control and Pre-
20 vention has determined that increasing the propor-
21 tion of people who know their HIV status is an es-
22 sential component of comprehensive HIV/AIDS
23 treatment and prevention efforts and that early di-
24 agnosis is critical in order for people with HIV/
25 AIDS to receive life-extending therapy. Additionally,

1 the Centers for Disease Control and Prevention rec-
2 ommend routine HIV screening in health care set-
3 tings for all patients aged 13 to 64, regardless of
4 risk.

5 (13) In 1998, Congress created the National
6 Minority AIDS Initiative to provide technical assist-
7 ance, build capacity, and strengthen outreach efforts
8 among local institutions and community-based orga-
9 nizations that serve racial and ethnic minorities liv-
10 ing with or vulnerable to HIV/AIDS.

11 (14) To combat the HIV epidemic in the United
12 States, the National HIV/AIDS Strategy (NHAS)
13 from the White House Office of National AIDS Pol-
14 icy provides a framework of increasing access to
15 care, reducing new infections, and eliminating HIV-
16 related health disparities. The vision of NHAS is
17 “The United States will become a place where new
18 HIV infections are rare and when they do occur,
19 every person, regardless of age, gender, race/eth-
20 nicity, gender identity, or socioeconomic cir-
21 cumstance, will have unfettered access to high qual-
22 ity, life-extending care, free from stigma and dis-
23 crimination.”.

24 (15) In recent years, several thousand people
25 across the country were waiting to receive AIDS

1 treatment through the AIDS Drug Assistance Pro-
2 gram authorized by the provisions popularly known
3 as the Ryan White CARE Act.

4 (16) At present, 34 States and 2 United States
5 territories have criminal statutes based on “expo-
6 sure” to HIV. Most of these laws were adopted be-
7 fore the availability of effective antiretroviral treat-
8 ment for HIV/AIDS.

9 (17) Although the cost of education, treatment
10 and care, and research are not inconsequential, they
11 are substantially less than the annual health care
12 cost attributable to HIV in the United States. The
13 lifetime cost of HIV care and treatment in 2004 was
14 estimated to be \$405,000 to \$648,000 annually.
15 Preventing 40,000 new infections in the United
16 States each year would save \$12.8 billion annually.

17 (18) According to the Centers for Disease Con-
18 trol and Prevention (CDC), latex condoms, when
19 used consistently and correctly, are highly effective
20 in preventing the transmission of HIV. Latex
21 condoms also reduce the risk of other STIs. Despite
22 the effectiveness of condoms in reducing the spread
23 of STIs, the Bureau of Prisons does not recommend
24 their use in correctional facilities.

1 (19) The distribution of condoms in correctional
2 facilities is currently legal in certain parts of the
3 United States and the world. The States of Vermont
4 and Mississippi, the District of Columbia, and the
5 cities of New York, San Francisco, Los Angeles,
6 Washington, DC, and Philadelphia allow condom
7 distribution in their correctional facilities. However,
8 these States and cities operate fewer than 1 percent
9 of all correctional facilities.

10 (20) Many correctional facilities in the United
11 States do not provide comprehensive testing and
12 treatment programs to reduce the spread of STIs.
13 Fewer than half of correctional facilities provide
14 counseling to HIV-positive incarcerated persons.

15 (21) Incarcerated individuals living with HIV/
16 AIDS who are eligible for Medicaid would benefit
17 from prompt and automatic enrollment upon their
18 release in order to ensure their continued ability to
19 access health services, including antiretroviral treat-
20 ment.

21 (22) Research shows that stable housing leads
22 to better health outcomes for those living with HIV.
23 Inadequate or unstable housing is not only a barrier
24 to effective treatment, but also increases the likeli-
25 hood of engaging in risky behaviors leading to HIV

1 infection. Insecure housing puts people with HIV/
2 AIDS at risk of premature death from exposure to
3 other diseases, poor nutrition, and lack of medical
4 care.

5 (23) Due to advances in treatment, many peo-
6 ple living with HIV/AIDS (PLWHA) today are liv-
7 ing healthy lives and have the ability and desire to
8 fully participate in all aspects of community life, in-
9 cluding employment. Research associates being em-
10 ployed with tremendous economic, social, and health
11 benefits for many people living with HIV/AIDS.

12 (24) The common benefits associated with em-
13 ployment include income, autonomy, productivity,
14 and status within society, daily structure, making a
15 contribution to one's community, and increased skills
16 and self-esteem. Research also indicates that many
17 people with disabilities, including PLWHA, report
18 perceiving themselves as being less disabled or not
19 disabled at all, when working. Furthermore, some
20 studies link working with better physical and mental
21 health outcomes for PLWHA when compared to
22 those who are not working. Preliminary data also
23 suggest that transitioning to employment is associ-
24 ated with reduced HIV-related health risk behavior
25 for many people.

1 (25) On July 16, 2012, the Food and Drug Ad-
2 ministration approved the first drug to reduce the
3 risk of HIV infection in uninfected individuals who
4 are at high risk of HIV infection and who may en-
5 gage in sexual activity with HIV-infected partners.

6 **SEC. 743. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
7 **ANCE PROGRAM TREATMENTS.**

8 Section 2623 of the Public Health Service Act (42
9 U.S.C. 300ff–31b) is amended by adding at the end the
10 following:

11 “(c) **ADDITIONAL FUNDING FOR AIDS DRUG AS-**
12 **SISTANCE PROGRAM TREATMENTS.**—In addition to
13 amounts otherwise authorized to be appropriated for car-
14 rying out this subpart, there are authorized to be appro-
15 priated such sums as may be necessary to carry out sec-
16 tions 2612(b)(3)(B) and 2616 for each of fiscal years
17 2015 through 2017.”.

18 **SEC. 744. ENHANCING THE NATIONAL HIV SURVEILLANCE**
19 **SYSTEM.**

20 (a) **GRANTS.**—The Secretary of Health and Human
21 Services, acting through the Director of the Centers for
22 Disease Control and Prevention, shall make grants to
23 States to support integration of public health surveillance
24 systems into all electronic health records in order to allow

1 rapid communications between the clinical setting and
2 health departments, by means that include—

3 (1) providing technical assistance and policy
4 guidance to State and local health departments, clin-
5 ical providers, and other agencies serving individuals
6 with HIV to improve the interoperability of data sys-
7 tems relevant to monitoring HIV care and sup-
8 portive services;

9 (2) capturing longitudinal data pertaining to
10 the initiation and ongoing prescription or dispensing
11 of antiretroviral therapy for individuals diagnosed
12 with HIV (such as through pharmacy-based report-
13 ing);

14 (3) obtaining information—

15 (A) on a voluntary basis, on sexual orienta-
16 tion and gender identity; and

17 (B) on sources of coverage (or the lack
18 thereof) for medical treatment (including cov-
19 erage through Medicaid, Medicare, the program
20 under title XXVI of the Public Health Service
21 Act (42 U.S.C. 300ff–11 et seq.; commonly re-
22 ferred to as the “Ryan White HIV/AIDS Pro-
23 gram”), other public funding, private insurance,
24 and health maintenance organizations); and

1 (4) obtaining and using current geographic
2 markers of residence (such as current address, zip
3 code, partial zip code, and census block).

4 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
5 rying out this section, the Secretary of Health and Human
6 Services shall ensure that appropriate privacy and security
7 safeguards are met to prevent unauthorized disclosure of
8 protected health information and compliance with the
9 HIPAA privacy and security law (as defined in section
10 3009 of the Public Health Service Act (42 U.S.C. 300jj–
11 19)) and other relevant laws and regulations.

12 (c) PROHIBITION AGAINST IMPROPER USE OF
13 DATA.—No grant under this section may be used to allow
14 or facilitate the collection or use of surveillance or clinical
15 data or records—

16 (1) for punitive measures of any kind, civil or
17 criminal, against the subject of such data or records;
18 or

19 (2) for imposing any requirement or restriction
20 with respect to an individual without the individual’s
21 written consent.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
23 out this section, there are authorized to be appropriated
24 such sums as may be necessary for each of fiscal years
25 2015 through 2019.

1 **SEC. 745. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
2 **LINKAGE TO AND RETENTION IN APPRO-**
3 **PRIATE CARE.**

4 (a) STRATEGIES.—The Secretary of Health and
5 Human Services, in collaboration with the Director of the
6 Centers for Disease Control and Prevention, the Adminis-
7 trator of the Substance Abuse and Mental Health Services
8 Administration, the Director of the Office of AIDS Re-
9 search, the Administrator of the Health Resources and
10 Services Administration, and the Administrator of the
11 Centers for Medicare & Medicaid Services, shall—

12 (1) identify evidence-based strategies most ef-
13 fective at addressing the multifaceted issues that im-
14 pede disease status awareness and linkage to and re-
15 tention in appropriate care, taking into consideration
16 health care systems issues, clinic and provider
17 issues, and individual psychosocial, environmental,
18 and other contextual factors;

19 (2) support the wide-scale implementation of
20 the evidence-based strategies identified pursuant to
21 paragraph (1), including through incorporating such
22 strategies into health care coverage supported by the
23 Medicaid program under title XIX of the Social Se-
24 curity Act (42 U.S.C. 1396 et seq.), the program
25 under title XXVI of the Public Health Service Act
26 (42 U.S.C. 300ff–11 et seq.; commonly referred to

1 as the “Ryan White HIV/AIDS Program”), and
2 health plans purchased through an American Health
3 Benefit Exchange established pursuant to section
4 1311 of the Patient Protection and Affordable Care
5 Act (42 U.S.C. 18031); and

6 (3) not later than 12 months after the date of
7 the enactment of this Act, submit a report to the
8 Congress on the status of activities under para-
9 graphs (1) and (2).

10 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
11 out this section, there are authorized to be appropriated
12 such sums as may be necessary for fiscal years 2015
13 through 2019.

14 **SEC. 746. IMPROVING ENTRY INTO AND RETENTION IN**
15 **CARE AND ANTIRETROVIRAL ADHERENCE**
16 **FOR PERSONS WITH HIV.**

17 (a) SENSE OF CONGRESS.—It is the sense of the Con-
18 gress that AIDS research has led to scientific advance-
19 ments that have—

20 (1) saved the lives of millions of people with
21 HIV/AIDS;

22 (2) prevented millions of people from being in-
23 fected; and

24 (3) had broad benefits that extend far beyond
25 helping people at risk for or living with HIV.

1 (b) IN GENERAL.—The Secretary of Health and
2 Human Services, acting through the Director of the Na-
3 tional Institutes of Health, shall expand, intensify, and co-
4 ordinate operational and translational research and other
5 activities of the National Institutes of Health regarding
6 methods—

7 (1) to increase adoption of evidence-based ad-
8 herence strategies within HIV care and treatment
9 programs;

10 (2) to increase HIV testing and case detection
11 rates;

12 (3) to reduce HIV-related health disparities;

13 (4) to ensure that research to improve adher-
14 ence to HIV care and treatment programs address
15 the unique concerns of women;

16 (5) to integrate HIV/AIDS prevention and care
17 services with mental health and substance use pre-
18 vention and treatment delivery systems; and

19 (6) to increase knowledge on the implementa-
20 tion of preexposure prophylaxis (PrEP), including
21 with respect to—

22 (A) who can benefit most from PrEP;

23 (B) how to provide PrEP safely and effi-
24 ciently;

1 (C) how to integrate PrEP with other es-
2 sential prevention methods such as condoms;
3 and

4 (D) how to ensure high levels of adherence.

5 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
6 out this section, there are authorized to be appropriated
7 such sums as may be necessary for fiscal years 2015
8 through 2019.

9 **SEC. 747. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
10 **ETHNIC MINORITY COMMUNITIES.**

11 (a) IN GENERAL.—For the purpose of reducing HIV/
12 AIDS in racial and ethnic minority communities, the Sec-
13 retary, acting through the Deputy Assistant Secretary for
14 Minority Health, may make grants to public health agen-
15 cies and faith-based organizations to conduct—

16 (1) outreach activities related to HIV/AIDS
17 prevention and testing activities;

18 (2) HIV/AIDS prevention activities; and

19 (3) HIV/AIDS testing activities.

20 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
21 out this section, there are authorized to be appropriated
22 \$50,000,000 for fiscal year 2015, and such sums as may
23 be necessary for fiscal years 2016 through 2019.

1 **SEC. 748. MINORITY AIDS INITIATIVE.**

2 (a) EXPANDED FUNDING.—The Secretary, in col-
3 laboration with the Deputy Assistant Secretary for Minor-
4 ity Health, the Director of the Centers for Disease Control
5 and Prevention, the Administrator of the Health Re-
6 sources and Services Administration, and the Adminis-
7 trator of the Substance Abuse and Mental Health Services
8 Administration, shall provide funds and carry out activi-
9 ties to expand the Minority HIV/AIDS Initiative.

10 (b) USE OF FUNDS.—The additional funds made
11 available under this section may be used, through the Mi-
12 nority AIDS Initiative, to support the following activities:

13 (1) Providing technical assistance and infra-
14 structure support to reduce HIV/AIDS in minority
15 populations.

16 (2) Increasing minority populations' access to
17 HIV/AIDS prevention and care services.

18 (3) Building strong community programs and
19 partnerships to address HIV prevention and the
20 health care needs of specific racial and ethnic minor-
21 ity populations.

22 (c) PRIORITY INTERVENTIONS.—Within the racial
23 and ethnic minority populations referred to in subsection
24 (b), priority in conducting intervention services shall be
25 given to—

26 (1) men who have sex with men;

1 (2) youth;

2 (3) persons who engage in intravenous drug
3 abuse;

4 (4) women;

5 (5) homeless individuals; and

6 (6) individuals incarcerated or in the penal sys-
7 tem.

8 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
9 rying out this section, there are authorized to be appro-
10 priated \$610,000,0000 for fiscal year 2015 and such sums
11 as may be necessary for each of fiscal years 2016 through
12 2019.

13 **SEC. 749. HEALTH CARE PROFESSIONALS TREATING INDI-**
14 **VIDUALS WITH HIV/AIDS.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services, acting through the Administrator of the
17 Health Resources and Services Administration, shall ex-
18 pand, intensify, and coordinate workforce initiatives of the
19 Health Resources and Services Administration to increase
20 the capacity of the health workforce focusing primarily on
21 HIV/AIDS to meet the demand for culturally competent
22 care, and may award grants for any of the following:

23 (1) Development of curricula for training pri-
24 mary care providers in HIV/AIDS prevention and
25 care, including routine HIV testing.

1 (2) Support to expand access to culturally and
2 linguistically accessible benefits counselors, trained
3 peer navigators, and mental and behavioral health
4 professionals with expertise in HIV/AIDS.

5 (3) Training health care professionals to pro-
6 vide care to individuals with HIV/AIDS.

7 (4) Development by grant recipients under title
8 XXVI of the Public Health Service Act (42 U.S.C.
9 300ff–11 et seq.; commonly referred to as the Ryan
10 White HIV/AIDS Program) and other persons, of
11 policies for providing culturally relevant and sen-
12 sitive treatment to individuals with HIV/AIDS, with
13 particular emphasis on treatment to racial and eth-
14 nic minorities, men who have sex with men, and
15 women, young people, and children with HIV/AIDS.

16 (5) Development and implementation of pro-
17 grams to increase the use of telehealth to respond to
18 HIV/AIDS-specific health care needs in rural and
19 minority communities, with particular emphasis
20 given to medically underserved communities and in-
21 sular areas.

22 (6) Evaluating interdisciplinary medical pro-
23 vider care team models that promote high quality
24 care, with particular emphasis on care to racial and
25 ethnic minorities.

1 (7) Training health care professionals to make
2 them aware of the high rates of chronic hepatitis B
3 and chronic hepatitis C in adult racial and ethnic
4 populations, and the importance of prevention, de-
5 tection, and medical management of hepatitis B and
6 hepatitis C and of liver cancer screening.

7 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
8 out this section, there are authorized to be appropriated
9 such sums as may be necessary for fiscal years 2015
10 through 2019.

11 **SEC. 750. HIV/AIDS PROVIDER LOAN REPAYMENT PRO-**
12 **GRAM.**

13 (a) IN GENERAL.—The Secretary may enter into an
14 agreement with any physician, nurse practitioner, or phy-
15 sician assistant under which—

16 (1) the physician, nurse practitioner, or physi-
17 cian assistant agrees to serve as a medical provider
18 for a period of not less than 2 years—

19 (A) at a Ryan White-funded or title X-
20 funded facility with a critical shortage of doc-
21 tors (as determined by the Secretary); or

22 (B) in an area with a high incidence of
23 HIV/AIDS; and

24 (2) the Secretary agrees to make payments in
25 accordance with subsection (b) on the professional

1 education loans of the physician, nurse practitioner,
2 or physician assistant.

3 (b) MANNER OF PAYMENTS.—The payments de-
4 scribed in subsection (a) shall be made by the Secretary
5 as follows:

6 (1) Upon completion by the physician, nurse
7 practitioner, or physician assistant for whom the
8 payments are to be made of the first year of the
9 service specified in the agreement entered into with
10 the Secretary under subsection (a), the Secretary
11 shall pay 30 percent of the principal of and the in-
12 terest on the individual's professional education
13 loans.

14 (2) Upon completion by the physician, nurse
15 practitioner, or physician assistant of the second
16 year of such service, the Secretary shall pay another
17 30 percent of the principal of and the interest on
18 such loans.

19 (3) Upon completion by that individual of a
20 third year of such service, the Secretary shall pay
21 another 25 percent of the principal of and the inter-
22 est on such loans.

23 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
24 provisions of subpart III of part D of title III of the Public
25 Health Service Act (42 U.S.C. 2541 et seq.) shall, except

1 as inconsistent with this section, apply to the program car-
2 ried out under this section in the same manner and to
3 the same extent as such provisions apply to the National
4 Health Service Corps Loan Repayment Program.

5 (d) REPORTS.—Not later than 18 months after the
6 date of the enactment of this Act, and annually thereafter,
7 the Secretary shall prepare and submit to the Congress
8 a report describing the program carried out under this sec-
9 tion, including statements regarding the following:

10 (1) The number of physicians, nurse practi-
11 tioners, and physician assistants enrolled in the pro-
12 gram.

13 (2) The number and amount of loan repay-
14 ments.

15 (3) The placement location of loan repayment
16 recipients at facilities described in subsection (a)(1).

17 (4) The default rate and actions required.

18 (5) The amount of outstanding default funds.

19 (6) To the extent that it can be determined, the
20 reason for the default.

21 (7) The demographics of individuals partici-
22 pating in the program.

23 (8) An evaluation of the overall costs and bene-
24 fits of the program.

25 (e) DEFINITIONS.—In this section:

1 (1) The term “HIV/AIDS” means human im-
2 munodeficiency virus and acquired immune defi-
3 ciency syndrome.

4 (2) The term “nurse practitioner” means a reg-
5 istered nurse who has completed an accredited grad-
6 uate degree program in advanced nurse practice and
7 has successfully passed a national certification exam.

8 (3) The term “physician” means a graduate of
9 a school of medicine who has completed post-
10 graduate training in general or pediatric medicine.

11 (4) The term “physician assistant” means a
12 medical provider who completed an accredited physi-
13 cian assistant training program and successfully
14 passed the Physician Assistant National Certifying
15 Examination.

16 (5) The term “professional education loan”—

17 (A) means a loan that is incurred for the
18 cost of attendance (including tuition, other rea-
19 sonable educational expenses, and reasonable
20 living costs) at a school of medicine, nursing, or
21 physician assistant training program; and

22 (B) includes only the portion of the loan
23 that is outstanding on the date the physician,
24 nurse practitioner, or physician assistant in-

1 (1) the dentist agrees to serve as a dentist for
2 a period of not less than 2 years at a facility with
3 a critical shortage of dentists (as determined by the
4 Secretary) in an area with a high incidence of HIV/
5 AIDS; and

6 (2) the Secretary agrees to make payments in
7 accordance with subsection (b) on the dental edu-
8 cation loans of the dentist.

9 (b) MANNER OF PAYMENTS.—The payments de-
10 scribed in subsection (a) shall be made by the Secretary
11 as follows:

12 (1) Upon completion by the dentist for whom
13 the payments are to be made of the first year of the
14 service specified in the agreement entered into with
15 the Secretary under subsection (a), the Secretary
16 shall pay 30 percent of the principal of and the in-
17 terest on the dental education loans of the dentist.

18 (2) Upon completion by the dentist of the sec-
19 ond year of such service, the Secretary shall pay an-
20 other 30 percent of the principal of and the interest
21 on such loans.

22 (3) Upon completion by that individual of a
23 third year of such service, the Secretary shall pay
24 another 25 percent of the principal of and the inter-
25 est on such loans.

1 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
2 provisions of subpart III of part D of title III of the Public
3 Health Service Act (42 U.S.C. 254l et seq.) shall, except
4 as inconsistent with this section, apply to the program car-
5 ried out under this section in the same manner and to
6 the same extent as such provisions apply to the National
7 Health Service 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 the Congress
11 a report describing the program carried out under this sec-
12 tion, including statements regarding the following:

13 (1) The number of dentists enrolled in the pro-
14 gram.

15 (2) The number and amount of loan repay-
16 ments.

17 (3) The placement location of loan repayment
18 recipients at facilities described in subsection (a)(1).

19 (4) The default rate and actions required.

20 (5) The amount of outstanding default funds.

21 (6) To the extent that it can be determined, the
22 reason for the default.

23 (7) The demographics of individuals partici-
24 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) The term “dental education loan”—

5 (A) means a loan that is incurred for the
6 cost of attendance (including tuition, other rea-
7 sonable educational expenses, and reasonable
8 living costs) at a school of dentistry; and

9 (B) includes only the portion of the loan
10 that is outstanding on the date the dentist in-
11 volved begins the service specified in the agree-
12 ment under subsection (a).

13 (2) The term “dentist” means a graduate of a
14 school of dentistry who has completed postgraduate
15 training in general or pediatric dentistry.

16 (3) The term “HIV/AIDS” means human im-
17 munodeficiency virus and acquired immune defi-
18 ciency syndrome.

19 (4) The term “school of dentistry” has the
20 meaning given to that term in section 799B of the
21 Public Health Service Act (42 U.S.C. 295p).

22 (5) The term “Secretary” means the Secretary
23 of Health and Human Services.

24 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
25 out this section, there are authorized to be appropriated

1 such sums as may be necessary for each of fiscal years
2 2015 through 2019.

3 **SEC. 752. REDUCING NEW HIV INFECTIONS AMONG INJECT-**
4 **ING DRUG USERS.**

5 (a) SENSE OF CONGRESS.—It is the sense of the Con-
6 gress that providing sterile syringes and sterilized equip-
7 ment to injecting drug users substantially reduces risk of
8 HIV infection, increases the probability that they will ini-
9 tiate drug treatment, and does not increase drug use.

10 (b) IN GENERAL.—The Secretary of Health and
11 Human Services may provide grants and technical assist-
12 ance for the purpose of reducing the rate of HIV infections
13 among injecting drug users through a comprehensive
14 package of services for such users, including the provision
15 of sterile syringes, education and outreach, access to infec-
16 tious disease testing, overdose prevention, and treatment
17 for drug dependence.

18 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 such sums as may be necessary for fiscal years 2015
21 through 2019.

1 **SEC. 753. SUPPORT FOR EXPANSION OF COMPREHENSIVE**
2 **SEXUAL HEALTH AND EDUCATION PRO-**
3 **GRAMS.**

4 (a) SENSE OF CONGRESS.—It is the sense of Con-
5 gress that—

6 (1) federally funded sex education programs
7 should aim to—

8 (A) reduce unintended pregnancy and sex-
9 ually transmitted infections, including HIV;

10 (B) promote safe and healthy relation-
11 ships;

12 (C) use, and be informed by, the best sci-
13 entific information available;

14 (D) be built on characteristics of effective
15 programs;

16 (E) expand the existing body of evidence
17 on comprehensive sex education programs
18 through program evaluation;

19 (F) expand training programs for teachers
20 of comprehensive sex education;

21 (G) build on the personal responsibility
22 education programs funded under section 513
23 of the Social Security Act (42 U.S.C. 713) and
24 the President's Teen Pregnancy Prevention pro-
25 gram, funded under title II of the Consolidated

1 Appropriations Act, 2010 (Public Law 111–
2 117; 123 Stat. 3253); and

3 (H) promote and uphold the rights of
4 young people to information in order to make
5 healthy and responsible decisions about their
6 sexual health; and

7 (2) no Federal funds should be used for health
8 education programs that—

9 (A) deliberately withhold life-saving infor-
10 mation about HIV;

11 (B) are medically inaccurate or have been
12 scientifically shown to be ineffective;

13 (C) promote gender stereotypes;

14 (D) are insensitive and unresponsive to the
15 needs of sexually active adolescents;

16 (E) are insensitive and unresponsive to the
17 needs of lesbian, gay, bisexual, or transgender
18 youth; or

19 (F) are inconsistent with the ethical im-
20 peratives of medicine and public health.

21 (b) GRANTS FOR COMPREHENSIVE SEX EDUCATION
22 FOR ADOLESCENTS.—

23 (1) PROGRAM AUTHORIZED.—The Secretary, in
24 coordination with the Director of the Office of Ado-
25 lescent Health, shall award grants, on a competitive

1 basis, to eligible entities to enable such eligible enti-
2 ties to carry out programs that provide adolescents
3 with comprehensive sex education, as described in
4 paragraph (6).

5 (2) DURATION.—Grants awarded under this
6 subsection shall be for a period of 5 years.

7 (3) ELIGIBLE ENTITY.—In this subsection, the
8 term “eligible entity” means a public or private enti-
9 ty that focuses on adolescent health or education or
10 has experience working with adolescents, which may
11 include—

12 (A) a State educational agency;

13 (B) a local educational agency;

14 (C) a tribe or tribal organization, as de-
15 fined in section 4 of the Indian Self-Determina-
16 tion and Education Assistance Act (25 U.S.C.
17 450b);

18 (D) a State or local department of health;

19 (E) a State or local department of edu-
20 cation;

21 (F) a nonprofit organization;

22 (G) a nonprofit or public institution of
23 higher education; or

24 (H) a hospital.

1 (4) APPLICATIONS.—An eligible entity desiring
2 a grant under this subsection shall submit an appli-
3 cation to the Secretary at such time, in such man-
4 ner, and containing such information as the Sec-
5 retary may require, including the evaluation plan de-
6 scribed in paragraph (7)(A).

7 (5) PRIORITY.—In awarding grants under this
8 subsection, the Secretary shall give priority to eligi-
9 ble entities that—

10 (A) are State or local public entities, with
11 an additional priority for State or local edu-
12 cational agencies; and

13 (B) address health disparities among
14 young people that are at highest risk for not
15 less than 1 of the following:

16 (i) Unintended pregnancies.

17 (ii) Sexually transmitted infections,
18 including HIV.

19 (iii) Dating violence and sexual as-
20 sault.

21 (6) USE OF FUNDS.—

22 (A) IN GENERAL.—Each eligible entity
23 that receives a grant under this subsection shall
24 use grant funds to carry out a program that

1 provides adolescents with comprehensive sex
2 education that—

3 (i) replicates evidence-based sex edu-
4 cation programs;

5 (ii) substantially incorporates ele-
6 ments of evidence-based sex education pro-
7 grams; or

8 (iii) creates a demonstration project
9 based on generally accepted characteristics
10 of effective sex education programs.

11 (B) CONTENTS OF SEX EDUCATION PRO-
12 GRAMS.—The sex education programs funded
13 under this subsection shall include curricula
14 and program materials that address—

15 (i) abstinence and delaying sexual ini-
16 tiation;

17 (ii) the health benefits and side effects
18 of all contraceptive and barrier methods as
19 a means to prevent pregnancy and sexually
20 transmitted infections, including HIV;

21 (iii) healthy relationships, including
22 the development of healthy attitudes and
23 skills necessary for understanding—

1 (I) healthy relationships between
2 oneself and family, others, and soci-
3 ety; and

4 (II) the prevention of sexual
5 abuse, teen dating violence, bullying,
6 harassment, and suicide;

7 (iv) healthy life skills including goal-
8 setting, decisionmaking, interpersonal skills
9 (such as communication, assertiveness, and
10 peer refusal skills), critical thinking, self-
11 esteem and self-efficacy, and stress man-
12 agement;

13 (v) how to make responsible decisions
14 about sex and sexuality, including—

15 (I) how to avoid, and how to
16 avoid making, unwanted verbal, phys-
17 ical, and sexual advances; and

18 (II) how alcohol and drug use
19 can affect responsible decisionmaking;

20 (vi) the development of healthy atti-
21 tudes and values about such topics as ado-
22 lescent growth and development, body
23 image, gender roles and gender identity,
24 racial and ethnic diversity, and sexual ori-
25 entation; and

1 (vii) referral services for local health
2 clinics and services where adolescents can
3 obtain additional information and services
4 related to sexual and reproductive health,
5 dating violence and sexual assault, and sui-
6 cide prevention.

7 (7) EVALUATION; REPORT.—

8 (A) INDEPENDENT EVALUATION.—Each
9 eligible entity applying for a grant under this
10 subsection shall develop and submit to the Sec-
11 retary a plan for a rigorous independent evalua-
12 tion of such grant program. The plan shall de-
13 scribe an independent evaluation that—

14 (i) uses sound statistical methods and
15 techniques relating to the behavioral
16 sciences, including random assignment
17 methodologies, whenever possible;

18 (ii) uses quantitative data for assess-
19 ments and impact evaluations, whenever
20 possible; and

21 (iii) is carried out by an entity inde-
22 pendent from such eligible entity.

23 (B) SELECTION OF EVALUATED PRO-
24 GRAMS; BUDGET.—

1 (i) SELECTION OF EVALUATED PRO-
2 GRAMS.—The Secretary shall select, at
3 random, a subset of the eligible entities
4 that the Secretary has selected to receive a
5 grant under this subsection to receive addi-
6 tional funding to carry out the evaluation
7 plan described in subparagraph (A).

8 (ii) BUDGET FOR EVALUATION ACTIVI-
9 TIES.—The Secretary, in coordination with
10 the Director of the Office of Adolescent
11 Health, shall establish a budget for each
12 eligible entity selected under clause (i) for
13 the costs of carrying out the evaluation
14 plan described in subparagraph (A).

15 (C) FUNDS FOR EVALUATION.—The Sec-
16 retary shall provide eligible entities who are se-
17 lected under subparagraph (B)(i) with addi-
18 tional funds, in accordance with the budget de-
19 scribed in subparagraph (B)(ii), to carry out
20 and report to the Secretary on the evaluation
21 plan described in subparagraph (A).

22 (D) PERFORMANCE MEASURES.—The Sec-
23 retary, in coordination with the Director of the
24 Centers for Disease Control and Prevention,
25 shall establish a common set of performance

1 measures to assess the implementation and im-
2 pact of grant programs funded under this sub-
3 section. Such performance measures shall in-
4 clude—

5 (i) output measures, such as the num-
6 ber of individuals served and the number
7 of hours of service delivery;

8 (ii) outcome measures, including
9 measures relating to—

10 (I) the knowledge that youth par-
11 ticipating in the grant program have
12 gained about—

13 (aa) adolescent growth and
14 development;

15 (bb) relationship dynamics;

16 (cc) ways to prevent unin-
17 tended pregnancy and sexually
18 transmitted infections, including
19 HIV; and

20 (dd) sexual health;

21 (II) the skills that adolescents
22 participating in the grant program
23 have gained regarding—

24 (aa) negotiation and commu-
25 nication;

1 (bb) decisionmaking and
2 goal-setting;

3 (cc) interpersonal skills and
4 healthy relationships; and

5 (dd) condom use; and

6 (III) the behaviors of adolescents
7 participating in the grant program,
8 including data about—

9 (aa) age of first intercourse;

10 (bb) number of sexual part-
11 ners;

12 (cc) condom and contracep-
13 tive use at first intercourse;

14 (dd) recent condom and con-
15 traceptive use; and

16 (ee) dating abuse and life-
17 time history of domestic violence,
18 sexual assault, dating violence,
19 bullying, harassment, and stalk-
20 ing.

21 (E) REPORT TO THE SECRETARY.—Eligi-
22 ble entities receiving a grant under this sub-
23 section who have been selected to receive funds
24 to carry out the evaluation plan described in
25 subparagraph (A), in accordance with subpara-

1 graph (B)(i), shall collect and report to the Sec-
2 retary—

3 (i) the results of the independent eval-
4 uation described in subparagraph (A); and

5 (ii) information about the perform-
6 ance measures described in subparagraph
7 (B).

8 (F) EFFECTIVE PROGRAMS.—The Sec-
9 retary, in coordination with the Director of the
10 Centers for Disease Control and Prevention,
11 shall publish on the Web site of the Centers for
12 Disease Control and Prevention, a list of pro-
13 grams funded under this subsection that the
14 Secretary has determined to be effective pro-
15 grams.

16 (c) GRANTS FOR COMPREHENSIVE SEX EDUCATION
17 AT INSTITUTIONS OF HIGHER EDUCATION.—

18 (1) PROGRAM AUTHORIZED.—The Secretary, in
19 coordination with the Office of Adolescent Health
20 and the Secretary of Education, shall award grants,
21 on a competitive basis, to institutions of higher edu-
22 cation to enable such institutions to provide young
23 people with comprehensive sex education, described
24 in paragraph (5)(B), with an emphasis on reducing

1 HIV, other sexually transmitted infections, and un-
2 intended pregnancy through instruction about—

3 (A) abstinence and contraception;

4 (B) reducing dating violence, sexual as-
5 sult, bullying, and harassment;

6 (C) increasing healthy relationships; and

7 (D) academic achievement.

8 (2) DURATION.—Grants awarded under this
9 subsection shall be for a period of 5 years.

10 (3) APPLICATIONS.—An institution of higher
11 education desiring a grant under this subsection
12 shall submit an application to the Secretary at such
13 time, in such manner, and containing such informa-
14 tion as the Secretary may require.

15 (4) PRIORITY.—In awarding grants under this
16 subsection, the Secretary shall give priority to an in-
17 stitution of higher education that—

18 (A) has an enrollment of needy students as
19 defined in section 318(b) of the Higher Edu-
20 cation Act of 1965 (20 U.S.C. 1059e(b));

21 (B) is a Hispanic-serving institution, as
22 defined in section 502(a) of such Act (20
23 U.S.C. 1101a(a));

1 (C) is a Tribal College or University, as
2 defined in section 316(b) of such Act (20
3 U.S.C. 1059c(b));

4 (D) is an Alaska Native-serving institution,
5 as defined in section 317(b) of such Act (20
6 U.S.C. 1059d(b));

7 (E) is a Native Hawaiian-serving institu-
8 tion, as defined in section 317(b) of such Act
9 (20 U.S.C. 1059d(b));

10 (F) is a Predominately Black Institution,
11 as defined in section 318(b) of such Act (20
12 U.S.C. 1059e(b));

13 (G) is a Native American-serving, non-
14 tribal institution, as defined in section 319(b)
15 of such Act (20 U.S.C. 1059f(b));

16 (H) is an Asian American and Native
17 American Pacific Islander-serving institution, as
18 defined in section 320(b) of such Act (20
19 U.S.C. 1059g(b)); or

20 (I) is a minority institution, as defined in
21 section 365 of such Act (20 U.S.C. 1067k),
22 with an enrollment of needy students, as de-
23 fined in section 312 of such Act (20 U.S.C.
24 1058).

25 (5) USES OF FUNDS.—

1 (A) IN GENERAL.—An institution of higher
2 education receiving a grant under this sub-
3 section may use grant funds to integrate issues
4 relating to comprehensive sex education into the
5 academic or support sectors of the institution of
6 higher education in order to reach a large num-
7 ber of students, by carrying out 1 or more of
8 the following activities:

9 (i) Developing educational content for
10 issues relating to comprehensive sex edu-
11 cation that will be incorporated into first-
12 year orientation or core courses.

13 (ii) Developing and employing
14 schoolwide educational programming out-
15 side of class that delivers elements of com-
16 prehensive sex education programs to stu-
17 dents, faculty, and staff.

18 (iii) Creating innovative technology-
19 based approaches to deliver sex education
20 to students, faculty, and staff.

21 (iv) Developing and employing peer-
22 outreach and education programs to gen-
23 erate discussion, educate, and raise aware-
24 ness among students about issues relating
25 to comprehensive sex education.

1 (B) CONTENTS OF SEX EDUCATION PRO-
2 GRAMS.—Each institution of higher education’s
3 program of comprehensive sex education funded
4 under this subsection shall include curricula
5 and program materials that address informa-
6 tion about—

7 (i) safe and responsible sexual behav-
8 ior with respect to the prevention of preg-
9 nancy and sexually transmitted infections,
10 including HIV, including through—

11 (I) abstinence;

12 (II) a reduced number of sexual
13 partners; and

14 (III) the use of condoms and con-
15 traception;

16 (ii) healthy relationships, including
17 the development of healthy attitudes and
18 insights necessary for understanding—

19 (I) relationships between oneself,
20 family, partners, others, and society;
21 and

22 (II) the prevention of sexual
23 abuse, dating violence, bullying, har-
24 assment, and suicide; and

1 (iii) referral services to local health
2 clinics where young people can obtain addi-
3 tional information and services related to
4 sexual and reproductive health, dating vio-
5 lence and sexual assault, and suicide pre-
6 vention.

7 (C) OPTIONAL COMPONENTS OF SEX EDU-
8 CATION.—Each institution of higher education’s
9 program of comprehensive sex education may
10 also include information and skills development
11 relating to—

12 (i) how to make responsible decisions
13 about sex and sexuality, including—

14 (I) how to avoid, and avoid mak-
15 ing, unwanted verbal, physical, and
16 sexual advances; and

17 (II) how alcohol and drug use
18 can affect responsible decisionmaking;

19 (ii) healthy life skills, including—

20 (I) goal-setting and decision-
21 making;

22 (II) interpersonal skills, such as
23 communication, assertiveness, and
24 peer refusal skills;

25 (III) critical thinking;

- 1 (IV) self-esteem and self-efficacy;
2 and
3 (V) stress management;
4 (iii) the development of healthy atti-
5 tudes and values about such topics as body
6 image, gender roles and gender identity,
7 racial and ethnic diversity, and sexual ori-
8 entation; and
9 (iv) the responsibilities of parenting
10 and the skills necessary to parent well.

11 (6) EVALUATION; REPORT.—The requirements
12 described in section 125B(g) shall also apply to eligi-
13 ble entities receiving a grant under this subsection
14 in the same manner as such requirements apply to
15 eligible entities receiving grants under section 125B.

16 (d) GRANTS FOR PRE-SERVICE AND IN-SERVICE
17 TEACHER TRAINING.—

18 (1) PROGRAM AUTHORIZED.—The Secretary, in
19 coordination with the Director of the Centers for
20 Disease Control and Prevention and the Secretary of
21 Education, shall award grants, on a competitive
22 basis, to eligible entities to enable such eligible enti-
23 ties to carry out the activities described in para-
24 graph (5).

1 (2) DURATION.—Grants awarded under this
2 subsection shall be for a period of 5 years.

3 (3) ELIGIBLE ENTITY.—In this subsection, the
4 term “eligible entity” means—

5 (A) a State educational agency;

6 (B) a local educational agency;

7 (C) a tribe or tribal organization, as de-
8 fined in section 4 of the Indian Self-Determina-
9 tion and Education Assistance Act (25 U.S.C.
10 450b);

11 (D) a State or local department of health;

12 (E) a State or local department of edu-
13 cation;

14 (F) a nonprofit institution of higher edu-
15 cation;

16 (G) a national or statewide nonprofit orga-
17 nization that has as its primary purpose the im-
18 provement of provision of comprehensive sex
19 education through effective teaching of com-
20 prehensive sex education; or

21 (H) a consortium of nonprofit organiza-
22 tions that has as its primary purpose the im-
23 provement of provision of comprehensive sex
24 education through effective teaching of com-
25 prehensive sex education.

1 (4) APPLICATION.—An eligible entity desiring a
2 grant under this subsection shall submit an applica-
3 tion to the Secretary at such time, in such manner,
4 and containing such information as the Secretary
5 may require.

6 (5) AUTHORIZED ACTIVITIES.—

7 (A) REQUIRED ACTIVITY.—Each eligible
8 entity receiving a grant under this subsection
9 shall use grant funds to train targeted faculty
10 and staff, in order to increase effective teaching
11 of comprehensive sex education for elementary
12 school and secondary school students.

13 (B) PERMISSIBLE ACTIVITIES.—Each eligi-
14 ble entity receiving a grant under this sub-
15 section may use grant funds to—

16 (i) strengthen and expand the eligible
17 entity's relationships with—

18 (I) institutions of higher edu-
19 cation;

20 (II) State educational agencies;

21 (III) local educational agencies;

22 or

23 (IV) other public and private or-
24 ganizations with a commitment to
25 comprehensive sex education and the

1 benefits of comprehensive sex edu-
2 cation;

3 (ii) support and promote research-
4 based training of teachers of comprehen-
5 sive sex education and related disciplines
6 in elementary schools and secondary
7 schools as a means of broadening student
8 knowledge about issues related to human
9 development, relationships, personal skills,
10 sexual behavior, sexual health, and society
11 and culture;

12 (iii) support the dissemination of in-
13 formation on effective practices and re-
14 search findings concerning the teaching of
15 comprehensive sex education;

16 (iv) support research on—

17 (I) effective comprehensive sex
18 education teaching practices; and

19 (II) the development of assess-
20 ment instruments and strategies to
21 document—

22 (aa) student understanding
23 of comprehensive sex education;
24 and

1 (bb) the effects of com-
2 prehensive sex education;

3 (v) convene national conferences on
4 comprehensive sex education, in order to
5 effectively train teachers in the provision of
6 comprehensive sex education; and

7 (vi) develop and disseminate appro-
8 priate research-based materials to foster
9 comprehensive sex education.

10 (C) SUBGRANTS.—Each eligible entity re-
11 ceiving a grant under this subsection may
12 award subgrants to nonprofit organizations,
13 State educational agencies, or local educational
14 agencies to enable such organizations or agen-
15 cies to—

16 (i) train teachers in comprehensive
17 sex education;

18 (ii) support Internet or distance learn-
19 ing related to comprehensive sex education;

20 (iii) promote rigorous academic stand-
21 ards and assessment techniques to guide
22 and measure student performance in com-
23 prehensive sex education;

1 (iv) encourage replication of best
2 practices and model programs to promote
3 comprehensive sex education;

4 (v) develop and disseminate effective,
5 research-based comprehensive sex edu-
6 cation learning materials;

7 (vi) develop academic courses on the
8 pedagogy of sex education at institutions
9 of higher education; or

10 (vii) convene State-based conferences
11 to train teachers in comprehensive sex edu-
12 cation and to identify strategies for im-
13 provement.

14 (e) REPORT TO CONGRESS.—

15 (1) IN GENERAL.—Not later than 1 year after
16 the date of the enactment of this Act, and annually
17 thereafter for a period of 5 years, the Secretary shall
18 prepare and submit to the appropriate committees of
19 Congress a report on the activities to provide adoles-
20 cents and young people with comprehensive sex edu-
21 cation funded under this section.

22 (2) REPORT ELEMENTS.—The report described
23 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 under subsections (b) and (c);

4 (B) the specific activities supported by
5 grant funds awarded under subsections (b) and
6 (c);

7 (C) the number of adolescents served by
8 grant programs funded under subsection (b);

9 (D) the number of young people served by
10 grant programs funded under subsection (c);
11 and

12 (E) the status of program evaluations de-
13 scribed under subsections (b) and (c).

14 (f) LIMITATION.—No Federal funds provided under
15 this section may be used for health education programs
16 that—

17 (1) deliberately withhold life-saving information
18 about HIV;

19 (2) are medically inaccurate or have been sci-
20 entifically shown to be ineffective;

21 (3) promote gender stereotypes;

22 (4) are insensitive and unresponsive to the
23 needs of sexually active youth or lesbian, gay, bisex-
24 ual, or transgender youth; or

1 (5) are inconsistent with the ethical imperatives
2 of medicine and public health.

3 (g) DEFINITIONS.—In this section:

4 (1) ESEA DEFINITIONS.—The terms “elemen-
5 tary school”, “local educational agency”, “secondary
6 school”, and “State educational agency” have the
7 meanings given the terms in section 9101 of the Ele-
8 mentary and Secondary Education Act of 1965 (20
9 U.S.C. 7801).

10 (2) AGE AND DEVELOPMENTALLY APPRO-
11 PRIATE.—The term “age and developmentally appro-
12 priate” means suitable for a particular age or age
13 group of children and adolescents, based on devel-
14 oping cognitive, emotional, and behavioral capacity
15 typical for that age or age group.

16 (3) ADOLESCENTS.—The term “adolescents”
17 means individuals who are ages 10 through 19 at
18 the time of commencement of participation in a pro-
19 gram supported under this section.

20 (4) CHARACTERISTICS OF EFFECTIVE PRO-
21 GRAMS.—The term “characteristics of effective pro-
22 grams” means the aspects of evidence-based pro-
23 grams, including development, content, and imple-
24 mentation of such programs, that—

1 (A) have been shown to be effective in
2 terms of increasing knowledge, clarifying values
3 and attitudes, increasing skills, and impacting
4 upon behavior; and

5 (B) are widely recognized by leading med-
6 ical and public health agencies to be effective in
7 changing sexual behaviors that lead to sexually
8 transmitted infections, including HIV, unin-
9 tended pregnancy, and dating violence and sex-
10 ual assault among young people.

11 (5) COMPREHENSIVE SEX EDUCATION.—The
12 term “comprehensive sex education” means a pro-
13 gram that—

14 (A) includes age- and developmentally ap-
15 propriate, culturally and linguistically relevant
16 information on a broad set of topics related to
17 sexuality including human development, rela-
18 tionships, decisionmaking, communication, ab-
19 stinence, contraception, and disease and preg-
20 nancy prevention;

21 (B) provides students with opportunities
22 for developing skills as well as learning informa-
23 tion;

1 (C) is inclusive of lesbian, gay, bisexual,
2 transgender, and heterosexual young people;
3 and

4 (D) aims to—

5 (i) provide scientifically accurate and
6 realistic information about human sexu-
7 ality;

8 (ii) provide opportunities for individ-
9 uals to understand their own, their fami-
10 lies', and their communities' values, atti-
11 tudes, and insights about sexuality;

12 (iii) help individuals develop healthy
13 relationships and interpersonal skills; and

14 (iv) help individuals exercise responsi-
15 bility regarding sexual relationships, which
16 includes addressing abstinence, pressures
17 to become prematurely involved in sexual
18 intercourse, and the use of contraception
19 and other sexual health measures.

20 (6) EVIDENCE-BASED PROGRAM.—The term
21 “evidence-based program” means a sex education
22 program that has been proven through rigorous eval-
23 uation to be effective in changing sexual behavior or
24 incorporates elements of other sex education pro-

1 grams that have been proven to be effective in
2 changing sexual behavior.

3 (7) INSTITUTION OF HIGHER EDUCATION.—The
4 term “institution of higher education” has the
5 meaning given the term in section 101 of the Higher
6 Education Act of 1965 (20 U.S.C. 1001).

7 (8) MEDICALLY ACCURATE AND COMPLETE.—
8 The term “medically accurate and complete”, when
9 used with respect to a sex education program, means
10 that—

11 (A) the information provided through the
12 program is verified or supported by the weight
13 of research conducted in compliance with ac-
14 cepted scientific methods and is published in
15 peer-reviewed journals, where applicable; or

16 (B)(i) the program contains information
17 that leading professional organizations and
18 agencies with relevant expertise in the field rec-
19 ognize as accurate, objective, and complete; and

20 (ii) the program does not withhold infor-
21 mation about the effectiveness and benefits of
22 correct and consistent use of condoms and
23 other contraceptives.

24 (9) SECRETARY.—The term “Secretary” means
25 the Secretary of Health and Human Services.

1 (10) YOUNG PEOPLE.—The term “young peo-
2 ple” means individuals who are ages 10 through 24
3 at the time of commencement of participation in a
4 program supported under this section.

5 (h) AUTHORIZATION OF APPROPRIATIONS.—To carry
6 out this section, there are authorized to be appropriated
7 such sums as may be necessary for fiscal years 2015
8 through 2019.

9 **SEC. 754. ELIMINATION OF ABSTINENCE-ONLY EDUCATION**
10 **PROGRAM.**

11 (a) IN GENERAL.—Title V of the Social Security Act
12 (42 U.S.C. 701 et seq.) is amended by striking section
13 510.

14 (b) RESCISSION.—Amounts appropriated for fiscal
15 years 2013 and 2014 under section 510(d) of the Social
16 Security Act (42 U.S.C. 710(d)) (as in effect on the day
17 before the date of enactment of this Act) that are unobli-
18 gated as of the date of enactment of this Act are re-
19 scinded.

20 (c) REPROGRAM OF ELIMINATED ABSTINENCE-ONLY
21 FUNDS FOR THE PERSONAL RESPONSIBILITY EDUCATION
22 PROGRAM (PREP).—Section 513(f) of the Social Security
23 Act (42 U.S.C. 713(f)) is amended by striking
24 “\$75,000,000 for each of fiscal years 2011 through 2015”
25 and inserting “\$75,000,000 for each of fiscal years 2011

1 through 2014, an amount for fiscal year 2015 equal to
2 \$75,000,000 increased by an amount equal to the unobli-
3 gated portion of funds appropriated for fiscal year 2014
4 and 2015 under section 510(d) that are rescinded by sec-
5 tion 754(b) of the Health Equity and Accountability Act
6 of 2014, and \$125,000,000 for each of fiscal years 2016
7 and 2017”.

8 **SEC. 755. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE**
9 **POPULATIONS.**

10 (a) IN GENERAL.—The Secretary shall submit to the
11 Congress and the President an annual report on the im-
12 pact of HIV/AIDS for racial and ethnic minority commu-
13 nities, women, and youth aged 24 and younger.

14 (b) CONTENTS.—The report under subsection (a)
15 shall include information on the—

16 (1) progress that has been made in reducing
17 the impact of HIV/AIDS in such communities;

18 (2) opportunities that exist to make additional
19 progress in reducing the impact of HIV/AIDS in
20 such communities;

21 (3) challenges that may impede such additional
22 progress; and

23 (4) Federal funding necessary to achieve sub-
24 stantial reductions in HIV/AIDS in racial and ethnic
25 minority communities.

1 **SEC. 756. NATIONAL HIV/AIDS OBSERVANCE DAYS.**

2 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
3 of the Congress that national observance days highlighting
4 the impact of HIV/AIDS on communities of color include
5 the following:

6 (1) National Black HIV/AIDS Awareness Day.

7 (2) National Latino AIDS Awareness Day.

8 (3) National Asian and Pacific Islander HIV/
9 AIDS Awareness Day.

10 (4) National Native American HIV/AIDS
11 Awareness Day.

12 (5) Caribbean-American HIV/AIDS Awareness
13 Day.

14 (6) National Youth HIV/AIDS Awareness Day.

15 (7) National Black Clergy HIV/AIDS Aware-
16 ness Sunday.

17 (b) CALL TO ACTION.—It is the sense of the Con-
18 gress that the President should call on members of com-
19 munities of color—

20 (1) to become involved at the local community
21 level in HIV/AIDS testing, policy, and advocacy;

22 (2) to become aware, engaged, and empowered
23 on the HIV/AIDS epidemic within their commu-
24 nities; and

25 (3) to urge members of their communities to re-
26 duce risk factors, practice safe sex and other preven-

1 tive measures, be tested for HIV/AIDS, and seek
2 care when appropriate.

3 **SEC. 757. REVIEW OF ALL FEDERAL AND STATE LAWS,**
4 **POLICIES, AND REGULATIONS REGARDING**
5 **THE CRIMINAL PROSECUTION OF INDIVID-**
6 **UALS FOR HIV-RELATED OFFENSES.**

7 (a) DEFINITIONS.—

8 (1) HIV AND HIV/AIDS.—The terms “HIV” and
9 “HIV/AIDS” have the meanings given to such terms
10 in section 2689 of the Public Health Service Act (42
11 U.S.C. 300ff–88).

12 (2) STATE.—The term “State” includes the
13 District of Columbia, American Samoa, the Com-
14 monwealth of the Northern Mariana Islands, Guam,
15 Puerto Rico, and the United States Virgin Islands.

16 (b) SENSE OF CONGRESS REGARDING LAWS OR REG-
17 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV/
18 AIDS.—It is the sense of the Congress that Federal and
19 State laws, policies, and regulations regarding people liv-
20 ing with HIV/AIDS—

21 (1) should not place unique or additional bur-
22 dens on such individuals solely as a result of their
23 HIV status; and

1 (2) should instead demonstrate a public health-
2 oriented, evidence-based, medically accurate, and
3 contemporary understanding of—

4 (A) the multiple factors that lead to HIV
5 transmission;

6 (B) the relative risk of HIV transmission
7 routes;

8 (C) the current health implications of liv-
9 ing with HIV;

10 (D) the associated benefits of treatment
11 and support services for people living with HIV;
12 and

13 (E) the impact of punitive HIV-specific
14 laws and policies on public health, on people liv-
15 ing with or affected by HIV, and on their fami-
16 lies and communities.

17 (c) REVIEW OF ALL FEDERAL AND STATE LAWS,
18 POLICIES, AND REGULATIONS REGARDING THE CRIMINAL
19 PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OF-
20 FENSES.—

21 (1) REVIEW OF FEDERAL AND STATE LAWS.—

22 (A) IN GENERAL.—No later than 90 days
23 after the date of the enactment of this Act, the
24 Attorney General, the Secretary of Health and
25 Human Services, and the Secretary of Defense

1 acting jointly (in this paragraph and paragraph
2 (2) referred to as the “designated officials”)
3 shall initiate a national review of Federal and
4 State laws, policies, regulations, and judicial
5 precedents and decisions regarding criminal and
6 related civil commitment cases involving people
7 living with HIV/AIDS, including in regards to
8 the Uniform Code of Military Justice.

9 (B) CONSULTATION.—In carrying out the
10 review under subparagraph (A), the designated
11 officials shall ensure diverse participation and
12 consultation from each State, including with—

13 (i) State attorneys general (or their
14 representatives);

15 (ii) State public health officials (or
16 their representatives);

17 (iii) State judicial and court system
18 officers, including judges, district attor-
19 neys, prosecutors, defense attorneys, law
20 enforcement, and correctional officers;

21 (iv) members of the United States
22 Armed Forces, including members of other
23 Federal services subject to the Uniform
24 Code of Military Justice;

1 (v) people living with HIV/AIDS, par-
2 ticularly those who have been subject to
3 HIV-related prosecution or who are from
4 communities whose members have been
5 disproportionately subject to HIV-specific
6 arrests and prosecutions;

7 (vi) legal advocacy and HIV/AIDS
8 service organizations that work with people
9 living with HIV/AIDS;

10 (vii) nongovernmental health organi-
11 zations that work on behalf of people living
12 with HIV/AIDS; and

13 (viii) trade organizations or associa-
14 tions representing persons or entities de-
15 scribed in clauses (i) through (vii).

16 (C) RELATION TO OTHER REVIEWS.—In
17 carrying out the review under subparagraph
18 (A), the designated officials may utilize other
19 existing reviews of criminal and related civil
20 commitment cases involving people living with
21 HIV/AIDS, including any such review con-
22 ducted by any Federal or State agency or any
23 public health, legal advocacy, or trade organiza-
24 tion or association if the designated officials de-
25 termine that such reviews were conducted in ac-

1 cordance with the principles set forth in sub-
2 section (b).

3 (2) REPORT.—No later than 180 days after ini-
4 tiating the review required by paragraph (1), the At-
5 torney General shall transmit to the Congress and
6 make publicly available a report containing the re-
7 sults of the review, which includes the following:

8 (A) For each State and for the Uniform
9 Code of Military Justice, a summary of the rel-
10 evant laws, policies, regulations, and judicial
11 precedents and decisions regarding criminal
12 cases involving people living with HIV/AIDS,
13 including, if applicable, the following:

14 (i) A determination of whether such
15 laws, policies, regulations, and judicial
16 precedents and decisions place any unique
17 or additional burdens upon people living
18 with HIV/AIDS.

19 (ii) A determination of whether such
20 laws, policies, regulations, and judicial
21 precedents and decisions demonstrate a
22 public health-oriented, evidence-based,
23 medically accurate, and contemporary un-
24 derstanding of—

1 (I) the multiple factors that lead
2 to HIV transmission;

3 (II) the relative risk of HIV
4 transmission routes;

5 (III) the current health implica-
6 tions of living with HIV;

7 (IV) the associated benefits of
8 treatment and support services for
9 people living with HIV; and

10 (V) the impact of punitive HIV-
11 specific laws and policies on public
12 health, on people living with or af-
13 fected by HIV, and on their families
14 and communities.

15 (iii) An analysis of the public health
16 and legal implications of such laws, poli-
17 cies, regulations, and judicial precedents,
18 including an analysis of the consequences
19 of having a similar penal scheme applied to
20 comparable situations involving other com-
21 municable diseases.

22 (iv) An analysis of the proportionality
23 of punishments imposed under HIV-spe-
24 cific laws, policies, regulations, and judicial
25 precedents, taking into consideration pen-

1 alties attached to violation of State laws
2 against similar degrees of endangerment or
3 harm, such as driving while intoxicated
4 (DWI) or transmission of other commu-
5 nicable diseases, or more serious harms,
6 such as vehicular manslaughter offenses.

7 (B) An analysis of common elements
8 shared among State laws, policies, regulations,
9 and judicial precedents.

10 (C) A set of best practice recommendations
11 directed to State governments, including State
12 attorneys general, public health officials, and
13 judicial officers, in order to ensure that laws,
14 policies, regulations, and judicial precedents re-
15 garding people living with HIV/AIDS are in ac-
16 cordance with the principles set forth in sub-
17 section (b).

18 (D) Recommendations for adjustments to
19 the Uniform Code of Military Justice, as may
20 be necessary, in order to ensure that laws, poli-
21 cies, regulations, and judicial precedents re-
22 garding people living with HIV/AIDS are in ac-
23 cordance with the principles set forth in sub-
24 section (b).

1 (3) GUIDANCE.—Within 90 days of the release
2 of the report required by paragraph (2), the Attor-
3 ney General and the Secretary of Health and
4 Human Services, acting jointly, shall develop and
5 publicly release updated guidance for States based
6 on the set of best practice recommendations required
7 by paragraph (2)(C) in order to assist States dealing
8 with criminal and related civil commitment cases re-
9 garding people living with HIV/AIDS.

10 (4) MONITORING AND EVALUATION SYSTEM.—
11 Within 60 days of the release of the guidance re-
12 quired by paragraph (3), the Attorney General and
13 the Secretary of Health and Human Services, acting
14 jointly, shall establish an integrated monitoring and
15 evaluation system which includes, where appropriate,
16 objective and quantifiable performance goals and in-
17 dicators to measure progress toward statewide im-
18 plementation in each State of the best practice rec-
19 ommendations required in paragraph (2)(C), includ-
20 ing to monitor, track, and evaluate the effectiveness
21 of assistance provided pursuant to subsection (d).

22 (5) ADJUSTMENTS TO FEDERAL LAWS, POLI-
23 CIES, OR REGULATIONS.—Within 90 days of the re-
24 lease of the report required by paragraph (2), the
25 Attorney General, the Secretary of Health and

1 Human Services, and the Secretary of Defense, act-
2 ing jointly, shall develop and transmit to the Presi-
3 dent and the Congress, and make publicly available,
4 such proposals as may be necessary to implement
5 adjustments to Federal laws, policies, or regulations,
6 including to the Uniform Code of Military Justice,
7 based on the recommendations required by para-
8 graph (2)(D), either through Executive order or
9 through changes to statutory law.

10 (6) AUTHORIZATION OF APPROPRIATIONS.—

11 (A) IN GENERAL.—There are authorized to
12 be appropriated such sums as may be necessary
13 for the purpose of carrying out this subsection.
14 Amounts authorized to be appropriated by the
15 preceding sentence are in addition to amounts
16 otherwise authorized to be appropriated for
17 such purpose.

18 (B) AVAILABILITY OF FUNDS.—Amounts
19 appropriated pursuant to the authorization of
20 appropriations in subparagraph (A) are author-
21 ized to remain available until expended.

22 (d) AUTHORIZATION TO PROVIDE GRANTS.—

23 (1) GRANTS BY ATTORNEY GENERAL.—

24 (A) IN GENERAL.—The Attorney General
25 may provide assistance to eligible State and

1 local entities and eligible nongovernmental orga-
2 nizations for the purpose of incorporating the
3 best practice recommendations developed under
4 subsection (c)(2)(C) within relevant State laws,
5 policies, regulations, and judicial decisions re-
6 garding people living with HIV/AIDS.

7 (B) AUTHORIZED ACTIVITIES.—The assist-
8 ance authorized by subparagraph (A) may in-
9 clude—

10 (i) direct technical assistance to eligi-
11 ble State and local entities in order to de-
12 velop, disseminate, or implement State
13 laws, policies, regulations, or judicial deci-
14 sions that conform with the best practice
15 recommendations developed under sub-
16 section (c)(2)(C);

17 (ii) direct technical assistance to eligi-
18 ble nongovernmental organizations in order
19 to provide education and training, includ-
20 ing through classes, conferences, meetings,
21 and other educational activities, to eligible
22 State and local entities; and

23 (iii) subcontracting authority to allow
24 eligible State and local entities and eligible
25 nongovernmental organizations to seek

1 technical assistance from legal and public
2 health experts with a demonstrated under-
3 standing of the principles underlying the
4 best practice recommendations developed
5 under subsection (c)(2)(C).

6 (2) GRANTS BY SECRETARY OF HEALTH AND
7 HUMAN SERVICES.—

8 (A) IN GENERAL.—The Secretary of
9 Health and Human Services, acting through the
10 Director of the Centers for Disease Control and
11 Prevention, may provide assistance to State and
12 local public health departments and eligible
13 nongovernmental organizations for the purpose
14 of supporting eligible State and local entities to
15 incorporate the best practice recommendations
16 developed under subsection (c)(2)(C) within rel-
17 evant State laws, policies, regulations, and judi-
18 cial decisions regarding people living with HIV/
19 AIDS.

20 (B) AUTHORIZED ACTIVITIES.—The assist-
21 ance authorized by subparagraph (A) may in-
22 clude—

23 (i) direct technical assistance to State
24 and local public health departments in
25 order to support the development, dissemi-

1 nation, or implementation of State laws,
2 policies, regulations, or judicial decisions
3 that conform with the set of best practice
4 recommendations developed under sub-
5 section (c)(2)(C);

6 (ii) direct technical assistance to eligi-
7 ble nongovernmental organizations in order
8 to provide education and training, includ-
9 ing through classes, conferences, meetings,
10 and other educational activities, to State
11 and local public health departments; and

12 (iii) subcontracting authority to allow
13 State and local public health departments
14 and eligible nongovernmental organizations
15 to seek technical assistance from legal and
16 public health experts with a demonstrated
17 understanding of the principles underlying
18 the best practice recommendations devel-
19 oped under subsection (c)(2)(C).

20 (3) LIMITATION.—As a condition of receiving
21 assistance through this subsection, eligible State and
22 local entities, State and local public health depart-
23 ments, and eligible nongovernmental organizations
24 shall agree—

1 (A) not to place any unique or additional
2 burdens on people living with HIV/AIDS solely
3 as a result of their HIV status; and

4 (B) that if the entity, department, or orga-
5 nization promulgates any laws, policies, regula-
6 tions, or judicial decisions regarding people liv-
7 ing with HIV/AIDS, such actions shall dem-
8 onstrate a public health-oriented, evidence-
9 based, medically accurate, and contemporary
10 understanding of—

11 (i) the multiple factors that lead to
12 HIV transmission;

13 (ii) the relative risk of HIV trans-
14 mission routes;

15 (iii) the current health implications of
16 living with HIV;

17 (iv) the associated benefits of treat-
18 ment and support services for people living
19 with HIV; and

20 (v) the impact of punitive HIV-spe-
21 cific laws and policies on public health, on
22 people living with or affected by HIV, and
23 on their families and communities.

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 Act. 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/AIDS;

5 (VI) legal advocacy and HIV/
6 AIDS service organizations that work
7 with people living with HIV/AIDS;
8 and

9 (VII) nongovernmental health or-
10 ganizations that work on behalf of
11 people living with HIV/AIDS.

12 (ii) Nongovernmental organizations,
13 including trade organizations or associa-
14 tions that demonstrate a public-health ori-
15 ented, evidence-based, medically accurate,
16 and contemporary understanding of—

17 (I) the multiple factors that lead
18 to HIV transmission;

19 (II) the relative risk of HIV
20 transmission routes;

21 (III) the current health implica-
22 tions of living with HIV;

23 (IV) the associated benefits of
24 treatment and support services for
25 people living with HIV; and

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.

6 (6) AUTHORIZATION OF APPROPRIATIONS.—

7 (A) IN GENERAL.—In addition to amounts
8 otherwise made available, there are authorized
9 to be appropriated to the Attorney General and
10 the Secretary of Health and Human Services
11 such sums as may be necessary to carry out
12 this subsection for each of the fiscal years 2015
13 through 2019.

14 (B) AVAILABILITY OF FUNDS.—Amounts
15 appropriated pursuant to the authorizations of
16 appropriations in subparagraph (A) are author-
17 ized to remain available until expended.

18 **SEC. 758. REPEAL OF LIMITATION AGAINST USE OF FUNDS**
19 **FOR EDUCATION OR INFORMATION DE-**
20 **SIGNED TO PROMOTE OR ENCOURAGE, DI-**
21 **RECTLY, HOMOSEXUAL OR HETEROSEXUAL**
22 **ACTIVITY OR INTRAVENOUS SUBSTANCE**
23 **ABUSE.**

24 Section 2500 of the Public Health Service Act (42
25 U.S.C. 300ee) is amended—

1 (1) by striking subsection (c); and

2 (2) by redesignating subsection (d) as sub-
3 section (c).

4 **SEC. 759. EXPANDING SUPPORT FOR CONDOMS IN PRIS-**
5 **ONS.**

6 (a) **AUTHORITY TO ALLOW COMMUNITY ORGANIZA-**
7 **TIONS TO PROVIDE STI COUNSELING, STI PREVENTION**
8 **EDUCATION, AND SEXUAL BARRIER PROTECTION DE-**
9 **VICES IN FEDERAL CORRECTIONAL FACILITIES.—**

10 (1) **DIRECTIVE TO ATTORNEY GENERAL.—**Not
11 later than 30 days after the date of enactment of
12 this Act, the Attorney General shall direct the Bu-
13 reau of Prisons to allow community organizations to
14 distribute sexual barrier protection devices and to
15 engage in STI counseling and STI prevention edu-
16 cation in Federal correctional facilities. These activi-
17 ties shall be subject to all relevant Federal laws and
18 regulations which govern visitation in correctional
19 facilities.

20 (2) **INFORMATION REQUIREMENT.—**Any com-
21 munity organization permitted to distribute sexual
22 barrier protection devices under paragraph (1) shall
23 ensure that the persons to whom the devices are dis-
24 tributed are informed about the proper use and dis-
25 posal of sexual barrier protection devices in accord-

1 ance with established public health practices. Any
2 community organization conducting STI counseling
3 or STI prevention education under paragraph (1)
4 shall offer comprehensive sexuality education.

5 (3) POSSESSION OF DEVICE PROTECTED.—No
6 Federal correctional facility may, because of the pos-
7 session or use of a sexual barrier protection device—

8 (A) take adverse action against an incar-
9 cerated person; or

10 (B) consider possession or use as evidence
11 of prohibited activity for the purpose of any
12 Federal correctional facility administrative pro-
13 ceeding.

14 (4) IMPLEMENTATION.—The Attorney General
15 and Bureau of Prisons shall implement this section
16 according to established public health practices in a
17 manner that protects the health, safety, and privacy
18 of incarcerated persons and of correctional facility
19 staff.

20 (b) SENSE OF CONGRESS REGARDING DISTRIBUTION
21 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
22 PRISON SYSTEMS.—It is the sense of the Congress that
23 States should allow for the legal distribution of sexual bar-
24 rier protection devices in State correctional facilities to re-
25 duce the prevalence and spread of STIs in those facilities.

1 (c) SURVEY OF AND REPORT ON CORRECTIONAL FA-
2 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
3 STIs.—

4 (1) SURVEY.—The Attorney General, after con-
5 sulting with the Secretary of Health and Human
6 Services, State officials, and community organiza-
7 tions, shall, to the maximum extent practicable, con-
8 duct a survey of all Federal and State correctional
9 facilities, not later than 180 days after the date of
10 enactment of this Act and annually thereafter for 5
11 years, to determine the following:

12 (A) COUNSELING, TREATMENT, AND SUP-
13 PORTIVE SERVICES.—Whether the correctional
14 facility requires incarcerated persons to partici-
15 pate in counseling, treatment, and supportive
16 services related to STIs, or whether it offers
17 such programs to incarcerated persons.

18 (B) ACCESS TO SEXUAL BARRIER PROTEC-
19 TION DEVICES.—Whether incarcerated persons
20 can—

21 (i) possess sexual barrier protection
22 devices;

23 (ii) purchase sexual barrier protection
24 devices;

1 (iii) purchase sexual barrier protection
2 devices at a reduced cost; and

3 (iv) obtain sexual barrier protection
4 devices without cost.

5 (C) INCIDENCE OF SEXUAL VIOLENCE.—

6 The incidence of sexual violence and assault
7 committed by incarcerated persons and by cor-
8 rectional facility staff.

9 (D) PREVENTION EDUCATION OFFERED.—

10 The type of prevention education, information,
11 or training offered to incarcerated persons and
12 correctional facility staff regarding sexual vio-
13 lence and the spread of STIs, including whether
14 such education, information, or training—

15 (i) constitutes comprehensive sexuality
16 education;

17 (ii) is compulsory for new incarcerated
18 persons and for new staff; and

19 (iii) is offered on an ongoing basis.

20 (E) STI TESTING.—Whether the correc-

21 tional facility tests incarcerated persons for
22 STIs or gives them the option to undergo such
23 testing—

24 (i) at intake;

25 (ii) on a regular basis; and

1 (iii) prior to release.

2 (F) STI TEST RESULTS.—The number of
3 incarcerated persons who are tested for STIs
4 and the outcome of such tests at each correc-
5 tional facility, disaggregated to include results
6 for—

7 (i) the type of sexually transmitted in-
8 fection tested for;

9 (ii) the race and/or ethnicity of indi-
10 viduals tested;

11 (iii) the age of individuals tested; and

12 (iv) the gender of individuals tested.

13 (G) PRERELEASE REFERRAL POLICY.—
14 Whether incarcerated persons are informed
15 prior to release about STI-related services or
16 other health services in their communities, in-
17 cluding free and low-cost counseling and treat-
18 ment options.

19 (H) PRERELEASE REFERRALS MADE.—
20 The number of referrals to community-based
21 organizations or public health facilities offering
22 STI-related or other health services provided to
23 incarcerated persons prior to release, and the
24 type of counseling or treatment for which the
25 referral was made.

1 (I) REINSTATEMENT OF MEDICAID BENE-
2 FITS.—Whether the correctional facility assists
3 incarcerated persons that were enrolled in the
4 State Medicaid program prior to their incarcer-
5 ation, in reinstating their enrollment upon re-
6 lease and whether such individuals receive refer-
7 rals as provided by subparagraph (G) to entities
8 that accept the State Medicaid program, includ-
9 ing if applicable—

10 (i) the number of such individuals, in-
11 cluding those diagnosed with the human
12 immunodeficiency virus, that have been re-
13 instated;

14 (ii) a list of obstacles to reinstating
15 enrollment or to making determinations of
16 eligibility for reinstatement, if any; and

17 (iii) the number of individuals denied
18 enrollment.

19 (J) OTHER ACTIONS TAKEN.—Whether the
20 correctional facility has taken any other action,
21 in conjunction with community organizations or
22 otherwise, to reduce the prevalence and spread
23 of STIs in that facility.

24 (2) PRIVACY.—In conducting the survey, the
25 Attorney General shall not request or retain the

1 identity of any person who has sought or been of-
2 fered counseling, treatment, testing, or prevention
3 education information regarding an STI (including
4 information about sexual barrier protection devices),
5 or who has tested positive for an STI.

6 (3) REPORT.—The Attorney General shall
7 transmit to Congress and make publicly available
8 the results of the survey required under paragraph
9 (1), both for the Nation as a whole and
10 disaggregated as to each State and each correctional
11 facility. To the maximum extent possible, the Attor-
12 ney General shall issue the first report no later than
13 1 year after the date of enactment of this Act and
14 shall issue reports annually thereafter for 5 years.

15 (d) STRATEGY.—

16 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
17 Attorney General, in consultation with the Secretary
18 of Health and Human Services, State officials, and
19 community organizations, shall develop and imple-
20 ment a 5-year strategy to reduce the prevalence and
21 spread of STIs in Federal and State correctional fa-
22 cilities. To the maximum extent possible, the strat-
23 egy shall be developed, transmitted to Congress, and
24 made publicly available no later than 180 days after

1 the transmission of the first report required under
2 subsection (c)(3).

3 (2) CONTENTS OF STRATEGY.—The strategy
4 shall include the following:

5 (A) PREVENTION EDUCATION.—A plan for
6 improving prevention education, information,
7 and training offered to incarcerated persons
8 and correctional facility staff, including infor-
9 mation and training on sexual violence and the
10 spread of STIs, and comprehensive sexuality
11 education.

12 (B) SEXUAL BARRIER PROTECTION DEVICE
13 ACCESS.—A plan for expanding access to sexual
14 barrier protection devices in correctional facili-
15 ties.

16 (C) SEXUAL VIOLENCE REDUCTION.—A
17 plan for reducing the incidence of sexual vio-
18 lence among incarcerated persons and correc-
19 tional facility staff, developed in consultation
20 with the National Prison Rape Elimination
21 Commission.

22 (D) COUNSELING AND SUPPORTIVE SERV-
23 ICES.—A plan for expanding access to coun-
24 seling and supportive services related to STIs in
25 correctional facilities.

1 (E) TESTING.—A plan for testing incarcerated
2 ated persons for STIs during intake, during
3 regular health exams, and prior to release, and
4 that—

5 (i) is conducted in accordance with
6 guidelines established by the Centers for
7 Disease Control and Prevention;

8 (ii) includes pretest counseling;

9 (iii) requires that incarcerated persons
10 are notified of their option to decline test-
11 ing at any time;

12 (iv) requires that incarcerated persons
13 are confidentially notified of their test re-
14 sults in a timely manner; and

15 (v) ensures that incarcerated persons
16 testing positive for STIs receive post-test
17 counseling, care, treatment, and supportive
18 services.

19 (F) TREATMENT.—A plan for ensuring
20 that correctional facilities have the necessary
21 medicine and equipment to treat and monitor
22 STIs and for ensuring that incarcerated per-
23 sons living with or testing positive for STIs re-
24 ceive and have access to care and treatment
25 services.

1 (G) STRATEGIES FOR DEMOGRAPHIC
2 GROUPS.—A plan for developing and imple-
3 menting culturally appropriate, sensitive, and
4 specific strategies to reduce the spread of STIs
5 among demographic groups heavily impacted by
6 STIs.

7 (H) LINKAGES WITH COMMUNITIES AND
8 FACILITIES.—A plan for establishing and
9 strengthening linkages to local communities and
10 health facilities that—

11 (i) provide counseling, testing, care,
12 and treatment services;

13 (ii) may receive persons recently re-
14 leased from incarceration who are living
15 with STIs; and

16 (iii) accept payment through the State
17 Medicaid program.

18 (I) ENROLLMENT IN STATE MEDICAID
19 PROGRAMS.—Plans to ensure that incarcerated
20 persons who were—

21 (i) enrolled in their State Medicaid
22 program prior to incarceration in a correc-
23 tional facility are automatically re-enrolled
24 in such program upon their release; and

1 (ii) not enrolled in their State Med-
2 icaid program prior to incarceration, but
3 who are diagnosed with the human im-
4 munodeficiency virus while incarcerated in
5 a correctional facility, are automatically
6 enrolled in such program upon their re-
7 lease.

8 (J) OTHER PLANS.—Any other plans de-
9 veloped by the Attorney General for reducing
10 the spread of STIs or improving the quality of
11 health care in correctional facilities.

12 (K) MONITORING SYSTEM.—A monitoring
13 system that establishes performance goals re-
14 lated to reducing the prevalence and spread of
15 STIs in correctional facilities and which, where
16 feasible, expresses such goals in quantifiable
17 form.

18 (L) MONITORING SYSTEM PERFORMANCE
19 INDICATORS.—Performance indicators that
20 measure or assess the achievement of the per-
21 formance goals described in subparagraph (K).

22 (M) COST ESTIMATE.—A detailed estimate
23 of the funding necessary to implement the
24 strategy at the Federal and State levels for all
25 5 years, including the amount of funds required

1 by community organizations to implement the
2 parts of the strategy in which they take part.

3 (3) REPORT.—The Attorney General shall
4 transmit to Congress and make publicly available an
5 annual progress report regarding the implementation
6 and effectiveness of the strategy described in para-
7 graph (1). The progress report shall include an eval-
8 uation of the implementation of the strategy using
9 the monitoring system and performance indicators
10 provided for in subparagraphs (K) and (L) of para-
11 graph (2).

12 (e) AUTHORIZATION OF APPROPRIATIONS.—

13 (1) IN GENERAL.—There are authorized to be
14 appropriated such sums as may be necessary to
15 carry out this section for each of fiscal years 2015
16 through 2020.

17 (2) AVAILABILITY OF FUNDS.—Amounts made
18 available under paragraph (1) are authorized to re-
19 main available until expended.

20 (f) DEFINITIONS.—For the purposes of this section:

21 (1) COMMUNITY ORGANIZATION.—The term
22 “community organization” means a public health
23 care facility or a nonprofit organization which pro-
24 vides health- or STI-related services according to es-
25 tablished public health standards.

1 (2) COMPREHENSIVE SEXUALITY EDUCATION.—

2 The term “comprehensive sexuality education”
3 means sexuality education that includes information
4 about abstinence and about the proper use and dis-
5 posal of sexual barrier protection devices and which
6 is—

7 (A) evidence-based;

8 (B) medically accurate;

9 (C) age and developmentally appropriate;

10 (D) gender and identity sensitive;

11 (E) culturally and linguistically appro-
12 priate; and

13 (F) structured to promote critical thinking,
14 self-esteem, respect for others, and the develop-
15 ment of healthy attitudes and relationships.

16 (3) CORRECTIONAL FACILITY.—The term “cor-
17 rectional facility” means any prison, penitentiary,
18 adult detention facility, juvenile detention facility,
19 jail, or other facility to which persons may be sent
20 after conviction of a crime or act of juvenile delin-
21 quency within the United States.

22 (4) INCARCERATED PERSON.—The term “incar-
23 cerated person” means any person who is serving a
24 sentence in a correctional facility after conviction of
25 a crime.

1 (5) SEXUALLY TRANSMITTED INFECTION.—The
2 term “sexually transmitted infection” or “STI”
3 means any disease or infection that is commonly
4 transmitted through sexual activity, including HIV/
5 AIDS, gonorrhea, chlamydia, syphilis, genital her-
6 pes, viral hepatitis, and human papillomavirus.

7 (6) SEXUAL BARRIER PROTECTION DEVICE.—
8 The term “sexual barrier protection device” means
9 any FDA-approved physical device which has not
10 been tampered with and which reduces the prob-
11 ability of STI transmission or infection between sex-
12 ual partners, including female condoms, male
13 condoms, and dental dams.

14 (7) STATE.—The term “State” includes the
15 District of Columbia, American Samoa, the Com-
16 monwealth of the Northern Mariana Islands, Guam,
17 Puerto Rico, and the United States Virgin Islands.

18 **SEC. 760. AUTOMATIC REINSTATEMENT OR ENROLLMENT**
19 **IN MEDICAID FOR PEOPLE WHO TEST POSI-**
20 **TIVE FOR HIV BEFORE REENTERING COMMU-**
21 **NITIES.**

22 (a) IN GENERAL.—Section 1902(e) of the Social Se-
23 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
24 the end the following:

25 “(15) ENROLLMENT OF EX-OFFENDERS.—

1 “(A) AUTOMATIC ENROLLMENT OR REIN-
2 STATEMENT.—

3 “(i) IN GENERAL.—The State plan
4 shall provide for the automatic enrollment
5 or reinstatement of enrollment of an eligi-
6 ble individual—

7 “(I) if such individual is sched-
8 uled to be released from a public insti-
9 tution due to the completion of sen-
10 tence, not less than 30 days prior to
11 the scheduled date of the release; and

12 “(II) if such individual is to be
13 released from a public institution on
14 parole or on probation, as soon as
15 possible after the date on which the
16 determination to release such indi-
17 vidual was made, and before the date
18 such individual is released.

19 “(ii) EXCEPTION.—If a State makes a
20 determination that an individual is not eli-
21 gible to be enrolled under the State plan—

22 “(I) on or before the date by
23 which the individual would be enrolled
24 under clause (i), such clause shall not
25 apply to such individual; or

1 “(II) after such date, the State
2 may terminate the enrollment of such
3 individual.

4 “(B) RELATIONSHIP OF ENROLLMENT TO
5 PAYMENT FOR SERVICES.—

6 “(i) IN GENERAL.—Subject to sub-
7 paragraph (A)(ii), an eligible individual
8 who is enrolled, or whose enrollment is re-
9 instated, under subparagraph (A) shall be
10 eligible for medical assistance that is pro-
11 vided after the date that the eligible indi-
12 vidual is released from the public institu-
13 tion.

14 “(ii) RELATIONSHIP TO PAYMENT
15 PROHIBITION FOR INMATES.—No provision
16 of this paragraph may be construed to per-
17 mit payment for care or services for which
18 payment is excluded under the subdivision
19 (A) that follows paragraph (29) of section
20 1905(a).

21 “(C) TREATMENT OF CONTINUOUS ELIGI-
22 BILITY.—

23 “(i) SUSPENSION FOR INMATES.—Any
24 period of continuous eligibility under this
25 title shall be suspended on the date an in-

1 dividual enrolled under this title becomes
2 an inmate of a public institution (except as
3 a patient of a medical institution).

4 “(ii) DETERMINATION OF REMAINING
5 PERIOD.—Notwithstanding any changes to
6 State law related to continuous eligibility
7 during the time that an individual is an in-
8 mate of a public institution (except as a
9 patient of a medical institution), subject to
10 clause (iii), with respect to an eligible indi-
11 vidual who was subject to a suspension
12 under clause (i), on the date that such in-
13 dividual is released from a public institu-
14 tion the suspension of continuous eligibility
15 under such clause shall be lifted for a pe-
16 riod that is equal to the time remaining in
17 the period of continuous eligibility for such
18 individual on the date that such period was
19 suspended under such clause.

20 “(iii) EXCEPTION.—If a State makes
21 a determination that an individual is not
22 eligible to be enrolled under the State
23 plan—

24 “(I) on or before the date that
25 the suspension of continuous eligibility

1 is lifted under clause (ii), such clause
2 shall not apply to such individual; or

3 “(II) after such date, the State
4 may terminate the enrollment of such
5 individual.

6 “(D) AUTOMATIC ENROLLMENT OR REIN-
7 STATEMENT OF ENROLLMENT DEFINED.—For
8 purposes of this paragraph, the term ‘automatic
9 enrollment or reinstatement of enrollment’
10 means that the State determines eligibility for
11 medical assistance under the State plan without
12 a program application from, or on behalf of, the
13 eligible individual, but an individual can only be
14 automatically enrolled in the State Medicaid
15 plan if the individual affirmatively consents to
16 being enrolled through affirmation in writing,
17 by telephone, orally, through electronic signa-
18 ture, or through any other means specified by
19 the Secretary.

20 “(E) ELIGIBLE INDIVIDUAL DEFINED.—
21 For purposes of this paragraph, the term ‘eligi-
22 ble individual’ means an individual who is an
23 inmate of a public institution (except as a pa-
24 tient in a medical institution)—

1 “(i) who was enrolled under the State
2 plan for medical assistance immediately be-
3 fore becoming an inmate of such an insti-
4 tution; or

5 “(ii) is diagnosed with human im-
6 munodeficiency virus.”.

7 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
8 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
9 ICAID BENEFITS.—

10 (1) IN GENERAL.—Subject to paragraph (6),
11 for each State for which the Secretary of Health and
12 Human Services has approved an application under
13 paragraph (3), the Federal matching payments (in-
14 cluding payments based on the Federal medical as-
15 sistance percentage) made to such State under sec-
16 tion 1903 of the Social Security Act (42 U.S.C.
17 1396b) shall be increased by 5.0 percentage points
18 for payments to the State for the activities per-
19 mitted under paragraph (2) or a period of one year.

20 (2) USE OF FUNDS.—A State may only use in-
21 creased matching payments authorized under para-
22 graph (1)—

23 (A) to strengthen the State’s enrollment
24 and administrative resources for the purpose of
25 improving processes for enrolling (or reinstating

1 the enrollment of) eligible individuals (as such
2 term is defined in subparagraph (E) of para-
3 graph (15) of section 1902(e) of the Social Se-
4 curity Act (as amended by subsection (a))); and

5 (B) for medical assistance (as such term is
6 defined in section 1905(a) of the Social Secu-
7 rity Act) provided to such eligible individuals.

8 (3) APPLICATION AND AGREEMENT.—The Sec-
9 retary may only make payments to a State in the in-
10 creased amount if—

11 (A) the State has amended the State plan
12 under section 1902(e) of the Social Security
13 Act to incorporate the requirements of para-
14 graph (15) of such section (as added by sub-
15 section (a));

16 (B) the State has submitted an application
17 to the Secretary that includes a plan for imple-
18 menting the requirements of section
19 1902(e)(15) of the Social Security Act under
20 the State's amended State plan before the end
21 of the 90-day period beginning on the date that
22 the State receives increased matching payments
23 under paragraph (1);

24 (C) the State's application meets the satis-
25 faction of the Secretary; and

1 (D) the State enters an agreement with
2 the Secretary that states that—

3 (i) the State will only use the in-
4 creased matching funds for the uses per-
5 mitted under paragraph (2); and

6 (ii) at the end of the period under
7 paragraph (1), the State will submit to the
8 Secretary, and make publicly available, a
9 report that contains the information re-
10 quired under paragraph (4).

11 (4) REQUIRED REPORT INFORMATION.—The in-
12 formation that is required in the report under para-
13 graph (3)(D)(ii) includes—

14 (A) the results of an evaluation of the im-
15 pact of the implementation of the requirements
16 of section 1902(e)(15) of the Social Security
17 Act on improving the State's processes for en-
18 rolling of individuals who are released from
19 public institutions into the Medicaid program;

20 (B) the number of individuals who were
21 automatically enrolled (or whose enrollment is
22 reinstated) under such section 1902(e)(15) dur-
23 ing the period under paragraph (1); and

24 (C) any other information that is required
25 by the Secretary.

1 (5) INCREASE IN CAP ON MEDICAID PAYMENTS
2 TO TERRITORIES.—Subject to paragraph (6), the
3 amounts otherwise determined for Puerto Rico, the
4 United States Virgin Islands, Guam, the Northern
5 Mariana Islands, and American Samoa under sub-
6 sections (f) and (g) of section 1108 of the Social Se-
7 curity Act (42 U.S.C. 1308) shall each be increased
8 by the necessary amount to allow for the increase in
9 the Federal matching payments under paragraph
10 (1), but only for the period under such paragraph
11 for such State. In the case of such an increase for
12 a territory, subsection (a)(1) of such section 1108
13 shall be applied without regard to any increase in
14 payment made to the territory under part E of title
15 IV of such Act that is attributable to the increase
16 in Federal medical assistance percentage effected
17 under paragraph (1) for the territory.

18 (6) LIMITATIONS.—

19 (A) TIMING.—With respect to a State, at
20 the end of the period under paragraph (1), no
21 increased matching payments may be made to
22 such State under this subsection.

23 (B) MAINTENANCE OF ELIGIBILITY.—

24 (i) IN GENERAL.—Subject to clause

25 (ii), a State is not eligible for an increase

1 in its Federal matching payments under
2 paragraph (1), or an increase in a cap
3 amount under paragraph (5), if eligibility
4 standards, methodologies, or procedures
5 under its State plan under title XIX of the
6 Social Security Act (including any waiver
7 under such title or under section 1115 of
8 such Act (42 U.S.C. 1315)) are more re-
9 strictive than the eligibility standards,
10 methodologies, or procedures, respectively,
11 under such plan (or waiver) as in effect on
12 the date of enactment of this Act.

13 (ii) STATE REINSTATEMENT OF ELIGI-
14 BILITY PERMITTED.—A State that has re-
15 stricted eligibility standards, methodolo-
16 gies, or procedures under its State plan
17 under title XIX of the Social Security Act
18 (including any waiver under such title or
19 under section 1115 of such Act (42 U.S.C.
20 1315)) after the date of enactment of this
21 Act, is no longer ineligible under subpara-
22 graph (A) beginning with the first calendar
23 quarter in which the State has reinstated
24 eligibility standards, methodologies, or pro-
25 cedures that are no more restrictive than

1 the eligibility standards, methodologies, or
2 procedures, respectively, under such plan
3 (or waiver) as in effect on such date.

4 (C) NO WAIVER AUTHORITY.—The Sec-
5 retary may not waive the application of this
6 subsection under section 1115 of the Social Se-
7 curity Act or otherwise.

8 (D) LIMITATION OF MATCHING PAYMENTS
9 TO 100 PERCENT.—In no case shall an increase
10 in Federal matching payments under this sub-
11 section result in Federal matching payments
12 that exceed 100 percent.

13 (c) EFFECTIVE DATE.—

14 (1) IN GENERAL.—Except as provided in para-
15 graph (2), the amendments made by subsection (a)
16 shall take effect 180 days after the date of the en-
17 actment of this Act and shall apply to services fur-
18 nished on or after such date.

19 (2) RULE FOR CHANGES REQUIRING STATE
20 LEGISLATION.—In the case of a State plan for med-
21 ical assistance under title XIX of the Social Security
22 Act which the Secretary of Health and Human Serv-
23 ices determines requires State legislation (other than
24 legislation appropriating funds) in order for the plan
25 to meet the additional requirement imposed by the

1 amendments made by this section, the State plan
2 shall not be regarded as failing to comply with the
3 requirements of such title solely on the basis of its
4 failure to meet this additional requirement before
5 the first day of the first calendar quarter beginning
6 after the close of the first regular session of the
7 State legislature that begins after the date of the en-
8 actment of this Act. For purposes of the previous
9 sentence, in the case of a State that has a 2-year
10 legislative session, each year of such session shall be
11 deemed to be a separate regular session of the State
12 legislature.

13 **SEC. 761. STOP AIDS IN PRISON.**

14 (a) **SHORT TITLE.**—This section may be cited as the
15 “Stop AIDS in Prison Act”.

16 (b) **IN GENERAL.**—The Bureau of Prisons (herein-
17 after in this section referred to as the “Bureau”) shall
18 develop a comprehensive policy to provide HIV testing,
19 treatment, and prevention for inmates within the correc-
20 tional setting and upon reentry.

21 (c) **PURPOSE.**—The purposes of this policy shall be
22 as follows:

23 (1) To stop the spread of HIV/AIDS among in-
24 mates.

1 (2) To protect prison guards and other per-
2 sonnel from HIV/AIDS infection.

3 (3) To provide comprehensive medical treat-
4 ment to inmates who are living with HIV/AIDS.

5 (4) To promote HIV/AIDS awareness and pre-
6 vention among inmates.

7 (5) To encourage inmates to take personal re-
8 sponsibility for their health.

9 (6) To reduce the risk that inmates will trans-
10 mit HIV/AIDS to other persons in the community
11 following their release from prison.

12 (d) CONSULTATION.—The Bureau shall consult with
13 appropriate officials of the Department of Health and
14 Human Services, the Office of National Drug Control Pol-
15 icy, the Office of National AIDS Policy, and the Centers
16 for Disease Control and Prevention regarding the develop-
17 ment of this policy.

18 (e) TIME LIMIT.—The Bureau shall draft appro-
19 priate regulations to implement this policy not later than
20 1 year after the date of the enactment of this Act.

21 (f) REQUIREMENTS FOR POLICY.—The policy created
22 under subsection (b) shall provide for the following:

23 (1) TESTING AND COUNSELING UPON IN-
24 TAKE.—

1 (A) Health care personnel shall provide
2 routine HIV testing to all inmates as a part of
3 a comprehensive medical examination imme-
4 diately following admission to a facility. (Health
5 care personnel need not provide routine HIV
6 testing to an inmate who is transferred to a fa-
7 cility from another facility if the inmate's med-
8 ical records are transferred with the inmate and
9 indicate that the inmate has been tested pre-
10 viously.)

11 (B) To all inmates admitted to a facility
12 prior to the effective date of this policy, health
13 care personnel shall provide routine HIV testing
14 within no more than 6 months. HIV testing for
15 these inmates may be performed in conjunction
16 with other health services provided to these in-
17 mates by health care personnel.

18 (C) All HIV tests under this paragraph
19 shall comply with the opt-out provision.

20 (2) PRE-TEST AND POST-TEST COUNSELING.—
21 Health care personnel shall provide confidential pre-
22 test and post-test counseling to all inmates who are
23 tested for HIV. Counseling may be included with
24 other general health counseling provided to inmates
25 by health care personnel.

1 (3) HIV/AIDS PREVENTION EDUCATION.—

2 (A) Health care personnel shall improve
3 HIV/AIDS awareness through frequent edu-
4 cational programs for all inmates. HIV/AIDS
5 educational programs may be provided by com-
6 munity-based organizations, local health depart-
7 ments, and inmate peer educators.

8 (B) HIV/AIDS educational materials shall
9 be made available to all inmates at orientation,
10 at health care clinics, at regular educational
11 programs, and prior to release. Both written
12 and audiovisual materials shall be made avail-
13 able to all inmates.

14 (C)(i) The HIV/AIDS educational pro-
15 grams and materials under this paragraph shall
16 include information on—

17 (I) modes of transmission, including
18 transmission through tattooing, sexual con-
19 tact, and intravenous drug use;

20 (II) prevention methods;

21 (III) treatment; and

22 (IV) disease progression.

23 (ii) The programs and materials shall be
24 culturally sensitive, written or designed for low-
25 literacy levels, available in a variety of lan-

1 guages, and present scientifically accurate in-
2 formation in a clear and understandable man-
3 ner.

4 (4) HIV TESTING UPON REQUEST.—

5 (A) Health care personnel shall allow in-
6 mates to obtain HIV tests upon request once
7 per year or whenever an inmate has a reason to
8 believe the inmate may have been exposed to
9 HIV. Health care personnel shall, both orally
10 and in writing, inform inmates, during orienta-
11 tion and periodically throughout incarceration,
12 of their right to obtain HIV tests.

13 (B) Health care personnel shall encourage
14 inmates to request HIV tests if the inmate is
15 sexually active, has been raped, uses intra-
16 venous drugs, receives a tattoo, or if the inmate
17 is concerned that the inmate may have been ex-
18 posed to HIV/AIDS.

19 (C) An inmate's request for an HIV test
20 shall not be considered an indication that the
21 inmate has put him/herself at risk of infection
22 and/or committed a violation of prison rules.

23 (5) HIV TESTING OF PREGNANT WOMAN.—

1 (A) Health care personnel shall provide
2 routine HIV testing to all inmates who become
3 pregnant.

4 (B) All HIV tests under this paragraph
5 shall comply with the opt-out provision.

6 (6) COMPREHENSIVE TREATMENT.—

7 (A) Health care personnel shall provide all
8 inmates who test positive for HIV—

9 (i) timely, comprehensive medical
10 treatment;

11 (ii) confidential counseling on man-
12 aging their medical condition and pre-
13 venting its transmission to other persons;
14 and

15 (iii) voluntary partner notification
16 services.

17 (B) Health care provided under this para-
18 graph shall be consistent with current Depart-
19 ment of Health and Human Services guidelines
20 and standard medical practice. Health care per-
21 sonnel shall discuss treatment options, the im-
22 portance of adherence to antiretroviral therapy,
23 and the side effects of medications with inmates
24 receiving treatment.

1 (C) Health care personnel and pharmacy
2 personnel shall ensure that the facility for-
3 mulary contains all Food and Drug Administra-
4 tion-approved medications necessary to provide
5 comprehensive treatment for inmates living with
6 HIV/AIDS, and that the facility maintains ade-
7 quate supplies of such medications to meet in-
8 mates' medical needs. Health care personnel
9 and pharmacy personnel shall also develop and
10 implement automatic renewal systems for these
11 medications to prevent interruptions in care.

12 (D) Correctional staff, health care per-
13 sonnel, and pharmacy personnel shall develop
14 and implement distribution procedures to en-
15 sure timely and confidential access to medica-
16 tions.

17 (7) PROTECTION OF CONFIDENTIALITY.—

18 (A) Health care personnel shall develop
19 and implement procedures to ensure the con-
20 fidentiality of inmate tests, diagnoses, and
21 treatment. Health care personnel and correc-
22 tional staff shall receive regular training on the
23 implementation of these procedures. Penalties
24 for violations of inmate confidentiality by health

1 care personnel or correctional staff shall be
2 specified and strictly enforced.

3 (B) HIV testing, counseling, and treat-
4 ment shall be provided in a confidential setting
5 where other routine health services are provided
6 and in a manner that allows the inmate to re-
7 quest and obtain these services as routine med-
8 ical services.

9 (8) TESTING, COUNSELING, AND REFERRAL
10 PRIOR TO REENTRY.—

11 (A) Health care personnel shall provide
12 routine HIV testing to all inmates no more
13 than 3 months prior to their release and re-
14 entry into the community. (Inmates who are al-
15 ready known to be infected need not be tested
16 again.) This requirement may be waived if an
17 inmate's release occurs without sufficient notice
18 to the Bureau to allow health care personnel to
19 perform a routine HIV test and notify the in-
20 mate of the results.

21 (B) All HIV tests under this paragraph
22 shall comply with the opt-out provision.

23 (C) To all inmates who test positive for
24 HIV and all inmates who already are known to

1 have HIV/AIDS, health care personnel shall
2 provide—

3 (i) confidential prerelease counseling
4 on managing their medical condition in the
5 community, accessing appropriate treat-
6 ment and services in the community, and
7 preventing the transmission of their condi-
8 tion to family members and other persons
9 in the community;

10 (ii) referrals to appropriate health
11 care providers and social service agencies
12 in the community that meet the inmate's
13 individual needs, including voluntary part-
14 ner notification services and prevention
15 counseling services for people living with
16 HIV/AIDS; and

17 (iii) a 30-day supply of any medically
18 necessary medications the inmate is cur-
19 rently receiving.

20 (9) OPT-OUT PROVISION.—Inmates shall have
21 the right to refuse routine HIV testing. Inmates
22 shall be informed both orally and in writing of this
23 right. Oral and written disclosure of this right may
24 be included with other general health information
25 and counseling provided to inmates by health care

1 personnel. If an inmate refuses a routine test for
2 HIV, health care personnel shall make a note of the
3 inmate's refusal in the inmate's confidential medical
4 records. However, the inmate's refusal shall not be
5 considered a violation of prison rules or result in dis-
6 ciplinary action. Any reference in this section to the
7 "opt-out provision" shall be deemed a reference to
8 the requirement of this paragraph.

9 (10) EXCLUSION OF TESTS PERFORMED UNDER
10 SECTION 4014(b) FROM THE DEFINITION OF ROUTINE
11 HIV TESTING.—HIV testing of an inmate under sec-
12 tion 4014(b) of title 18, United States Code, is not
13 routine HIV testing for the purposes of the opt-out
14 provision. Health care personnel shall document the
15 reason for testing under section 4014(b) of title 18,
16 United States Code, in the inmate's confidential
17 medical records.

18 (11) TIMELY NOTIFICATION OF TEST RE-
19 SULTS.—Health care personnel shall provide timely
20 notification to inmates of the results of HIV tests.

21 (g) CHANGES IN EXISTING LAW.—

22 (1) SCREENING IN GENERA.—Section 4014(a)
23 of title 18, United States Code, is amended—

24 (A) by striking "for a period of 6 months
25 or more";

1 (B) by striking “, as appropriate,”; and

2 (C) by striking “if such individual is deter-
3 mined to be at risk for infection with such virus
4 in accordance with the guidelines issued by the
5 Bureau of Prisons relating to infectious disease
6 management” and inserting “unless the indi-
7 vidual declines. The Attorney General shall also
8 cause such individual to be so tested before re-
9 lease unless the individual declines.”.

10 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
11 CIVIL AND CRIMINAL PROCEEDINGS.—Section
12 4014(d) of title 18, United States Code, is amended
13 by inserting “or under the Stop AIDS in Prison
14 Act” after “under this section”.

15 (3) SCREENING AS PART OF ROUTINE SCREEN-
16 ING.—Section 4014(e) of title 18, United States
17 Code, is amended by adding at the end the fol-
18 lowing: “Such rules shall also provide that the initial
19 test under this section be performed as part of the
20 routine health screening conducted at intake.”.

21 (h) REPORTING REQUIREMENTS.—

22 (1) REPORT ON HEPATITIS AND OTHER DIS-
23 EASES.—Not later than 1 year after the date of the
24 enactment of this Act, the Bureau shall provide a re-
25 port to the Congress on Bureau policies and proce-

1 dures to provide testing, treatment, and prevention
2 education programs for hepatitis and other diseases
3 transmitted through sexual activity and intravenous
4 drug use. The Bureau shall consult with appropriate
5 officials of the Department of Health and Human
6 Services, the Office of National Drug Control Policy,
7 the Office of National AIDS Policy, and the Centers
8 for Disease Control and Prevention regarding the
9 development of this report.

10 (2) ANNUAL REPORTS.—

11 (A) GENERALLY.—Not later than 2 years
12 after the date of the enactment of this Act, and
13 then annually thereafter, the Bureau shall re-
14 port to Congress on the incidence among in-
15 mates of diseases transmitted through sexual
16 activity and intravenous drug use.

17 (B) MATTERS PERTAINING TO VARIOUS
18 DISEASES.—Reports under paragraph (1) shall
19 discuss—

20 (i) the incidence among inmates of
21 HIV/AIDS, hepatitis, and other diseases
22 transmitted through sexual activity and in-
23 travenous drug use; and

1 (ii) updates on Bureau testing, treat-
2 ment, and prevention education programs
3 for these diseases.

4 (C) MATTERS PERTAINING TO HIV/AIDS
5 ONLY.—Reports under paragraph (1) shall also
6 include—

7 (i) the number of inmates who tested
8 positive for HIV upon intake;

9 (ii) the number of inmates who tested
10 positive prior to reentry;

11 (iii) the number of inmates who were
12 not tested prior to reentry because they
13 were released without sufficient notice;

14 (ix) the number of inmates who opted-
15 out of taking the test;

16 (x) the number of inmates who were
17 tested under section 4014(b) of title 18,
18 United States Code; and

19 (xi) the number of inmates under
20 treatment for HIV/AIDS.

21 (D) CONSULTATION.—The Bureau shall
22 consult with appropriate officials of the Depart-
23 ment of Health and Human Services, the Office
24 of National Drug Control Policy, the Office of
25 National AIDS Policy, and the Centers for Dis-

1 ease Control and Prevention regarding the de-
2 velopment of reports under paragraph (1).

3 **SEC. 762. SUPPORT DATA SYSTEM REVIEW AND INDICA-**
4 **TORS FOR MONITORING HIV CARE.**

5 The Secretary of Health and Human Services, in col-
6 laboration with the Assistant Secretary for Health, the Di-
7 rector of the Office of HIV/AIDS and Infectious Disease
8 Policy, the Director of the Centers for Disease Control and
9 Prevention, the Administrator of the Substance Abuse and
10 Mental Health Services Administration, the Director of
11 the Department of Housing and Urban Development, the
12 Director of the Office of AIDS Research, the Adminis-
13 trator of the Health Resources and Services Administra-
14 tion, and the Administrator of the Centers for Medicare
15 & Medicaid Services, shall expand and coordinate efforts
16 to align metrics across agencies and modify Federal data
17 systems, to—

18 (1) adopt the Institute of Medicine’s clinical
19 HIV care indicators as the core metrics for moni-
20 toring the quality of HIV care, mental health, sub-
21 stance abuse, and supportive services;

22 (2) better enable assessment of the impact of
23 the National HIV/AIDS Strategy and the Patient
24 Protection and Affordable Care Act on improving

1 HIV/AIDS care and access to supportive services for
2 individuals with HIV;

3 (3) expand the demographic data elements to be
4 captured by Federal data systems relevant to HIV
5 care to permit calculation of the indicators for sub-
6 groups of the population of people with diagnosed
7 HIV infection, including—

8 (A) age;

9 (B) race;

10 (C) ethnicity;

11 (D) sex (assigned at birth);

12 (E) gender identity;

13 (F) sexual orientation;

14 (G) current geographic marker of resi-
15 dence;

16 (H) income or poverty level; and

17 (I) primary means of reimbursement for
18 medical services (including Medicaid, Medicare,
19 the Ryan White HIV/AIDS Program, private
20 insurance, health maintenance organizations,
21 and no coverage); and

22 (4) streamline data collection and systematically
23 review all existing reporting requirements for feder-
24 ally funded HIV/AIDS programs to ensure that only
25 essential data are collected.

1 **SEC. 763. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**
2 **NATIONAL HIV/AIDS STRATEGY.**

3 Title II of the Public Health Service Act (42 U.S.C.
4 202 et seq.) is amended by inserting after section 241 the
5 following:

6 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
7 **OF NATIONAL HIV/AIDS STRATEGY.**

8 “(a) TRANSFER AUTHORIZATION.—Of the discre-
9 tionary appropriations made available to the Department
10 of Health and Human Services for any fiscal year for pro-
11 grams and activities that, as determined by the Secretary
12 of Health and Human Services, pertain to HIV/AIDS, the
13 Secretary, in coordination with the Director of the Office
14 of National HIV/AIDS Policy, may transfer up to 1 per-
15 cent of such appropriations to the Office of the Assistant
16 Secretary for Health for implementation of the National
17 HIV/AIDS Strategy.

18 “(b) CONGRESSIONAL NOTIFICATION.—Not less than
19 30 days before making any transfer under this section,
20 the Secretary shall give notice of the transfer to the Con-
21 gress.

22 “(c) DEFINITIONS.—In this section:

23 “(1) The term ‘HIV/AIDS’ has the meaning
24 given to such term in section 2689.

25 “(2) The term ‘National HIV/AIDS Strategy’
26 means the National HIV/AIDS Strategy for the

1 United States issued by the President in July 2010
2 and includes any subsequent revisions to such Strat-
3 egy.”.

4 **SEC. 764. HIV INTEGRATED SERVICES DELIVERY MODEL**
5 **DEMONSTRATION.**

6 (a) IN GENERAL.—Consistent with the National
7 HIV/AIDS Strategy for the United States and in accord-
8 ance with this section, the Secretary of Health and
9 Human Services acting through the Center for Medicare
10 & Medicaid Innovation and in cooperation with CDC,
11 HRSA, SAMHSA, and HUD, shall conduct a 3-year dem-
12 onstration project that is designed to integrate services
13 and funding under the Medicare and Medicaid programs,
14 under HIV-related programs conducted by the CDC, and
15 under the Ryan White HIV/AIDS Program, to reduce new
16 HIV infections, to increase the proportion of people who
17 know their status, to increase access to care, to improve
18 health outcomes, to reduce HIV-related health disparities
19 among Medicaid and Medicare beneficiaries, and to reduce
20 the cost of care provided to HIV positive Medicare and
21 Medicaid beneficiaries.

22 (b) OBJECTIVES.—The objectives of the demonstra-
23 tion are the following:

24 (1) To ensure the early identification of HIV
25 positive beneficiaries to reduce costly HIV-related

1 clinical conditions through HIV screening and rapid
2 linkage to high quality HIV medical care.

3 (2) To reduce new HIV infections among Med-
4 icaid and Medicare beneficiaries through routine
5 HIV testing, prevention services for HIV negative
6 beneficiaries, and intensive “prevention for positive”
7 services for HIV positive beneficiaries.

8 (3) To reduce morbidity, mortality, and high
9 cost inpatient and specialty care among HIV positive
10 beneficiaries by ensuring access to high quality HIV
11 medical care, HIV medications, and support services.

12 (4) To promote HIV treatment adherence and
13 retention in care through intensive case manage-
14 ment, treatment education, and outreach services.

15 (5) To effectively treat behavioral health condi-
16 tions among HIV positive beneficiaries that impair
17 their HIV treatment adherence and lead to sec-
18 ondary HIV infections through services funded
19 under Medicare and Medicaid and programs admin-
20 istered by SAMHSA.

21 (6) To promote independence, treatment adher-
22 ence, and stable housing for HIV positive bene-
23 ficiaries through highly coordinated HIV health,
24 housing, and support services funded by HRSA and
25 HUD.

1 (c) DEMONSTRATION DESIGN.—

2 (1) IN GENERAL.—The Secretary shall design
3 the demonstration to test both—

4 (A) the service delivery model described in
5 paragraph (2); and

6 (B) the payment model described in para-
7 graph (3).

8 (2) SERVICE DELIVERY MODEL.—

9 (A) IN GENERAL.—Under the service deliv-
10 ery model described in this paragraph, the dem-
11 onstration shall test comprehensive HIV test-
12 ing, linkage to care, HIV medical care, and an-
13 cillary services to individuals enrolled under
14 Medicare, Medicaid, or both. The service deliv-
15 ery model will integrate services furnished
16 under Medicare and Medicaid with prevention
17 services funded by CDC for HIV positive bene-
18 ficiaries, intensive case management services
19 funded by HRSA, behavioral services funded by
20 SAMHSA, and housing assistance services
21 funded through HUD.

22 (B) CORE ELEMENTS.—The model under
23 this paragraph shall have the following 8 core
24 elements:

1 (i) HIV testing services that apply the
2 CDC's 2006 recommendations for uni-
3 versal opt-out testing among Medicare and
4 Medicaid beneficiary populations.

5 (ii) Rapid linkage from HIV testing
6 settings to treatment for HIV positive
7 beneficiaries to ensure they are engaged in
8 care in a timely basis.

9 (iii) Access to high quality HIV expe-
10 rienced medical care, laboratory moni-
11 toring, HIV medications, and other re-
12 quired services.

13 (iv) Routine screening and treatment
14 for HIV-related and other chronic condi-
15 tions, including behavioral health.

16 (v) Prevention and treatment edu-
17 cation services, including an adapted Medi-
18 cation Therapy Management (MTM) pro-
19 gram model, to optimize the benefit of
20 HIV therapeutics.

21 (vi) Risk-stratified medical case man-
22 agement.

23 (vii) Provision of preventive care, in-
24 cluding counseling to prevent secondary
25 HIV infection.

1 (viii) Wrap-around support and hous-
2 ing services.

3 (3) PAYMENT MODEL.—Under the payment
4 model described in this paragraph, the demonstra-
5 tion shall test the following:

6 (A) A prepaid capitated payment model
7 that adjusts payment for HIV and behavioral
8 health acuity, to be applied under contracts
9 with managed care organizations with dem-
10 onstrated HIV experience.

11 (B) Use of funds under the Ryan White
12 HIV/AIDS Program to purchase capitated serv-
13 ices from the contracted managed care organi-
14 zations.

15 (C) Provision of additional funds to sup-
16 port services to the extent that Medicaid and
17 Medicare coverage is limited, including for serv-
18 ices such as HIV testing (for Medicaid bene-
19 ficiaries), medical case management, prevention
20 case management, treatment education, case
21 finding, behavioral health services, and housing
22 assistance.

23 (d) BENEFICIARY CRITERIA.—Beneficiaries eligible
24 for participation in the demonstration are the following:

1 (1) MEDICAID FFS BENEFICIARIES.—Fee-for-
2 service Medicaid beneficiaries 18 years of age or
3 older.

4 (2) DUAL ELIGIBLES.—Individuals who are—
5 (A) entitled to medical assistance under
6 Medicaid; and
7 (B) entitled to benefits under part A, and
8 enrolled under part B, of Medicare but are not
9 enrolled under a Medicare Advantage plan
10 under Medicare.

11 (e) ROLES AND RESPONSIBILITIES IN DEMONSTRA-
12 TION.—

13 (1) IN GENERAL.—Consistent with the National
14 HIV/AIDS Strategy for the United States, Federal
15 agencies shall coordinate their funding for the se-
16 lected States or cities covered under the demonstra-
17 tion to provide resources to fund the delivery of serv-
18 ices within the demonstration.

19 (2) HHS.—In carrying out the demonstration,
20 the Secretary shall—

21 (A) design the application process;
22 (B) solicit applications from 5 to 7 State
23 Medicaid agencies to host the demonstration;
24 (C) with respect to the service delivery
25 model described in subsection (c)(2), collaborate

1 with the CDC, HRSA, and the National Insti-
2 tutes of Health to design a minimum service de-
3 livery model that reflects the current standard
4 of care as established by the Public Health
5 Service and CDC guidelines and recommenda-
6 tions; and

7 (D) fund an evaluation of the demonstra-
8 tion to ensure collection of system, provider,
9 and beneficiary-level data to address their rou-
10 tine reporting requirements.

11 The Secretary may carry out the Secretary's author-
12 ity under this paragraph through CMMI.

13 (3) CDC.—The CDC shall collaborate with the
14 Secretary and CDC-funded HIV prevention grantees
15 in the selected States and cities to provide technical
16 assistance to design cost-effective HIV and sexually
17 transmitted infection (STI) screening and testing
18 services for Medicaid and Medicare beneficiaries, in-
19 cluding partner notification services and commu-
20 nicable disease reporting. CDC and CMS shall deter-
21 mine the extent to which testing funds shall be sup-
22 ported jointly or separately by these agencies.

23 (4) HRSA.—HRSA shall allocate funds avail-
24 able through the Special Projects of National Sig-
25 nificance (SPNS) Initiative Program (under subpart

1 I of part F of the Ryan White HIV/AIDS Program)
2 to support wrap-around core and support services
3 not covered under Medicare or Medicaid and shall
4 authorize the use of Ryan White HIV/AIDS Pro-
5 gram funds to purchase services through capitated
6 managed care programs that meet or exceed the
7 services covered by the Ryan White HIV/AIDS Pro-
8 gram at rates that are no greater than current per
9 capita expenditures. HRSA is authorized to use
10 funds under SPNS, and to waive such requirements
11 of SPNS as may be necessary, to carry out the dem-
12 onstration.

13 (5) SAMHSA.—SAMHSA shall allocate funds
14 through the Minority HIV/AIDS Initiative or other
15 programs to support behavioral health services not
16 covered under Medicare or Medicaid.

17 (6) HOPWA.—HUD shall directly allocate
18 funds under the Housing Opportunities for People
19 With AIDS (HOPWA) program to the States or cit-
20 ies participating in the demonstration to provide
21 supportive housing and other housing assistance to
22 beneficiaries who otherwise meet HOPWA eligibility
23 criteria. HUD is authorized to use such HOPWA
24 funds, and to waive such requirements under

1 HOPWA as may be necessary, to carry out the dem-
2 onstration.

3 (7) STATE MEDICAID AGENCIES.—Single State
4 agencies responsible for administration of the Med-
5 icaid program for individuals who are accepted to
6 participate in the demonstration shall—

7 (A) collaborate with CMS to design or re-
8 fine a prepaid capitated payment model, to allo-
9 cate and award contracts with capitated man-
10 aged care plans, to ensure such plans meet
11 State statutory or regulatory requirements, to
12 contract with a coordinating agency to organize
13 and deliver integrated HIV testing, medical
14 care, support, and housing services funded
15 under Medicare and Medicaid, other Federal,
16 State, and local government sponsors, and to
17 coordinate their activities with the State HIV/
18 AIDS program; and

19 (B) identify and contract with a coordi-
20 nating agency to organize the demonstration in
21 the State, to establish a coordinating body rep-
22 resenting State, local, and provider agencies
23 participating in the demonstration, to establish
24 systems of care that integrate HIV prevention,
25 testing, treatment, support, and housing serv-

1 ices, to establish mechanisms to gather evalua-
2 tion data for reporting to CMMI and other par-
3 ticipating Federal agencies, and to establish a
4 quality management program to monitor pro-
5 vider performance in delivering the services pro-
6 vided to participating beneficiaries under the
7 demonstration.

8 (8) MANAGED CARE ORGANIZATIONS.—

9 Capitated managed care organizations participating
10 in the demonstration shall organize and deliver serv-
11 ices as specified by the minimum service delivery
12 model established by CMMI through a network of
13 providers with demonstrated HIV experience, high
14 quality, and sufficient provider capacity.

15 (f) DEFINITIONS.—In this section:

16 (1) CDC.—The term “CDC” means the Direc-
17 tor of the Centers for Disease Control and Preven-
18 tion.

19 (2) CMMI.—The term “CMMI” means the Di-
20 rector of the Center for Medicare & Medicaid Inno-
21 vation.

22 (3) CMS.—The term “CMS” means the Ad-
23 ministrator of the Centers for Medicare & Medicaid
24 Services.

1 (4) DEMONSTRATION.—The term “demonstra-
2 tion” means the demonstration conducted under this
3 section.

4 (5) HRSA.—The term “HRSA” means the Ad-
5 ministrator of the Health Resources and Services
6 Administration.

7 (6) HUD.—The term “HUD” means the Sec-
8 retary of Housing and Urban Development.

9 (7) MEDICARE; MEDICAID.—The terms “Medi-
10 care” and “Medicaid” mean the programs under ti-
11 tles XVIII and XIX, respectively, of the Social Secu-
12 rity Act.

13 (8) NATIONAL HIV/AIDS STRATEGY FOR THE
14 UNITED STATES.—The term “National HIV/AIDS
15 Strategy for the United States” has the meaning
16 given such term under section 241A(b) of the Public
17 Health Service Act.

18 (9) RYAN WHITE HIV/AIDS PROGRAM.—The
19 term “Ryan White HIV/AIDS Program” means the
20 program under title XXVI of the Public Health
21 Service Act.

22 (10) SAMHSA.—The term “SAMHSA” means
23 the Substance Abuse and Mental Health Services
24 Administration.

1 (11) SECRETARY.—The term “Secretary”
2 means the Secretary of Health and Human Services,
3 acting through CMMI.

4 **SEC. 765. REPORT ON THE IMPLEMENTATION OF GOAL 4**
5 **(IMPROVED COORDINATION) OF THE NA-**
6 **TIONAL HIV/AIDS STRATEGY.**

7 (a) REPORT REQUIRED.—The President, in consulta-
8 tion with the heads of all relevant Federal departments
9 and agencies including the Department of Education, the
10 Department of Health and Human Services, the Depart-
11 ment of Housing and Urban Development, the Depart-
12 ment of Justice, the Department of Labor, the Depart-
13 ment of Veteran Affairs, and the Social Security Adminis-
14 tration, shall transmit to the Congress and make publicly
15 available a report on the status of implementation of Goal
16 4 of the National HIV/AIDS Strategy.

17 (b) CONTENTS.—The report required by subsection
18 (a) shall include a description, an analysis, and an evalua-
19 tion of—

20 (1) the extent to which the National HIV/AIDS
21 Strategy has improved coordination of efforts, en-
22 hanced capacity, and strengthened infrastructure in
23 order to maximize the effective delivery of HIV/
24 AIDS prevention, care, and treatment services at the
25 community level, including coordination—

1 (A) within and among Federal agencies
2 and departments;

3 (B) between the Federal Government and
4 State and local governments and health depart-
5 ments;

6 (C) between the Federal Government and
7 nonprofit foundations and civil society organiza-
8 tions, including community- and faith-based or-
9 ganizations focused on addressing the issue of
10 HIV/AIDS; and

11 (D) between the Federal Government and
12 private businesses; and

13 (2) efforts by the Federal Government to edu-
14 cate, involve, and establish and strengthen partner-
15 ships with civil society organizations, including
16 community- and faith-based organizations, in order
17 to implement the National HIV/AIDS Strategy and
18 achieve its goals.

19 (c) DEFINITION.—In this section, the term “National
20 HIV/AIDS Strategy” means the National HIV/AIDS
21 Strategy for the United States issued by the President in
22 July 2010 and includes any subsequent revisions to such
23 Strategy.

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 the Congress,
13 not later than 1 year after the date of enact-
14 ment of this section, an effective and com-
15 prehensive Federal plan (including all appro-
16 priate Federal health programs) to address
17 prediabetes and diabetes in minority popu-
18 lations.

19 “(2) CONTENTS.—The report under paragraph
20 (1)(A) shall at minimum address each of the fol-
21 lowing:

22 “(A) Research on diabetes and prediabetes
23 in minority populations, including such research
24 on—

1 “(i) genetic, behavioral, and environ-
2 mental factors; and

3 “(ii) prevention and complications
4 among individuals within these populations
5 who have already developed diabetes.

6 “(B) Surveillance and data collection on
7 diabetes and prediabetes in minority popu-
8 lations, including with respect to—

9 “(i) efforts to better determine the
10 prevalence of diabetes among Asian-Amer-
11 ican and Pacific Islander subgroups; and

12 “(ii) efforts to coordinate data collec-
13 tion on the American Indian population.

14 “(C) Community-based interventions to ad-
15 dress diabetes and prediabetes targeting minor-
16 ity populations, including—

17 “(i) the evidence base for such inter-
18 ventions;

19 “(ii) the cultural appropriateness of
20 such interventions; and

21 “(iii) efforts to educate the public on
22 the causes and consequences of diabetes.

23 “(D) Education and training programs for
24 health professionals (including community
25 health workers) on the prevention and manage-

1 ment of diabetes and its related complications
2 that is supported by the Health Resources and
3 Services Administration, including such pro-
4 grams supported by—

5 “(i) the National Health Service
6 Corps; or

7 “(ii) the community health centers
8 program under section 330.

9 “(d) EDUCATION.—The Director of NIH shall—

10 “(1) through the National Institute on Minority
11 Health and Health Disparities and the National Di-
12 abetes Education Program—

13 “(A) make grants to programs funded
14 under section 464z-4 (relating to centers of ex-
15 cellence) for the purpose of establishing a men-
16 toring program for health care professionals to
17 be more involved in weight counseling, obesity
18 research, and nutrition; and

19 “(B) provide for the participation of mi-
20 nority health professionals in diabetes-focused
21 research programs; and

22 “(2) make grants for programs to establish a
23 pipeline from high school to professional school that
24 will increase minority representation in diabetes-fo-
25 cused health fields by expanding Minority Access to

1 Research Careers (MARC) program internships and
2 mentoring opportunities for recruitment.

3 “(e) DEFINITIONS.—For purposes of this section:

4 “(1) The ‘Diabetes Mellitus Interagency Coordinating
5 Committee’ means the Diabetes Mellitus
6 Interagency Coordinating Committee established
7 under section 429.

8 “(2) The term ‘minority population’ means a
9 racial and ethnic minority group, as defined in section
10 1707.”.

11 **SEC. 772. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

12 Part B of title III of the Public Health Service Act
13 (42 U.S.C. 243 et seq.) is amended by inserting after section
14 317T the following section:

15 **“SEC. 317U. DIABETES IN MINORITY POPULATIONS.**

16 “(a) RESEARCH AND OTHER ACTIVITIES.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Director of the Centers for Disease
19 Control and Prevention, shall conduct and support
20 research and public health activities with respect to
21 diabetes in minority populations.

22 “(2) CERTAIN ACTIVITIES.—Activities under
23 paragraph (1) regarding diabetes in minority populations
24 shall include the following:

1 “(A) Further enhancing the National
2 Health and Nutrition Examination Survey by
3 over-sampling Asian-American, Native Hawai-
4 ian, and Other Pacific Islanders in appropriate
5 geographic areas to better determine the preva-
6 lence of diabetes in such populations as well as
7 to improve the data collection of diabetes pene-
8 tration disaggregated into major ethnic groups
9 within such populations. The Secretary shall en-
10 sure that any such oversampling does not re-
11 duce the oversampling of other minority popu-
12 lations including African-American and Latino
13 populations.

14 “(B) Through the Division of Diabetes
15 Translation—

16 “(i) providing for prevention research
17 to better understand how to influence
18 health care systems changes to improve
19 quality of care being delivered to such pop-
20 ulations;

21 “(ii) carrying out model demonstra-
22 tion projects to design, implement, and
23 evaluate effective diabetes prevention and
24 control interventions for minority popu-

1 lations, including culturally appropriate
2 community-based interventions;

3 “(iii) developing and implementing a
4 strategic plan to reduce diabetes in minor-
5 ity populations through applied research to
6 reduce disparities and culturally and lin-
7 guistically appropriate community-based
8 interventions;

9 “(iv) supporting, through the national
10 diabetes prevention program under section
11 399V–3, diabetes prevention program sites
12 in underserved regions highly impacted by
13 diabetes; and

14 “(v) implementing, through the na-
15 tional diabetes prevention program under
16 section 399V–3, a demonstration program
17 developing new metrics measuring health
18 outcomes related to diabetes that can be
19 stratified by specific minority populations.

20 “(b) EDUCATION.—The Secretary, acting through
21 the Director of the Centers for Disease Control and Pre-
22 vention, shall direct the Division of Diabetes Translation
23 to conduct and support both programs to educate the pub-
24 lic on diabetes in minority populations and programs to

1 educate minority populations about the causes and effects
2 of diabetes.

3 “(c) **DIABETES; HEALTH PROMOTION, PREVENTION**
4 **ACTIVITIES, AND ACCESS.**—The Secretary, acting through
5 the Director of the Centers for Disease Control and Pre-
6 vention and the National Diabetes Education Program,
7 shall conduct and support programs to educate specific
8 minority populations through culturally appropriate and
9 linguistically appropriate information campaigns about
10 prevention of, and managing, diabetes.

11 “(d) **DEFINITION.**—For purposes of this section, the
12 term ‘minority population’ means a racial and ethnic mi-
13 nority group, as defined in section 1707.”.

14 **SEC. 773. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

15 Part P of title III of the Public Health Service Act
16 (42 U.S.C. 280g et seq.), as amended, is further amended
17 by adding at the end the following new section:

18 **“SEC. 399V-7. PROGRAMS TO EDUCATE HEALTH PRO-**
19 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
20 **ABETES IN MINORITY POPULATIONS.**

21 “(a) **IN GENERAL.**—The Secretary, acting through
22 the Director of the Health Resources and Services Admin-
23 istration, shall conduct and support programs described
24 in subsection (b) to educate health professionals on the
25 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) 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, Centers for Excel-
14 lence, and the Minority Faculty Fellowship Program
15 to partner with the Office of Minority Health under
16 section 1707 and the National Institutes of Health
17 to strengthen programs for career opportunities fo-
18 cused on diabetes treatment and care within under-
19 served 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, is further amended
8 by adding at the end the following section:

9 **“SEC. 399V-8. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
10 **TIES REGARDING DIABETES IN AMERICAN IN-**
11 **DIAN POPULATIONS.**

12 “In addition to activities under sections 317V-6 and
13 434B, the Secretary, acting through the Indian Health
14 Service and in collaboration with other appropriate Fed-
15 eral agencies, shall—

16 “(1) conduct and support research and other
17 activities with respect to diabetes; and

18 “(2) coordinate the collection of data on clini-
19 cally and culturally appropriate diabetes treatment,
20 care, prevention, and services by health care profes-
21 sionals to the American Indian population.”.

22 **SEC. 775. UPDATED REPORT ON HEALTH DISPARITIES.**

23 The Secretary of Health and Human Services shall
24 seek to enter into an arrangement with the Institute of
25 Medicine under which the Institute will—

1 (1) not later than 1 year after the date of en-
2 actment of this Act, submit to the Congress an up-
3 dated version of the Institute’s 2002 report entitled
4 “Unequal Treatment: Confronting Racial and Ethnic
5 Disparities in Health Care”; and

6 (2) in such updated version, address how racial
7 and ethnic health disparities have changed since the
8 publication of the original report.

9 **Subtitle G—Lung Disease**

10 **SEC. 776. EXPANSION OF THE NATIONAL ASTHMA EDU-** 11 **CATION AND PREVENTION PROGRAM.**

12 (a) IN GENERAL.—Not later than 2 years after the
13 date of the enactment of this Act, the Secretary of Health
14 and Human Services shall convene a working group com-
15 prised of patient groups, nonprofit organizations, medical
16 societies, and other relevant governmental and nongovern-
17 mental entities, including those that participate in the Na-
18 tional Asthma Education and Prevention Program, to de-
19 velop a report to Congress that—

20 (1) catalogs, with respect to asthma prevention,
21 management, and surveillance—

22 (A) the activities of the Federal Govern-
23 ment, including identifying all Federal pro-
24 grams that carry out asthma-related activities,
25 as well as assessment of the progress of the

1 Federal Government and States, with respect to
2 achieving the goals of the Healthy People 2020
3 initiative; and

4 (B) the activities of other entities that par-
5 ticipate in the program, including nonprofit or-
6 ganizations, patient advocacy groups, and med-
7 ical societies; and

8 (2) makes recommendations for the future di-
9 rection of asthma activities, in consultation with re-
10 searchers from the National Institutes of Health and
11 other member bodies of the National Asthma Edu-
12 cation and Prevention Program who are qualified to
13 review and analyze data and evaluate interventions,
14 including—

15 (A) description of how the Federal Govern-
16 ment may better coordinate and improve its re-
17 sponse to asthma including identifying any bar-
18 riers that may exist;

19 (B) description of how the Federal Govern-
20 ment may continue, expand, and improve its
21 private-public partnerships with respect to asth-
22 ma including identifying any barriers that may
23 exist;

24 (C) identification of steps that may be
25 taken to reduce the—

- 1 (i) morbidity, mortality, and overall
2 prevalence of asthma;
- 3 (ii) financial burden of asthma on so-
4 ciety;
- 5 (iii) burden of asthma on dispro-
6 tionately affected areas, particularly those
7 in medically underserved populations (as
8 defined in section 330(b)(3) of the Public
9 Health Service Act (42 U.S.C.
10 254b(b)(3))); and
- 11 (iv) burden of asthma as a chronic
12 disease;
- 13 (D) identification of programs and policies
14 that have achieved the steps described in sub-
15 paragraph (C), and steps that may be taken to
16 expand such programs and policies to benefit
17 larger populations; and
- 18 (E) recommendations for future research
19 and interventions.
- 20 (b) REPORT TO CONGRESS.—At the end of the 5-year
21 period following the submission of the report under sub-
22 section (a), the National Asthma Education and Preven-
23 tion Program shall evaluate the analyses and rec-
24 ommendations under such report and determine whether

1 a new report to the Congress is necessary, and make ap-
2 propriate recommendations to the Congress.

3 **SEC. 777. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
4 **FOR DISEASE CONTROL AND PREVENTION.**

5 Section 317I of the Public Health Service Act (42
6 U.S.C. 247b–10) is amended to read as follows:

7 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
8 **FOR DISEASE CONTROL AND PREVENTION.**

9 “(a) PROGRAM FOR PROVIDING INFORMATION AND
10 EDUCATION TO THE PUBLIC.—The Secretary, acting
11 through the Director of the Centers for Disease Control
12 and Prevention, shall collaborate with State and local
13 health departments to conduct activities, including the
14 provision of information and education to the public re-
15 garding asthma including—

16 “(1) deterring the harmful consequences of un-
17 controlled asthma; and

18 “(2) disseminating health education and infor-
19 mation regarding prevention of asthma episodes and
20 strategies for managing asthma.

21 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—
22 The Secretary, acting through the Director of the Centers
23 for Disease Control and Prevention, shall collaborate with
24 State and local health departments to develop State plans
25 incorporating public health responses to reduce the burden

1 of asthma, particularly regarding disproportionately af-
2 fected populations.

3 “(c) COMPILATION OF DATA.—The Secretary, acting
4 through the Director of the Centers for Disease Control
5 and Prevention, shall, in cooperation with State and local
6 public health officials—

7 “(1) conduct asthma surveillance activities to
8 collect data on the prevalence and severity of asth-
9 ma, the effectiveness of public health asthma inter-
10 ventions, and the quality of asthma management, in-
11 cluding—

12 “(A) collection of household data on the
13 local burden of asthma;

14 “(B) surveillance of health care facilities;
15 and

16 “(C) collection of data not containing indi-
17 vidually identifiable information from electronic
18 health records or other electronic communica-
19 tions;

20 “(2) compile and annually publish data regard-
21 ing the prevalence and incidence of childhood asth-
22 ma, the child mortality rate, and the number of hos-
23 pital admissions and emergency department visits by
24 children associated with asthma nationally and in
25 each State and at the county level by age, sex, race,

1 and ethnicity, as well as lifetime and current preva-
2 lence; and

3 “(3) compile and annually publish data regard-
4 ing the prevalence and incidence of adult asthma,
5 the adult mortality rate, and the number of hospital
6 admissions and emergency department visits by
7 adults associated with asthma nationally and in each
8 State and at the county level by age, sex, race, eth-
9 nicity, industry, and occupation, as well as lifetime
10 and current prevalence.

11 “(d) COORDINATION OF DATA COLLECTION.—The
12 Director of the Centers for Disease Control and Preven-
13 tion, in conjunction with State and local health depart-
14 ments, shall coordinate data collection activities under
15 subsection (c)(2) so as to maximize comparability of re-
16 sults.

17 “(e) COLLABORATION.—The Centers for Disease
18 Control and Prevention are encouraged to collaborate with
19 national, State, and local nonprofit organizations to pro-
20 vide information and education about asthma, and to
21 strengthen such collaborations when possible.

22 “(f) ADDITIONAL FUNDING.—In addition to any
23 other authorization of appropriations that is available to
24 the Centers for Disease Control and Prevention for the
25 purpose of carrying out this section, there are authorized

1 to be appropriated to such Centers such sums as may be
2 necessary for each of fiscal years 2015 through 2019 for
3 the purpose of carrying out this section.”.

4 **SEC. 778. INFLUENZA AND PNEUMONIA VACCINATION CAM-**
5 **PAIGN.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall—

8 (1) enhance the annual campaign by the De-
9 partment of Health and Human Services to increase
10 the number of people vaccinated each year for influ-
11 enza and pneumonia; and

12 (2) include in such campaign the use of written
13 educational materials, public service announcements,
14 physician education, and any other means which the
15 Secretary deems effective.

16 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
17 out the annual campaign described in subsection (a), the
18 Secretary of Health and Human Services shall ensure
19 that—

20 (1) educational materials and public service an-
21 nouncements are readily and widely available in
22 communities experiencing disparities in the incidence
23 and mortality rates of influenza and pneumonia; and

1 providers, public health professionals, and other
2 stakeholders.

3 (2) CONTENTS.—At a minimum, such plan
4 shall include recommendations for—

5 (A) public health interventions for the pur-
6 pose of implementation of the national plan;

7 (B) biomedical, health services, and public
8 health research on chronic obstructive pul-
9 monary disease; and

10 (C) inclusion of chronic obstructive pul-
11 monary disease in the health data collections of
12 all Federal agencies.

13 (3) CONSIDERATION.—In developing such plan,
14 the Director of the National Heart, Lung, and Blood
15 Institute shall consider the recommendations and
16 findings of the Institute of Medicine in the report
17 entitled “A Nationwide Framework for Surveillance
18 of Cardiovascular and Chronic Lung Diseases” (July
19 22, 2011).

20 (c) CHRONIC DISEASE PREVENTION PROGRAMS.—

21 The Director of the National Heart, Lung, and Blood In-
22 stitute shall carry out the following:

23 (1) Conduct public education and awareness ac-
24 tivities with patient and professional organizations
25 to stimulate earlier diagnosis and improve patient

1 outcomes from treatment of chronic obstructive pul-
2 monary disease. To the extent known and relevant,
3 such public education and awareness activities shall
4 reflect differences in chronic obstructive pulmonary
5 disease by cause (tobacco, environmental, occupa-
6 tional, biological, and genetic) and include a focus
7 on outreach to undiagnosed and, as appropriate, mi-
8 nority populations.

9 (2) Supplement and expand upon the activities
10 of the National Heart, Lung, and Blood Institute by
11 making grants to nonprofit organizations, State and
12 local jurisdictions, and Indian tribes for the purpose
13 of reducing the burden of chronic obstructive pul-
14 monary disease, especially in disproportionately im-
15 pacted communities, through public health interven-
16 tions and related activities.

17 (3) Coordinate with the Centers for Disease
18 Control and Prevention, the Indian Health Service,
19 the Health Resources and Services Administration,
20 and the Department of Veterans Affairs to develop
21 pilot programs to demonstrate best practices for the
22 diagnosis and management of chronic obstructive
23 pulmonary disease.

24 (4) Develop improved techniques and identify
25 best practices, in coordination with the Secretary of

1 Veterans Affairs, for assisting chronic obstructive
2 pulmonary disease patients to successfully stop
3 smoking, including identification of subpopulations
4 with different needs. Initiatives under this para-
5 graph may include research to determine whether
6 successful smoking cessation strategies are different
7 for chronic obstructive pulmonary disease patients
8 compared to such strategies for patients with other
9 chronic diseases.

10 (d) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
11 PROGRAMS.—The Director of the Centers for Disease
12 Control and Prevention shall—

13 (1) support research into the environmental and
14 occupational causes and biological mechanisms that
15 contribute to chronic obstructive pulmonary disease;
16 and

17 (2) develop and disseminate public health inter-
18 ventions that will lessen the impact of environmental
19 and occupational causes of chronic obstructive pul-
20 monary disease.

21 (e) DATA COLLECTION.—Not later than 180 days
22 after the enactment of this Act, the Director of the Na-
23 tional Heart, Lung, and Blood Institute and the Director
24 of the Centers for Disease Control and Prevention, acting
25 jointly, shall assess the depth and quality of information

1 on chronic obstructive pulmonary disease that is collected
2 in surveys and population studies conducted by the Cen-
3 ters for Disease Control and Prevention, including wheth-
4 er there are additional opportunities for information to be
5 collected in the National Health and Nutrition Examina-
6 tion Survey, the National Health Interview Survey, and
7 the Behavioral Risk Factors Surveillance System surveys.
8 The Director of the National Heart, Lung, and Blood In-
9 stitute shall include the results of such assessment in the
10 national action plan under subsection (b).

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 2015 through 2019.

15 **Subtitle H—Osteoarthritis and** 16 **Musculoskeletal Diseases**

17 **SEC. 781. FINDINGS.**

18 The Congress finds as follows:

19 (1) Eighty percent of African-American women
20 and nearly 74 percent of Hispanic men are either
21 overweight or obese, speeding the onset and progres-
22 sion of arthritis.

23 (2) Arthritis affects 46 million Americans, and
24 that number will rise to 67 million by the year 2030.

1 (3) Twenty-seven million Americans suffer from
2 osteoarthritis, the most common form of arthritis,
3 making it the leading cause of disability in the
4 United States. Osteoarthritis is sometimes referred
5 to as degenerative joint disease.

6 (4) Obesity accelerates the onset of arthritis: 70
7 percent of obese adults with mild osteoarthritis of
8 the knee at age 60 will develop advanced end-stage
9 disease by age 80. In contrast, just 43 percent of
10 non-obese adults will have end-stage disease over the
11 same time period.

12 (5) Arthritis affects one in five Americans, and
13 is the single greatest cause of chronic pain and dis-
14 ability in the United States.

15 (6) Women, African-Americans, and Hispanics
16 have more severe arthritis and functional limitations.
17 These same individuals are more likely to be obese,
18 diabetic, and have higher incidence of heart dis-
19 ease—medical conditions that can be improved with
20 physical activity. Instead of moving; however, these
21 groups have an inactivity rate of 40 to 50 percent,
22 which continues to increase.

23 (7) Arthritis costs \$128 billion a year, including
24 \$81 billion in direct costs (medical) and \$47 billion
25 in indirect costs (lost earnings). Each year, \$309 bil-

1 lion in direct and indirect costs is lost due to dis-
2 parities in osteoarthritis and musculoskeletal dis-
3 eases.

4 (8) Obesity and other chronic health conditions
5 exacerbate the debilitating impact of arthritis, lead-
6 ing to inactivity, loss of independence, and a per-
7 petual cycle of comorbid chronic conditions.

8 (9) Sixty-one percent of arthritis sufferers are
9 women, and women represent 64 percent of an esti-
10 mated 43 million annual visits to physicians' offices
11 and outpatient clinics where arthritis was the pri-
12 mary diagnosis. Women also represented 60 percent
13 of approximately 1 million hospitalizations that oc-
14 curred in 2003 for which arthritis was the primary
15 diagnosis.

16 (10) Women ages 65 and older have up to 2½
17 times more disabilities than men of the same age.
18 Higher rates of obesity and arthritis among this
19 group explained up to 48 percent of the gender gap
20 in disability, above all other common chronic health
21 conditions.

22 (11) The primary indication for total knee
23 arthroplasty (TKA), also known as knee replace-
24 ment, is relief of significant, disabling pain caused
25 by severe arthritis.

1 (12) Knee replacement is surgery for people
2 with severe knee damage. Knee replacement can re-
3 lieve pain and allow you to be more active. When
4 you have a total knee replacement, the surgeon re-
5 moves damaged cartilage and bone from the surface
6 of your knee joint and replaces them with a man-
7 made surface of metal and plastic. In a partial knee
8 replacement, the surgeon only replaces one part of
9 your knee joint.

10 (13) Total hip replacement, also called total hip
11 arthroplasty (THA), is used if your hip pain inter-
12 feres with daily activities and more-conservative
13 treatments have not helped. Arthritis damage is the
14 most common reason to need hip replacement.

15 (14) The odds of a family practice physician
16 recommending TKA to a male patient with moderate
17 arthritis are twice that of a female patient, while the
18 odds of an orthopaedic surgeon recommending TKA
19 to a male patient with moderate arthritis are 22
20 times that of a female patient.

21 (15) African-Americans with doctor-diagnosed
22 arthritis have a higher prevalence of severe pain at-
23 tributable to arthritis, compared with Whites (34.0
24 percent versus 22.6 percent). African-Americans,
25 compared to Whites, report a higher proportion of

1 work limitations (39.5 percent versus 28.0 percent)
2 and a higher prevalence of arthritis-attributable
3 work limitation (6.6 percent versus 4.6 percent).

4 (16) Hispanics are 50 percent more likely than
5 non-Hispanic Whites to report needing assistance
6 with at least one instrumental activity of daily living
7 and to have difficulty walking.

8 (17) African-Americans and Hispanics were 1.3
9 times more likely to have activity limitation, 1.6
10 times more likely to have work limitations, and 1.9
11 times more likely to have severe joint pain than
12 Whites.

13 (18) In 2003, the Institute of Medicine reported
14 that the rates of TKA and THA among African-
15 American and Hispanic patients are significantly
16 lower than for Whites—even for those with equitable
17 health care coverage such as through Medicare or
18 the Department of Veterans Affairs.

19 (19) According to the Centers for Disease Con-
20 trol and Prevention, in 2000, African-American
21 Medicare enrollees were 37 percent less likely than
22 White Medicare enrollees to undergo total knee re-
23 placements. In 2006, the disparity increased to 39
24 percent.

1 (20) Even after adjusting for insurance and
2 health access, Hispanics and African-Americans are
3 almost 50 percent less likely to undergo total knee
4 replacement than Whites.

5 **SEC. 782. OSTEOARTHRITIS AND OTHER MUSCULO-**
6 **SKELETAL HEALTH-RELATED ACTIVITIES OF**
7 **THE CENTERS FOR DISEASE CONTROL AND**
8 **PREVENTION.**

9 (a) EDUCATION AND AWARENESS ACTIVITIES.—The
10 Secretary of Health and Human Services, acting through
11 the Director of the Centers for Disease Control and Pre-
12 vention, shall direct the National Center for Chronic Dis-
13 ease Prevention and Health Promotion to conduct and ex-
14 pand the Health Community Program and Arthritis Pro-
15 gram to educate the public on—

16 (1) the causes of, preventive health actions for,
17 and effects of arthritis and other musculoskeletal
18 conditions in minority patient populations; and

19 (2) the effects of such conditions on other
20 comorbidities including obesity, hypertension, and
21 cardiovascular disease.

22 (b) PROGRAMS ON ARTHRITIS AND MUSCULO-
23 SKELETAL CONDITIONS.—Education and awareness pro-
24 grams of the Centers for Disease Control and Prevention

1 on arthritis and other musculoskeletal conditions in minor-
2 ity communities shall—

3 (1) be culturally and linguistically appropriate
4 to minority patients, targeting musculoskeletal
5 health promotion and prevention programs of each
6 major ethnic group, including—

7 (A) Native Americans and Alaska Natives;

8 (B) Asian-Americans;

9 (C) African-Americans/Blacks;

10 (D) Hispanic/Latino-Americans; and

11 (E) Native Hawaiians and Pacific Island-
12 ers; and

13 (2) include public awareness campaigns directed
14 toward these patient populations that emphasize the
15 importance of musculoskeletal health, physical activ-
16 ity, diet and healthy lifestyle, and weight reduction
17 for overweight and obese patients.

18 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 such sums as necessary for fiscal year 2015 and each sub-
21 sequent fiscal year.

1 **Subtitle I—Sleep and Circadian**
2 **Rhythm Disorders**

3 **SEC. 791. SHORT TITLE; FINDINGS.**

4 (a) **SHORT TITLE.**—This subtitle may be cited as the
5 “Sleep and Circadian Rhythm Disorders Health Dispari-
6 ties Act”.

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

8 (1) Decrements in sleep health such as sleep
9 apnea, insufficient sleep time, and insomnia, affect
10 50–70 million United States adults. Twelve to eight-
11 een million United States adults have sleep apnea, a
12 chronic disorder characterized by one or more
13 pauses in breathing which can last from a few sec-
14 onds to minutes. They may occur 30 times or more
15 an hour, disrupting sleep and resulting in excessive
16 daytime sleepiness and loss in productivity.

17 (2) Seventy percent of high school students are
18 not getting enough sleep on school nights, while 33
19 percent of Americans get fewer than 7 hours of sleep
20 per night and roughly 6,000 fatal motor vehicle
21 crashes are caused by drowsy drivers.

22 (3) Insufficient sleep and insomnia are more
23 prevalent in women. Women who are pregnant and
24 have sleep apnea are at an increased risk of cardio-
25 vascular complications during pregnancy. The im-

1 pact of disparities in sleep health is associated with
2 a growing number of health problems, including the
3 following:

4 (A) Hypertension.

5 (B) Cancer.

6 (C) Stroke.

7 (D) Cardiac arrhythmia.

8 (E) Chronic heart failure and heart dis-
9 ease.

10 (F) Diabetes.

11 (G) Cognitive functioning and behavior.

12 (H) Depression and bipolar disorder.

13 (I) Substance abuse.

14 (4) A “sleep disparity” exists in that poor sleep
15 quality is strongly associated with poverty and race.
16 Factors such as employment, education, and health
17 status, amongst others, significantly mediated this
18 effect only in poor subjects, suggesting a differential
19 vulnerability to these factors in poor relative to non-
20 poor individuals in the context of sleep quality.

21 (5) African-Americans sleep worse than Cauca-
22 sian Americans. African-Americans take longer to
23 fall asleep, report poorer sleep quality, have more
24 light and less deep sleep, and nap more often and
25 longer.

1 (6) African-Americans and individuals in lower
2 socioeconomic status groups may be at an increased
3 risk for sleep disturbances and associated health
4 consequences.

5 (7) Among young African-Americans, the likeli-
6 hood of having sleep disordered breathing and exhib-
7 iting risk factors for poor sleep is twice that in
8 young Caucasians. Frequent snoring is more com-
9 mon among African-American and Hispanic women
10 and Hispanic men compared to non-Hispanic Cauca-
11 sians, independent of other factors including obesity.

12 (8) African-Americans with sleep disordered
13 breathing develop symptoms at a younger age than
14 Caucasians but appear less likely to be diagnosed
15 and treated in a timely manner. This delay may at
16 least in part be due to reduced access to care.

17 (9) Sleep loss contributes to increased risk for
18 chronic conditions such as obesity, diabetes, and hy-
19 pertension, all of which have increased prevalence in
20 underserved, underrepresented minorities. Racial
21 and ethnic disparities related to obesity may also
22 contribute to disparities in health outcomes related
23 to sleep disordered breathing.

1 (10) Non-Caucasian adults report an insomnia
2 rate of 12.9 percent compared to only 6.6 percent
3 for Caucasians.

4 (11) African-American women have a higher in-
5 cidence of insomnia than African-American men,
6 perhaps related in part to higher risk for chronic
7 persisting symptoms.

8 **SEC. 792. SLEEP AND CIRCADIAN RHYTHM DISORDERS RE-**
9 **SEARCH ACTIVITIES OF THE NATIONAL IN-**
10 **STITUTES OF HEALTH.**

11 (a) IN GENERAL.—The Director of the National In-
12 stitutes of Health, acting through the Director of the Na-
13 tional Heart, Lung, and Blood Institute, shall—

14 (1) continue to expand research activities ad-
15 dressing sleep health disparities; and

16 (2) continue implementation of the “NIH Sleep
17 Disorders Research Plan” across all institutes and
18 centers of the National Institutes of Health to im-
19 prove treatment and prevention of sleep health dis-
20 parities.

21 (b) REQUIRED RESEARCH ACTIVITIES.—In con-
22 ducting or supporting research relating to sleep and circa-
23 dian rhythm, the Director of the National Heart, Lung,
24 and Blood Institute shall—

1 (1) advance epidemiology and clinical research
2 to achieve a more complete understanding of dispari-
3 ties in domains of sleep health and across population
4 subgroups for which cardiovascular and metabolic
5 health disparities exist, including—

6 (A) prevalence and severity of sleep apnea;

7 (B) habitual sleep duration;

8 (C) sleep timing and regularity; and

9 (D) insomnia;

10 (2) develop study designs and analytical ap-
11 proaches to explain and predict multilevel and life-
12 course determinants of sleep health and to elucidate
13 the sleep-related causes of cardiovascular and meta-
14 bolic health disparities across the age spectrum, in-
15 cluding such determinants and causes that are—

16 (A) environmental;

17 (B) biological or genetic;

18 (C) psychosocial;

19 (D) societal;

20 (E) political; or

21 (F) economic;

22 (3) determine the contribution of sleep impair-
23 ments such as sleep apnea, insufficient sleep dura-
24 tion, irregular sleep schedules, and insomnia to un-

1 explained disparities in cardiovascular and metabolic
2 risk and disease outcomes;

3 (4) develop study designs, data sampling and
4 collection tools, and analytical approaches to opti-
5 mize understanding of mediating and moderating
6 factors, and feedback mechanisms coupling sleep to
7 cardiovascular and metabolic health disparities;

8 (5) advance research to understand cultural
9 and linguistic barriers (on the person, provider, or
10 system level) to access to care, medical diagnosis,
11 and treatment of sleep disorders in diverse popu-
12 lation groups;

13 (6) develop and test multilevel interventions (in-
14 cluding sleep health education in diverse commu-
15 nities) to reduce disparities in sleep health that will
16 impact ability to improve disparities in cardio-
17 vascular and metabolic risk or disease;

18 (7) create opportunities to integrate sleep and
19 health disparity science by strategically utilizing re-
20 sources (existing or anticipated cohorts), exchanging
21 scientific data and ideas (cross-over into scientific
22 meetings), and develop multidisciplinary investi-
23 gator-initiated grant applications; and

1 (c) REQUIRED SURVEILLANCE AND EDUCATION
2 AWARENESS ACTIVITIES.—In conducting or supporting
3 research relating to sleep and circadian rhythm disorders
4 surveillance and education awareness activities, the Direc-
5 tor of the Centers for Disease Control and Prevention
6 shall—

7 (1) ensure that such activities are culturally
8 and linguistically appropriate to minority patients,
9 targeting sleep and circadian rhythm health pro-
10 motion and prevention programs of each major eth-
11 nic group, including—

12 (A) Native Americans and Alaska Natives;

13 (B) Asian-Americans;

14 (C) African-Americans/Blacks;

15 (D) Hispanic/Latino-Americans; and

16 (E) Native Hawaiians and Pacific Island-
17 ers;

18 (2) collect and compile national and State sur-
19 veillance data on sleep disorders health disparities;

20 (3) continue to develop and implement new
21 sleep questions in public health surveillance systems
22 to increase public awareness of sleep health and
23 sleep disorders and their impact on health;

24 (4) publish monthly reports highlighting geo-
25 graphic, racial, and ethnic disparities in sleep health,

1 as well as relationships between insufficient sleep
2 and chronic disease, health risk behaviors, and other
3 outcomes as determined necessary by the Director;
4 and

5 (5) include public awareness campaigns that in-
6 form patient populations from major ethnic groups
7 about the prevalence of sleep and circadian rhythm
8 disorders and emphasize the importance of sleep
9 health.

10 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
11 out this section, there are authorized to be appropriated
12 such sums as may be necessary for fiscal year 2015 and
13 each subsequent fiscal year.

14 **TITLE VIII—HEALTH**
15 **INFORMATION TECHNOLOGY**

16 **SEC. 800. DEFINITIONS.**

17 In this title:

18 (1) The term “certified EHR technology” has
19 the meaning given to that term in section 3000 of
20 the Public Health Service Act (42 U.S.C. 300jj).

21 (2) The term “EHR” means an electronic
22 health record.

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.—

21 (1) IN GENERAL.—The National Coordinator
22 for Health Information Technology shall conduct an
23 evaluation of the level of use and accessibility of
24 electronic health records in racial and ethnic minor-
25 ity communities focusing on whether patients in

1 those communities have providers with EHRs,
2 stratified by disparity variables.

3 (2) CONTENT.—In conducting the evaluation
4 under paragraph (1), the National Coordinator shall
5 publish the results of a study regarding the 100,000
6 providers recruited by the Regional Extension Cen-
7 ter established under section 3012 of the Public
8 Health Service Act (42 U.S.C. 300jj–32), including
9 the race and ethnicity of such providers and the popu-
10 lations served by such providers, with the popu-
11 lations stratified by disparity variables.

12 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—
13 As soon as practicable after the date of enactment of this
14 Act, the Director of the National Center for Health Statis-
15 tics shall provide to Congress a more detailed analysis of
16 the data presented in the Data Brief 79 published by such
17 Center in November 2011 (entitled “Electronic Health
18 Record Systems and Intent to Apply for Meaningful Use
19 Incentives Among Office-Based Physician Practices”).

20 (c) INSTITUTE OF MEDICINE.—The Secretary of
21 Health and Human Services may enter into an agreement
22 with the Institute of Medicine of the National Academies
23 that provides such Institute will—

1 (1) evaluate the impact of health information
2 technology in racial and ethnic minority commu-
3 nities; and

4 (2) publish a report regarding such evaluation.

5 (d) CENTERS FOR MEDICARE & MEDICAID SERV-
6 ICES.—

7 (1) IN GENERAL.—As part of the process of
8 collecting information, with respect to a provider, at
9 registration and attestation for purposes of the
10 Medicare and Medicaid Electronic Health Records
11 Incentive Programs, the Secretary of Health and
12 Human Services shall collect the race and ethnicity
13 of such provider.

14 (2) MEDICARE AND MEDICAID ELECTRONIC
15 HEALTH RECORDS INCENTIVE PROGRAMS DE-
16 FINED.—For purposes of paragraph (1), the term
17 “Medicare and Medicaid Electronic Health Records
18 Incentive Programs” means the incentive programs
19 under section 1814(l)(3), subsections (a)(7) and (o)
20 of section 1848, subsections (l) and (m) of section
21 1853, subsections (b)(3)(B)(ix)(I) and (n) of section
22 1886, and subsections (a)(3)(F) and (t) of section
23 1903 of the Social Security Act (42 U.S.C.
24 1395f(l)(3), 1395w-4, 1395w-23, 1395ww, and
25 1396b).

1 (e) NATIONAL COORDINATOR'S ASSESSMENT OF IM-
2 PACT OF HIT.—Section 3001(e)(6)(C) of the Public
3 Health Service Act (42 U.S.C. 300jj–11(e)(6)(C)) is
4 amended—

5 (1) in the heading by inserting “, RACIAL AND
6 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
7 DISPARITIES”;

8 (2) by inserting “, in communities with a high
9 proportion of individuals from racial and ethnic mi-
10 nority groups (as defined in section 1707(g)), in-
11 cluding people with disabilities in these groups,”
12 after “communities with health disparities”; and

13 (3) by adding at the end the following new sen-
14 tence: “In any publication under the previous sen-
15 tence, the National Coordinator shall include best
16 practices for encouraging partnerships between the
17 Federal Government, States, and private entities to
18 expand outreach for and the adoption of certified
19 EHR technology in communities with a high propor-
20 tion of individuals from racial and ethnic minority
21 groups (as so defined), while also maintaining the
22 accessibility requirements of section 508 of the Re-
23 habilitation Act to encourage patient involvement in
24 their own health care. The National Coordinator
25 shall—

1 “(i) not later than 6 months after the
2 submission to the Congress of the report
3 required by section 832 of the Health Eq-
4 uity and Accountability Act of 2014, estab-
5 lish criteria for evaluating the impact of
6 health information technology on commu-
7 nities with a high proportion of individuals
8 from racial and ethnic minority groups (as
9 so defined) taking into account the find-
10 ings in such report; and

11 “(ii) not later than 12 months after
12 the submission to the Congress of such re-
13 ports, conduct and publish the results of
14 an evaluation of such impact.”.

15 **Subtitle B—Modifications To**
16 **Achieve Parity in Existing Pro-**
17 **grams**

18 **SEC. 811. EXTENDING FUNDING TO STRENGTHEN THE**
19 **HEALTH IT INFRASTRUCTURE IN RACIAL**
20 **AND ETHNIC MINORITY COMMUNITIES.**

21 Section 3011 of the Public Health Service Act (42
22 U.S.C. 300jj–31) is amended—

23 (1) in subsection (a), by adding at the end the
24 following new paragraph:

1 “(8) Activities described in the previous para-
2 graphs of this subsection with respect to commu-
3 nities with a high proportion of individuals from ra-
4 cial and ethnic minority groups (as defined in sec-
5 tion 1707(g)).”; and

6 (2) by adding at the end the following new sub-
7 section:

8 “(e) ANNUAL REPORT ON EXPENDITURES.—The
9 National Coordinator shall report annually to the Con-
10 gress on activities and expenditures under this section.”.

11 **SEC. 812. PRIORITIZING REGIONAL EXTENSION CENTER AS-**
12 **SISTANCE TO RACIAL AND ETHNIC MINORITY**
13 **GROUPS.**

14 (a) IN GENERAL.—Section 3012(c)(4)(C) of the Pub-
15 lic Health Service Act (42 U.S.C. 300jj–32(e)(4)(C)) is
16 amended by inserting “or individuals from racial and eth-
17 nic minority groups (as defined in section 1707(g))” after
18 “medically underserved individuals”.

19 (b) BIENNIAL EVALUATION.—Section 3012(c)(8) of
20 such Act (42 U.S.C. 300jj–32(e)(8)) is amended—

21 (1) by inserting: “Each evaluation panel shall
22 include at least one consumer advocate from a racial
23 and ethnic minority community served by the center
24 involved, at least one patient or family caregiver,

1 and at least one representative of a minority-serving
2 institution.” after “‘and of Federal officials.’; and

3 (2) by inserting “and shall determine the de-
4 gree to which such center provides outreach and as-
5 sistance to providers predominantly serving racial
6 and ethnic minority groups (as defined in section
7 1707(g))” after “specified in paragraph (3)”.

8 **SEC. 813. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
9 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
10 **TATE ADOPTION OF CERTIFIED EHR TECH-**
11 **NOLOGY BY PROVIDERS SERVING RACIAL**
12 **AND ETHNIC MINORITY GROUPS.**

13 Section 3014(e) of the Public Health Service Act (42
14 U.S.C. 300jj–34(e)) is amended—

15 (1) in paragraph (3), by striking at the end
16 “or”;

17 (2) in paragraph (4), by striking the period at
18 the end and inserting “; or”; and

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

21 “(5) carry out any of the activities described in
22 a previous paragraph of this subsection with respect
23 to communities with a high proportion of individuals
24 from racial and ethnic minority groups (as defined
25 in section 1707(g)).”.

1 **SEC. 814. AUTHORIZATION OF APPROPRIATIONS.**

2 Section 3018 of the Public Health Service Act (42
3 U.S.C. 300jj–38) is amended by striking “fiscal years
4 2009 through 2013” and inserting “fiscal years 2014
5 through 2021”.

6 **Subtitle C—Additional Research**
7 **and Studies**

8 **SEC. 831. DATA COLLECTION AND ASSESSMENTS CON-**
9 **DUCTED IN COORDINATION WITH MINORITY-**
10 **SERVING INSTITUTIONS.**

11 Section 3001(c)(6) of the Public Health Service Act
12 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
13 end the following new subparagraph:

14 “(F) DATA COLLECTION AND ASSESS-

15 MENTS CONDUCTED IN COORDINATION WITH

16 MINORITY-SERVING INSTITUTIONS.—

17 “(i) IN GENERAL.—In carrying out

18 subparagraph (C) with respect to commu-

19 nities with a high proportion of individuals

20 from racial and ethnic minority groups (as

21 defined in section 1707(g)), the National

22 Coordinator shall, to the greatest extent

23 possible, coordinate with an entity de-

24 scribed in clause (ii).

25 “(ii) MINORITY-SERVING INSTITU-

26 TIONS.—For purposes of clause (i), an en-

1 tity described in this clause is a historically
2 Black college or university, a Hispanic-
3 serving institution, a tribal college or uni-
4 versity, or an Asian-American-, Native
5 American-, and Pacific Islander-serving in-
6 stitution with an accredited public health,
7 health policy, or health services research
8 program.”.

9 **SEC. 832. STUDY OF HEALTH INFORMATION TECHNOLOGY**
10 **IN MEDICALLY UNDERSERVED COMMU-**
11 **NITIES.**

12 (a) IN GENERAL.—Not later than 24 months after
13 the date of enactment of this Act, the Secretary of Health
14 and Human Services shall—

15 (1) enter into an agreement with the Institute
16 of Medicine of the National Academies (or, if the In-
17 stitute of Medicine declines, another appropriate
18 public or nonprofit private entity) to conduct a study
19 on the development, implementation, and effective-
20 ness of health information technology within medi-
21 cally underserved areas (as described in subsection
22 (c)); and

23 (2) submit a report to Congress describing the
24 results of such study, including any recommenda-
25 tions for legislative or administrative action.

1 (b) STUDY.—The study described in subsection
2 (a)(1) shall—

3 (1) identify barriers to successful implementa-
4 tion of health information technology in medically
5 underserved areas;

6 (2) examine the impact of health information
7 technology on providing quality care and reducing
8 the cost of care to individuals in such areas, includ-
9 ing the impact of such technology on improved
10 health outcomes for individuals, including which
11 technology worked for which population and how it
12 improved health outcomes for that population;

13 (3) examine the impact of health information
14 technology on improving health-care-related deci-
15 sions by both patients and providers in such areas;

16 (4) identify specific best practices for using
17 health information technology to foster the con-
18 sistent provision of physical accessibility and reason-
19 able policy accommodations in health care to individ-
20 uals with disabilities in such areas;

21 (5) assess the feasibility and costs associated
22 with the use of health information technology in
23 such areas;

24 (6) evaluate whether the adoption and use of
25 qualified electronic health records (as described in

1 section 3000(13) of the Public Health Service Act
2 (42 U.S.C. 300jj(13)) is effective in reducing health
3 disparities, including analysis of clinical quality
4 measures reported by Medicare and Medicaid pro-
5 viders pursuant to programs to encourage the adop-
6 tion and use of certified EHR technology;

7 (7) identify providers in medically underserved
8 areas that are not electing to adopt and use elec-
9 tronic health records and determine what barriers
10 are preventing those providers from adopting and
11 using such records; and

12 (8) examine urban and rural community health
13 systems and determine the impact that health infor-
14 mation technology may have on the capacity of pri-
15 mary health providers in those systems.

16 (c) MEDICALLY UNDERSERVED AREA.—The term
17 “medically underserved area” means—

18 (1) a population that has been designated as a
19 medically underserved population under section
20 330(b)(3) of the Public Health Service Act (42
21 U.S.C. 254b(b)(3));

22 (2) an area that has been designated as a
23 health professional shortage area under section 332
24 of the Public Health Service Act (42 U.S.C. 254e);

1 (3) an area or population that has been des-
2 ignated as a medically underserved community under
3 section 799B(6) of the Public Health Service Act
4 (42 U.S.C. 295p(6)); or

5 (4) an area or population that—

6 (A) is not described in paragraphs (1)
7 through (3) of this subsection;

8 (B) experiences significant barriers to ac-
9 cessing quality health services; and

10 (C) has a high prevalence of diseases or
11 conditions described in title VII of this Act,
12 with such diseases or conditions having a dis-
13 proportionate impact on racial and ethnic mi-
14 nority groups (as defined in section 1707(g) of
15 the Public Health Service Act (42 U.S.C. 300u-
16 6(g))) or a subgroup of people with disabilities
17 who have specific functional impairments.

18 **Subtitle D—Closing Gaps in**
19 **Funding To Adopt Certified EHRs**

20 **SEC. 841. APPLICATION OF MEDICARE HITECH PAYMENTS**
21 **TO HOSPITALS IN PUERTO RICO.**

22 (a) IN GENERAL.—Subsection (n)(6)(B) of section
23 1886 of the Social Security Act (42 U.S.C. 1395ww) is
24 amended by striking “subsection (d) hospital” and insert-

1 ing “hospital that is a subsection (d) hospital or a sub-
2 section (d) Puerto Rico hospital”.

3 (b) OFFSETTING REDUCTION.—Subsection (n)(2) of
4 section 1886 of the Social Security Act (42 U.S.C.
5 1395ww) is amended by adding at the end the following
6 new subparagraph:

7 “(H) BUDGET NEUTRALITY ADJUST-
8 MENT.—The Secretary shall reduce the applica-
9 ble amounts that would otherwise be deter-
10 mined under this subsection with respect to—

11 “(i) the first fiscal year to which this
12 subparagraph applies by an amount that
13 the Secretary estimates would ensure that
14 estimated aggregate payments under this
15 subsection for such fiscal year are not in-
16 creased as a result of the amendments
17 made by subsection (a) of section 841 of
18 the Health Equity and Accountability Act
19 of 2014; or

20 “(ii) a succeeding fiscal year by an
21 amount that the Secretary estimates would
22 ensure that estimated aggregate payments
23 under this subsection for such fiscal year
24 are not increased as a result of the amend-

1 ments made by subsections (a) and (c) of
2 such section.”.

3 (c) CONFORMING AMENDMENTS.—(1) Subsection
4 (b)(3)(B)(ix) of such section is amended—

5 (A) in subclause (I), by striking “(n)(6)(A)”
6 and inserting “(n)(6)(B)”; and

7 (B) in subclause (II), by striking “subsection
8 (d) hospital” and inserting “an eligible hospital”.

9 (2) Paragraphs (2) and (4)(A) of section 1853(m) of
10 the Social Security Act (42 U.S.C. 1395w–23(m)) are
11 each amended by striking “1886(n)(6)(A)” and inserting
12 “1886(n)(6)(B)”.

13 (d) IMPLEMENTATION.—Notwithstanding any other
14 provision of law, the Secretary of Health and Human
15 Services may implement the amendments made by sub-
16 sections (a), (b) and (c) by program instruction or other-
17 wise.

18 (e) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to payments for payment years for
20 fiscal years beginning after the date of the enactment of
21 this Act.

1 **SEC. 842. EXTENDING MEDICAID EHR INCENTIVE PAY-**
2 **MENTS TO REHABILITATION FACILITIES,**
3 **LONG-TERM CARE FACILITIES, AND HOME**
4 **HEALTH AGENCIES.**

5 Section 1903(t)(2)(B) of the Social Security Act (42
6 U.S.C. 1396b(t)(2)(B)) is amended—

7 (1) in clause (i), by striking “, or” and insert-
8 ing a semicolon;

9 (2) in clause (ii), by striking the period at the
10 end and inserting a semicolon; and

11 (3) by inserting after clause (ii) the following
12 new clauses:

13 “(iii) a rehabilitation facility (as defined in
14 section 1886(j)(1)) that furnishes acute or
15 subacute rehabilitation services;

16 “(iv) a long-term care hospital (as defined
17 in section 1886(d)(1)(B)(iv)(I)); or

18 “(v) a home health agency (as defined in
19 section 1861(o)).”.

20 **SEC. 843. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**
21 **FOR MEDICAID ELECTRONIC HEALTH**
22 **RECORD INCENTIVE PAYMENTS.**

23 (a) IN GENERAL.—Section 1903(t)(3)(B)(v) of the
24 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is
25 amended to read as follows:

1 “(v) physician assistant, in the case
2 that the assistant is a primary care pro-
3 vider, including an assistant who practices
4 in a rural health clinic that is led by a phy-
5 sician assistant or practices in a federally
6 qualified health center that is so led.”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) shall apply with respect to amounts ex-
9 pended under section 1903(a)(3)(F) of the Social Security
10 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
11 ginning on or after the date of the enactment of this Act.

12 **TITLE IX—ACCOUNTABILITY** 13 **AND EVALUATION**

14 **SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL**
15 **ASSISTED HEALTH CARE SERVICES AND RE-**
16 **SEARCH PROGRAMS ON THE BASIS OF SEX,**
17 **RACE, COLOR, NATIONAL ORIGIN, MARITAL**
18 **STATUS, FAMILIAL STATUS, SEXUAL ORI-**
19 **ENTATION, GENDER IDENTITY, OR DIS-**
20 **ABILITY STATUS.**

21 (a) IN GENERAL.—No person in the United States
22 shall, on the basis of sex, race, color, national origin, mar-
23 ital status, familial status, sexual orientation, gender iden-
24 tity, or disability status, be excluded from participation
25 in, be denied the benefits of, or be subjected to discrimina-

1 tion under any health program or activity, including any
2 health research program or activity, receiving Federal fi-
3 nancial assistance.

4 (b) DEFINITION.—In this section, the term “familial
5 status” means, with respect to one or more individuals—

6 (1) being domiciled with any individual related
7 by blood or affinity whose close association with the
8 individual is the equivalent of a family relationship;

9 (2) being in the process of securing legal cus-
10 tody of any individual; or

11 (3) being pregnant.

12 **SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER**
13 **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

14 A payment to a provider of services, physician, or
15 other supplier under part B, C, or D of title XVIII of
16 the Social Security Act shall be deemed a grant, and not
17 a contract of insurance or guaranty, for the purposes of
18 title VI of the Civil Rights Act of 1964.

19 **SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
20 **THE DEPARTMENT OF HEALTH AND HUMAN**
21 **SERVICES.**

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

1 **“Subtitle C—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 which receive Federal financial as-
11 sistance are in compliance with title VI of the Civil Rights
12 Act, which prohibits discrimination on the basis of race,
13 color, or national origin. The activities of the Office shall
14 include the following:

15 “(1) The development and implementation of
16 an action plan to address racial and ethnic health
17 care disparities, which shall address concerns relat-
18 ing to the Office for Civil Rights as released by the
19 United States Commission on Civil Rights in the re-
20 port entitled ‘Health Care Challenge: Acknowledging
21 Disparity, Confronting Discrimination, and Ensuring
22 Equity’ (September 1999) in conjunction with
23 the reports by the Institute of Medicine entitled ‘Un-
24 equal Treatment: Confronting Racial and Ethnic
25 Disparities in Health Care’, ‘Crossing the Quality

1 Chasm: A New Health System for the 21st Cen-
2 tury’, ‘In the Nation’s Compelling Interest: Ensur-
3 ing Diversity in the Health Care Workforce’, ‘The
4 National Partnership for Action to End Health Dis-
5 parities’, and ‘The Health of Lesbian, Gay, Bisexual,
6 and Transgender People’, and other related reports
7 by the Institute of Medicine. This plan shall be pub-
8 licly disclosed for review and comment and the final
9 plan shall address any comments or concerns that
10 are received by the Office.

11 “(2) Investigative and enforcement actions
12 against intentional discrimination and policies and
13 practices that have a disparate impact on minorities.

14 “(3) The review of racial, ethnic, gender iden-
15 tity, sexual orientation, sex, disability status, socio-
16 economic status, and primary language health data
17 collected by Federal health agencies to assess health
18 care disparities related to intentional discrimination
19 and policies and practices that have a disparate im-
20 pact on minorities.

21 “(4) Outreach and education activities relating
22 to compliance with title VI of the Civil Rights Act.

23 “(5) The provision of technical assistance for
24 health entities to facilitate compliance with title VI
25 of the Civil Rights Act.

1 “(6) Coordination and oversight of activities of
2 the civil rights compliance offices established under
3 section 3442.

4 “(7) Ensuring—

5 “(A) at a minimum, compliance with the
6 1997 Office of Management and Budget Stand-
7 ards for Maintaining, Collecting, and Pre-
8 senting Federal Data on Race and Ethnicity;
9 and

10 “(B) consideration of available data and
11 language standards such as—

12 “(i) the standards for collecting and
13 reporting data under section 3101; and

14 “(ii) the National Standards on Cul-
15 turally and Linguistically Appropriate
16 Services of the Office of Minority Health
17 within the Department of Health and
18 Human Services.

19 “(c) FUNDING AND STAFF.—The Secretary shall en-
20 sure the effectiveness of the Office of Health Disparities
21 by ensuring that the Office is provided with—

22 “(1) adequate funding to enable the Office to
23 carry out its duties under this section; and

24 “(2) staff with expertise in—

25 “(A) epidemiology;

1 “(B) statistics;
2 “(C) health quality assurance;
3 “(D) minority health and health dispari-
4 ties;
5 “(E) cultural and linguistic competency;
6 “(F) civil rights; and
7 “(G) social, behavioral, and economic de-
8 terminants of health.

9 “(d) REPORT.—Not later than December 31, 2015,
10 and annually thereafter, the Secretary, in collaboration
11 with the Director of the Office for Civil Rights and the
12 Deputy Assistant Secretary for Minority Health, shall
13 submit a report to the Committee on Health, Education,
14 Labor, and Pensions of the Senate and the Committee on
15 Energy and Commerce of the House of Representatives
16 that includes—

17 “(1) the number of cases filed, broken down by
18 category;

19 “(2) the number of cases investigated and
20 closed by the office;

21 “(3) the outcomes of cases investigated;

22 “(4) the staffing levels of the office including
23 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 2015 through 2020.

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 their programs, services, and activities in a
21 manner 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 an agency within the Department of
12 Health and Human Services including the establish-
13 ment of disparity reduction standards to encompass
14 disparities in health and health care related to race,
15 national origin, language, ethnicity, sex, age, dis-
16 ability, sexual orientation, and gender identity.

17 “(2) The development and implementation of
18 program-specific guidelines that interpret and apply
19 Department of Health and Human Services guid-
20 ance under title VI of the Civil Rights Act of 1964
21 and section 1557 of the Patient Protection and Af-
22 fordable Care Act to each Federal health program
23 administered by the agency.

24 “(3) The development of a disparity-reduction
25 impact analysis methodology that shall be applied to

1 every rule issued by the agency and published as
2 part of the formal rulemaking process under sections
3 555, 556, and 557 of title 5, United States Code.

4 “(4) Oversight of data collection, analysis, and
5 publication requirements for all recipients of Federal
6 financial assistance under each Federal health pro-
7 gram administered by the agency; compliance with,
8 at a minimum, the 1997 Office of Management and
9 Budget Standards for Maintaining, Collecting, and
10 Presenting Federal Data on Race and Ethnicity; and
11 consideration of available data and language stand-
12 ards 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 within the Depart-
18 ment of Health and Human Services.

19 “(5) The conduct of publicly available studies
20 regarding discrimination within Federal health pro-
21 grams administered by the agency as well as dis-
22 parity reduction initiatives by recipients of Federal
23 financial assistance under Federal health programs.

24 “(6) Annual reports to the Committee on
25 Health, Education, Labor, and Pensions and the

1 Committee on Finance of the Senate and the Com-
2 mittee on Energy and Commerce and the Committee
3 on Ways and Means of the House of Representatives
4 on the progress in reducing disparities in health and
5 health care through the Federal programs adminis-
6 tered by the agency.

7 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
8 IN THE DEPARTMENT OF JUSTICE.—

9 “(1) DEPARTMENT OF HEALTH AND HUMAN
10 SERVICES.—The Office for Civil Rights in the De-
11 partment of Health and Human Services shall pro-
12 vide standard-setting and compliance review inves-
13 tigation support services to the Civil Rights Compli-
14 ance Office for each agency.

15 “(2) DEPARTMENT OF JUSTICE.—The Office
16 for Civil Rights in the Department of Justice shall
17 continue to maintain the power to institute formal
18 proceedings when an agency Office for Civil Rights
19 determines that a recipient of Federal financial as-
20 sistance is not in compliance with the disparity re-
21 duction standards of the 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 racial or ethnic
23 minority groups, coordinate such activities of—

24 “(A) the Office for Civil Rights within the
25 Department of Justice;

1 “(B) the Office of Justice Programs within
2 the Department of Justice;

3 “(C) the Office for Civil Rights within the
4 Department of Health and Human Services;
5 and

6 “(D) the Office of Minority Health within
7 the Department of Health and Human Services
8 (headed by the Deputy Assistant Secretary for
9 Minority Health).”.

10 (b) **AUTHORIZATION OF APPROPRIATIONS.**—Section
11 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
12 1975c) is amended by striking the first sentence and in-
13 serting the following: “For the purpose of carrying out
14 this Act, there are authorized to be appropriated
15 \$30,000,000 for fiscal year 2015, and such sums as may
16 be necessary for each of the fiscal years 2016 through
17 2020.”.

18 **SEC. 905. SENSE OF CONGRESS CONCERNING FULL FUND-**
19 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
20 **AND ETHNIC HEALTH DISPARITIES.**

21 (a) **FINDINGS.**—Congress makes the following find-
22 ings:

23 (1) The health status of the American populace
24 is declining and the United States currently ranks

1 below most industrialized nations in health status
2 measured by longevity, sickness, and mortality.

3 (2) Racial and ethnic minority populations tend
4 have the poorest health status and face substantial
5 cultural, social, and economic barriers to obtaining
6 quality health care.

7 (3) Lesbian, gay, bisexual and transgender
8 (LGBT) populations experience significant personal
9 and structural barriers to obtaining high-quality
10 health care.

11 (4) Efforts to improve minority health have
12 been limited by inadequate resources (funding, staff-
13 ing, and stewardship) and lack of accountability.

14 (b) SENSE OF CONGRESS.—It is the sense of Con-
15 gress that—

16 (1) funding should be doubled by fiscal year
17 2016 for the National Institute for Minority Health
18 Disparities, the Office of Civil Rights in the Depart-
19 ment of Health and Human Services, the National
20 Institute of Nursing Research, and the Office of Mi-
21 nority Health;

22 (2) adequate funding by fiscal year 2016, and
23 subsequent funding increases, should be provided for
24 health and human service professions training pro-
25 grams, the Racial and Ethnic Approaches to Com-

1 munity Health (REACH) Initiative at the Centers
2 for Disease Control and Prevention, the Minority
3 HIV/AIDS Initiative, and the Excellence Centers to
4 Eliminate Ethnic/Racial Disparities (EXCEED)
5 Program at the Agency for Healthcare Research and
6 Quality;

7 (3) funding should be fully restored to the Ra-
8 cial and Ethnic Approaches to Community Health
9 (REACH) Initiative at the Centers for Disease Con-
10 trol and Prevention, which has been a successful
11 program at the community health level, and efforts
12 should continue to place a strong emphasis on build-
13 ing community capacity to secure financial resources
14 and technical assistance to eliminate health dispari-
15 ties;

16 (4) adequate funding for fiscal year 2016 and
17 increased funding for future years should be pro-
18 vided for the REACH Initiative's United States Risk
19 Factor Survey to ensure adequate data collection to
20 track health disparities, and there should be appro-
21 priate avenues provided to disseminate findings to
22 the general public;

23 (5) current and newly created health disparity
24 elimination incentives, programs, agencies, and de-
25 partments under this Act (and the amendments

1 made by this Act) should receive adequate staffing
2 and funding by fiscal year 2016; and

3 (6) stewardship and accountability should be
4 provided to the Congress and the President for
5 measurable and sustainable progress toward health
6 disparity elimination.

7 **SEC. 906. GAO AND NIH REPORTS.**

8 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-
9 NIC DIVERSITY.—

10 (1) IN GENERAL.—The Comptroller General of
11 the United States shall conduct a study on the racial
12 and ethnic diversity among the following groups:

13 (A) All applicants for grants, contracts,
14 and cooperative agreements awarded by the Na-
15 tional Institutes of Health during the period be-
16 ginning on January 1, 1990, and ending De-
17 cember 31, 2013.

18 (B) All recipients of such grants, con-
19 tracts, and cooperative agreements.

20 (C) All members of the peer review panels
21 of such applicants and recipients, respectively.

22 (2) REPORT.—Not later than six months after
23 the date of the enactment of this Act, the Comp-
24 troller General shall complete the study under para-

1 graph (1) and submit to Congress a report con-
2 taining the results of such study.

3 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
4 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
5 DISPARITIES.—Not later than six months after the date
6 of the enactment of this Act, and biennially thereafter, the
7 Director of the National Institutes of Health, in collabora-
8 tion with the Director of the National Institute on Minor-
9 ity Health and Health Disparities, shall submit to Con-
10 gress a report that details and evaluates—

11 (1) the steps taken during the applicable report
12 period by the Director of the National Institutes of
13 Health to enforce the expanded planning, coordina-
14 tion, review, and evaluation authority provided the
15 National Institute on Minority Health and Health
16 Disparities under section 464z–3(h) of the Public
17 Health Service Act (42 U.S.C. 285(h)), as added by
18 section 10334(c) of the Patient Protection and Af-
19 fordable Care Act, over all minority health and
20 health disparity research that is conducted or sup-
21 ported by the Institutes and Centers at the National
22 Institutes of Health; and

23 (2) the outcomes of such steps.

24 (c) GAO REPORT RELATED TO RECIPIENTS OF
25 PPACA FUNDING.—Not later than one year after the

1 date of the enactment of this Act and biennially thereafter
2 until 2024, the Comptroller General of the United States
3 shall submit to Congress a report that identifies, with re-
4 spect to minority community-based organizations that ap-
5 plied during the applicable report period for Federal fund-
6 ing provided pursuant to the provisions of (and amend-
7 ments made by) the Patient Protection and Affordable
8 Care Act for purposes of achieving health equity and elimi-
9 nating health disparities, the percentage of such organiza-
10 tions that were awarded such funding.

11 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
12 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
13 PARITIES.—The Director of the National Institute on Mi-
14 nority Health and Health Disparities shall prepare an an-
15 nual report on the activities carried out or to be carried
16 out by the Institute, and shall submit each such report
17 to the Committee on Health, Education, Labor, and Pen-
18 sions of the Senate, the Committee on Energy and Com-
19 merce of the House of Representatives, the Secretary of
20 Health and Human Services, and the Director of the Na-
21 tional Institutes of Health. With respect to the fiscal year
22 involved, the report shall—

23 (1) describe and evaluate the progress made in
24 health disparities research conducted or supported

1 by institutes and centers of the National Institutes
2 of Health;

3 (2) summarize and analyze expenditures made
4 for activities with respect to health disparities re-
5 search conducted or supported by the National Insti-
6 tutes of Health;

7 (3) include a separate statement applying the
8 requirements of paragraphs (1) and (2) specifically
9 to minority health disparities research; and

10 (4) contain such recommendations as the Direc-
11 tor of the Institute considers appropriate.

12 **TITLE X—ADDRESSING SOCIAL**
13 **DETERMINANTS AND IM-**
14 **PROVING ENVIRONMENTAL**
15 **JUSTICE**

16 **SEC. 1001. DEFINITIONS.**

17 (a) DETERMINANTS OF HEALTH.—The term “deter-
18 minants of health”—

19 (1) refers to the range of personal, social, eco-
20 nomic, and environmental factors that influence
21 health status; and

22 (2) includes social determinants of health
23 (which are sometimes referred to as “social and eco-
24 nomic determinants of health” or “socioeconomic de-

1 terminants of health”), environmental determinants
2 of health, and personal determinants of health.

3 (b) ENVIRONMENTAL DETERMINANTS OF
4 HEALTH.—The term “environmental determinants of
5 health” refers to the broad physical, psychological, social,
6 and aesthetic environment.

7 (c) PERSONAL DETERMINANTS OF HEALTH.—The
8 term “personal determinants of health” refers to an indi-
9 vidual’s behavior, biology, and genetics.

10 (d) SOCIAL DETERMINANTS OF HEALTH .—The term
11 “social determinants of health” refers to a subset of deter-
12 minants of the health of individuals and environments
13 (such as communities, neighborhoods, and societies) that
14 describe people’s social identity, describe the social and
15 economic resources to which people have access, and de-
16 scribe the conditions in which people work, live, and play.

17 **SEC. 1002. FINDINGS.**

18 The Congress finds as follows:

19 (1) There are more opportunities to improve
20 health for everyone when we understand that health
21 starts, first, not in a medical setting, but in our
22 families, in our schools and workplaces, in our
23 neighborhoods, and in the air we breathe and water
24 we drink.

1 (2) The social determinants of health are the
2 largest predictors of health outcomes.

3 (3) Healthy People 2020 identifies health and
4 health care quality as a function of not only access
5 to health care, but also the social determinants of
6 health, categorized into the following: neighborhoods
7 and the built environment; social and community
8 context; education; and economic stability. The fol-
9 lowing examples illustrate the nexus between the un-
10 equal distribution of the social determinants of
11 health and health disparities:

12 (A) The built environment influences resi-
13 dents' level of physical activity. Neighborhoods
14 with high levels of poverty are significantly less
15 likely to have places where children can be
16 physically active, such as parks, green spaces,
17 and bike paths and lanes. Neighborhoods and
18 communities can provide opportunities for phys-
19 ical activity and support active lifestyles
20 through accessible and safe parks and open
21 spaces and through land use policy, zoning, and
22 healthy community design.

23 (B) Emotional and physical health and
24 well-being are directly impacted by perceived
25 levels of safety, such as unlit streets at night.

1 Community members have expressed that safety
2 is not only a barrier to accessing programs and
3 services that increase quality of life but they
4 are also not able to access physical activity in
5 their community through the built environment.

6 (C) In many workplace environments, toxic
7 chemicals have lasting detrimental effects on
8 employees' health. The hazardous compounds
9 found in most nail salon products affect the
10 respiratory system, reproductive system, and
11 central nervous system, and also cause kidney
12 and liver damage. Recognizing the importance
13 of addressing occupational hazards as a matter
14 of public health, especially for Asian-American
15 women who constitute 40 percent of nail salon
16 technicians—with Vietnamese-American women
17 accounting for 37 percent of this—the White
18 House Initiative on Asian American Pacific Is-
19 landers has created an interagency working
20 group to coordinate efforts by the Environ-
21 mental Protection Agency, Occupational and
22 Safety Health Administration, Food and Drug
23 Administration, and other Federal agencies to
24 create programming, draft regulations, and con-

1 duct more outreach on educating workers on
2 health and safety issues.

3 (D) Historical and institutional discrimina-
4 tion against certain racial groups in the United
5 States has shaped the way in which social and
6 economic resources and exposure to health pro-
7 moting environments are distributed. Income,
8 education, occupation, neighborhood conditions,
9 schools, workplaces, the use of and health and
10 social services, and experiences with the crimi-
11 nal justice system are all highly patterned by
12 race, with racial minorities (compared to
13 Whites) experiencing more that is health harm-
14 ing. Finding ways to uncouple the link between
15 race and access to resources and healthy envi-
16 ronments is a principal means of reducing
17 health disparities. Additionally, the anticipation
18 of racism itself causes higher psychological and
19 cardiovascular stress levels that are linked to
20 poor health outcomes. Remedying discrimina-
21 tory practices at the individual and systemic
22 levels will likely reduce health disparities caused
23 by this unequal distribution of stress.

24 (E) Poor health among Native Americans
25 has largely been driven by post-colonial oppres-

1 sion and historical trauma. The expropriation of
2 native lands and territories to the American
3 state had severe consequences on Native Amer-
4 ican health. This resulted in the deprivation of
5 traditional food sources—and nutrients—for
6 Native Americans and also the destruction of
7 traditional economies and community organiza-
8 tion. Today, Native Americans have twice the
9 rate of diabetes than non-Hispanic Whites. Rec-
10 ognition of the origins of the diabetes as having
11 a social and community context, rather than
12 just individual responsibility and genetic pre-
13 disposition, will shape better policy to provide
14 food security.

15 (F) In the context of prisons, overcrowding
16 has led to the deterioration of the physical and
17 mental health of individuals after they leave
18 prison. In particular, the mass incarceration of
19 African-American males as a result of unequal
20 contact with and treatment in the criminal jus-
21 tice system has contributed to an overburdening
22 of certain infectious diseases within the African-
23 American community. As a social institution,
24 incarceration amplifies existing adverse health
25 conditions by concentrating diseases and harm

1 health behaviors such as tobacco use, drug use,
2 and violence.

3 (G) Educational attainment is the strong-
4 est predictor of adult mortality. It is a basic
5 component of socioeconomic status by shaping
6 earning potential to access resources that pro-
7 mote health. People with more education are
8 less likely to report that they are in poor health,
9 and are also less likely to have diabetes and
10 other chronic diseases.

11 (H) Similarly, reading ability is a strong
12 predictor of adult health status and is often
13 correlated with other child health issues, such
14 as developmental problems, vision and hearing
15 impairments, and frequent school absence due
16 to illness.

17 (I) Individuals with lower levels of edu-
18 cational attainment are much more likely to re-
19 port to be current smokers. In 2011, smoking
20 prevalence was 45.3 percent among adults with
21 a GED diploma, 34.6 percent with nine to 11
22 years of education, and 23.8 percent with a
23 high school diploma, while dropping signifi-
24 cantly to 9.3 percent among adults with an un-

1 dergraduate college degree and 5.0 percent with
2 a postgraduate college degree.

3 (J) Social class differences account for a
4 large part of health disparities. For example,
5 children living in poverty experience poorer
6 housing conditions, increased exposure to in-
7 door allergens and toxins (such as pesticides,
8 lead, mercury, radon, air pollution, and carcino-
9 gens), and more psychological stress. These ex-
10 periences culminate in worse adult health as
11 compared with children with higher socio-
12 economic status. Specifically, children living in
13 socioeconomic neighborhoods have higher rates
14 of asthma due to higher rates of psychological
15 stress resulting from higher rates of violence.

16 (K) Lesbian, gay, bisexual, and
17 transgender (LGBT) individuals face health
18 disparities linked to societal stigma, discrimina-
19 tion, and denial of their civil and human rights.
20 Discrimination against LGBT individuals has
21 been associated with high rates of psychiatric
22 disorders, substance abuse, and suicide. Experi-
23 ences of violence and victimization are frequent
24 for LGBT individuals, and have long-lasting ef-
25 fects on the individual and the community. Per-

1 sonal, family, and social acceptance of sexual
2 orientation and gender identity affects the men-
3 tal health and personal safety of LGBT individ-
4 uals.

5 (4) Laws and regulations that improve opportu-
6 nities to live in safe neighborhoods, with more social
7 cohesion, attain higher education, sustain stable em-
8 ployment, and bridge class differences help foster
9 the health and safety of individuals.

10 (5) The global public health community has
11 reached consensus through the Rio Political Declara-
12 tion of Social Determinants of Health that
13 “[c]ollaboration in coordinated and intersectoral pol-
14 icy actions has proven to be effective. Health in All
15 Policies, together with intersectoral cooperation and
16 action, is one promising approach to enhance ac-
17 countability in other sectors of health, as well as the
18 promotion of health equity and more inclusive and
19 productive societies.”

20 **SEC. 1003. HEALTH IMPACT ASSESSMENTS.**

21 (a) FINDINGS.—Congress makes the following find-
22 ings:

23 (1) Health Impact Assessment is a tool to help
24 planners, health officials, decisionmakers, and the
25 public make more informed decisions about the po-

1 potential health effects of proposed plans, policies, pro-
2 grams, and projects in order to maximize health
3 benefits and minimize harms.

4 (2) Health Impact Assessments can be done at
5 a fraction of the cost and time typically required for
6 other planning and permitting reviews.

7 (3) Health Impact Assessments can build com-
8 munity support and reduce opposition to a project or
9 policy, thereby facilitating economic growth by aid-
10 ing the development of consensus regarding new de-
11 velopment proposals.

12 (4) Health Impact Assessments facilitate col-
13 laboration across sectors.

14 (b) PURPOSES.—It is the purpose of this section to—

15 (1) provide more information about the poten-
16 tial human health effects of policy decisions and the
17 distribution of those effects;

18 (2) improve how health is considered in plan-
19 ning and decisionmaking processes; and

20 (3) build stronger, healthier communities
21 through the use of Health Impact Assessment.

22 (c) HEALTH IMPACT ASSESSMENTS.—Part P of title
23 III of the Public Health Service Act (42 U.S.C. 280g et
24 seq.), as amended, is further amended by adding at the
25 end the following:

1 **“SEC. 399V-9. HEALTH IMPACT ASSESSMENTS.**

2 “(a) DEFINITIONS.—In this section and section
3 399V-10:

4 “(1) ADMINISTRATOR.—The term ‘Adminis-
5 trator’ means the Administrator of the Environ-
6 mental Protection Agency.

7 “(2) BUILT ENVIRONMENT.—The term ‘built
8 environment’ means the components of the environ-
9 ment, and the location of these components in a geo-
10 graphically defined space, that are created or modi-
11 fied by individuals to form the physical and social
12 characteristics of a community or enhance quality of
13 human life, including—

14 “(A) homes, schools, and places of work
15 and worship;

16 “(B) parks, recreation areas, and green-
17 ways;

18 “(C) transportation systems;

19 “(D) business, industry, and agriculture;
20 and

21 “(E) land-use plans, projects, and policies
22 that impact the physical or social characteris-
23 tics of a community, including access to services
24 and amenities.

1 “(3) DIRECTOR.—The term ‘Director’ means
2 the Director of the Centers for Disease Control and
3 Prevention.

4 “(4) ELIGIBLE ENTITY.—The term ‘eligible en-
5 tity’ means a unit of State or tribal government the
6 jurisdiction of which includes individuals or popu-
7 lations the health of which are, or will be, affected
8 by an activity or a proposed activity.

9 “(5) ELIGIBLE INSTITUTION.—The term ‘eligi-
10 ble institution’ means a public agency or private
11 nonprofit institution that submits to the Secretary,
12 in consultation with the Administrator, an applica-
13 tion for a grant authorized under such section at
14 such time, in such manner, and containing such
15 agreements, assurances, and information as the Sec-
16 retary and Administrator may require.

17 “(6) HEALTH IMPACT ASSESSMENT.—The term
18 ‘Health Impact Assessment’ means a systematic
19 process that uses an array of data sources and ana-
20 lytic methods and considers input from stakeholders
21 to determine the potential effects of a proposed pol-
22 icy, plan, program, or project on the health of a pop-
23 ulation and the distribution of those effects within
24 the population. Such term includes identifying and
25 recommending appropriate actions on monitoring

1 and maximizing potential benefits and minimizing
2 the potential harms.

3 “(7) HEALTH DISPARITIES.—The term ‘health
4 disparities’ are a particular type of health dif-
5 ferences that are closely linked with social, economic,
6 and/or environmental disadvantage. Health dispari-
7 ties adversely affect groups of people who have sys-
8 tematically experienced greater obstacles to health
9 based on their racial or ethnic group; religion; socio-
10 economic status; gender; age; mental health; cog-
11 nitive, sensory, or physical disability; sexual orienta-
12 tion or gender identity; geographic location; or other
13 characteristics historically linked to discrimination
14 or exclusion.

15 “(8) PROPOSED ACTIVITY.—The term ‘proposed
16 activity’ means a proposed policy, program, plan, or
17 project currently under consideration by a local,
18 State, tribal, or Federal agency or government.

19 “(b) ESTABLISHMENT.—The Secretary, acting
20 through the Director and in collaboration with the Admin-
21 istrator, shall carry out the following:

22 “(1) Establish a program at the National Cen-
23 ter for Environmental Health at the Centers for Dis-
24 ease Control and Prevention focused on advancing
25 the field of Health Impact Assessment. In devel-

1 oping and implementing the program, the Director
2 of the National Center for Environmental Health
3 shall consult with the Director of the National Cen-
4 ter for Chronic Disease Prevention and Health Pro-
5 motion as well as relevant offices within the Depart-
6 ment of Housing and Urban Development, the De-
7 partment of Transportation, and the Department of
8 Agriculture. The program shall include—

9 “(A) collecting and disseminating best
10 practices;

11 “(B) administering capacity building
12 grants to States to support grantees in initi-
13 ating Health Impact Assessments, in accord-
14 ance with subsection (d);

15 “(C) providing technical assistance;

16 “(D) developing training tools and pro-
17 viding training on conducting Health Impact
18 Assessment and the implementation of built en-
19 vironment and health indicators;

20 “(E) making information available, as ap-
21 propriate, regarding the existence of other com-
22 munity healthy living tools, checklists, and indi-
23 ces that help connect public health to other sec-
24 tors, and tools to help examine the effect of the

1 indoor built environment and building codes on
2 population health;

3 “(F) conducting research and evaluations
4 of Health Impact Assessments; and

5 “(G) awarding competitive extramural re-
6 search grants.

7 “(2) In accordance with subsection (c), develop
8 guidance and guidelines to conduct Health Impact
9 Assessments.

10 “(3) In accordance with subsection (d), estab-
11 lish a grant program to allow States to fund eligible
12 entities to conduct Health Impact Assessments.

13 “(c) GUIDANCE.—The Director, in consultation with
14 the Director of the National Center for Environmental
15 Health and, the Director of the National Center for
16 Chronic Disease Prevention and Health Promotion, and
17 relevant offices within the Department of Housing and
18 Urban Development, the Department of Transportation,
19 and the Department of Agriculture, shall—

20 “(1) develop guidance for conducting Health
21 Impact Assessment, including—

22 “(A) background on national and inter-
23 national efforts to bridge urban planning and
24 public health institutions and disciplines, in-

1 including a review of Health Impact Assessment
2 best practices internationally;

3 “(B) evidence-based direct and indirect
4 pathways that link land-use planning, transpor-
5 tation, and housing policy and objectives to
6 human health outcomes;

7 “(C) data resources and quantitative and
8 qualitative forecasting methods to evaluate both
9 the status of health determinants and health ef-
10 fects, including identification of existing pro-
11 grams that can disseminate these resources;

12 “(D) best practices for inclusive public in-
13 volvement in conducting Health Impact Assess-
14 ments; and

15 “(E) technical assistance for other agen-
16 cies seeking to develop their own guidelines and
17 procedures for Health Impact Assessment;

18 “(2) in developing the guidance, consider avail-
19 able international Health Impact Assessment guid-
20 ance, North American Health Impact Assessment
21 Practice Standards, and recommendations from the
22 National Academy of Science; and

23 “(3) not later than 1 year after the date of en-
24 actment of this section, publish the guidance.

1 “(d) GRANT PROGRAM.—The Secretary, acting
2 through the Director and in collaboration with the Admin-
3 istrator, shall establish a program under which the Sec-
4 retary shall award grants to States to fund eligible entities
5 for capacity building or to prepare Health Impact Assess-
6 ments, and shall ensure that States receiving a grant
7 under this subsection further support training and tech-
8 nical assistance for grantees under the program by fund-
9 ing and overseeing appropriate local, State, tribal, Fed-
10 eral, university, or nonprofit Health Impact Assessment
11 experts to provide technical assistance. Such assessments
12 shall—

13 “(1) ensure that appropriate health factors are
14 taken into consideration as early as practicable dur-
15 ing the planning, review, or decisionmaking proc-
16 esses;

17 “(2) assess the effect on the health of individ-
18 uals and populations of proposed policies, projects,
19 or plans that result in modifications to the built en-
20 vironment; and

21 “(3) assess the distribution of health effects
22 across various factors, such as race, income, eth-
23 nicity, age, disability status, gender, and geography.

24 “(e) APPLICATIONS.—

1 “(1) IN GENERAL.—To be eligible to receive a
2 grant under this section, an eligible entity shall sub-
3 mit to the Secretary an application in accordance
4 with this subsection, at such time, in such manner,
5 and containing such additional information as the
6 Secretary may require.

7 “(2) INCLUSION.—An application under this
8 subsection shall include a list of proposed activities
9 that require or would benefit from conducting a
10 Health Impact Assessment within six months of
11 awarding funds. The list should be accompanied by
12 supporting documentation, including letters of sup-
13 port, from potential conductors of Health Impact
14 Assessments for the listed proposed activities. Each
15 application should also include an assessment by the
16 eligible entity of the health of the population of its
17 jurisdiction and describe potential adverse or positive
18 effects on health that the proposed activities may
19 create.

20 “(3) PREFERENCE.—Preference in awarding
21 funds under this section may be given to eligible en-
22 tities that demonstrate the potential to significantly
23 improve population health or lower health care costs
24 as a result of potential Health Impact Assessment
25 work.

1 “(f) USE OF FUNDS.—

2 “(1) IN GENERAL.—An eligible entity shall use
3 amounts provided under a grant under this section
4 to conduct Health Impact Assessment capacity
5 building or to conduct or fund subgrantees to con-
6 duct a Health Impact Assessment for a proposed ac-
7 tivity in accordance with this subsection.

8 “(2) PURPOSES.—The purposes of a Health
9 Impact Assessment under this subsection are—

10 “(A) to facilitate the involvement of tribal,
11 State, and local public health officials in com-
12 munity planning, transportation, housing, and
13 land use decisions and other decisions affecting
14 the built environment to identify any potential
15 health concern or health benefit relating to an
16 activity or proposed activity;

17 “(B) to provide for an investigation of any
18 health-related issue of concern raised in a plan-
19 ning process, an environmental impact assess-
20 ment process, or policy appraisal relating to a
21 proposed activity;

22 “(C) to describe and compare alternatives
23 (including no-action alternatives) to a proposed
24 activity to provide clarification with respect to
25 the potential health outcomes associated with

1 the proposed activity and, where appropriate, to
2 the related benefit-cost or cost-effectiveness of
3 the proposed activity and alternatives;

4 “(D) to contribute, when applicable, to the
5 findings of a planning process, policy appraisal,
6 or an environmental impact statement with re-
7 spect to the terms and conditions of imple-
8 menting a proposed activity or related mitiga-
9 tion recommendations, as necessary;

10 “(E) to ensure that the disproportionate
11 distribution of negative impacts among vulner-
12 able populations is minimized as much as pos-
13 sible;

14 “(F) to engage affected community mem-
15 bers and ensure adequate opportunity for public
16 comment on all stages of the Health Impact As-
17 sessment; and

18 “(G) where appropriate, to consult with
19 local and county health departments and appro-
20 priate organizations, including planning, trans-
21 portation, and housing organizations and pro-
22 viding them with information and tools regard-
23 ing how to conduct and integrate Health Im-
24 pact Assessment into their work.

25 “(3) ELIGIBLE ACTIVITIES.—

1 “(A) IN GENERAL.—Eligible entities fund-
2 ed under this subsection shall conduct an eval-
3 uation of any proposed activity to determine
4 whether it will have a significant adverse or
5 positive effect on the health of the affected pop-
6 ulation in the jurisdiction of the eligible entity,
7 based on the criteria described in subparagraph
8 (B).

9 “(B) CRITERIA.—The criteria described in
10 this subparagraph include, as applicable to the
11 proposed activity, the following:

12 “(i) Any substantial adverse effect or
13 significant health benefit on health out-
14 comes or factors known to influence health,
15 including the following:

16 “(I) Physical activity.

17 “(II) Injury.

18 “(III) Mental health.

19 “(IV) Accessibility to health-pro-
20 moting goods and services.

21 “(V) Respiratory health.

22 “(VI) Chronic disease.

23 “(VII) Nutrition.

1 “(VIII) Land use changes that
2 promote local, sustainable food
3 sources.

4 “(IX) Infectious disease.

5 “(X) Health disparities.

6 “(XI) Existing air quality,
7 ground or surface water quality or
8 quantity, or noise levels; and

9 “(ii) Other factors that may be con-
10 sidered, including—

11 “(I) the potential for a proposed
12 activity to result in systems failure
13 that leads to a public health emer-
14 gency;

15 “(II) the probability that the pro-
16 posed activity will result in a signifi-
17 cant increase in tourism, economic de-
18 velopment, or employment in the ju-
19 risdiction of the eligible entity;

20 “(III) any other significant po-
21 tential hazard or enhancement to
22 human health, as determined by the
23 eligible entity; or

24 “(IV) whether the evaluation of a
25 proposed activity would duplicate an-

1 other analysis or study being under-
2 taken in conjunction with the pro-
3 posed activity.

4 “(C) FACTORS FOR CONSIDERATION.—In
5 evaluating a proposed activity under subpara-
6 graph (A), an eligible entity may take into con-
7 sideration any reasonable, direct, indirect, or
8 cumulative effect that can be clearly related to
9 potential health effects and that is related to
10 the proposed activity, including the effect of
11 any action that is—

12 “(i) included in the long-range plan
13 relating to the proposed activity;

14 “(ii) likely to be carried out in coordi-
15 nation with the proposed activity;

16 “(iii) dependent on the occurrence of
17 the proposed activity; or

18 “(iv) likely to have a disproportionate
19 impact on high-risk or vulnerable popu-
20 lations.

21 “(4) REQUIREMENTS.—A Health Impact As-
22 sessment prepared with funds awarded under this
23 subsection shall incorporate the following, after con-
24 ducting the screening phase (identifying projects or
25 policies for which a Health Impact Assessment

1 would be valuable and feasible) through the applica-
2 tion process:

3 “(A) SCOPING.—Identifying which health
4 effects to consider and the research methods to
5 be utilized.

6 “(B) ASSESSING RISKS AND BENEFITS.—
7 Assessing the baseline health status and factors
8 known to influence the health status in the af-
9 fected community, which may include aggreg-
10 ating and synthesizing existing health assess-
11 ment evidence and data from the community.

12 “(C) DEVELOPING RECOMMENDATIONS.—
13 Suggesting changes to proposals to promote
14 positive or mitigate adverse health effects.

15 “(D) REPORTING.—Synthesizing the as-
16 sessment and recommendations and commu-
17 nicating the results to decisionmakers.

18 “(E) MONITORING AND EVALUATING.—
19 Tracking the decision and implementation effect
20 on health determinants and health status.

21 “(5) PLAN.—An eligible entity that is awarded
22 a grant under this section shall develop and imple-
23 ment a plan, to be approved by the Director, for
24 meaningful and inclusive stakeholder involvement in
25 all phases of the Health Impact Assessment. Stake-

1 holders may include community-based organizations,
2 youth-serving organizations, planners, public health
3 experts, State and local public health departments
4 and officials, health care experts or officials, housing
5 experts or officials, and transportation experts or of-
6 ficials.

7 “(6) SUBMISSION OF FINDINGS.—An eligible
8 entity that is awarded a grant under this section
9 shall submit the findings of any funded Health Im-
10 pact Assessment activities to the Secretary and
11 make these findings publicly available.

12 “(7) ASSESSMENT OF IMPACTS.—An eligible en-
13 tity that is awarded a grant under this section shall
14 ensure the assessment of the distribution of health
15 impacts (related to the proposed activity) across
16 race, ethnicity, income, age, gender, disability status,
17 and geography.

18 “(8) CONDUCT OF ASSESSMENT.—To the great-
19 est extent feasible, a Health Impact Assessment
20 shall be conducted under this section in a manner
21 that respects the needs and timing of the decision-
22 making process it evaluates.

23 “(9) METHODOLOGY.—In preparing a Health
24 Impact Assessment under this subsection, an eligible

1 entity or partner shall follow the guidance published
2 under subsection (c).

3 “(g) HEALTH IMPACT ASSESSMENT DATABASE.—

4 The Secretary, acting through the Director and in collabo-
5 ration with the Administrator, shall establish, maintain,
6 and make publicly available a Health Impact Assessment
7 database, including—

8 “(1) a catalog of Health Impact Assessments
9 received under this section;

10 “(2) an inventory of tools used by eligible enti-
11 ties to conduct Health Impact Assessments; and

12 “(3) guidance for eligible entities with respect
13 to the selection of appropriate tools described in
14 paragraph (2).

15 “(h) EVALUATION OF GRANTEE ACTIVITIES.—The
16 Secretary shall award competitive grants to Prevention
17 Research Centers, or nonprofit organizations or academic
18 institutions with expertise in Health Impact Assessments
19 to—

20 “(1) assist grantees with the provision of train-
21 ing and technical assistance in the conducting of
22 Health Impact Assessments;

23 “(2) evaluate the activities carried out with
24 grants under subsection (d); and

1 “(3) assist the Secretary in disseminating evi-
2 dence, best practices, and lessons learned from
3 grantees.

4 “(i) REPORT TO CONGRESS.—Not later than 1 year
5 after the date of enactment of this section, the Secretary
6 shall submit to Congress a report concerning the evalua-
7 tion of the programs under this section, including rec-
8 ommendations as to how lessons learned from such pro-
9 grams can be incorporated into future guidance docu-
10 ments developed and provided by the Secretary and other
11 Federal agencies, as appropriate.

12 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary.

15 **“SEC. 399V-10. ADDITIONAL RESEARCH ON THE RELATION-**
16 **SHIP BETWEEN THE BUILT ENVIRONMENT**
17 **AND HEALTH OUTCOMES.**

18 “(a) RESEARCH GRANT PROGRAM.—

19 “(1) GRANTS.—The Secretary, in collaboration
20 with the Administrator, shall award grants to eligi-
21 ble institutions to conduct and coordinate research
22 on the built environment and its influence on human
23 health. Factors that influence health that may be
24 considered include—

25 “(A) levels of physical activity;

- 1 “(B) consumption of nutritional foods;
2 “(C) rates of crime;
3 “(D) air, water, and soil quality;
4 “(E) risk or rate of injury;
5 “(F) accessibility to health-promoting
6 goods and services;
7 “(G) chronic disease rates;
8 “(H) community design;
9 “(I) housing; and
10 “(J) other indicators as determined appro-
11 priate by the Secretary.

12 “(2) RESEARCH.—The Secretary, in consulta-
13 tion with the Administrator, shall support research
14 under this section that—

15 “(A) investigates and defines links between
16 the built environment and human health and
17 identifies causal relationships;

18 “(B) examines—

19 “(i) the scope and intensity of the im-
20 pact that the built environment (including
21 the various characteristics of the built en-
22 vironment) has on the human health; or

23 “(ii) the distribution of such impacts
24 by—

25 “(I) location; and

1 “(II) population subgroup;

2 “(C) is used to develop—

3 “(i) measures and indicators to ad-

4 dress health impacts and the connection of

5 health to the built environment;

6 “(ii) efforts to link the measures to

7 transportation, land use, and health data-

8 bases; and

9 “(iii) efforts to enhance the collection

10 of built environment surveillance data;

11 “(D) distinguishes carefully between per-

12 sonal attitudes and choices and external influ-

13 ences on behavior to determine how much the

14 association between the built environment and

15 the health of residents, versus the lifestyle pref-

16 erences of the people that choose to live in the

17 neighborhood, reflects the physical characteris-

18 tics of the neighborhood; and

19 “(E)(i) identifies or develops effective

20 intervention strategies focusing on enhance-

21 ments to the built environment that promote in-

22 creased use physical activity, access to nutri-

23 tious foods, or other health-promoting activities

24 by residents; and

1 “(ii) in developing the intervention strate-
2 gies under clause (i), ensures that the interven-
3 tion strategies will reach out to high-risk or vul-
4 nerable populations, including low-income urban
5 and rural communities and aging populations,
6 in addition to the general population.

7 “(3) SURVEYS.—The Secretary may use funds
8 appropriated under this section to support the ex-
9 pansion of national surveys and data tracking sys-
10 tems to provide more detailed information about the
11 connection between the built environment and
12 health.

13 “(4) PRIORITY.—In providing assistance under
14 the grant program under this section, the Secretary
15 and the Administrator shall give priority to research
16 that incorporates—

17 “(A) interdisciplinary approaches; or

18 “(B) the expertise of the public health,
19 physical activity, urban planning, land use, and
20 transportation research communities in the
21 United States and abroad.

22 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated such sums as may be
24 necessary to carry out this section. Not to exceed 20 per-
25 cent of amounts appropriated for each fiscal year under

1 this subsection may be used for the research component
2 of the program under this section.”.

3 **SEC. 1004. IMPLEMENTATION OF RECOMMENDATIONS BY**
4 **ENVIRONMENTAL PROTECTION AGENCY.**

5 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The
6 Administrator of the Environmental Protection Agency
7 shall, as promptly as practicable, carry out each of the
8 following recommendations of the Inspector General of the
9 Agency as set forth in Report No. 2006–P–00034 entitled
10 “EPA needs to conduct environmental justice reviews of
11 its programs, policies and activities”:

12 (1) The recommendation that the Agency’s pro-
13 gram and regional offices identify which programs,
14 policies, and activities need environmental justice re-
15 views and require these offices to establish a plan to
16 complete the necessary reviews.

17 (2) The recommendation that the Administrator
18 of the Agency ensure that these reviews determine
19 whether the programs, policies, and activities may
20 have a disproportionately high and adverse health or
21 environmental impact on minority and low-income
22 populations.

23 (3) The recommendation that each program
24 and regional office develop specific environmental

1 justice review guidance for conducting environmental
2 justice reviews.

3 (4) The recommendation that the Administrator
4 designate a responsible office to compile results of
5 environmental justice reviews and recommend appro-
6 priate actions.

7 (b) GAO RECOMMENDATIONS.—In developing rules
8 under laws administered by the Environmental Protection
9 Agency, the Administrator of the Agency shall, as prompt-
10 ly as practicable, carry out each of the following rec-
11 ommendations of the Comptroller General of the United
12 States as set forth in GAO Report numbered GAO–05–
13 289 entitled “EPA Should Devote More Attention to En-
14 vironmental Justice when Developing Clean Air Rules”:

15 (1) The recommendation that the Administrator
16 ensure that workgroups involved in developing a rule
17 devote attention to environmental justice while draft-
18 ing and finalizing the rule.

19 (2) The recommendation that the Administrator
20 enhance the ability of such workgroups to identify
21 potential environmental justice issues through such
22 steps as providing workgroup members with guid-
23 ance and training to help them identify potential en-
24 vironmental justice problems and involving environ-

1 mental justice coordinators in the workgroups when
2 appropriate.

3 (3) The recommendation that the Administrator
4 improve assessments of potential environmental jus-
5 tice impacts in economic reviews by identifying the
6 data and developing the modeling techniques needed
7 to assess such impacts.

8 (4) The recommendation that the Administrator
9 direct appropriate Agency officers and employees to
10 respond fully when feasible to public comments on
11 environmental justice, including improving the Agen-
12 cy’s explanation of the basis for its conclusions, to-
13 gether with supporting data.

14 (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-
15 ministrators of the Environmental Protection Agency shall,
16 as promptly as practicable, carry out each of the following
17 recommendations of the Inspector General of the Agency
18 as set forth in the report entitled “EPA Needs to Consist-
19 ently Implement the Intent of the Executive Order on En-
20 vironmental Justice” (Report No. 2004–P–00007):

21 (1) The recommendation that the Agency clear-
22 ly define the mission of the Office of Environmental
23 Justice (OEJ) and provide Agency staff with an un-
24 derstanding of the roles and responsibilities of the
25 Office.

1 (2) The recommendation that the Agency estab-
2 lish (through issuing guidance or a policy statement
3 from the Administrator) specific timeframes for the
4 development of definitions, goals, and measurements
5 regarding environmental justice and provide the re-
6 gions and program offices a standard and consistent
7 definition for a minority and low-income community,
8 with instructions on how the Agency will implement
9 and put into operation environmental justice in the
10 Agency’s daily activities.

11 (3) The recommendation that the Agency en-
12 sure the comprehensive training program currently
13 under development includes standard and consistent
14 definitions of the key environmental justice concepts
15 (such as “low-income”, “minority”, and “dispropor-
16 tionately impacted”) and instructions for implemen-
17 tation of those concepts.

18 The Administrator shall submit an initial report to Con-
19 gress within 6 months after the enactment of this Act re-
20 garding the Administrator’s strategy for implementing the
21 recommendations referred to in paragraphs (1), (2), and
22 (3). Thereafter, the Administrator shall provide semi-
23 annual reports to Congress regarding the Administrator’s
24 progress in implementing such recommendations and
25 modifying the Administrator’s emergency management

1 procedures to incorporate environmental justice in the
2 Agency’s Incident Command Structure (in accordance
3 with the December 18, 2006, letter from the Deputy Ad-
4 ministrator to the Acting Inspector General of the Agen-
5 cy).

6 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,
7 PROTECTING PEOPLE AND THEIR FAMILIES FROM
8 RADON.—

9 (1) IN GENERAL.—Because radon is a naturally
10 occurring radioactive gas that is recognized as the
11 leading cause of lung cancer among nonsmokers and
12 is a particular environmental threat for low-income
13 and minority individuals because of the lack of infor-
14 mation about radon levels in their own homes, the
15 Administrator of the Environmental Protection
16 Agency shall within 6 months after the date of the
17 enactment of this Act, implement the action plan en-
18 titled “Protecting People and Families from Radon:
19 A Federal Action Plan for Saving Lives” (June 20,
20 2011), working with the Secretary of Health and
21 Human Services acting through the Director of the
22 Centers for Disease Control and Prevention, and
23 with the other Federal agencies mentioned in and as
24 set forth in the action plan.

1 (2) SPECIFIC STEPS.—In carrying out para-
2 graph (1), the Administrator shall take steps to
3 achieve each of the following:

4 (A) The recommendation that the
5 workgroup comprised of the Federal agencies
6 participating in the development of the action
7 plan referred to in paragraph (1) implement
8 specific steps within the current authority and
9 activities of each Federal agency to reduce ex-
10 posure to radon.

11 (B) The recommendation that such
12 workgroup meet on the 1-year anniversary of
13 the plan to assess and recognize achievements
14 of the plan.

15 (3) REPORT.—The Administrator shall report
16 to the Congress on the 1-year assessment of the
17 plan’s implementation, including the challenges re-
18 maining and the progress in reducing radon expo-
19 sure particularly to low-income and minority fami-
20 lies.

21 **SEC. 1005. GRANT PROGRAM TO CONDUCT ENVIRON-**
22 **MENTAL HEALTH IMPROVEMENT ACTIVITIES**
23 **AND TO IMPROVE SOCIAL DETERMINANTS OF**
24 **HEALTH.**

25 (a) DEFINITIONS.—In this section:

1 (1) DIRECTOR.—The term “Director” means
2 the Director of the Centers for Disease Control and
3 Prevention, acting in collaboration with the Adminis-
4 trator of the Environmental Protection Agency and
5 the Director of the National Institute of Environ-
6 mental Health Sciences.

7 (2) ELIGIBLE ENTITY.—The term “eligible enti-
8 ty” means a State or local community that—

9 (A) bears a disproportionate burden of ex-
10 posure to environmental health hazards;

11 (B) bears a disproportionate burden of ex-
12 posure to unhealthy living conditions, low
13 standard housing conditions, low socioeconomic
14 status, poor nutrition, less opportunity for edu-
15 cational attainment, disproportionate unemploy-
16 ment rates, or lower literacy levels;

17 (C) has established a coalition—

18 (i) with not less than 1 community-
19 based organization or demonstration pro-
20 gram; and

21 (ii) with not less than 1—

22 (I) public health entity;

23 (II) health care provider organi-
24 zation;

1 (III) academic institution, includ-
2 ing any minority-serving institution
3 (including a Hispanic-serving institu-
4 tion, a historically Black college or
5 university, and a tribal college or uni-
6 versity); or

7 (IV) child-serving institution;

8 (D) ensures planned activities and funding
9 streams are coordinated to improve community
10 health; and

11 (E) submits an application in accordance
12 with subsection (c).

13 (b) ESTABLISHMENT.—The Director shall establish a
14 grant program under which eligible entities shall receive
15 grants to conduct environmental health improvement ac-
16 tivities and to improve social determinants of health.

17 (c) APPLICATION.—To receive a grant under this sec-
18 tion, an eligible entity shall submit an application to the
19 Director at such time, in such manner, and accompanied
20 by such information as the Director may require.

21 (d) COOPERATIVE AGREEMENTS.—An eligible entity
22 may use a grant under this section—

23 (1) to promote environmental health;

24 (2) to address environmental health disparities
25 among all populations, including children; and

1 (3) to address racial and ethnic disparities in
2 social determinants of health.

3 (e) AMOUNT OF COOPERATIVE AGREEMENT.—

4 (1) IN GENERAL.—The Director shall award
5 grants to eligible entities at the 3 different funding
6 levels described in this subsection.

7 (2) LEVEL 1 COOPERATIVE AGREEMENTS.—

8 (A) IN GENERAL.—An eligible entity
9 awarded a grant under this paragraph shall use
10 the funds to identify environmental health prob-
11 lems and solutions by—

12 (i) establishing a planning and
13 prioritizing council in accordance with sub-
14 paragraph (B); and

15 (ii) conducting an environmental
16 health assessment in accordance with sub-
17 paragraph (C).

18 (B) PLANNING AND PRIORITIZING COUN-
19 CIL.—

20 (i) IN GENERAL.—A prioritizing and
21 planning council established under sub-
22 paragraph (A)(i) (referred to in this para-
23 graph as a “PPC”) shall assist the envi-
24 ronmental health assessment process and

1 environmental health promotion activities
2 of the eligible entity.

3 (ii) MEMBERSHIP.—Membership of a
4 PPC shall consist of representatives from
5 various organizations within public health,
6 planning, development, and environmental
7 services and shall include stakeholders
8 from vulnerable groups such as children,
9 the elderly, disabled, and minority ethnic
10 groups that are often not actively involved
11 in democratic or decisionmaking processes.

12 (iii) DUTIES.—A PPC shall—

13 (I) identify key stakeholders and
14 engage and coordinate potential part-
15 ners in the planning process;

16 (II) establish a formal advisory
17 group to plan for the establishment of
18 services;

19 (III) conduct an in-depth review
20 of the nature and extent of the need
21 for an environmental health assess-
22 ment, including a local epidemiological
23 profile, an evaluation of the service
24 provider capacity of the community,

1 and a profile of any target popu-
2 lations; and

3 (IV) define the components of
4 care and form essential programmatic
5 linkages with related providers in the
6 community.

7 (C) ENVIRONMENTAL HEALTH ASSESS-
8 MENT.—

9 (i) IN GENERAL.—A PPC shall carry
10 out an environmental health assessment to
11 identify environmental health concerns.

12 (ii) ASSESSMENT PROCESS.—The
13 PPC shall—

14 (I) define the goals of the assess-
15 ment;

16 (II) generate the environmental
17 health issue list;

18 (III) analyze issues with a sys-
19 tems framework;

20 (IV) develop appropriate commu-
21 nity environmental health indicators;

22 (V) rank the environmental
23 health issues;

24 (VI) set priorities for action;

25 (VII) develop an action plan;

1 (VIII) implement the plan; and
2 (IX) evaluate progress and plan-
3 ning for the future.

4 (D) EVALUATION.—Each eligible entity
5 that receives a grant under this paragraph shall
6 evaluate, report, and disseminate program find-
7 ings and outcomes.

8 (E) TECHNICAL ASSISTANCE.—The Direc-
9 tor may provide such technical and other non-
10 financial assistance to eligible entities as the
11 Director determines to be necessary.

12 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—

13 (A) ELIGIBILITY.—

14 (i) IN GENERAL.—The Director shall
15 award grants under this paragraph to eli-
16 gible entities that have already—

17 (I) established broad-based col-
18 laborative partnerships; and

19 (II) completed environmental as-
20 sessments.

21 (ii) NO LEVEL 1 REQUIREMENT.—To
22 be eligible to receive a grant under this
23 paragraph, an eligible entity is not re-
24 quired to have successfully completed a

1 Level 1 Cooperative Agreement (as de-
2 scribed in paragraph (2)).

3 (B) USE OF GRANT FUNDS.—An eligible
4 entity awarded a grant under this paragraph
5 shall use the funds to further activities to carry
6 out environmental health improvement activi-
7 ties, including—

8 (i) addressing community environ-
9 mental health priorities in accordance with
10 paragraph (2)(C)(ii), including—

11 (I) geography;

12 (II) the built environment;

13 (III) air quality;

14 (IV) water quality;

15 (V) land use;

16 (VI) solid waste;

17 (VII) housing;

18 (VIII) crime;

19 (IX) socioeconomic status;

20 (X) ethnicity, social construct
21 and language preference;

22 (XI) educational attainment;

23 (XII) employment;

24 (XIII) food safety;

25 (XIV) nutrition;

1 (XV) health care services; and

2 (XVI) injuries;

3 (ii) building partnerships between
4 planning, public health, and other sectors,
5 including child-serving institutions, to ad-
6 dress how the built environment impacts
7 food availability and access and physical
8 activity to promote healthy behaviors and
9 lifestyles and reduce overweight and obe-
10 sity, musculoskeletal diseases, respiratory
11 conditions, dental, oral and mental health
12 conditions, poverty, and related co-
13 morbidities;

14 (iii) establishing programs to ad-
15 dress—

16 (I) how environmental and social
17 conditions of work and living choices
18 influence physical activity and dietary
19 intake; or

20 (II) how those conditions influ-
21 ence the concerns and needs of people
22 who have impaired mobility and use
23 assistance devices, including wheel-
24 chairs, lower limb prostheses, and hip,

1 knee, and other joint replacements;
2 and

3 (iv) convening intervention and dem-
4 onstration programs that examine the role
5 of the social environment in connection
6 with the physical and chemical environ-
7 ment in—

8 (I) determining access to nutri-
9 tional food; and

10 (II) improving physical activity to
11 reduce overweight, obesity, and co-
12 morbidities and increase quality of
13 life.

14 (4) LEVEL 3 COOPERATIVE AGREEMENTS.—

15 (A) IN GENERAL.—An eligible entity
16 awarded a grant under this paragraph shall use
17 the funds to identify and address racial and
18 ethnic disparities in social determinants of
19 health by creating demonstration programs that
20 assess the feasibility of establishing a federally
21 funded comprehensive program and describe
22 key outcomes that address racial and ethnic dis-
23 parities in social determinants of health.

24 (B) PROGRAM DESIGN.—

1 (i) EVALUATION.—No later than 1
2 year after enactment of this Act, the Di-
3 rector shall evaluate the best practices of
4 existing programs from the private, public,
5 community based, and academically sup-
6 ported initiatives focused on reducing dis-
7 parities in the social determinants of
8 health for racial and ethnic populations.

9 (ii) DEMONSTRATION PROJECTS.—
10 Not later than two years after the date of
11 enactment of this Act, the Director shall
12 implement at least ten demonstration
13 projects including at least one project for
14 each major racial and ethnic minority
15 group, each of which is unique to the cul-
16 tural and linguistic needs of each of the
17 following groups:

18 (I) Native Americans and Alaska
19 Natives.

20 (II) Asian-Americans.

21 (III) African-Americans/Blacks.

22 (IV) Hispanic/Latino-Americans.

23 (V) Native Hawaiians and Pacific
24 Islanders.

1 (iii) REPORT TO CONGRESS.—No later
2 than 2 years after the implementation of
3 the initial demonstration projects, the Di-
4 rector shall submit to Congress a report
5 which includes—

6 (I) a description of each dem-
7 onstration project and design;

8 (II) an evaluation of the cost ef-
9 fectiveness of each project’s preven-
10 tion and treatment efforts;

11 (III) an evaluation of the cultural
12 and linguistic appropriateness of each
13 project by racial and ethnic group;
14 and

15 (IV) an evaluation of the bene-
16 ficiary’s health status improvement
17 under the demonstration project.

18 (iv) ANY OTHER INFORMATION
19 DEEMED APPROPRIATE BY THE DIREC-
20 TOR.—The Director shall require any other
21 information deemed appropriate to be
22 shared by or developed by eligible entities
23 awarded a grant under this paragraph, in-
24 cluding the following:

1 (I) Developing models and evalu-
2 ating methods that improve the cul-
3 tural and linguistically appropriate
4 services provided through the Centers
5 for Disease Control and Prevention to
6 target individuals impacted by health
7 disparities based on their race, eth-
8 nicity, and gender.

9 (II) Promoting the collaboration
10 between primary and specialty care
11 health care providers and patients, to
12 ensure patients impacted by health
13 disparities based on race, ethnicity,
14 and gender are receiving comprehen-
15 sive and organized treatment and
16 care.

17 (III) Educating health care pro-
18 fessionals on the causes and effects of
19 disparities in the social determinants
20 of health as it relates to minority and
21 racial and ethnic communities and the
22 need for culturally and linguistically
23 appropriate care in the prevention and
24 treatment of high-impact diseases.

1 (IV) Encouraging collaboration
2 among community and patient-based
3 organizations which work to address
4 disparities in the social determinants
5 of health as it relates to high-impact
6 diseases in minority and racial and
7 ethnic populations.

8 (f) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to carry out this sec-
10 tion—

11 (1) \$25,000,000 for fiscal year 2015; and

12 (2) such sums as may be necessary for fiscal
13 years 2016 through 2018.

14 **SEC. 1006. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
15 **BETWEEN THE BUILT ENVIRONMENT AND**
16 **THE HEALTH OF COMMUNITY RESIDENTS.**

17 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
18 section, the term “eligible institution” means a public or
19 private nonprofit institution that submits to the Secretary
20 of Health and Human Services (in this section referred
21 to as the “Secretary”) and the Administrator of the Envi-
22 ronmental Protection Agency (in this section referred to
23 as the “Administrator”) an application for a grant under
24 the grant program authorized under subsection (b)(2) at
25 such time, in such manner, and containing such agree-

1 ments, assurances, and information as the Secretary and
2 Administrator may require.

3 (b) RESEARCH GRANT PROGRAM.—

4 (1) DEFINITION OF HEALTH.—In this section,
5 the term “health” includes—

6 (A) levels of physical activity;

7 (B) degree of mobility due to factors such
8 as musculoskeletal diseases, arthritis, and obe-
9 sity;

10 (C) consumption of nutritional foods;

11 (D) rates of crime;

12 (E) air, water, and soil quality;

13 (F) risk of injury;

14 (G) accessibility to health care services;

15 (H) levels of educational attainment; and

16 (I) other indicators as determined appro-
17 priate by the Secretary.

18 (2) GRANTS.—The Secretary, in collaboration
19 with the Administrator, shall provide grants to eligi-
20 ble institutions to conduct and coordinate research
21 on the built environment and its influence on indi-
22 vidual and population-based health.

23 (3) RESEARCH.—The Secretary shall support
24 research that—

- 1 (A) investigates and defines the causal
2 links between all aspects of the built environ-
3 ment and the health of residents;
- 4 (B) examines—
- 5 (i) the extent of the impact of the
6 built environment (including the various
7 characteristics of the built environment) on
8 the health of residents;
- 9 (ii) the variance in the health of resi-
10 dents by—
- 11 (I) location (such as inner cities,
12 inner suburbs, and outer suburbs);
13 and
- 14 (II) population subgroup (includ-
15 ing children, the elderly, the disadvan-
16 tagged); or
- 17 (iii) the importance of the built envi-
18 ronment to the total health of residents,
19 which is the primary variable of interest
20 from a public health perspective;
- 21 (C) is used to develop—
- 22 (i) measures to address health and the
23 connection of health to the built environ-
24 ment; and

1 (ii) efforts to link the measures to
2 travel and health databases; and

3 (D) distinguishes carefully between per-
4 sonal attitudes and choices and external influ-
5 ences on observed behavior to determine how
6 much an observed association between the built
7 environment and the health of residents, versus
8 the lifestyle preferences of the people that
9 choose to live in the neighborhood, reflects the
10 physical characteristics of the neighborhood;
11 and

12 (E)(i) identifies or develops effective inter-
13 vention strategies to promote better health
14 among residents with a focus on behavioral
15 interventions and enhancements of the built en-
16 vironment that promote increased use by resi-
17 dents; and

18 (ii) in developing the intervention strate-
19 gies under clause (i), ensures that the interven-
20 tion strategies will reach out to high-risk popu-
21 lations, including racial and ethnic minorities,
22 low-income urban and rural communities, and
23 children.

24 (4) PRIORITY.—In providing assistance under
25 the grant program authorized under paragraph (2),

1 the Secretary and the Administrator shall give pri-
2 ority to research that incorporates—

3 (A) minority-serving institutions as grant-

4 ees;

5 (B) interdisciplinary approaches; or

6 (C) the expertise of the public health,

7 physical activity, nutrition and health care (in-

8 cluding child health), urban planning, and

9 transportation research communities in the

10 United States and abroad.

11 **SEC. 1007. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**

12 **TION.**

13 (a) FINDINGS.—

14 (1) GENERAL FINDINGS.—The Congress finds
15 as follows:

16 (A) As human beings, we share our envi-
17 ronment with a wide variety of habitats and
18 ecosystems that nurture and sustain a diversity
19 of species.

20 (B) The abundance of natural resources in
21 our environment forms the basis for our econ-
22 omy and has greatly contributed to human de-
23 velopment throughout history.

24 (C) The accelerated pace of human devel-
25 opment over the last several hundred years has

1 significantly impacted our natural environment
2 and its resources, the health and diversity of
3 plant and animal wildlife, the availability of
4 critical habitats, the quality of our air and our
5 water, and our global climate.

6 (D) The intervention of the Federal Gov-
7 ernment is necessary to minimize and mitigate
8 human impact on the environment for the ben-
9 efit of public health, to maintain air quality and
10 water quality, to sustain the diversity of plants
11 and animals, to combat global climate change,
12 and to protect the environment.

13 (E) Laws and regulations in the United
14 States have been created and promulgated to
15 minimize and mitigate human impact on the en-
16 vironment for the benefit of public health, to
17 maintain air quality and water quality, to sus-
18 tain wildlife, and to protect the environment.

19 (F) Such laws include the Antiquities Act
20 of 1906 (16 U.S.C. 431 et seq.) initiated by
21 President Theodore Roosevelt to create the na-
22 tional park system, the National Environmental
23 Policy Act of 1969 (42 U.S.C. 4321 et seq.),
24 the Clean Air Act (42 U.S.C. 7401 et seq.), the
25 Federal Water Pollution Control Act (33 U.S.C.

1 1251 et seq.), the Comprehensive Environ-
2 mental Response, Compensation, and Liability
3 Act of 1980 (Public Law 96–510), the Endan-
4 gered Species Act of 1973 (Public Law 93–
5 205), and the National Forest Management Act
6 of 1976 (Public Law 94–588).

7 (G) Attempts to repeal or weaken key envi-
8 ronmental safeguards pose dangers to the pub-
9 lic health, air quality, water quality, wildlife,
10 and the environment.

11 (2) FINDINGS ON CHANGES AND PROPOSED
12 CHANGES IN LAW.—The Congress finds that, since
13 2001, the following changes and proposed changes
14 to existing law or regulations have negatively im-
15 pacted or will negatively impact the environment and
16 public health:

17 (A) CLEAN WATER.—

18 (i) On May 9, 2002, the Environ-
19 mental Protection Agency (EPA) and the
20 Army Corps of Engineers put forth a final
21 rule that reconciled regulations imple-
22 menting section 404 of the Federal Water
23 Pollution Control Act by redefining the
24 term “fill material” and amending the def-
25 inition of the term “discharge of fill mate-

1 rial”, reversing a 25-year-old regulation.
2 The new rule fails to restrict the dumping
3 of hardrock mining waste, construction de-
4 bris, and other industrial wastes into riv-
5 ers, streams, lakes, and wetlands. The rule
6 further allows destructive mountaintop re-
7 moval coal mining companies to dump
8 waste into streams and lakes, polluting the
9 surrounding natural habitat and poisoning
10 plants and animals that depend on those
11 water sources.

12 (ii) On February 12, 2003, the Envi-
13 ronmental Protection Agency published the
14 rule “National Pollutant Discharge Elim-
15 ination System Permit Regulation and Ef-
16 fluent Limitation Guidelines and Stand-
17 ards for Concentrated Animal Feeding Op-
18 erations”, new livestock waste regulations
19 that aimed to control factory farm pollu-
20 tion but which would severely undermine
21 existing protections under the Federal
22 Water Pollution Control Act. This regula-
23 tion allows large-scale animal factories to
24 foul the Nation’s waters with animal
25 waste, allows livestock owners to draft

1 their own pollution-management plans and
2 avoid ground water monitoring, legalizes
3 the discharge of contaminated runoff water
4 rich in nitrogen, phosphorus, bacteria, and
5 metals, and ensures that large factory
6 farms are not held liable for the environ-
7 mental damage they cause. In a 2005 Fed-
8 eral court decision (“Waterkeeper Alliance,
9 et al. v. Environmental Protection Agency”,
10 399 F.3d 486 (2nd Cir. 2005)), major
11 parts of the rule were upheld, others va-
12 cated, and still others remanded back to
13 the EPA. On November 20, 2008, the En-
14 vironmental Protection Agency published a
15 revised final rule which undermines envi-
16 ronmental protection provisions by remov-
17 ing mandatory permitting requirements
18 and allowing large animal farms to self-
19 certify the absence of pollutant discharge
20 activity.

21 (iii) On March 19, 2003, the Environ-
22 mental Protection Agency published a new
23 rule regarding the Total Maximum Daily
24 Load program of the Federal Water Pollu-
25 tion Control Act that regulates the max-

1 imum amount of a particular pollutant
2 that can be present in a body of water and
3 still meet water quality standards. The new
4 rule withdrew the existing regulation put
5 forth on July 13, 2000, and halted mo-
6 mentum in cleaning up polluted waterways
7 throughout the Nation. By abandoning the
8 existing rule, the Environmental Protection
9 Agency is undermining the effectiveness of
10 cleanup plans and is allowing States to
11 avoid cleaning polluted waters entirely by
12 dropping them from their cleanup lists.
13 Waterways play a crucial role in the lives
14 of the people of the United States and are
15 critical to the livelihood of fish and wildlife.
16 The result of dropping the July 2000 rule
17 is that the restoration of polluted rivers,
18 shoreslines, and lakes will be delayed, harm-
19 ing more fish and wildlife and worsening
20 the quality of drinking water.

21 (iv) On December 2, 2008, the Envi-
22 ronmental Protection Agency and the
23 Army Corps of Engineers jointly issued a
24 guidance document in the form of a legal
25 memorandum, titled “Clean Water Act Ju-

1 jurisdiction Following the U.S. Supreme
2 Court’s Decision in *Rapanos v. United*
3 *States & Carabell v. United States*”. This
4 new guidance dictates enforcement actions
5 under the Federal Water Pollution Control
6 Act and calls for a complicated “case-by-
7 case” analysis to determine jurisdiction for
8 waterways that do not flow all year. Such
9 actions endanger small streams and wet-
10 lands that serve as important habitats for
11 aquatic life, which play a fundamental role
12 in safeguarding sources of clean drinking
13 water and mitigate the risks and effects of
14 floods and droughts. Further, the defini-
15 tion provided therein for “waters of the
16 United States” is applicable to the Federal
17 Water Pollution Control Act as a whole,
18 potentially affecting programs that control
19 industrial pollution and sewage levels, pre-
20 vent oil spills, and set water quality stand-
21 ards for all waters in the United States
22 protected under the Federal Water Pollu-
23 tion Control Act.

24 (B) FORESTS AND LAND MANAGEMENT.—

1 (i) On December 3, 2003, the Presi-
2 dent signed into law the Healthy Forests
3 Restoration Act of 2003 (Public Law 108-
4 148; 16 U.S.C. 6501 et seq.). Although the
5 law attempts to reduce the risk of cata-
6 strophic forest fires, it provides a boon to
7 timber companies by accelerating the ag-
8 gressive thinning of backcountry forests
9 that are far from at-risk communities. The
10 law allows for increased logging of large,
11 fire-resistant trees that are not in close
12 proximity of homes and communities; it
13 undermines critical protections for endan-
14 gered species by exempting Federal land
15 management agencies from consulting with
16 the United States Fish and Wildlife Serv-
17 ice before approving any action that could
18 harm endangered plants or wildlife; and it
19 limits public participation by reducing the
20 number of environmental project reviews.

21 (ii) On April 21, 2008, the Depart-
22 ment of Agriculture issued a Final Plan-
23 ning Rule and Record of Decision for Na-
24 tional Forest System Land Management
25 Planning. Similar to rules enacted by the

1 Administration on January 5, 2005, later
2 remanded back to the agency in Federal
3 district court for violating the National
4 Environmental Policy Act of 1969, the En-
5 dangered Species Act of 1973, and the Ad-
6 ministrative Procedure Act (“Citizens for
7 Better Forestry v. United States Depart-
8 ment of Agriculture”, 481 F. Supp. 2d
9 1059 (N.D. Cal. 2007)), this revised rule
10 eliminates strict forest planning standards
11 established in 1982, and opens millions of
12 acres of public lands to damaging and
13 invasive logging, mining, and drilling oper-
14 ations. These regulations would reverse
15 more than 20 years of protection for wild-
16 life and national forests by removing the
17 overall goal of ensuring ecological sustain-
18 ability in managing the national forest sys-
19 tem, weakening the National Forest Man-
20 agement Act of 1976, and effectively end-
21 ing the review of forest management plans
22 under the National Environmental Policy
23 Act of 1969.

24 (iii) On September 20, 2006, the Dis-
25 trict Court for the Northern District of

1 California vacated the Protection of Inven-
2 toried Roadless Areas rule, enacted on May
3 13, 2005, which gave State Governors 18
4 months to petition the Federal Government
5 to either restore the previous rule for their
6 States, or submit a new management and
7 development plan for national forest areas
8 inventoried under the rule. Despite the
9 enjoinder of the Administration's 2005
10 rule, and the subsequent restoration of the
11 original Roadless Area Conservation Rule,
12 the United States Forest Service has con-
13 tinued to allow States to petition for a spe-
14 cial rule under the authority of the Admin-
15 istrative Procedure Act, publishing a final
16 special rule for Idaho on October 16, 2008.
17 As a result, 58.5 million acres of wild na-
18 tional forests are still vulnerable to log-
19 ging, road building, and other develop-
20 ments that may fragment natural habitats
21 and negatively impact fish and wildlife.

22 (iv) On November 17, 2008, the De-
23 partment of the Interior's Bureau of Land
24 Management (BLM) signed the Record of
25 Decision (ROD) amending 12 resource

1 management plans in Colorado, Utah, and
2 Wyoming, opening 2,000,000 acres of pub-
3 lic lands to commercial tar sands and oil
4 shale exploration and development. On No-
5 vember 18, 2008, the BLM published a
6 final rule for Oil Shale Management set-
7 ting the policies and procedures for a com-
8 mercial leasing program for the manage-
9 ment of federally owned oil shale in those
10 three States. Previously barred by a con-
11 gressional moratorium on the commercial
12 leasing regulations for oil shale until Sep-
13 tember 30, 2008, the development of oil
14 shale on public lands poses a serious threat
15 to land conservation, endangered and
16 threatened species, and critical habitat.
17 Domestic shale oil production allowed by
18 these regulations is highly water and en-
19 ergy intensive, the impacts of which will in-
20 tensify existing water scarcity in the arid
21 Western Region and potentially degrade
22 air and water quality for surrounding pop-
23 ulations.

24 (C) SCIENTIFIC REVIEW.—On December
25 16, 2008, the United States Fish and Wildlife

1 Service of the Department of the Interior and
2 the National Oceanic and Atmospheric Admin-
3 istration of the Department of Commerce joint-
4 ly issued a new rule amending regulations gov-
5 erning interagency cooperation under section 7
6 of the Endangered Species Act of 1973 (ESA).
7 This rule undermines the intention of the ESA
8 to protect species and the ecosystems upon
9 which they depend by allowing Federal agencies
10 to carry out, permit, or fund an action without
11 proper environmental review and expert third-
12 party consultation from Federal wildlife ex-
13 perts. Under this new rule, Federal agencies
14 can unilaterally circumvent the formal review
15 process, eliminating longstanding and scientif-
16 ically grounded safeguards that serve to protect
17 the biodiversity of our Nation's ecosystems and
18 avert harm to thousands of endangered and
19 threatened species.

20 (b) STATEMENT OF POLICY.—It is the policy of the
21 United States Government to work in conjunction with
22 States, territories, tribal governments, international orga-
23 nizations, and foreign governments in order to act as a
24 steward of the environment for the benefit of public
25 health, to maintain air quality and water quality, to sus-

1 tain the diversity of plant and animal species, to combat
2 global climate change, and to protect the environment for
3 future generations to enjoy.

4 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
5 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
6 TIONS, LAWS, OR PROPOSED LAWS.—

7 (1) STUDY.—Not later than 30 days after the
8 date of enactment of this Act, the President shall
9 enter into an arrangement under which the National
10 Academy of Sciences will conduct a study to deter-
11 mine the impact on public health, air quality, water
12 quality, wildlife, and the environment of the fol-
13 lowing regulations, laws, and proposed laws:

14 (A) CLEAN WATER.—

15 (i) Final revisions to the Federal
16 Water Pollution Control Act regulatory
17 definitions of “fill material” and “dis-
18 charge of fill material”, finalized and pub-
19 lished in the Federal Register on May 9,
20 2002 (67 Fed. Reg. 31129), amending
21 part 232 of title 40, Code of Federal Regu-
22 lations.

23 (ii) Revised National Pollutant Dis-
24 charge Elimination System Permit Regula-
25 tion and Effluent Limitation Guidelines

1 and Standards for Concentrated Animal
2 Feeding Operations in response to the
3 “Waterkeeper Alliance, et al. v.
4 Environmental Protection Agency” decision,
5 finalized and published in the Federal Reg-
6 ister on November 20, 2008 (73 Fed. Reg.
7 225), amending parts 9, 122, and 412 of
8 title 40, Code of Federal Regulations.

9 (iii) A March 19, 2003, rule published
10 in the Federal Register (68 Fed. Reg.
11 13608) withdrawing a July 13, 2000, rule
12 revising the Total Maximum Daily Load
13 program of the Federal Water Pollution
14 Control Act (65 Fed. Reg. 43586), amend-
15 ing parts 9, 122, 123, 124, and 130 of
16 title 40, Code of Federal Regulations.

17 (iv) Official Guidance Document,
18 “Clean Water Act Jurisdiction Following
19 the United States Supreme Court’s Deci-
20 sion in *Rapanos v. United States &*
21 *Carabell v. United States*”, issued on De-
22 cember 2, 2008, relating to jurisdiction
23 under section 404 of the Federal Water
24 Pollution Control Act.

25 (B) FORESTS AND LAND MANAGEMENT.—

1 (i) Healthy Forests Restoration Act of
2 2003, signed into law on December 3,
3 2003 (Public Law 108–148; 16 U.S.C.
4 6501 et seq.).

5 (ii) National Forest System Land
6 Management Planning Rule, finalized and
7 published in the Federal Register on April
8 21, 2008 (73 Fed. Reg. 21468), replacing
9 the 2005 final rule (70 Fed. Reg. 1022,
10 Jan. 5, 2005), as amended March 3, 2006
11 (71 Fed. Reg. 10837) and the 2000 final
12 rule adopted on November 9, 2000 (65
13 Fed. Reg. 67514) as amended on Sep-
14 tember 29, 2004 (69 Fed. Reg. 58055),
15 amending title 36, Code of Federal Regula-
16 tions, part 219.

17 (iii) The application of the Adminis-
18 trative Procedure Act (5 U.S.C. 551 to
19 559, 701 to 706, et seq.), such that States
20 may petition for a special rule for the
21 roadless areas in all or part of said State.

22 (iv) Record of Decision, “Oil Shale
23 and Tar Sands Resources Resource Man-
24 agement Plan Amendments”, issued on
25 November 17, 2008, along with the Final

1 Rule, Oil Shale Management-General, pub-
2 lished in the Federal Register on Novem-
3 ber 18, 2008 (73 Fed. Reg. 223), amend-
4 ing title 43, Code of Federal Regulations,
5 parts 3900, 3910, 3920, and 3930.

6 (C) SCIENTIFIC REVIEW.—Final Rule,
7 Interagency Cooperation Under the Endangered
8 Species Act, published in the Federal Register
9 on December 16, 2008, amending title 50, Code
10 of Federal Regulations, part 402.

11 (2) METHOD.—In conducting the study under
12 paragraph (1), the National Academy of Sciences
13 may utilize and compare existing scientific studies
14 regarding the regulations, laws, and proposed laws
15 listed in paragraph (1).

16 (3) REPORT.—Under the arrangement entered
17 into under paragraph (1), not later than 270 days
18 after the date on which such arrangement is entered
19 into, the National Academy of Sciences shall make
20 publicly available and shall submit to the Congress
21 and to the head of each department and agency of
22 the Federal Government that issued, implements, or
23 would implement a regulation, law, or proposed law
24 listed in paragraph (1), a report containing—

1 (A) a description of the impact of all such
2 regulations, laws, and proposed laws on public
3 health, air quality, water quality, wildlife, and
4 the environment, compared to the impact of
5 preexisting regulations, or laws in effect, includ-
6 ing—

7 (i) any negative impacts to air quality
8 or water quality;

9 (ii) any negative impacts to wildlife;

10 (iii) any delays in hazardous waste
11 cleanup that are projected to be hazardous
12 to public health; and

13 (iv) any other negative impact on pub-
14 lic health or the environment; and

15 (B) any recommendations that the Na-
16 tional Academy of Sciences considers appro-
17 priate to maintain, restore, or improve in whole
18 or in part protections for public health, air
19 quality, water quality, wildlife, and the environ-
20 ment for each of the regulations, laws, and pro-
21 posed laws listed in paragraph (1), which may
22 include recommendations for the adoption of
23 any regulation or law in place or proposed prior
24 to January 1, 2001.

1 (d) DEPARTMENT AND AGENCY REVISION OF EXIST-
2 ING RULES, REGULATIONS, OR LAWS.—Not later than
3 180 days after the date on which the report is submitted
4 pursuant to subsection (c)(3), the head of each depart-
5 ment and agency that has issued or implemented a regula-
6 tion or law listed in subsection (c)(1) shall submit to the
7 Congress a plan describing the steps such department or
8 such agency will take, or has taken, to restore or improve
9 protections for public health and the environment in whole
10 or in part that were in existence prior to the issuance of
11 such regulation or law.

12 **SEC. 1008. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
13 **WATER HORIZON OIL RIG EXPLOSION IN THE**
14 **GULF COAST.**

15 (a) STUDY.—The Comptroller General of the United
16 States shall conduct a study on the type and scope of
17 health care services administered through the Department
18 of Health and Human Services addressing the provision
19 of health care to racial and ethnic minorities (whether
20 residents, cleanup workers, or volunteers) affected by the
21 explosion of the mobile offshore drilling unit Deepwater
22 Horizon that occurred on April 20, 2010.

23 (b) SPECIFIC COMPONENTS; REPORTING.—In car-
24 rying out subsection (a), the Comptroller General shall—

1 (1) assess the type, size, and scope of programs
2 administered by the Department of Health and
3 Human Services that focus on provision of health
4 care to communities in the Gulf Coast;

5 (2) identify the merits and disadvantages asso-
6 ciated with each the programs;

7 (3) perform an analysis of the costs and bene-
8 fits of the programs;

9 (4) determine whether there is any duplication
10 of programs; and

11 (5) not later than 180 days after the date of
12 the enactment of this Act, report findings and rec-
13 ommendations for improving access to health care
14 for racial and ethnic minorities to the Congress.

○