

112TH CONGRESS
1ST SESSION

H. R. 2954

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 15, 2011

Ms. LEE of California (for herself, Mrs. CHRISTENSEN, Ms. ROYBAL-ALLARD, Ms. BASS of California, Mr. BISHOP of Georgia, Ms. BORDALLO, Mr. BROOKS, Ms. BROWN of Florida, Mr. BUTTERFIELD, Mr. CARSON of Indiana, Ms. CHU, Mr. CLARKE of Michigan, Ms. CLARKE of New York, Mr. CLAY, Mr. CLEAVER, Mr. COHEN, Mr. CONYERS, Mr. CUMMINGS, Mr. DAVIS of Illinois, Ms. DEGETTE, Ms. DELAURO, Ms. EDWARDS, Mr. ELLISON, Mr. FALEOMAVAEGA, Mr. FATTAH, Ms. FUDGE, Mr. GONZALEZ, Mr. AL GREEN of Texas, Mr. GRIJALVA, Mr. GUTIERREZ, Ms. HAHN, Ms. HANABUSA, Mr. HASTINGS of Florida, Ms. HIRONO, Mr. HONDA, Mr. JACKSON of Illinois, Ms. JACKSON LEE of Texas, Mr. JOHNSON of Georgia, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. LEWIS of Georgia, Mr. KUCINICH, Ms. MATSUI, Mr. MCGOVERN, Mr. MEEKS, Ms. MOORE, Mrs. NAPOLITANO, Ms. NORTON, Mr. OLVER, Mr. PAYNE, Mr. PIERLUISI, Mr. RANGEL, Mr. REYES, Ms. RICHARDSON, Mr. RICHMOND, Mr. RUSH, Mr. SABLAN, Ms. LINDA T. SÁNCHEZ of California, Ms. SCHAKOWSKY, Mr. SCOTT of Virginia, Mr. DAVID SCOTT of Georgia, Mr. SERRANO, Mr. SIRES, Ms. SLAUGHTER, Mr. THOMPSON of Mississippi, Mr. TOWNS, Ms. WATERS, Mr. WATT, Ms. WILSON of Florida, and Ms. WOOLSEY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, the Budget, Veterans' Affairs, Armed Services, Agriculture, 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 2011”.

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

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

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1 **SEC. 3. FINDINGS.**

2 The Congress finds as follows:

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

9 (2) Health disparities are a function of not only
10 access to health care, but also the social deter-
11 minants of health—including the environment, the
12 physical structure of communities, nutrition and
13 food options, educational attainment, employment,
14 race, ethnicity, sex, geography, language preference,
15 immigrant or citizenship status, sexual orientation,
16 gender identity, socioeconomic status, or disability
17 status—that directly and indirectly affect the health,
18 health care, and wellness of individuals and commu-
19 nities.

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

6 (4) All efforts to reduce health disparities and
7 barriers to quality health services require better and
8 more consistent data.

9 (5) A full range of culturally and linguistically
10 appropriate health care and public health services
11 must be available and accessible in every community.

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

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

22 (8) In 2011, the Department of Health and
23 Human Services developed the HHS Action Plan to
24 Reduce Racial and Ethnic Health Disparities and
25 the National Stakeholder Strategy for Achieving

1 Health Equity, two strategic plans that represent
2 the country's first coordinated roadmap to reducing
3 health disparities. Along with the National Preven-
4 tion Strategy and the National Health Care Quality
5 Strategy, these comprehensive plans will work to in-
6 crease the number of Americans who are healthy at
7 every stage of life.

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

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

18 **TITLE I—DATA COLLECTION** 19 **AND REPORTING**

20 **SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE** 21 **ACT.**

22 (a) PURPOSE.—It is the purpose of this section to
23 promote data collection, analysis, and reporting by race,
24 ethnicity, sex, primary language, sexual orientation, dis-

1 ability status, gender identity, and socioeconomic status
2 among federally supported health programs.

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

7 **“Subtitle B—Strengthening Data**
8 **Collection, Improving Data**
9 **Analysis, and Expanding Data**
10 **Reporting**

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

12 “(a) REQUIREMENTS.—

13 “(1) IN GENERAL.—Each health-related pro-
14 gram operated by or that receives funding or reim-
15 bursement, in whole or in part, either directly or in-
16 directly from the Department of Health and Human
17 Services shall—

18 “(A) require the collection, by the agency
19 or program involved, of data on the race, eth-
20 nicity, sex, primary language, sexual orienta-
21 tion, disability status, gender identity, and so-
22 cioeconomic status of each applicant for and re-
23 cipient of health-related assistance under such
24 program—

1 “(i) using, at a minimum, the stand-
2 ards for data collection on race, ethnicity,
3 sex, primary language, sexual orientation,
4 disability status, gender identity, and so-
5 cioeconomic status developed under section
6 3101;

7 “(ii) collecting data for additional
8 population groups if such groups can be
9 aggregated into the minimum race and
10 ethnicity categories;

11 “(iii) additionally referring, where
12 practicable, to the standards developed by
13 the Institute of Medicine in ‘Race, Eth-
14 nicity, and Language Data: Standardiza-
15 tion for Health Care Quality Improve-
16 ment’; and

17 “(iv) where practicable, through self-
18 reporting;

19 “(B) with respect to the collection of the
20 data described in subparagraph (A), for appli-
21 cants and recipients who are minors, require
22 communication assistance in speech or writing,
23 and for applicants and recipients who are other-
24 wise legally incapacitated, require that—

1 “(i) such data be collected from the
2 parent or legal guardian of such an appli-
3 cant or recipient; and

4 “(ii) the primary language of the par-
5 ent or legal guardian of such an applicant
6 or recipient be collected;

7 “(C) systematically analyze such data
8 using the smallest appropriate units of analysis
9 feasible to detect racial and ethnic disparities,
10 as well as disparities along the lines of primary
11 language, sex, disability status, sexual orienta-
12 tion, gender identity, and socioeconomic status
13 in health and health care, and report the results
14 of such analysis to the Secretary, the Director
15 of the Office for Civil Rights, each agency listed
16 in section 3101(c)(1), the Committee on
17 Health, Education, Labor, and Pensions and
18 the Committee on Finance of the Senate, and
19 the Committee on Energy and Commerce and
20 the Committee on Ways and Means of the
21 House of Representatives;

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

24 “(E) ensure that the provision of assist-
25 ance to an applicant or recipient of assistance

1 is not denied or otherwise adversely affected be-
2 cause of the failure of the applicant or recipient
3 to provide race, ethnicity, primary language,
4 sex, sexual orientation, disability status, gender
5 identity, and socioeconomic status data.

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

8 “(A) permit the use of information col-
9 lected under this subsection in a manner that
10 would adversely affect any individual providing
11 any such information; and

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

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

18 “(1) under the same privacy protections as the
19 Secretary applies to other health data under the reg-
20 ulations promulgated under section 264(c) of the
21 Health Insurance Portability and Accountability Act
22 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
23 lating to the privacy of individually identifiable
24 health information and other protections; and

1 “(2) from all inappropriate internal use by any
2 entity that collects, stores, or receives the data, in-
3 cluding use of such data in determinations of eligi-
4 bility (or continued eligibility) in health plans, and
5 from other inappropriate uses, as defined by the
6 Secretary.

7 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
8 Secretary shall develop and implement a national plan to
9 ensure the collection of data in a culturally appropriate
10 and competent manner, to improve the collection, analysis,
11 and reporting of racial, ethnic, sex, primary language, sex-
12 ual orientation, disability status, gender identity, and so-
13 cioeconomic status data at the Federal, State, territorial,
14 tribal, and local levels, including data to be collected under
15 subsection (a), and to ensure that data collection activities
16 carried out under this section are in compliance with the
17 standards developed under section 3101. The Data Coun-
18 cil of the Department of Health and Human Services, in
19 consultation with the National Committee on Vital Health
20 Statistics, the Office of Minority Health, Office on Wom-
21 en’s Health, and other appropriate public and private enti-
22 ties, shall make recommendations to the Secretary con-
23 cerning the development, implementation, and revision of
24 the national plan. Such plan shall include recommenda-
25 tions on how to—

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

4 “(2) expand awareness among Federal agencies,
5 States, territories, Indian tribes, health providers,
6 health plans, health insurance issuers, and the gen-
7 eral public that data collection, analysis, and report-
8 ing by race, ethnicity, primary language, sexual ori-
9 entation, disability status, gender identity, and socio-
10 economic status is legal and necessary to assure eq-
11 uity and nondiscrimination in the quality of health
12 care services;

13 “(3) ensure that future patient record systems
14 have data code sets for racial, ethnic, primary lan-
15 guage, sexual orientation, disability status, gender
16 identity, and socioeconomic status identifiers and
17 that such identifiers can be retrieved from clinical
18 records, including records transmitted electronically;

19 “(4) improve health and health care data collec-
20 tion and analysis for more population groups if such
21 groups can be aggregated into the minimum race
22 and ethnicity categories, including exploring the fea-
23 sibility of enhancing collection efforts in States for
24 racial and ethnic groups that comprise a significant
25 proportion of the population of the State;

1 “(5) provide researchers with greater access to
2 racial, ethnic, primary language, sexual orientation,
3 disability status, gender identity, and socioeconomic
4 status data, subject to privacy and confidentiality
5 regulations; and

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

8 “(d) COMPLIANCE WITH STANDARDS.—Data col-
9 lected under subsection (a) shall be obtained, maintained,
10 and presented (including for reporting purposes) in ac-
11 cordance with the 1997 Office of Management and Budget
12 Standards for Maintaining, Collecting, and Presenting
13 Federal Data on Race and Ethnicity (at a minimum).

14 “(e) TECHNICAL ASSISTANCE FOR THE COLLECTION
15 AND REPORTING OF DATA.—

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

21 “(2) TYPES OF ASSISTANCE.—Assistance pro-
22 vided under this subsection may include assistance
23 to—

24 “(A) enhance or upgrade computer tech-
25 nology that will facilitate racial, ethnic, primary

1 language, sexual orientation, disability status,
2 gender identity, and socioeconomic status data
3 collection and analysis;

4 “(B) improve methods for health data col-
5 lection and analysis including additional popu-
6 lation groups beyond the Office of Management
7 and Budget categories if such groups can be
8 aggregated into the minimum race and ethnicity
9 categories;

10 “(C) develop mechanisms for submitting
11 collected data subject to existing privacy and
12 confidentiality regulations; and

13 “(D) develop educational programs to in-
14 form health insurance issuers, health plans,
15 health providers, health-related agencies, and
16 the general public that data collection and re-
17 porting by race, ethnicity, primary language,
18 sexual orientation, disability status, gender
19 identity, and socioeconomic status are legal and
20 essential for eliminating health and health care
21 disparities.

22 “(f) ANALYSIS OF HEALTH DISPARITY DATA.—The
23 Secretary, acting through the Director of the Agency for
24 Healthcare Research and Quality and in coordination with
25 the Administrator of the Centers for Medicare & Medicaid

1 Services, shall provide technical assistance to agencies of
2 the Department of Health and Human Services in meeting
3 Federal standards for health disparity data collection and
4 for analysis of racial and ethnic disparities in health and
5 health care in public programs by—

6 “(1) identifying appropriate quality assurance
7 mechanisms to monitor for health disparities;

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

10 “(3) developing new quality measures relating
11 to racial and ethnic disparities and their overlap
12 with other disparity factors in health and health
13 care;

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

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

18 “(g) DEFINITION.—In this section, the term ‘health-
19 related program’ mean a program—

20 “(1) under the Social Security Act (42 U.S.C.
21 301 et seq.) that pays for health care and services;
22 and

23 “(2) under this Act that provides Federal finan-
24 cial assistance for health care, biomedical research,

1 or health services research and or is designed to im-
2 prove the public's health.

3 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section,
5 such sums as may be necessary for each of fiscal years
6 2012 through 2017.

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

8 “(a) ESTABLISHMENT OF EPIDEMIOLOGY CEN-
9 TERS.—The Secretary shall establish an epidemiology cen-
10 ter in each service area to carry out the functions de-
11 scribed in subsection (b). Any new center established after
12 the date of the enactment of the Health Equity and Ac-
13 countability Act of 2011 may be operated under a grant
14 authorized by subsection (d), but funding under such a
15 grant shall not be divisible.

16 “(b) FUNCTIONS OF CENTERS.—In consultation with
17 and upon the request of Indian tribes, tribal organizations,
18 and urban indian organizations, each service area epidemi-
19 ology center established under this subsection shall, with
20 respect to such service area—

21 “(1) collect data relating to, and monitor
22 progress made toward meeting, each of the health
23 status objectives of the service, the Indian tribes,
24 tribal organizations, and urban indian organizations
25 in the service area;

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

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

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

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

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

18 “(7) provide disease surveillance and assist In-
19 dian tribes, tribal organizations, and urban Indian
20 organizations to promote public health.

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

25 “(d) GRANTS FOR STUDIES.—

1 “(1) IN GENERAL.—The Secretary may make
2 grants to Indian tribes, tribal organizations, urban
3 indian organizations, and eligible intertribal con-
4 sortia to conduct epidemiological studies of Indian
5 communities.

6 “(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An
7 intertribal consortium is eligible to receive a grant
8 under this subsection if—

9 “(A) the intertribal consortium is incor-
10 porated for the primary purpose of improving
11 Indian health; and

12 “(B) the intertribal consortium is rep-
13 resentative of the Indian tribes or urban Indian
14 communities in which the intertribal consortium
15 is located.

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

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

22 “(A) demonstrate the technical, adminis-
23 trative, and financial expertise necessary to
24 carry out the functions described in paragraph
25 (5);

1 “(B) consult and cooperate with providers
2 of related health and social services in order to
3 avoid duplication of existing services; and

4 “(C) demonstrate cooperation from Indian
5 tribes or urban Indian organizations in the area
6 to be served.

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

9 “(A) to carry out the functions described
10 in subsection (b);

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

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

20 “(e) ACCESS TO INFORMATION.—An epidemiology
21 center operated by a grantee pursuant to a grant awarded
22 under subsection (d) shall be treated as a public health
23 authority for purposes of the Health Insurance Portability
24 and Accountability Act of 1996 (Public Law 104–191; 110
25 Stat. 2033), as such entities are defined in part 164.501

1 of title 45, Code of Federal Regulations (or a successor
2 regulation). The Secretary shall grant such grantees ac-
3 cess to and use of data, data sets, monitoring systems,
4 delivery systems, and other protected health information
5 in the possession of the Secretary.”.

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

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

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

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

14 **SEC. 103. COLLECTION OF RACE AND ETHNICITY DATA BY**
15 **THE SOCIAL SECURITY ADMINISTRATION.**

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

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

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

24 “(1) require the collection of data on the race,
25 ethnicity, primary language, and disability status of

1 all applicants for Social Security account numbers or
2 benefits under title II or part A of title XVIII and
3 all individuals with respect to whom the Commis-
4 sioner maintains records of wages and self-employ-
5 ment income in accordance with reports received by
6 the Commissioner or the Secretary of the Treas-
7 ury—

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

12 “(B) where practicable, collecting data for
13 additional population groups if such groups can
14 be aggregated into the minimum race and eth-
15 nicity categories; and

16 “(C) additionally referring, where prac-
17 ticable, to the standards developed by the Insti-
18 tute of Medicine in ‘Race, Ethnicity, and Lan-
19 guage Data: Standardization for Health Care
20 Quality Improvement’ (released August 31,
21 2009);

22 “(2) with respect to the collection of the data
23 described in paragraph (1) for applicants who are
24 under 18 years of age or otherwise legally incapac-
25 itated, 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 2012 through 2017.”.

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 “2016”;

11 (2) in paragraph (2), in the first sentence, by
12 striking “2003” and inserting “2016”; and

13 (3) in paragraph (3), by striking “2002” and
14 inserting “2016”.

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 2012 through 2017.”.

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 LINGUISTIC DATA COL-**
4 **LECTED 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 linguistic data during the preceding cal-
10 endar year shall submit such data to the Secretary of
11 Health and Human Services.

12 (b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
13 Not later than April 30, 2012, 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 linguistic data submitted under subsection (a) for
20 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. OPTIONAL COLLECTION OF HEALTH DATA ON IM-**
5 **MIGRANTS AND INDIVIDUALS IN THEIR**
6 **HOUSEHOLDS.**

7 Section 3101(a) of the Public Health Service Act (42
8 U.S.C. 300k(a)) is amended by adding at the end the fol-
9 lowing:

10 “(4) **OPTIONAL UNIFORM CATEGORIES.**—Not
11 later than 12 months after the date of the enact-
12 ment of this paragraph, the Secretary shall—

13 “(A) enter into an arrangement with the
14 Institute of Medicine of the National Academies
15 (or, if the Institute of Medicine declines to
16 enter into such an arrangement, another appro-
17 priate entity) to—

18 “(i) conduct a study and develop rec-
19 ommended standards for the optional col-
20 lection of data on immigrants, as well as
21 citizens living within immigrant households
22 (mixed-status households), in order to
23 measure disparities in health coverage,
24 health care access and quality, and health
25 status among these populations, and

1 “(ii) include ensuing recommendations
2 and results in a report to the Secretary
3 that includes best practices to protect the
4 privacy of respondents to the full extent of
5 applicable law;

6 “(B) promulgate standards based on the
7 recommendations and results of subparagraph
8 (A) for the optional collection of data in major
9 health surveys and research; and

10 “(C) provide clear guidance that immi-
11 grant and mixed-status households are optional
12 uniform categories and data concerning such
13 households shall—

14 “(i) not be required to be collected by
15 the standards under subparagraph (B);

16 “(ii) be collected only in accordance
17 with—

18 “(I) the ‘Tri-Agency Guidance’
19 issued by the Food and Nutrition
20 Service of the Department of Agri-
21 culture, the Centers for Medicare &
22 Medicaid Services, the Administration
23 for Children and Families, and Office
24 for Civil Rights; and

25 “(II) other applicable law; and

1 “(iii) not be collected for program ap-
2 plication and enrollment processes beyond
3 statutory requirements.”.

4 **SEC. 112. 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. 113. 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 505D the following:

20 **“SEC. 505E. 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 “(aa) 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 505E.”.

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 505E”.

18 **SEC. 114. GAO STUDY ON COMPLIANCE WITH EXISTING FDA**
19 **REQUIREMENTS TO PRESENT DRUG AND DE-**
20 **VICE SAFETY AND EFFECTIVENESS DATA BY**
21 **SEX, AGE, AND RACIAL AND ETHNIC SUB-**
22 **GROUPS.**

23 (a) IN GENERAL.—The Comptroller General of the
24 United States shall conduct a study investigating the ex-
25 tent to which sponsors of clinical studies of investigational

1 drugs, biologics, and devices and sponsors of applications
2 for approval or licensure of new drugs, biologics, and de-
3 vices comply with Food and Drug Administration require-
4 ments and follow guidance for presentation of clinical
5 study safety and effectiveness data by sex, age, and racial
6 and ethnic subgroups.

7 (b) REPORT BY GAO.—

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

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

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

23 (B) An assessment of the effectiveness of
24 the Food and Drug Administration's enforce-
25 ment of compliance with such requirements.

1 (C) An analysis of the extent to which fe-
2 males, racial and ethnic minorities, and adults
3 of all ages are adequately represented in Food
4 and Drug Administration-approved clinical
5 studies (at all phases) so that product safety
6 and effectiveness data can be evaluated by sex,
7 age, and racial and ethnic subgroup.

8 (D) An analysis of the extent to which a
9 summary of product safety and effectiveness
10 data disaggregated by sex, age, and racial and
11 ethnic subgroup is readily available to the pub-
12 lic in a timely manner by means of the product
13 label or the Food and Drug Administration's
14 Web site.

15 (E) Recommendations for—

16 (i) modifications to the requirements
17 and guidance referred to in subsection (a);
18 or

19 (ii) oversight by the Food and Drug
20 Administration of such requirements.

21 (c) REPORT BY HHS.—Not later than 6 months
22 after the submission by the Comptroller General of the
23 report required under subsection (b), the Secretary of
24 Health and Human Services shall submit to the Com-
25 mittee on Energy and Commerce of the House of Rep-

1 representatives and the Committee on Health, Education,
 2 Labor, and Pensions of the Senate a response to that re-
 3 port, including a corrective action plan as needed to re-
 4 spond to the recommendations in that report.

5 (d) DEFINITIONS.—In this section:

6 (1) The term “biologic” has the meaning given
 7 to the term “biological product” in section 351(i) of
 8 the Public Health Service Act (42 U.S.C. 262(i)).

9 (2) The term “device” has the meaning given to
 10 such term in section 201(h) of the Federal Food,
 11 Drug, and Cosmetic Act (21 U.S.C. 321(h)).

12 (3) The term “drug” has the meaning given to
 13 such term in section 201(g) of the Federal Food,
 14 Drug, and Cosmetic Act (21 U.S.C. 321(g)).

15 **SEC. 115. IMPROVING HEALTH DATA REGARDING NATIVE**
 16 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

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

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

22 “(a) DEFINITIONS.—In this section:

23 “(1) COMMUNITY GROUP.—The term ‘commu-
 24 nity group’ means a group of NHOPI who are orga-
 25 nized at the community level, and may include a

1 church group, social service group, national advocacy
2 organization, or cultural group.

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

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

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

19 “(5) NATIVE HAWAIIANS AND OTHER PACIFIC
20 ISLANDERS (NHOPI).—The term ‘Native Hawaiians
21 and Other Pacific Islanders’ or ‘NHOPI’ means peo-
22 ple having origins in any of the original peoples of
23 American Samoa, the Commonwealth of the North-
24 ern Mariana Islands, the Federated States of Micro-
25 nesia, Guam, Hawaii, the Republic of the Marshall

1 Islands, the Republic of Palau, or any other Pacific
2 island.

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

9 “(b) NATIONAL STRATEGY.—

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

1 “(2) CONSULTATION.—In developing and imple-
2 menting a national strategy, as described in para-
3 graph (1), not later than 180 days after the date of
4 enactment of the Health Equity and Accountability
5 Act of 2011, the Secretary—

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

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

13 “(c) PRELIMINARY HEALTH SURVEY.—

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

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

1 “(A) useful in determining health status
2 and health care needs; or

3 “(B) required for developing or imple-
4 menting a national strategy.

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

13 “(4) TIMEFRAME.—The survey required under
14 this subsection shall be completed not later than 18
15 months after the date of enactment of the Health
16 Equity and Accountability Act of 2011.

17 “(d) PROGRESS REPORT.—Not later than 2 years
18 after the date of enactment of the Health Equity and Ac-
19 countability Act of 2011, the Secretary shall submit to
20 Congress a progress report, which shall include the na-
21 tional strategy described in subsection (b)(1).

22 “(e) STUDY AND REPORT BY THE IOM.—

23 “(1) IN GENERAL.—The Secretary shall enter
24 into an agreement with the Institute of Medicine to

1 conduct a study, with input from stakeholders in in-
2 sular areas, on the following:

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

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

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

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

21 “(2) REPORT.—An agreement described in
22 paragraph (1) shall require the Institute of Medicine
23 to submit to the Secretary and to Congress, not
24 later than 2 years after the date of the enactment
25 of the Health Equity and Accountability Act of

1 2011, a report containing a description of the results
2 of the study conducted under paragraph (1), includ-
3 ing the conclusions and recommendations of the In-
4 stitute of Medicine for each of the items described
5 in subparagraphs (A) through (D) of such para-
6 graph.

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
8 carry out this section, there are authorized to be appro-
9 priated such sums as may be necessary for fiscal years
10 2012 through 2017.”.

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

14 **SEC. 201. DEFINITIONS.**

15 In this title, the definitions contained in section 3400
16 of the Public Health Service Act, as added by section 202,
17 shall apply.

18 **SEC. 202. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

19 **ACT.**

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

21 (1) Effective communication is essential to
22 meaningful access to quality physical and mental
23 health care.

24 (2) Research indicates that the lack of appro-
25 priate language services creates languages barriers

1 that result in increased risk of misdiagnosis, ineffec-
2 tive treatment plans and poor health outcomes for
3 limited-English-proficient individuals and individuals
4 with communication disabilities such as hearing, vi-
5 sion or print impairments.

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

11 (4) The responsibility to fund language services
12 in the provision of health care and health care-re-
13 lated services to limited-English-proficient individ-
14 uals and individuals with communication disabilities
15 such as hearing, vision, or print impairments is a so-
16 cietal one that cannot fairly be visited solely upon
17 the health care, public health or social services com-
18 munity.

19 (5) Title VI of the Civil Rights Act of 1964
20 prohibits discrimination based on the grounds of
21 race, color or national origin by any entity receiving
22 Federal financial assistance. In order to avoid dis-
23 crimination on the grounds of national origin, all
24 programs or activities administered by the Depart-
25 ment must take adequate steps to ensure that their

1 policies and procedures do not deny or have the ef-
2 fect of denying limited-English-proficient individuals
3 with equal access to benefits and services for which
4 such persons qualify.

5 (6) Linguistic diversity in the healthcare and
6 health-care-related-services workforce is important
7 for providing all patients the environment most con-
8 ducive to positive health outcomes.

9 (7) All members of the health care and health-
10 care-related-services community should continue to
11 educate their staff and constituents about limited-
12 English proficient and disability communication
13 issues and help them identify resources to improve
14 access to quality care for limited-English-proficient
15 individuals and individuals with communication dis-
16 abilities such as hearing, vision, or print impair-
17 ments.

18 (8) Access to English as a second language and
19 sign language instructions is an important mecha-
20 nism for ensuring effective communication and elimi-
21 nating the language barriers that impede access to
22 health care.

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

1 (b) AMENDMENT.—The Public Health Service Act
2 (42 U.S.C. 201 et seq.) is amended by adding at the end
3 the following:

4 **“TITLE XXXIV—CULTURALLY**
5 **AND LINGUISTICALLY APPRO-**
6 **PRIATE HEALTH CARE**

7 **“SEC. 3400. DEFINITIONS.**

8 “In this title:

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

12 “(2) COMMUNITY HEALTH WORKER.—The term
13 ‘community health worker’ includes a community
14 health advocate, a lay health educator, a community
15 health representative, a peer health promoter, a
16 community health outreach worker, and in Spanish,
17 promotores de salud.

18 “(3) COMPETENT INTERPRETER SERVICES.—
19 The term ‘competent interpreter services’ means a
20 translanguage rendition of a spoken or signed mes-
21 sage in which the interpreter comprehends the
22 source language and can communicate comprehen-
23 sively in the target language to convey the meaning
24 intended in the source language. The interpreter
25 knows health and health-related terminology and

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

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

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

24 “(A) the term ‘cultural’ refers to inte-
25 grated patterns of human behavior that include

1 the language, thoughts, communications, ac-
2 tions, customs, beliefs, values, and institutions
3 of racial, ethnic, religious, or social groups, in-
4 cluding lesbian, gay, bisexual, transgender and
5 intersex individuals, and individuals with phys-
6 ical and mental disabilities; and

7 “(B) the term ‘competence’ implies having
8 the capacity to function effectively as an indi-
9 vidual and an organization within the context of
10 the cultural beliefs, behaviors, and needs pre-
11 sented by consumers and their communities.

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

22 “(7) GRIEVANCE RESOLUTION PROCESS.—The
23 term ‘grievance resolution process’ means all aspects
24 of dispute resolution including filing complaints,
25 grievance and appeal procedures, and court action.

1 “(8) HEALTH CARE GROUP.—The term ‘health
2 care group’ means a group of physicians organized,
3 at least in part, for the purposes of providing physi-
4 cians’ services under the Medicaid, SCHIP, or Medi-
5 care programs and may include a hospital and any
6 other individual or entity furnishing services covered
7 under the Medicaid, SCHIP, or Medicare programs
8 that is affiliated with the health care group.

9 “(9) HEALTH-CARE SERVICES.—The term
10 ‘health care services’ means services that address
11 physical as well as mental health conditions in all
12 care settings.

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

17 “(11) INDIAN TRIBE.—The term ‘Indian tribe’
18 means any Indian tribe, band, nation, or other orga-
19 nized group or community, including any Alaska Na-
20 tive village or group or regional or village corpora-
21 tion as defined in or established pursuant to the
22 Alaska Native Claims Settlement Act (85 Stat. 688)
23 (43 U.S.C. 1601 et seq.), which is recognized as eli-
24 gible for the special programs and services provided

1 by the United States to Indians because of their sta-
2 tus as Indians.

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

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

20 “(14) LANGUAGE ACCESS.—The term ‘language
21 access’ means the provision of language services to
22 an LEP individual or individual with communication
23 disabilities designed to enhance that individual’s ac-
24 cess to, understanding of or benefit from health care
25 or health-care-related services.

1 “(15) LANGUAGE OR LANGUAGE ACCESS SERV-
2 ICES.—The term ‘language or language access serv-
3 ices’ means provision of health care services directly
4 in a non-English language, interpretation, trans-
5 lation, signage, video recording, and English or non-
6 English alternative formats.

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

9 “(17) LEP RELATED DATA COLLECTION AC-
10 TIVITIES.—The term ‘LEP related data collection
11 activities’ includes identifying, collecting, storing,
12 tracking, and analyzing primary language data, and
13 information on the methods used to meet the lan-
14 guage access needs of limited-English-proficient indi-
15 viduals.

16 “(18) MEDICARE, MEDICAID, AND SCHIP.—The
17 terms ‘Medicare’, ‘Medicaid’, and ‘SCHIP’ means
18 the respective programs under titles XVIII, XIX,
19 and XXI of the Social Security Act.

20 “(19) MINORITY.—

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

1 “(B) POPULATIONS.—The term ‘minority’,
2 with respect to populations, refers to racial and
3 ethnic minority groups.

4 “(20) MINORITY GROUP.—The term ‘minority
5 group’ has the meaning given the term ‘racial and
6 ethnic minority group’.

7 “(21) RACIAL AND ETHNIC MINORITY GROUP.—
8 The term ‘racial and ethnic minority group’ means
9 American Indians and Alaska Natives, African-
10 Americans (including Caribbean Blacks, Africans
11 and other Blacks), Asian-Americans, Hispanics (in-
12 cluding Latinos), and Native Hawaiians and other
13 Pacific Islanders.

14 “(22) ON-SITE INTERPRETING/INTERPRETA-
15 TION.—The term ‘on-site interpreting/interpretation’
16 means a method of interpreting or interpretation for
17 which the interpreter is in the physical presence of
18 the provider of health care or health-care-related
19 services and the recipient of such services who is
20 limited in English proficiency or has a communica-
21 tion impairment such as hearing, vision, or learning.

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

24 “(24) SIGHT TRANSLATION.—The term ‘sight
25 translation’ means the transmission of a written

1 message in one language into a spoken or signed
2 message in another language, or an alternative for-
3 mat in English or another language.

4 “(25) STATE.—The term ‘State’ means each of
5 the several States, the District of Columbia, the
6 Commonwealth of Puerto Rico, the Indian tribes,
7 the United States Virgin Islands, Guam, American
8 Samoa, and the Commonwealth of the Northern
9 Mariana Islands.

10 “(26) TELEPHONIC INTERPRETATION.—The
11 term ‘telephonic interpretation’ (also known as over
12 the phone interpretation or OPI) means a method of
13 interpreting/interpretation for which the interpreter
14 is not in the physical presence of the provider of
15 health care or related services and the limited-
16 English-proficient recipient of such services but is
17 connected via telephone.

18 “(27) TRANSLATION.—The term ‘translation’
19 means the transmission of a written message in one
20 language into a written or signed message in an-
21 other language, and includes translation into an-
22 other language or alternative format, such as large
23 print font, Braille, audio recording, or CD.

24 “(28) VIDEO INTERPRETATION.—The term
25 ‘video interpretation’ means a method of inter-

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

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

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

3 “(a) PURPOSE.—As provided in Executive Order
4 13166, it is the purpose of this section—

5 “(1) to improve Federal agency performance re-
6 garding access to federally conducted and federally
7 assisted programs and activities for individuals who
8 are limited in their English proficiency;

9 “(2) to require each Federal agency to examine
10 the services it provides and develop and implement
11 a system by which limited-English-proficient individ-
12 uals can obtain cultural competence and meaningful
13 access to those services consistent with, and without
14 substantially burdening, the fundamental mission of
15 the agency;

16 “(3) to require each Federal agency to ensure
17 that recipients of Federal financial assistance pro-
18 vide cultural competence and meaningful access to
19 their limited-English-proficient applicants and bene-
20 ficiaries;

21 “(4) to ensure that recipients of Federal finan-
22 cial assistance take reasonable steps, consistent with
23 the guidelines set forth in the Limited English Pro-
24 ficient Guidance of the Department of Justice (as
25 issued on June 12, 2002), to ensure cultural com-
26 petence and meaningful access to their programs

1 and activities by limited-English-proficient individ-
2 uals; and

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

7 “(b) **FEDERALLY CONDUCTED PROGRAMS AND AC-**
8 **TIVITIES.—**

9 “(1) **IN GENERAL.—**Not later than 120 days
10 after the date of enactment of this title, each Fed-
11 eral agency that carries out health-care-related ac-
12 tivities shall prepare a plan to improve access cul-
13 tural competence to the federally conducted, health-
14 are-related programs and activities of the agency by
15 limited-English-proficient individuals. Each Federal
16 agency must ensure that such plan is fully imple-
17 mented not later than one year after the date of en-
18 actment of this Act.

19 “(2) **PLAN REQUIREMENT.—**Each plan under
20 paragraph (1) shall include—

21 “(A) the steps the agency will take to en-
22 sure that limited-English-proficient individuals
23 have access to the agency’s federally conducted
24 health care and health-care-related programs
25 and activities;

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

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

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

1 “(E) the resources the agency will provide
2 to improve cultural competence to assist recipi-
3 ents of Federal funds to improve access to
4 health care or health-care-related programs and
5 activities for limited-English-proficient individ-
6 uals.

7 Each agency shall send a copy of such plan to the
8 Department of Justice, which shall serve as the cen-
9 tral repository of the Agency’s plans.

10 “(c) **FEDERALLY ASSISTED PROGRAMS AND ACTIVI-**
11 **TIES.—**

12 “(1) **IN GENERAL.—**Not later than 120 days
13 after the date of enactment of this title, each Fed-
14 eral agency providing health-care-related Federal fi-
15 nancial assistance shall ensure that the guidance for
16 recipients of Federal financial assistance developed
17 by the agency to ensure compliance with title VI of
18 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
19 seq.) is specifically tailored to the recipients of such
20 assistance. Each agency shall send a copy of such
21 guidance to the Department of Justice which shall
22 serve as the central repository of the Agency’s plans.
23 After approval by the Department of Justice, each
24 agency shall publish its guidance document in the
25 Federal Register for public comment.

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

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

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

17 “(d) CONSULTATIONS.—

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

1 portunity to provide input with respect to the actions
2 of the agency.

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

5 “(A) particular needs of the limited-
6 English-proficient individuals served by the
7 agency;

8 “(B) particular needs of the limited-
9 English-proficient individuals served by the
10 agency’s recipients of Federal financial assist-
11 ance; and

12 “(C) burdens of compliance with the agen-
13 cy guidance and this section for the agency and
14 its recipients.

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

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

1 “(1) implement strategies to recruit, retain, and
2 promote individuals at all levels of the organization
3 to maintain a diverse staff and leadership that can
4 provide culturally and linguistically appropriate
5 health care to patient populations of the service area
6 of the organization;

7 “(2) ensure that staff at all levels and across all
8 disciplines of the organization receive ongoing edu-
9 cation and training in culturally and linguistically
10 appropriate service delivery;

11 “(3) offer and provide language assistance serv-
12 ices, including trained bilingual staff and interpreter
13 services, at no cost to each patient with limited-
14 English proficiency at all points of contact, in a
15 timely manner during all hours of operation;

16 “(4) notify patients, in a culturally appropriate
17 manner, of their right to receive language assistance
18 services in their primary language;

19 “(5) ensure the competence of language assist-
20 ance provided to limited-English-proficient patients
21 by interpreters and bilingual staff, and ensure that
22 family, particularly minor children, and friends are
23 not used to provide interpretation services—

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

1 “(B) except on request of the patient, who
2 has been informed in his or her preferred lan-
3 guage of the availability of free interpretation
4 services;

5 “(6) make available easily understood patient-
6 related materials, if such materials exist for non-lim-
7 ited-English-proficient patients, including informa-
8 tion or notices about termination of benefits and
9 post signage in the languages of the commonly en-
10 countered groups or groups represented in the serv-
11 ice area of the organization;

12 “(7) develop and implement clear goals, poli-
13 cies, operational plans, and management account-
14 ability and oversight mechanisms to provide cul-
15 turally and linguistically appropriate services;

16 “(8) conduct initial and ongoing organizational
17 assessments of culturally and linguistically appro-
18 priate services-related activities and integrate valid
19 linguistic, competence-related measures into the in-
20 ternal audits, performance improvement programs,
21 patient satisfaction assessments, and outcomes-based
22 evaluations of the organization;

23 “(9) ensure that, consistent with the privacy
24 protections provided for under the regulations pro-
25 mulgated under section 264(c) of the Health Insur-

1 ance Portability and Accountability Act of 1996 (42
2 U.S.C. 1320d–2 note)—

3 “(A) data on the individual patient’s race,
4 ethnicity, primary language, alternative format
5 preferences, and policy modification needs are
6 collected in health records, integrated into the
7 organization’s management information sys-
8 tems, and periodically updated; and

9 “(B) if the patient is a minor or is inca-
10 pacitated, the primary language of the parent
11 or legal guardian is collected;

12 “(10) maintain a current demographic, cultural,
13 and epidemiological profile of the community as well
14 as a needs assessment to accurately plan for and im-
15 plement services that respond to the cultural and
16 linguistic characteristics of the service area of the
17 organization;

18 “(11) develop participatory, collaborative part-
19 nerships with communities and utilize a variety of
20 formal and informal mechanisms to facilitate com-
21 munity and patient involvement in designing and im-
22 plementing culturally and linguistically appropriate
23 services-related activities;

24 “(12) ensure that conflict and grievance resolu-
25 tion processes are culturally and linguistically sen-

1 sitive and capable of identifying, preventing, and re-
2 solving cross-cultural conflicts or complaints by pa-
3 tients;

4 “(13) regularly make available to the public in-
5 formation about their progress and successful inno-
6 vations in implementing the standards under this
7 section and provide public notice in their commu-
8 nities about the availability of this information; and

9 “(14) if requested, regularly make available to
10 the head of each Federal entity from which Federal
11 funds are received, information about their progress
12 and successful innovations in implementing the
13 standards under this section as required by the head
14 of such entity.

15 **“SEC. 3403. ROBERT T. MATSUI CENTER FOR CULTURAL**
16 **AND LINGUISTIC COMPETENCE IN HEALTH**
17 **CARE.**

18 “(a) ESTABLISHMENT.—The Secretary, acting
19 through the Director of the Agency for Healthcare Re-
20 search and Quality, shall establish and support a center
21 to be known as the ‘Robert T. Matsui Center for Cultural
22 and Linguistic Competence in Health Care’ (referred to
23 in this section as the ‘Center’) to carry out the following
24 activities:

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

5 “(2) TRANSLATION OF WRITTEN MATERIAL.—

6 “(A) The Center shall provide, directly or
7 through contract, vital documents from com-
8 petent translation services for providers of
9 health care and health-care-related services at
10 no cost to such providers. Materials may be
11 submitted for translation into non-English lan-
12 guages. Translation services shall be provided
13 in a timely and reasonable manner and in ac-
14 cordance with the guidelines and standards set
15 forth in subsection (c) when such standards be-
16 come available. The quality of such translation
17 services shall be monitored and reported pub-
18 licly.

19 “(B) For each form developed or revised
20 by the Secretary that will be used by LEP indi-
21 viduals in health care or health-care-related set-
22 tings, the Center shall translate the form, at a
23 minimum, into the top 15 non-English lan-
24 guages in the United States according to the
25 most recent data from the American Commu-

1 nity Survey or its replacement. The translation
2 must be completed within 45 days of the Sec-
3 retary receiving final approval of the form from
4 the Office of Management and Budget.

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

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

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

15 “(C) to learn how to access language serv-
16 ices.

17 “(4) HEALTH INFORMATION CLEARING-
18 HOUSE.—

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

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

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

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

18 “(I) intake forms;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 “(F) INFORMATION ABOUT PROGRESS.—

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

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) INTERPRETATION AND TRANSLATION GUIDE-
8 LINES AND STANDARDS.—The Center shall convene a
9 working group to develop and adopt interpretation and
10 translation quality guidelines and standards for use by the
11 Center. The guidelines and standards must be sufficient
12 to ensure that LEP individuals have the equal opportunity
13 to benefit from health care services to the same extent
14 as non-LEP individuals. The guidelines and standards
15 shall address the training, assessment, and certification of
16 individuals to provide competent interpreter and trans-
17 lator services to work in health care and health-care-re-
18 lated settings and of bilingual staff who provide services
19 directly in non-English languages. The working group may
20 develop different guidelines and standards for bilingual
21 staff, interpreters, and translators.

22 “(d) MEMBERSHIP.—

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

1 “(A) Four members from organizations
2 that advocate on behalf of LEP individuals.

3 “(B) One member who represents a profes-
4 sional interpreter association (that is not the
5 National Council on Interpreting in Health
6 Care) or translator association.

7 “(C) One member from a nonprofit com-
8 munity-based organization that provides lan-
9 guage services.

10 “(D) Three members recommended by the
11 National Council on Interpreting in Health
12 Care, including one individual who is a
13 professional interpreter.

14 “(E) Four members who are health care or
15 mental health providers or represent health care
16 provider associations, including one individual
17 who represents a health care practice of fewer
18 than 5 clinicians.

19 “(F) One member who works in or has ex-
20 tensive knowledge of issues related to health
21 care risk management.

22 “(2) GEOGRAPHIC REPRESENTATION.—The
23 membership of the Working Group shall reflect a
24 broad geographic representation including both

1 urban and rural representatives, including represent-
2 atives of the United States territories.

3 “(3) PROHIBITED APPOINTMENTS.—Members
4 of the Working Group shall not include Members of
5 Congress or other elected Federal, State, or local
6 government officials.

7 “(4) VACANCIES.—Any vacancies in the Work-
8 ing Group shall not affect the power and duties of
9 the Working Group but shall be filled in the same
10 manner as the original appointment.

11 “(5) SUBCOMMITTEES.—The Working Group
12 may establish subcommittees if doing so increases
13 the efficiency of the Working Group in completing
14 its tasks, including subcommittees to develop dif-
15 ferent guidelines and standards for interpreters,
16 translators, and bilingual staff.

17 “(6) ADVISORY PANEL TO THE WORKING
18 GROUP.—The Working Group shall consult with the
19 Advisory Panel in the development of the guidelines
20 and standards. The Advisory Panel shall include—

21 “(A) representatives from the American
22 Translators Association, Association of Lan-
23 guage Companies, the National Center for
24 State Courts, and States which have developed
25 interpreter standards such as California, Mas-

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

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

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

14 “(7) PUBLICATION.—

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

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

1 “(ii) accept public comment on such
2 guidelines and standards for a period of
3 not less than 90 days.

4 “(B) FINAL STANDARDS.—Not later than
5 120 days after the expiration of the public com-
6 ment period described in subparagraph (A), the
7 Director of the Agency for Healthcare Research
8 and Quality shall publish, after consultation
9 with and the approval of the Working Group,
10 final guidelines and standards in the Federal
11 Register and on the Internet.

12 “(C) TESTING DEVELOPMENT.—Not later
13 than 120 days after the publication of the final
14 recommendations described in subparagraph
15 (B), the Director of the Agency for Healthcare
16 Research and Quality shall, if deemed necessary
17 by the Working Group, enter into a contract
18 with an entity experienced in the development
19 of designing certification tests in language re-
20 lated fields to develop such tests as may be nec-
21 essary to implement the guidelines and stand-
22 ards.

23 “(D) PILOT PROJECT.—

24 “(i) Not later than 120 days after
25 completion of the test development de-

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

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

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

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

1 “(v) If the Working Group determines
2 that any revisions to guidelines and stand-
3 ards are necessary as a result of the pilot
4 project, it shall revise such guidelines and
5 standards and the Director of the Agency
6 for Healthcare Research and Quality shall
7 publish the revisions in the Federal Reg-
8 ister for notice and comment. Not later
9 than 120 days after the expiration of the
10 public comment period on such revisions,
11 the Director of the Agency for Healthcare
12 Research and Quality shall publish, after
13 consultation with and the approval of the
14 Working Group, final revisions to the
15 guidelines and standards in the Federal
16 Register and on the Internet.

17 “(8) ADMINISTRATION.—

18 “(A) CHAIRPERSON.—Not later than 15
19 days after the date on which all members of the
20 Working Group have been appointed under sub-
21 section (d), the Working Group shall designate
22 its chairperson.

23 “(B) COMPENSATION.—While serving on
24 the business of the Working Group (including
25 travel time), a member of the Working Group

1 or the Advisory Panel shall be entitled to com-
2 pensation at the per diem equivalent of the rate
3 provided for level IV of the Executive Schedule
4 under section 5315 of title 5, United States
5 Code, and while so serving away from home and
6 the member's regular place of business, a mem-
7 ber may be allowed travel expenses, as author-
8 ized by the chairperson of the Working Group.
9 For purposes of pay and employment benefits,
10 rights, and privileges, all personnel of the
11 Working Group shall be treated as if they were
12 employees of the House of Representatives.

13 “(C) INFORMATION FROM FEDERAL AGEN-
14 CIES.—The Working Group may secure directly
15 from any Federal department or agency such
16 information as the Working Group considers
17 necessary to carry out this section. Upon re-
18 quest of the Working Group, the head of such
19 department or agency shall furnish such infor-
20 mation. Any information that contains individ-
21 ually identifiable information received by the
22 Working Group shall not be disseminated or
23 disclosed outside of the Working Group and
24 shall not be used except by the Working Group.

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

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

16 “(F) AUTHORIZATION OF APPROPRIA-
17 TIONS.—There are authorized to be appro-
18 priated to carry out this section such sums as
19 may be necessary for the activities of the Work-
20 ing Group and Advisory Panel for each of fiscal
21 years 2012 through 2016, and for the funding
22 of the pilot project.

23 “(9) DEEMED STATUS.—

24 “(A) CERTIFICATION BY PRIVATE ORGANI-
25 ZATION.—If a private accreditation organization

1 establishes training, assessment, or certification
2 standards for interpreters or translators in
3 health care which the Secretary determines are
4 at least equivalent to the training, assessment,
5 or certification standards promulgated by the
6 Secretary as described in subsection (c), the
7 Secretary shall find that all organizations or in-
8 dividuals accredited by such organization com-
9 ply also with the standard described in sub-
10 section (c) if—

11 “(i) such organization or individual
12 authorizes the organization to release to
13 the Secretary upon the Secretary’s request
14 (or such State agency as the Secretary
15 may designate) a copy of the most current
16 accreditation survey of such organization
17 or individual made by the organization, to-
18 gether with any other information directly
19 related to the survey as the Secretary may
20 require (including corrective action plans);
21 and

22 “(ii) such organization releases such a
23 copy and any such information to the Sec-
24 retary.

1 “(B) CERTIFICATION BY A STATE OR LO-
2 CALITY.—If a State or locality has or estab-
3 lishes training, assessment, or certification
4 standards for interpreters or translators in
5 health care which the Secretary determines are
6 at least equivalent to the training, assessment,
7 or certification standards promulgated by the
8 Secretary as described in subsection (c), the
9 Secretary shall find that all organizations or in-
10 dividuals accredited by such State or locality
11 comply also with the standard described in sub-
12 section (c) if—

13 “(i) such organization or individual
14 authorizes the State or locality to release
15 to the Secretary upon his request (or such
16 State agency as the Secretary may des-
17 ignate) a copy of the most current accredi-
18 tation survey of such organization or indi-
19 vidual made by such State or locality, to-
20 gether with any other information directly
21 related to the survey as the Secretary may
22 require (including corrective action plans);
23 and

1 “(ii) such State or locality releases
2 such a copy and any such information to
3 the Secretary.

4 “(C) TIMELY ACTION ON APPLICATION.—
5 The Secretary shall determine, within 210 days
6 after the date the Secretary receives an applica-
7 tion by a private accrediting organization,
8 State, or locality whether the process of the pri-
9 vate accrediting organization, State, or locality
10 meets the requirements with respect to training,
11 assessment, or certification standards for inter-
12 preters or translators with respect to which
13 standards the application is made. The Sec-
14 retary may not deny an application on the basis
15 that it seeks to meet the requirements with re-
16 spect to only one, or more than one, training,
17 assessment, or certification standards for inter-
18 preters or translators.

19 “(D) DISCLOSURE OF ACCREDITATION
20 SURVEY.—The Secretary may not disclose any
21 accreditation survey made and released to him
22 by the National Council on Interpreting in
23 Health Care or any State or locality of an ac-
24 credited organization or individual, except that
25 the Secretary may disclose such a survey and

1 information related to such a survey to the ex-
2 tent such survey and information relate to an
3 enforcement action taken by the Secretary.

4 “(E) DEFICIENCIES.—If the Secretary
5 finds that an accredited organization or indi-
6 vidual has significant deficiencies (as defined in
7 regulations pertaining to the training, assess-
8 ment, or certification standards), the organiza-
9 tion or individual shall, after the date of notice
10 of such finding to the organization and for such
11 period as may be prescribed in regulations, be
12 deemed not to meet the conditions or require-
13 ments the organization or individual has been
14 treated as meeting pursuant to subparagraph
15 (A).

16 “(e) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
17 rector shall collaborate with the Administrator of the Of-
18 fice of Minority Health, the Administrator of the Centers
19 for Medicare & Medicaid Services, and the Administrator
20 of the Health Resources and Services Administration to
21 notify health care providers and health care organizations
22 about the availability of language access services by the
23 Center.

24 “(f) EDUCATION.—The Secretary, directly or through
25 contract, shall undertake a national education campaign

1 to inform providers, LEP individuals, health professionals,
2 graduate schools, and community health centers about—

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

5 “(2) the value of using trained interpreters and
6 the risks associated with using family members,
7 friends, minors, and untrained bilingual staff;

8 “(3) funding sources for developing and imple-
9 menting language services; and

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

12 “(g) AUTHORIZATION OF APPROPRIATIONS.—In ad-
13 dition to the amounts authorized under subsection
14 (e)(8)(F), there are authorized to be appropriated to carry
15 out this section such sums as may be necessary for each
16 of fiscal years 2012 through 2016.

17 **“SEC. 3404. INNOVATIONS IN CULTURAL AND LINGUISTIC**
18 **COMPETENCE GRANTS.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Director of the Agency for Healthcare Research and
21 Quality, shall award grants to eligible entities to enable
22 such entities to design, implement, and evaluate innova-
23 tive, cost-effective programs to improve cultural com-
24 petence and language access in health care for individuals
25 with limited-English proficiency. The Director of the

1 Agency for Healthcare Research and Quality shall coordi-
2 nate with, and ensure the participation of, other agencies
3 including but not limited to the Health Resources and
4 Services Administration, the Center on Minority Health
5 and Health Disparities at the National Institutes of
6 Health, and the Office of Minority Health, regarding the
7 design and evaluation of the grants program.

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

10 “(1) be—

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

13 “(B) an organization described in section
14 501(c)(3) of the Internal Revenue Code of
15 1986;

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

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

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

21 “(F) a public hospital;

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

24 “(H) other entity designated by the Sec-
25 retary; and

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

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

7 “(1) develop, implement, and evaluate models of
8 providing competent interpretation services through
9 on-site interpretation, telephonic interpretation, or
10 video interpretation;

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

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

21 “(4) develop a strategic plan to implement lan-
22 guage services;

23 “(5) develop participatory, collaborative part-
24 nerships with communities encompassing the LEP

1 patient populations being served to gain input in de-
2 signing and implementing language services;

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

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

11 “(8) develop formal training programs, includ-
12 ing continued professional development and edu-
13 cation programs as well as supervision, for individ-
14 uals interested in becoming dedicated health care in-
15 terpreters and culturally competent providers;

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

19 “(10) develop policies that address compensa-
20 tion in salary for staff who receive training to be-
21 come either a staff interpreter or bi-lingual provider;

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

24 “(12) develop, implement, and evaluate models
25 of improving cultural competence; and

1 “(13) ensure that, consistent with the privacy
2 protections provided for under the regulations pro-
3 mulgated under section 264(c) of the Health Insur-
4 ance Portability and Accountability Act of 1996 (42
5 U.S.C. 1320d–2 note), and any applicable State pri-
6 vacy laws, data on the individual patient or recipi-
7 ent’s race, ethnicity, and primary language are col-
8 lected (and periodically updated) in health records
9 and integrated into the organization’s information
10 management systems or any similar system used to
11 store and retrieve data.

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

17 “(e) EVALUATION.—

18 “(1) An entity that receives a grant under this
19 section shall submit to the Secretary an evaluation
20 that describes, in the manner and to the extent re-
21 quired by the Secretary, the activities carried out
22 with funds received under the grant, and how such
23 activities improved access to health and health-care-
24 related services and the quality of health care for in-
25 dividuals with limited-English proficiency. Such eval-

1 uation shall be collected and disseminated through
2 the Robert T. Matsui Center for Cultural and Lin-
3 guistic Competence in Health Care established under
4 section 3403. The Director of the Agency for
5 Healthcare Research and Quality shall notify grant-
6 ees of the availability of technical assistance for the
7 evaluation and provide such assistance upon request.

8 “(2) The Director of the Agency for Healthcare
9 Research and Quality shall evaluate or arrange with
10 other individuals or organizations to evaluate
11 projects funded under this section.

12 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section,
14 \$5,000,000 for each of fiscal years 2012 through 2016.

15 **“SEC. 3405. RESEARCH ON CULTURAL AND LANGUAGE COM-
16 PETENCE.**

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

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

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

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

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

9 “(3) To identify optimal approaches for deliv-
10 ering language access.

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

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

19 “(B) the development and implementation
20 of data collection and reporting systems; and

21 “(C) effective privacy safeguards for col-
22 lected data.

23 “(5) To develop a minimum data collection set
24 for primary language.

1 “(6) To evaluate the most effective ways in
2 which the Department can create or coordinate, and
3 then subsidize or otherwise fund telephonic interpre-
4 tation providers for health care providers, taking
5 into consideration, among other factors, the flexi-
6 bility necessary for such a system to accommodate
7 variations in—

8 “(A) provider type;

9 “(B) languages needed and their frequency
10 of use;

11 “(C) type of encounter;

12 “(D) time of encounter, including regular
13 business hours and after hours; and

14 “(E) location of encounter.

15 “(d) 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 2012 through 2016.”.

19 **SEC. 203. FEDERAL REIMBURSEMENT FOR CULTURALLY**
20 **AND LINGUISTICALLY APPROPRIATE SERV-**
21 **ICES UNDER THE MEDICARE, MEDICAID, AND**
22 **STATE CHILDREN’S HEALTH INSURANCE**
23 **PROGRAMS.**

24 (a) LANGUAGE ACCESS GRANTS FOR MEDICARE
25 PROVIDERS.—

1 (1) ESTABLISHMENT.—

2 (A) IN GENERAL.—Not later than 6
3 months after the date of the enactment of this
4 Act, the Secretary of Health and Human Serv-
5 ices, acting through the Centers for Medicare &
6 Medicaid Services and in consultation with the
7 Center for Medicare and Medicaid Innovation,
8 shall establish demonstration program under
9 which the Secretary shall award grants to eligi-
10 ble Medicare service providers to improve com-
11 munication between such providers and limited-
12 English-proficient Medicare beneficiaries, in-
13 cluding beneficiaries who live in diverse and un-
14 derserved communities.

15 (B) APPLICATION OF INNOVATION
16 RULES.—The demonstration project under sub-
17 paragraph (A) shall be conducted in a manner
18 that is consistent with the applicable provisions
19 of subsections (b), (c), and (d) of section 1115A
20 of the Social Security Act.

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

24 (D) GRANT PERIOD.—Except as provided
25 under paragraph (2)(D), each grant awarded

1 under this subsection shall be for a 3-year pe-
2 riod.

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

6 (A) MEDICARE PROVIDER.—The entity
7 must be—

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

10 (ii) a provider of services under part
11 B of such title;

12 (iii) a Medicare Advantage organiza-
13 tion offering a Medicare Advantage plan
14 under part C of such title; or

15 (iv) a PDP sponsor offering a pre-
16 scription drug plan under part D of such
17 title.

18 (B) UNDERSERVED COMMUNITIES.—The
19 entity must serve a community that with re-
20 spect to necessary language services for improv-
21 ing access and utilization of health care among
22 limited-English proficient individuals, is
23 disproportinaly underserved.

24 (C) APPLICATION.—The entity must pre-
25 pare and submit to the Secretary an applica-

1 tion, at such time, in such manner, and accom-
2 panied by such additional information as the
3 Secretary may require.

4 (D) REPORTING.—In the case of a grantee
5 that received a grant under this subsection in
6 a previous year, such grantee is only eligible for
7 continued payments under a grant under this
8 subsection if the grantee met the reporting re-
9 quirements under paragraph (9) for such year.
10 If a grantee fails to meet the requirement of
11 such paragraph for the first year of a grant, the
12 Secretary may terminate the grant and solicit
13 applications from new grantees to participate in
14 the demonstration program.

15 (3) DISTRIBUTION.—To the extent feasible, the
16 Secretary shall award—

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

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

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

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

25 (4) CONSIDERATIONS IN AWARDING GRANTS.—

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

4 (i) The grantees provide many dif-
5 ferent types of language services.

6 (ii) The grantees serve Medicare bene-
7 ficiaries who speak different languages,
8 and who, as a population, have differing
9 needs for language services.

10 (iii) The grantees serve Medicare
11 beneficiaries in both urban and rural set-
12 tings.

13 (iv) The grantees serve Medicare
14 beneficiaries in at least two geographic re-
15 gions, as defined by the Secretary.

16 (v) The grantees serve Medicare bene-
17 ficiaries in at least two large metropolitan
18 statistical areas with racial, ethnic, and
19 economically diverse populations.

20 (B) PRIORITY FOR PARTNERSHIPS WITH
21 COMMUNITY ORGANIZATIONS AND AGENCIES.—
22 In awarding grants under this subsection, the
23 Secretary shall give priority to eligible entities
24 that have a partnership with—

25 (i) a community organization; or

1 (ii) a consortia of community
2 organizations, state agencies, and local
3 agencies,
4 that has experience in providing language serv-
5 ices.

6 (5) USE OF FUNDS FOR COMPETENT LANGUAGE
7 SERVICES.—

8 (A) IN GENERAL.—Subject to subpara-
9 graph (E), a grantee may only use grant funds
10 received under this subsection to pay for the
11 provision of competent language services to
12 Medicare beneficiaries who are limited-English
13 proficient.

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

17 (i) interpreter and translation services
18 that—

19 (I) subject to the exceptions
20 under subparagraph (C)—

21 (aa) if the grantee operates
22 in a State that has statewide
23 health care interpreter standards,
24 meet the State standards cur-
25 rently in effect; or

1 (bb) if the grantee operates
2 in a State that does not have
3 statewide health care interpreter
4 standards, utilizes competent in-
5 terpreters who follow the Na-
6 tional Council on Interpreting in
7 Health Care's Code of Ethics and
8 Standards of Practice; and

9 (II) that, in the case of inter-
10 preter services, are provided
11 through—

12 (aa) on-site interpretation;

13 (bb) telephonic interpreta-
14 tion; or

15 (cc) video interpretation;

16 and

17 (ii) the direct provision of health care
18 or health-care-related services by a com-
19 petent bilingual health care provider.

20 (C) EXCEPTIONS.—The requirements of
21 subparagraph (B)(i)(I) do not apply—

22 (i) to a Medicare beneficiary who is
23 limited-English-proficient who has been in-
24 formed, in the beneficiary's primary lan-
25 guage, of the availability of free interpreter

1 and translation services and who, instead,
2 requests that a family member, friend, or
3 other person provide such services, if the
4 grantee documents such request in the
5 beneficiary's medical 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) MA ORGANIZATIONS AND PDP SPON-
20 SORS.—If a grantee is a MA organization or a
21 PDP sponsor, such entity must provide at least
22 50 percent of the grant funds that the entity
23 receives under this subsection directly to the en-
24 tity's network providers (including physicians
25 and pharmacies) for the purpose of providing

1 support for such providers to provide competent
2 language services to Medicare beneficiaries who
3 are limited-English proficient.

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

10 (6) DETERMINATION OF AMOUNT OF GRANT
11 PAYMENTS.—

12 (A) IN GENERAL.—Payments to grantees
13 under this subsection shall be calculated based
14 on the estimated numbers of limited-English-
15 proficient Medicare beneficiaries in a grantee’s
16 service area utilizing—

17 (i) data on the numbers of limited-
18 English-proficient individuals who speak
19 English less than “very well” from the
20 most recently available data from the Bu-
21 reau of the Census or other State-based
22 study the Secretary determines likely to
23 yield accurate data regarding the number
24 of such individuals in such service area; or

1 (ii) data provided by the grantee, if
2 the grantee routinely collects data on the
3 primary language of the Medicare bene-
4 ficiaries that the grantee serves and the
5 Secretary determines that the data is accu-
6 rate and shows a greater number of lim-
7 ited-English-proficient individuals than
8 would be estimated using the data under
9 clause (i).

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

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

21 (7) ASSURANCES.—Grantees under this sub-
22 section shall—

23 (A) ensure that clinical and support staff
24 receive appropriate ongoing education and

1 training in linguistically appropriate service de-
2 livery;

3 (B) ensure the linguistic competence of bi-
4 lingual providers;

5 (C) offer and provide appropriate language
6 services at no additional charge to each patient
7 with limited-English proficiency for all points of
8 contact between the patient and the grantee, in
9 a timely manner during all hours of operation;

10 (D) notify Medicare beneficiaries of their
11 right to receive language services in their pri-
12 mary language;

13 (E) post signage in the primary languages
14 commonly used by the patient population in the
15 service area of the organization; and

16 (F) ensure that—

17 (i) primary language data is collected
18 for recipients of language services and
19 such data is consistent with standards de-
20 veloped under title XXXIV of the Public
21 Health Service Act, as added by section
22 202 of this Act, to the extent such stand-
23 ards are available upon the initiation of the
24 demonstration program; and

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

10 (8) NO COST SHARING.—Limited-English-pro-
11 ficient Medicare beneficiaries shall not have to pay
12 cost-sharing or co-payments for competent language
13 services provided under this demonstration program.

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

19 (A) The number of Medicare beneficiaries
20 to whom competent language services are pro-
21 vided.

22 (B) The primary languages of those Medi-
23 care beneficiaries.

24 (C) The types of language services pro-
25 vided to such beneficiaries.

1 (D) Whether such language services were
2 provided by employees of the grantee or
3 through a contract with external contractors or
4 agencies).

5 (E) The types of interpretation services
6 provided to such beneficiaries, and the approxi-
7 mate length of time such service is provided to
8 such beneficiaries.

9 (F) The costs of providing competent lan-
10 guage services.

11 (G) An account of the training or accredi-
12 tation of bilingual staff, interpreters, and trans-
13 lators providing services funded by the grant
14 under this subsection.

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

21 (A) An analysis of the patient outcomes
22 and the costs of furnishing care to the limited-
23 English-proficient Medicare beneficiaries par-
24 ticipating in the project as compared to such
25 outcomes and costs for limited-English-pro-

1 efficient Medicare beneficiaries not participating,
2 based on the data provided under paragraph (9)
3 and any other information available to the Sec-
4 retary.

5 (B) The effect of delivering language serv-
6 ices on—

7 (i) Medicare beneficiary access to care
8 and utilization of services;

9 (ii) the efficiency and cost effective-
10 ness of health care delivery;

11 (iii) patient satisfaction;

12 (iv) health outcomes; and

13 (v) the provision of culturally appro-
14 priate services provided to such
15 beneficiaries.

16 (C) The extent to which bilingual staff, in-
17 terpreters, and translators providing services
18 under such demonstration were trained or ac-
19 credited and the nature of accreditation or
20 training needed by type of provider, service, or
21 other category as determined by the Secretary
22 to ensure the provision of high-quality interpre-
23 tation, translation, or other language services to
24 Medicare beneficiaries if such services are ex-

1 panded pursuant to subsection (c) of section
2 1907 of this Act.

3 (D) Recommendations, if any, regarding
4 the extension of such project to the entire Medi-
5 care program, subject the to provision of section
6 1115A(c) of the Social Security Act.

7 (11) APPROPRIATIONS.—There is appropriated
8 to carry out this subsection, in equal parts from the
9 Federal Hospital Insurance Trust Fund and the
10 Federal Supplementary Medical Insurance Trust
11 Fund, \$16,000,000 for each fiscal year of the dem-
12 onstration program.

13 (b) LANGUAGE SERVICES UNDER THE MEDICARE
14 PROGRAM.—

15 (1) Subsection (aa)(1) of section 1861 of the
16 Social Security Act (42 U.S.C. 1395x) is amended—

17 (A) in subparagraph (B), by striking the
18 “and” at the end;

19 (B) in subparagrph (C), by inserting
20 “and” after the comma at the end; and

21 (C) by inserting after subparagraph (C)
22 the following:

23 “(D) language services as defined in sub-
24 section (iii),”.

1 (2) Section 1833(a) of the Social Security Act
2 (42 U.S.C. 1395l(a)) is amended—

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

5 (B) by edesignating paragraph (9) as para-
6 graph (10); and

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

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

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

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

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

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

22 “(K) language services (as defined in sec-
23 tion 1861(iii)) furnished by a interpreter or
24 translator.”.

1 (4) Section 1861 of the Social Security Act (42
2 U.S.C. 1395x) is amended by adding at the end the
3 following new subsection:

4 “Language Services and Related Terms

5 “(iii)(1) LANGUAGE SERVICES DEFINED.—The term
6 ‘language services’ has the same meaning given ‘language
7 or language access services’ in section 3400 of the Public
8 Health Service Act.

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

13 “(3) INTERPRETER DEFINED.—The term ‘inter-
14 preter’—

15 “(A) means an individual—

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

19 “(ii) who knows health and health-related
20 terminology in both languages; and

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

23 “(4) TRANSLATION DEFINED.—The term ‘trans-
24 lation’ means the transmission of a written message in one

1 language into a written message in another language that
2 retains the intended meaning of the original message.

3 “(5) LIMITED-ENGLISH-PROFICIENT AND LEP DE-
4 FINED.—The terms ‘Limited-English-proficient’ and
5 ‘LEP’ have the meaning given the term ‘limited english
6 proficient’ under section 9101(25) of the Elementary and
7 Secondary Education Act of 1965, except that subpara-
8 graphs (A), (B), and (D) of such section not apply.”.

9 (5) WAIVER OF BUDGET NEUTRALITY.—For
10 the 3-year period beginning on the date of enact-
11 ment of this section, the budget neutrality provision
12 of section 1848(c)(2)(B)(ii) of the Social Security
13 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not
14 apply to language services (as such term is defined
15 in section 1861(iii) of such Act).

16 (c) MEDICARE PART C AND PART D.—

17 (1) IN GENERAL.—Medicare Advantage plans
18 under part C of the Social Security Act and Pre-
19 scription Drug Plans under part D of such Act shall
20 provide effective language services to enrollees of
21 such plans.

22 (2) REPORTING REQUIREMENTS.—Medicare
23 Advantage and Prescription Drug plans shall annu-
24 ally submit to the Secretary of Health and Human
25 Services a report that contains information on the

1 plan's internal policies and procedures related to re-
2 cruitment and retention efforts directed to workforce
3 diversity and linguistically and culturally appropriate
4 provision of services in each of the following con-
5 texts:

6 (A) The collection of data in a manner
7 that meets the requirements of title I of this
8 Act, regarding the enrollee population.

9 (B) Education of staff and contractors who
10 have routine contact with enrollees regarding
11 the various needs of the diverse enrollee popu-
12 lation.

13 (C) Evaluation of the health plan's lan-
14 guage services programs and services with re-
15 spect to the plan's enrollee population, such as
16 through analysis of complaints or satisfaction
17 survey results.

18 (D) Methods by which the plan provides to
19 the Secretary information regarding the ethnic
20 diversity of the plan's enrollee population.

21 (E) The periodic provision of educational
22 information to plan enrollees on the plan's lan-
23 guage services and programs.

24 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID

25 AND SCHIP.—

1 (1) Section 1903(a)(2)(E) of the Social Secu-
2 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended
3 by—

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

5 (B) striking “translation or interpretation
6 services” and inserting “language services”;
7 and

8 (C) striking “children of families” and in-
9 serting “individuals”.

10 (2) Section 1902(a)(10)(A) of the Social Secu-
11 rity Act (42 U.S.C. 1396a(a)(10)(A)) is amended by
12 striking “and (28)” and inserting “(28), and (29)”.

13 (3) Section 1905(a) of the Social Security Act
14 (42 U.S.C. 1396d(a)) is amended by—

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

17 (B) by redesignating paragraph (29) as
18 paragraph (30); and

19 (C) by inserting after paragraph (28) the
20 following new paragraph:

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

1 (4) Section 1916(a)(2) of the Social Security
2 Act (42 U.S.C. 1396o(2)) is amended by—

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

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

7 (C) by adding at the end the following new
8 subparagraph:

9 “(F) language services described in section
10 1905(a)(29); and”.

11 (5) Section 2103 of the Social Security Act (42
12 U.S.C. 1397ee) is amended—

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

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

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

24 (C) in subsection (e)(2)—

- 1 (i) in the heading, by striking “PRE-
2 VENTIVE” and inserting “CERTAIN”; and
3 (ii) by inserting “, subsection (c)(9),”
4 after “subsection (c)(1)(C)”.

5 (6) Section 2110(a)(27) of the Social Security
6 Act (42 U.S.C. 1397jj) is amended by striking
7 “translation” and inserting “language services as
8 described in section 2103(c)(9)”.

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

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

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

20 (8) Section 2105 of the Social Security Act (42
21 U.S.C. 1397ee(e)) 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 entity’s eligible costs (as defined
16 under paragraph (3)) for such services for the
17 quarter.

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

24 (C) RELATION TO MEDICAID DSH.—Pay-
25 ments under this subsection shall not offset or

1 reduce payments under section 1923 of the So-
2 cial Security Act, nor shall payments under
3 such section be considered when determining
4 uncompensated costs associated with the provi-
5 sion of language services.

6 (2) ELIGIBLE ENTITY.—In order to receive
7 grants under this paragraph, an entity must—

8 (A) be a Medicaid provider that is—

9 (i) a physician;

10 (ii) a hospital with a low-income utili-
11 zation rate (as defined in section
12 1923(b)(3) of the Social Security Act (42
13 U.S.C. 1396r-4(b)(3))) of greater than 25
14 percent; or

15 (iii) a federally qualified health center
16 (as defined in section 1905(l)(2)(B) of the
17 Social Security Act (42 U.S.C.
18 1396d(l)(2)(B)));

19 (B) provide language services to at least 8
20 percent of the entity's total number of patients,
21 not later than 6 months after the date of the
22 enactment of the Act; and

23 (C) prepare and submit an application to
24 the Secretary, at such time, in such manner,
25 and accompanied by such information as the

1 Secretary may require to ascertain the entity's
2 eligibility for funding under this subsection.

3 (3) ELIGIBLE COSTS DEFINED.—

4 (A) IN GENERAL.—In this subsection, the
5 term “eligible costs” means, with respect to an
6 eligible entity that provides language services to
7 LEP individuals, the product of—

8 (i) the average per person cost of lan-
9 guage services, determined according to
10 the methodology devised under subpara-
11 graph (B); and

12 (ii) the number of limited-English-pro-
13 ficient individuals who are provided lan-
14 guage services by the entity and for whom
15 no reimbursement is available for such
16 services under the amendments made by
17 subsections (a), (b), (c), or (d) or by pri-
18 vate health insurance.

19 (B) METHODOLOGY.—

20 (i) IN GENERAL.—The Secretary shall
21 establish a methodology to determine the
22 average per person cost of language serv-
23 ices.

24 (ii) DIFFERENT ENTITIES.—In estab-
25 lishing such methodology, the Secretary

1 may establish different methodologies for
2 different types of eligible entities.

3 (iii) NO INDIVIDUAL CLAIMS.—The
4 Secretary may not require eligible entities
5 to submit individual claims for language
6 services for individual patients as a re-
7 quirement for payment under this sub-
8 section.

9 (4) DATA COLLECTION INSTRUMENT.—For pur-
10 poses of this subsection, the Secretary shall create a
11 standard data collection instrument that is con-
12 sistent with any existing reporting requirements by
13 the Secretary or relevant accrediting organizations
14 regarding the number of individuals to whom lan-
15 guage access are provided.

16 (5) REPORTING REQUIREMENTS.—Entities re-
17 ceiving payment under this subsection shall provide
18 the Secretary with a quarterly report on how the en-
19 tity used such funds. Such report shall contain ag-
20 gregate (and may not contain individualized) data
21 collected using the instrument under paragraph (4)
22 and shall otherwise be in a form and manner deter-
23 mined by the Secretary.

24 (6) LANGUAGE SERVICES.—For purposes of
25 this subsection, the term “language services” has

1 the meaning given such term in section 1861(iii) of
2 the Social Security Act.

3 (7) GUIDELINES AND REPORT.—

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

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

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

20 (g) EFFECTIVE DATE.—The amendments made by
21 this section shall take effect on October 1, 2011.

22 **SEC. 204. INCREASING UNDERSTANDING OF AND IMPROV-**
23 **ING HEALTH LITERACY.**

24 (a) IN GENERAL.—The Secretary, acting through the
25 Director of the Agency for Healthcare Research and Qual-

1 ity and the Administrator of the Health Resources and
2 Services Administration, in consultation with the Director
3 of the National Institute on Minority Health and Health
4 Disparities and the Office of Minority Health, shall award
5 grants to eligible entities to improve health care for pa-
6 tient populations that have low functional health literacy.

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

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

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

16 (c) USE OF FUNDS.—

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

21 (A) to define and increase the under-
22 standing of health literacy;

23 (B) to investigate the correlation between
24 low health literacy and health and health care;

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

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

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

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

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

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

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

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

1 (F) other activities determined appropriate
2 by the Administrator of the Health Resources
3 and Services Administration.

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

8 (e) 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 2012 through 2016.

12 **SEC. 205. ASSURANCES FOR RECEIVING FEDERAL FUNDS.**

13 (a) IN GENERAL.—Entities that receive Federal
14 funds under sections 201 or 202 (including under the
15 amendments made by such section), in order to ensure the
16 right of LEP individuals to receive access to quality health
17 care, shall—

18 (1) ensure that appropriate clinical and support
19 staff receive ongoing education and training in lin-
20 guistically appropriate service delivery;

21 (2) offer and provide appropriate language serv-
22 ices at no additional charge to each patient with lim-
23 ited-English proficiency at all points of contact, in a
24 timely manner during all hours of operation;

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

3 (4) utilize only competent interpreter or trans-
4 lation services which—

5 (A) until adoption of the Interpreter and
6 Translator Guidelines and Standards described
7 in section 3403(c) of the Public Health Service
8 Act, are defined in section 3400 of the Public
9 Health Service Act; and

10 (B) after adoption of the Interpreter and
11 Translator Guidelines and Standards described
12 in section 3403(c) of the Public Health Service
13 Act, meet those guidelines and standards;

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

16 (1) When a patient (who has been informed in
17 his or her primary language of the availability of
18 free interpreter and translation services) requests
19 the use of family, friends, or other persons untrained
20 in interpretation or translation if the following con-
21 ditions are met:

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

24 (B) The recipient informs the patient that
25 he or she has the option of having the recipient

1 provide an interpreter for him/her without
2 charge, or of using his/her own interpreter.

3 (C) The recipient informs the patient that
4 the recipient may not require an LEP person to
5 use a family member or friend as an inter-
6 preter.

7 (D) The recipient evaluates whether the
8 person the patient wishes to use as an inter-
9 preter is competent. If the recipient has reason
10 to believe that the interpreter is not competent,
11 the recipient provides the recipient's own inter-
12 preter to protect the recipient from liability if
13 the patient's interpreter is later found not com-
14 petent.

15 (E) If the recipient has reason to believe
16 that there is a conflict of interest between the
17 interpreter and patient, the recipient may not
18 use the patient's interpreter.

19 (F) The recipient has the patient sign a
20 waiver, witnessed by at least 1 individual not
21 related to the patient, that includes the infor-
22 mation stated in subparagraphs (A) through
23 (E) and is translated into the patient's lan-
24 guage.

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

12 **SEC. 206. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
13 **TURALLY AND LINGUISTICALLY APPRO-**
14 **PRIATE HEALTH CARE SERVICES.**

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

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

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

5 (3) recommendations on the development and
6 implementation of policies and practices by providers
7 of health care and health-care-related services for
8 limited-English-proficient individuals;

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

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

14 (b) **AUTHORIZATION OF APPROPRIATIONS.**—There
15 are authorized to be appropriated to carry out this section
16 such sums as may be necessary for each of fiscal years
17 2012 through 2016.

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

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

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

5 (c) APPLICATION.—An eligible entity may apply for
6 a grant under this section by submitting such information
7 as the Secretary may require and in such form and man-
8 ner as the Secretary may require.

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

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

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

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

1 (e) ADDITIONAL DUTIES OF THE SECRETARY.—The
2 Secretary of Education shall—

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

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

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

12 (B) the extent of waiting lists including
13 how many programs maintain waiting lists and,
14 for programs that do not have waiting lists, the
15 reasons why not;

16 (C) the availability of programs to geo-
17 graphically isolated communities;

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

21 (E) the number individuals in the State
22 and each participating locality;

23 (F) the effectiveness of the instruction in
24 meeting the needs of individuals receiving in-
25 struction and those needing instruction;

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

5 (H) the availability of ESL slots by State
6 and locality;

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

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

17 (f) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to the Secretary of Edu-
19 cation for each of fiscal years 2012 through 2015
20 \$250,000,000 to carry out this section.

21 **SEC. 208. IMPLEMENTATION.**

22 (a) GENERAL PROVISIONS.—

23 (1) A State shall not be immune under the
24 Eleventh Amendment of the Constitution of the
25 United States from suit in Federal court for failing

1 to provide the language access funded pursuant to
2 this title.

3 (2) In a suit against a State for a violation of
4 this title, remedies (including remedies at both at
5 law and in equity) are available for such a violation
6 to the same extent as such remedies are available for
7 such a violation in the suit against any public or pri-
8 vate entity other than a State.

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

14 **SEC. 209. LANGUAGE ACCESS SERVICES.**

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

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

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

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

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

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

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

18 (3) by adding at the end the following new sub-
19 paragraph:

20 “(E) reduce health disparities through the
21 provision of language access services, including
22 oral interpretation and written translations.”.

1 **TITLE III—HEALTH WORKFORCE**
2 **DIVERSITY**

3 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
4 **ACT.**

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

8 **“Subtitle A—Diversifying the**
9 **Health Care Workplace**

10 **“SEC. 3411. REPORT ON WORKFORCE DIVERSITY.**

11 “(a) IN GENERAL.—Not later than July 1, 2012, and
12 biannually thereafter, the Secretary, acting through the
13 director of each entity within the Department of Health
14 and Human Services, shall prepare and submit to the
15 Committee on Health, Education, Labor, and Pensions of
16 the Senate and the Committee on Energy and Commerce
17 of the House of Representatives a report on health work-
18 force diversity.

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

21 “(1) A description of any grant support that is
22 provided by each entity for workforce diversity ini-
23 tiatives with the following information—

24 “(A) the number of grants made;

25 “(B) the purpose of the grants;

1 “(C) the populations served through the
2 grants;

3 “(D) the organizations and institutions re-
4 ceiving the grants; and

5 “(E) the tracking efforts that were used to
6 follow the progress of participants.

7 “(2) A description of the entity’s plan to
8 achieve workforce diversity goals that includes, to
9 the extent relevant to such entity—

10 “(A) the number of underrepresented mi-
11 nority health professionals that will be needed
12 in various disciplines over the next 10 years to
13 achieve population parity;

14 “(B) the level of funding needed to fully
15 expand and adequately support health profes-
16 sions pipeline programs;

17 “(C) the impact such programs have had
18 on the admissions practices and policies of
19 health professions schools;

20 “(D) the management strategy necessary
21 to effectively administer and institutionalize
22 health profession pipeline programs; and

23 “(E) the impact that the Government Per-
24 formance and Results Act (GPRA) has had on
25 evaluating the performance of grantees and

1 whether the GPRA is the best assessment tool
2 for programs under titles VII and VIII.

3 “(3) A description of measurable objectives of
4 each entity relating to workforce diversity initiatives.

5 “(c) PUBLIC AVAILABILITY.—The report under sub-
6 section (a) shall be made available for public review and
7 comment.

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

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Bureau of Health Professions within the Health Re-
12 sources and Services Administration, shall award a grant
13 to an entity determined appropriate by the Secretary for
14 the establishment of a national working group on work-
15 force diversity.

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

18 “(1) The grantee shall ensure that the group
19 has representatives of the following:

20 “(A) The Health Resources and Services
21 Administration.

22 “(B) The Department of Health and
23 Human Services Data Council.

24 “(C) The Office of Minority Health.

1 “(D) The Bureau of Labor Statistics of
2 the Department of Labor.

3 “(E) The Public Health Practice Program
4 Office—Office of Workforce Policy and Plan-
5 ning.

6 “(F) The National Institute on Minority
7 Health and Health Disparities.

8 “(G) The Agency for Healthcare Research
9 and Quality.

10 “(H) The Institute of Medicine Study
11 Committee for the 2004 workforce diversity re-
12 port.

13 “(I) The Indian Health Service.

14 “(J) Minority-serving academic institu-
15 tions.

16 “(K) Consumer organizations.

17 “(L) Health professional associations, in-
18 cluding those that represent underrepresented
19 minority populations.

20 “(M) Researchers in the area of health
21 workforce.

22 “(N) Health workforce accreditation enti-
23 ties.

24 “(O) Private foundations that have spon-
25 sored workforce diversity initiatives.

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

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

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

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

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

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

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

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

1 “(7) Develop curriculum guidelines for diversity
2 training.

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

6 “(9) Other activities determined appropriate by
7 the Secretary.

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

16 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
17 is authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2012 through 2017.

20 **“SEC. 3413. TECHNICAL CLEARINGHOUSE FOR HEALTH**
21 **WORKFORCE DIVERSITY.**

22 “(a) IN GENERAL.—The Secretary, acting through
23 the Office of Minority Health, and in collaboration with
24 the Bureau of Health Professions within the Health Re-
25 sources and Services Administration, the National Insti-

1 tute on Minority Health and Health Disparities, shall es-
2 tablish a technical clearinghouse on health workforce di-
3 versity within the Office of Minority Health and coordi-
4 nate current and future clearinghouses.

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

8 “(1) Information on the importance of health
9 workforce diversity.

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

13 “(3) Model health workforce diversity practices
14 and programs.

15 “(4) Admissions policies that promote health
16 workforce diversity and are in compliance with Fed-
17 eral and State laws.

18 “(5) Lists of scholarship, loan repayment, and
19 loan cancellation grants as well as fellowship infor-
20 mation for underserved populations for health pro-
21 fessions schools.

22 “(6) Foundation and other large organizational
23 initiatives relating to health workforce diversity.

24 “(c) CONSULTATION.—In carrying out this section,
25 the Secretary shall consult with non-Federal entities which

1 may include minority health professional associations to
2 ensure the adequacy and accuracy of information.

3 “(d) 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 2012 through 2017.

7 **“SEC. 3414. SUPPORT FOR INSTITUTIONS COMMITTED TO**
8 **WORKFORCE DIVERSITY.**

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

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

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

20 “(A) historically Black colleges and univer-
21 sities;

22 “(B) Hispanic-serving health professions
23 schools;

24 “(C) Hispanic-serving institutions;

25 “(D) tribal colleges and universities;

1 “(E) Asian-American, Native American,
2 and Pacific Islander-serving institutions;

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

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

11 “(H) institutions—

12 “(i) located in communities with pre-
13 dominantly underrepresented minority pop-
14 ulations;

15 “(ii) with whom partnerships have
16 been formed for the purpose of increasing
17 workforce diversity; and

18 “(iii) in which at least 20 percent of
19 the enrolled participants are underrep-
20 resented minorities; 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 under subsection (a) shall be used to expand existing

1 workforce diversity programs, implement new workforce
2 diversity programs, or evaluate existing or new workforce
3 diversity programs, including with respect to mental
4 health care professions. Such programs shall enhance di-
5 versity by considering minority status as part of an indi-
6 vidualized consideration of qualifications. Possible activi-
7 ties may include—

8 “(1) educational outreach programs relating to
9 opportunities in the health professions;

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

12 “(3) postbaccalaureate programs;

13 “(4) academic enrichment programs, particu-
14 larly targeting those who would not be competitive
15 for health professions schools;

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

18 “(6) mentoring programs;

19 “(7) internship or rotation programs involving
20 hospitals, health systems, health plans and other
21 health entities;

22 “(8) community partnership development for
23 purposes relating to workforce diversity; or

24 “(9) leadership training.

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

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

12 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section,
14 such sums as may be necessary for each of fiscal years
15 2012 through 2017.

16 **“SEC. 3415. CAREER DEVELOPMENT FOR SCIENTISTS AND**
17 **RESEARCHERS.**

18 “(a) IN GENERAL.—The Secretary, acting through
19 the Director of the National Institutes of Health, the Di-
20 rector of the Centers for Disease Control and Prevention,
21 the Commissioner of Food and Drugs, and the Director
22 of the Agency for Healthcare Research and Quality, shall
23 award grants that expand existing opportunities for sci-
24 entists and researchers and promote the inclusion of
25 underrepresented minorities in the health professions.

1 “(b) RESEARCH FUNDING.—The head of each entity
2 within the Department of Health and Human Services
3 shall establish or expand existing programs to provide re-
4 search funding to scientists and researchers in training.
5 Under such programs, the head of each such entity shall
6 give priority in allocating research funding to support
7 health research in traditionally underserved communities,
8 including underrepresented minority communities, and re-
9 search classified as community or participatory.

10 “(c) DATA COLLECTION.—The head of each entity
11 within the Department of Health and Human Services
12 shall collect data on the number (expressed as an absolute
13 number and a percentage) of underrepresented minority
14 and nonminority applicants who receive and are denied
15 agency funding at every stage of review. Such data shall
16 be reported annually to the Secretary and the appropriate
17 committees of Congress.

18 “(d) STUDENT LOAN REIMBURSEMENT.—The Sec-
19 retary shall establish a student loan reimbursement pro-
20 gram to provide student loan reimbursement assistance to
21 researchers who focus on racial and ethnic disparities in
22 health. The Secretary shall promulgate regulations to de-
23 fine the scope and procedures for the program under this
24 subsection.

1 “(e) STUDENT LOAN CANCELLATION.—The Sec-
2 retary shall establish a student loan cancellation program
3 to provide student loan cancellation assistance to research-
4 ers who focus on racial and ethnic disparities in health.
5 Students participating in the program shall make a min-
6 imum 5-year commitment to work at an accredited health
7 profession school. The Secretary shall promulgate addi-
8 tional regulations to define the scope and procedures for
9 the program under this subsection.

10 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section,
12 such sums as may be necessary for each of fiscal years
13 2012 through 2017.

14 **“SEC. 3416. CAREER SUPPORT FOR NON-RESEARCH**
15 **HEALTH PROFESSIONALS.**

16 “(a) IN GENERAL.—The Secretary, acting through
17 the Director of the Centers for Disease Control and Pre-
18 vention, the Administrator of the Substance Abuse and
19 Mental Health Services Administration, the Administrator
20 of the Health Resources and Services Administration, and
21 the Administrator of the Centers for Medicare and Med-
22 icaid Services shall establish a program to award grants
23 to eligible individuals for career support in non-research-
24 related health care.

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

3 “(1) be a student in a health professions school,
4 a graduate of such a school who is working in a
5 health profession, or a faculty member of such a
6 school; 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.—An individual shall use
11 amounts received under a grant under this section to—

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

15 “(2) support health-related career advancement
16 activities;

17 “(3) to pay, or as reimbursement for payments
18 of, student loans for individuals who are health pro-
19 fessionals and are focused on health issues affecting
20 underserved communities, including racial and eth-
21 nic minority communities; and

22 “(4) to establish and promote leadership train-
23 ing programs to decrease health disparities and to
24 increase cultural competence with the goal of in-
25 creasing diversity in leadership positions.

1 “(d) DEFINITION.—In this section, the term ‘career
2 in non-research-related health care’ means employment or
3 intended employment in the field of public health, health
4 policy, health management, health administration, medi-
5 cine, nursing, pharmacy, psychology, social work, psychi-
6 atry, other mental and behavioral health, allied health,
7 community health, social work, or other fields determined
8 appropriate by the Secretary, other than in a position that
9 involves research.

10 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section,
12 such sums as may be necessary for each of fiscal years
13 2012 through 2017.

14 **“SEC. 3417. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
15 **VERSITY ON QUALITY.**

16 “(a) IN GENERAL.—The Director of the Agency for
17 Healthcare Research and Quality, in collaboration with
18 the Deputy Assistant Secretary for Minority Health and
19 the Director of the National Institute on Minority Health
20 and Health Disparities, shall award grants to eligible enti-
21 ties to expand research on the link between health work-
22 force diversity and quality health care.

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

1 “(1) be a clinical, public health, or health serv-
2 ices research entity or other entity determined ap-
3 propriate by the Director; and

4 “(2) 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.—Amounts received under a
8 grant awarded under subsection (a) shall be used to sup-
9 port research that investigates the effect of health work-
10 force diversity on—

11 “(1) language access;

12 “(2) cultural competence;

13 “(3) patient satisfaction;

14 “(4) timeliness of care;

15 “(5) safety of care;

16 “(6) effectiveness of care;

17 “(7) efficiency of care;

18 “(8) patient outcomes;

19 “(9) community engagement;

20 “(10) resource allocation;

21 “(11) organizational structure;

22 “(12) compliance of care; or

23 “(13) other topics determined appropriate by
24 the Director.

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

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section,
8 such sums as may be necessary for each of fiscal years
9 2012 through 2017.

10 **“SEC. 3418. HEALTH DISPARITIES EDUCATION PROGRAM.**

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

24 “(b) ACTIVITIES.—The Secretary, through the edu-
25 cation program established under subsection (a) shall,

1 through the use of public awareness and outreach cam-
2 paigns targeting the general public and the medical com-
3 munity at large—

4 “(1) disseminate scientific evidence for the ex-
5 istence and extent of racial and ethnic disparities in
6 health care, including disparities that are not other-
7 wise attributable to known factors such as access to
8 care, patient preferences, or appropriateness of
9 intervention, as described in the 2002 Institute of
10 Medicine Report entitled ‘Unequal Treatment: Con-
11 fronting Racial and Ethnic Disparities in Health
12 Care’, as well as the impact of disparities related to
13 age, disability status, socioeconomic status, sex, gen-
14 der identity, and sexual orientation on racial and
15 ethnic minorities;

16 “(2) disseminate new research findings to
17 health care providers and patients to assist them in
18 understanding, reducing, and eliminating health and
19 health care disparities;

20 “(3) disseminate information about the impact
21 of linguistic and cultural barriers on health care
22 quality and the obligation of health providers who
23 receive Federal financial assistance to ensure that
24 people with limited-English proficiency have access
25 to language access services;

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

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

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

13 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
14 is authorized to be appropriated to carry out this section,
15 such sums as may be necessary for each of fiscal years
16 2012 through 2017.”.

17 **SEC. 302. HISPANIC-SERVING HEALTH PROFESSIONS**
18 **SCHOOLS.**

19 Part B of title VII of the Public Health Service Act
20 (42 U.S.C. 293 et seq.) is amended by adding at the end
21 the following:

22 **“SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS**
23 **SCHOOLS.**

24 “(a) IN GENERAL.—The Secretary, acting through
25 the Administrator of the Health Resources and Services

1 Administration, shall award grants to Hispanic-serving
2 health professions schools for the purpose of carrying out
3 programs to recruit Hispanic individuals to enroll in and
4 graduate from such schools, which may include providing
5 scholarships and other financial assistance as appropriate.

6 “(b) ELIGIBILITY.—In subsection (a), the term ‘His-
7 panic-serving health professions school’ means an entity
8 that—

9 “(1) is a school or program under section
10 799B;

11 “(2) has an enrollment of full-time equivalent
12 students that is made up of at least 9 percent His-
13 panic students;

14 “(3) has been effective in carrying out pro-
15 grams to recruit Hispanic individuals to enroll in
16 and graduate from the school;

17 “(4) has been effective in recruiting and retain-
18 ing Hispanic faculty members;

19 “(5) has a significant number of graduates who
20 are providing health services to medically under-
21 served populations or to individuals in health profes-
22 sional shortage areas; and

23 “(6) Regional Hispanic Centers of Excellence.”.

1 **SEC. 303. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
2 **DISEASE CONTROL AND PREVENTION.**

3 Section 317F(c) of the Public Health Service Act (42
4 U.S.C. 247b-7(c)) is amended—

5 (1) by striking “and” after “1994,”; and

6 (2) by inserting before the period the following:

7 “\$750,000 for fiscal year 2012, and such sums as
8 may be necessary for each of the fiscal years 2013
9 through 2017.”.

10 **SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
11 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
12 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

13 Part B of title VII of the Public Health Service Act
14 (42 U.S.C. 293 et seq.), as amended by section 302, is
15 further amended by adding at the end the following:

16 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
17 **GREE PROGRAMS.**

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

1 “(b) PRIORITY.—In awarding cooperative agreements
2 under this section, the Secretary shall give priority to any
3 school of public health or school of allied health that has
4 an established track record of serving medically under-
5 served communities.

6 “(c) REQUIREMENTS.—Awardees must design and
7 implement an online degree program, that meet the fol-
8 lowing restrictions:

9 “(1) Enrollment of individuals who have ob-
10 tained a secondary school diploma or its recognized
11 equivalent.

12 “(2) Maintaining a significant enrollment of
13 underrepresented minority or disadvantaged stu-
14 dents.

15 “(d) 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 2012 through 2017.”.

19 **SEC. 305. NATIONAL REPORT ON THE PREPAREDNESS OF**
20 **HEALTH PROFESSIONALS TO CARE FOR DI-**
21 **VERSE POPULATIONS.**

22 The Secretary of Health and Human Services, in col-
23 laboration with the Bureau of Health Professions, the Of-
24 fice of Minority Health and the National Institute on Mi-
25 nority Health and Health Disparities, shall prepare and

1 disseminate a report that details and assesses the pre-
2 paredness of health professionals to care for racially and
3 ethnically diverse populations. Such information, which
4 shall be collected by the Bureau of Health Professions,
5 shall include—

6 (1) with respect to health professions education,
7 the number and percentage of hours of classroom
8 discussion relating to minority health issues, includ-
9 ing cultural competence;

10 (2) a description of the coursework involved in
11 such education;

12 (3) a description of the results of an evaluation
13 of the preparedness of students in such education;

14 (4) a description of the types of exposure that
15 students have during their education to minority pa-
16 tient populations; and

17 (5) a description of model programs and prac-
18 tices.

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

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

1 **“SEC. 3419. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
2 **SERVICES CORPS.**

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

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

12 “(1) be a clinical, public health or health serv-
13 ices organization, community-based or nonprofit en-
14 tity, or other entity determined appropriate by the
15 Director of the Centers for Disease Control and Pre-
16 vention;

17 “(2) serve a health professional shortage area,
18 as determined by the Secretary;

19 “(3) work with students, including those from
20 racial and ethnic minority backgrounds, that have
21 expressed an interest in the health professions; and

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

25 “(c) USE OF FUNDS.—Grant awards under sub-
26 section (a) shall be used to support internships that will

1 increase awareness among students of non-research-based
2 and career opportunities in the following health profes-
3 sions:

4 “(1) Medicine.

5 “(2) Nursing.

6 “(3) Public Health.

7 “(4) Pharmacy.

8 “(5) Health administration and management.

9 “(6) Health policy.

10 “(7) Psychology.

11 “(8) Dentistry.

12 “(9) International health.

13 “(10) Social work.

14 “(11) Allied health.

15 “(12) Psychiatry.

16 “(13) Hospice care.

17 “(14) Other professions deemed appropriate by

18 the Director of the Centers for Disease Control and

19 Prevention.

20 “(d) PRIORITY.—In awarding grants under sub-

21 section (a), the Director of the Centers for Disease Con-

22 trol and Prevention shall give priority to those entities

23 that—

24 “(1) serve a high proportion of individuals from

25 disadvantaged backgrounds;

1 “(2) have experience in health disparity elimi-
2 nation programs;

3 “(3) facilitate the entry of disadvantaged indi-
4 viduals into institutions of higher education; and

5 “(4) provide counseling or other services de-
6 signed to assist disadvantaged individuals in success-
7 fully completing their education at the postsecondary
8 level.

9 “(e) STIPENDS.—The Secretary may approve sti-
10 pends under this section for individuals for any period of
11 education in student-enhancement programs (other than
12 regular courses) at health professions schools, programs,
13 or entities, except that such a stipend may not be provided
14 to an individual for more than 6 months, and such a sti-
15 pend may not exceed \$20 per day (notwithstanding any
16 other provision of law regarding the amount of stipends).

17 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
18 is authorized to be appropriated to carry out this section,
19 such sums as may be necessary for each of fiscal years
20 2012 through 2017.

21 **“SEC. 3420. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
22 **PROGRAM.**

23 “(a) IN GENERAL.—The Director of the Centers for
24 Disease Control and Prevention, in collaboration with the
25 Deputy Assistant Secretary for Minority Health, shall

1 award scholarships to postsecondary students who seek a
2 career in public health.

3 “(b) ELIGIBILITY.—To be eligible to receive a schol-
4 arship under subsection (a) an individual shall—

5 “(1) have experience in public health research
6 or public health practice, or other health professions
7 as determined appropriate by the Director of the
8 Centers for Disease Control and Prevention;

9 “(2) reside in a health professional shortage
10 area as determined by the Secretary;

11 “(3) have expressed an interest in public health;

12 “(4) demonstrate promise for becoming a leader
13 in public health;

14 “(5) secure admission to a 4-year institution of
15 higher education;

16 “(6) comply with subsection (f); and

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

20 “(c) USE OF FUNDS.—Amounts received under an
21 award under subsection (a) shall be used to support oppor-
22 tunities for students to become public health professionals.

23 “(d) PRIORITY.—In awarding grants under sub-
24 section (a), the Director shall give priority to those stu-
25 dents that—

1 “(1) are from disadvantaged backgrounds;

2 “(2) have secured admissions to a minority-
3 serving institution; and

4 “(3) have identified a health professional as a
5 mentor at their school or institution and an aca-
6 demic advisor to assist in the completion of their
7 baccalaureate degree.

8 “(e) SCHOLARSHIPS.—The Secretary may approve
9 payment of scholarships under this section for such indi-
10 viduals for any period of education in student under-
11 graduate tenure, except that such a scholarship may not
12 be provided to an individual for more than 4 years, and
13 such scholarships may not exceed \$10,000 per academic
14 year (notwithstanding any other provision of law regard-
15 ing the amount of scholarship).

16 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
17 is authorized to be appropriated to carry out this section,
18 such sums as may be necessary for each of fiscal years
19 2012 through 2017.

20 **“SEC. 3420A. PATSY MINK HEALTH AND GENDER RESEARCH**
21 **FELLOWSHIP PROGRAM.**

22 “(a) IN GENERAL.—The Director of the Centers for
23 Disease Control and Prevention, in collaboration with the
24 Deputy Assistant Secretary for Minority Health, the Ad-
25 ministrator of the Substance Abuse and Mental Health

1 Services Administration, and the Director of the Indian
2 Health Services, shall award research fellowships to post-
3 baccalaureate students to conduct research that will exam-
4 ine gender and health disparities and to pursue a career
5 in the health professions.

6 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
7 ship under subsection (a) an individual shall—

8 “(1) have experience in health research or pub-
9 lic health practice;

10 “(2) reside in a health professional shortage
11 area as determined by the Secretary;

12 “(3) have expressed an interest in the health
13 professions;

14 “(4) demonstrate promise for becoming a leader
15 in the field of women’s health;

16 “(5) secure admission to a health professions
17 school or graduate program with an emphasis in
18 gender studies;

19 “(6) comply with subsection (f); and

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

23 “(c) USE OF FUNDS.—Amounts received under an
24 award under subsection (a) shall be used to support oppor-
25 tunities for students to become researchers and advance

1 the research base on the intersection between gender and
2 health.

3 “(d) PRIORITY.—In awarding grants under sub-
4 section (a), the Director of the Centers for Disease Con-
5 trol and Prevention shall give priority to those applicants
6 that—

7 “(1) are from disadvantaged backgrounds; and

8 “(2) have identified a mentor and academic ad-
9 visor who will assist in the completion of their grad-
10 uate or professional degree and have secured a re-
11 search assistant position with a researcher working
12 in the area of gender and health.

13 “(e) FELLOWSHIPS.—The Director of the Centers for
14 Disease Control and Prevention may approve fellowships
15 for individuals under this section for any period of edu-
16 cation in the student’s graduate or health profession ten-
17 ure, except that such a fellowship may not be provided
18 to an individual for more than 3 years, and such a fellow-
19 ship may not exceed \$18,000 per academic year (notwith-
20 standing any other provision of law regarding the amount
21 of fellowship).

22 “(f) 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 2012 through 2017.

1 **“SEC. 3420B. PAUL DAVID WELLSTONE INTERNATIONAL**
2 **HEALTH FELLOWSHIP PROGRAM.**

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

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

11 “(1) have educational experience in the field of
12 international health;

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

15 “(3) demonstrate promise for becoming a leader
16 in the field of international health;

17 “(4) be a college senior or recent graduate of
18 a four-year higher education institution;

19 “(5) comply with subsection (f); and

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

23 “(c) USE OF FUNDS.—Amounts received under an
24 award under subsection (a) shall be used to support oppor-
25 tunities for students to become health professionals and

1 to advance their knowledge about international issues re-
2 lating to health care access and quality.

3 “(d) PRIORITY.—In awarding grants under sub-
4 section (a), the Director shall give priority to those appli-
5 cants that—

6 “(1) are from a disadvantaged background; and

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

16 “(e) FELLOWSHIPS.—The Secretary shall approve
17 fellowships for college seniors or recent graduates, except
18 that such a fellowship may not be provided to an indi-
19 vidual for more than 6 months, may not be awarded to
20 a graduate that has not been enrolled in school for more
21 than 1 year, and may not exceed \$4,000 per academic year
22 (notwithstanding any other provision of law regarding the
23 amount of fellowship).

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 2012 through 2017.

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

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

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

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

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

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

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

1 “(c) USE OF FUNDS.—Amounts received under a
2 grant awarded under subsection (a) shall be used to sup-
3 port opportunities that expose students to non-research-
4 based health professions, including—

5 “(1) public health policy;

6 “(2) health care and pharmaceutical policy;

7 “(3) health care administration and manage-
8 ment;

9 “(4) health economics; and

10 “(5) other professions determined appropriate
11 by the Director of the Agency for Healthcare Re-
12 search and Quality.

13 “(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Director of the Agency for Healthcare Re-
15 search and Quality shall give priority to those entities
16 that—

17 “(1) have experience with health disparity elimi-
18 nation programs;

19 “(2) facilitate training in the fields described in
20 subsection (c); and

21 “(3) provide counseling or other services de-
22 signed to assist such individuals in successfully com-
23 pleting their education at the postsecondary level.

24 “(e) STIPENDS.—The Secretary may approve the
25 payment of stipends for individuals under this section for

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

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 2012 through 2017.”.

11 **SEC. 307. ADVISORY COMMITTEE ON HEALTH PROFES-**
12 **SIONS TRAINING FOR DIVERSITY.**

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

19 (b) COMPOSITION.—

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

1 (2) APPOINTMENT.—Not later than 60 days
2 after the date of enactment of this section, the Sec-
3 retary shall appoint the members of the Advisory
4 Committee from among individuals who are health
5 professionals. In making such appointments, the
6 Secretary shall ensure a fair balance between the
7 health professions, that at least 75 percent of the
8 members of the Advisory Committee are health pro-
9 fessionals, a broad geographic representation of
10 members and a balance between urban and rural
11 members. Members shall be appointed based on their
12 competence, interest, and knowledge of the mission
13 of the profession involved.

14 (3) MINORITY REPRESENTATION.—In appoint-
15 ing the members of the Advisory Committee under
16 paragraph (2), the Secretary shall ensure the ade-
17 quate representation of women and minorities.

18 (c) TERMS.—

19 (1) IN GENERAL.—A member of the Advisory
20 Committee shall be appointed for a term of 3 years,
21 except that of the members first appointed—

22 (A) $\frac{1}{3}$ of such members shall serve for a
23 term of 1 year;

24 (B) $\frac{1}{3}$ of such members shall serve for a
25 term of 2 years; and

1 (C) $\frac{1}{3}$ of such members shall serve for a
2 term of 3 years.

3 (2) VACANCIES.—

4 (A) IN GENERAL.—A vacancy on the Advi-
5 sory Committee shall be filled in the manner in
6 which the original appointment was made and
7 shall be subject to any conditions which applied
8 with respect to the original appointment.

9 (B) FILLING UNEXPIRED TERM.—An indi-
10 vidual chosen to fill a vacancy shall be ap-
11 pointed for the unexpired term of the member
12 replaced.

13 (d) DUTIES.—

14 (1) IN GENERAL.—The Advisory Committee
15 shall—

16 (A) provide advice and recommendations to
17 the Secretary concerning policy and program
18 development and other matters of significance
19 concerning activities under this part; and

20 (B) not later than 2 years after the date
21 of enactment of this section, and annually
22 thereafter, prepare and submit to the Secretary,
23 and the Committee on Health, Education,
24 Labor, and Pensions of the Senate, and the
25 Committee on Energy and Commerce of the

1 House of Representatives, a report describing
2 the activities of the Committee.

3 (2) CONSULTATION WITH STUDENTS.—In car-
4 rying out duties under paragraph (1), the Advisory
5 Committee shall consult with individuals who are at-
6 tending health professions schools with which this
7 part is concerned.

8 (e) MEETINGS AND DOCUMENTS.—

9 (1) MEETINGS.—The Advisory Committee shall
10 meet not less than 2 times each year. Such meetings
11 shall be held jointly with other related entities estab-
12 lished under this title where appropriate.

13 (2) DOCUMENTS.—Not later than 14 days prior
14 to the convening of a meeting under paragraph (1),
15 the Advisory Committee shall prepare and make
16 available an agenda of the matters to be considered
17 by the Advisory Committee at such meeting. At any
18 such meeting, the Advisory Committee shall dis-
19 tribute materials with respect to the issues to be ad-
20 dressed at the meeting. Not later than 30 days after
21 the adjourning of such a meeting, the Advisory Com-
22 mittee shall prepare and make available a summary
23 of the meeting and any actions taken by the Com-
24 mittee based upon the meeting.

25 (f) COMPENSATION AND EXPENSES.—

1 (1) COMPENSATION.—Each member of the Ad-
2 visory Committee shall be compensated at a rate
3 equal to the daily equivalent of the annual rate of
4 basic pay prescribed for level IV of the Executive
5 Schedule under section 5315 of title 5, United
6 States Code, for each day (including travel time)
7 during which such member is engaged in the per-
8 formance of the duties of the Committee.

9 (2) EXPENSES.—The members of the Advisory
10 Committee shall be allowed travel expenses, includ-
11 ing per diem in lieu of subsistence, at rates author-
12 ized for employees of agencies under subchapter I of
13 chapter 57 of title 5, United States Code, while
14 away from their homes or regular places of business
15 in the performance of services for the Committee.

16 (g) FACA.—The Federal Advisory Committee Act
17 shall apply to the Advisory Committee under this section
18 only to the extent that the provisions of such Act do not
19 conflict with the requirements of this section.

20 **SEC. 308. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
21 **PROGRAM.**

22 Section 402E of the Higher Education Act of 1965
23 (20 U.S.C. 1070a-15) is amended by striking subsection
24 (g) and inserting the following:

1 “(g) **COLLABORATION IN HEALTH PROFESSION DI-**
2 **VERSITY TRAINING PROGRAMS.**—The Secretary shall co-
3 ordinate with the Secretary of Health and Human Serv-
4 ices to ensure that there is collaboration between the goals
5 of the program under this section and programs of the
6 Health Resources and Services Administration that pro-
7 mote health workforce diversity. The Secretary of Edu-
8 cation shall take such measures as may be necessary to
9 encourage participants in programs under this section to
10 consider health profession careers.

11 “(h) **FUNDING.**—From amounts appropriated pursu-
12 ant to the authority of section 402A(g), the Secretary
13 shall, to the extent practicable, allocate funds for projects
14 authorized by this section in an amount which is not less
15 than \$31,000,000 for each of the fiscal years 2012
16 through 2018.”.

17 **SEC. 309. RULES FOR DETERMINATION OF FULL-TIME**
18 **EQUIVALENT RESIDENTS FOR COST REPORT-**
19 **ING PERIODS.**

20 (a) **DGME DETERMINATIONS.**—Section 1886(h)(4)
21 of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B))
22 is amended—

23 (1) in subparagraph (E), by striking “Subject
24 to subparagraphs (J) and (K), such rules” and in-

1 serting “Subject to subparagraphs (J), (K), and (L),
2 such rules”;

3 (2) in subparagraph (J), by striking “Such
4 rules” and inserting “Subject to subparagraph (L),
5 such rules”;

6 (3) in subparagraph (K), by striking “In deter-
7 mining” and inserting “Subject to subparagraph
8 (L), in determining”; and

9 (4) by adding at the end the following new sub-
10 paragraph:

11 “(L) For purposes of cost-reporting peri-
12 ods beginning on or after October 1, 2011, in
13 determining the hospital’s number of full-time
14 equivalent residents for purposes of this sub-
15 paragraph, all the time spent by an intern or
16 resident in an approved medical residency train-
17 ing program shall be counted toward the deter-
18 mination of full-time equivalency if the hos-
19 pital—

20 “(i) is recognized as a subsection (d)
21 hospital;

22 “(ii) is recognized as a subsection (d)
23 Puerto Rico hospital;

1 “(iii) is reimbursed under a reim-
2 bursement system authorized under section
3 1814(b)(3); or

4 “(iv) is a provider-based hospital out-
5 patient department.”.

6 (b) **IME DETERMINATIONS.**—Section 1886(d)(5)(B)
7 of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

8 (1) in clause (x)(II), by striking “In deter-
9 mining” and inserting “Subject to subclause (x)(IV),
10 in determining”;

11 (2) in clause (x)(III), by striking “In deter-
12 mining” and inserting “Subject to subclause (x)(IV),
13 in determining”; and

14 (3) by adding at the end the following new sub-
15 clause:

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

21 **SEC. 310. DEVELOPING AND IMPLEMENTING STRATEGIES**
22 **FOR LOCAL HEALTH EQUITY.**

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

1 (1) in accordance with subsection (b), devel-
2 oping capacity—

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

5 (B) to serve as national models of driving
6 local health equity;

7 (2) in accordance with subsection (c), devel-
8 oping a strategic partnership with the community in
9 which the academic institution is located; and

10 (3) collecting data on, and periodically evalu-
11 ating, the effectiveness of the institution’s programs
12 funded through this section to enable the institution
13 to adapt accordingly for maximum efficiency and
14 success.

15 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
16 HEALTH EQUITY.—As a condition on receipt of a grant
17 under subsection (a), an academic institution shall agree
18 to use the grant to build an evidence base for successful
19 strategies for increasing local health equity, and to serve
20 as a national model of driving local health equity, by sup-
21 porting—

22 (1) resources to strengthen institutional metrics
23 and capacity to execute institutionwide health work-
24 force goals that can serve as models for increasing
25 health equity in communities across the country ;

1 (2) collaborations among a cohort of institu-
2 tions in implementing systemic change, partnership
3 development, and programmatic efforts supportive of
4 health equity goals across disciplines and popu-
5 lations; and

6 (3) enhanced or newly developed data systems
7 and research infrastructure capable of informing
8 current and future workforce efforts and building a
9 foundation for a broader research agenda targeting
10 urban health disparities.

11 (c) STRATEGIC PARTNERSHIPS.—As a condition on
12 receipt of a grant under subsection (a), an academic insti-
13 tution shall agree to use the grant to develop a strategic
14 partnership with the community in which the institution
15 is located for the purposes of—

16 (1) strengthening connections between the insti-
17 tution and the community—

18 (A) to improve evaluation of and address
19 the community's health and health workforce
20 needs; and

21 (B) to engage the community in health
22 workforce development;

23 (2) developing, enhancing, or accelerating inno-
24 vative undergraduate and graduate programs in the
25 biomedical sciences and health professions; and

1 (3) strengthening the “birth to career” pipeline
2 in the biomedical sciences and health professions, in-
3 cluding by developing partnerships between institu-
4 tions of higher education and elementary and sec-
5 ondary schools to recruit the next generation of
6 health professionals earlier in the pipeline to a
7 health care career.

8 **SEC. 311. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**
9 **IORAL HEALTH SOCIAL WORKERS.**

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

13 “(q) **REPAYMENT PLAN FOR MENTAL AND BEHAV-**
14 **IORAL HEALTH SOCIAL WORKERS.—**

15 “(1) **IN GENERAL.—**The Secretary shall cancel
16 the balance of interest and principal due on any eli-
17 gible Federal Direct Loan not in default for a bor-
18 rower who—

19 “(A) has made 120 monthly payments on
20 the eligible Federal Direct Loan after October
21 1, 2012, pursuant to any one or a combination
22 of the following—

23 “(i) payments under an income-based
24 repayment plan under section 493C;

1 “(ii) payments under a standard re-
2 payment plan under subsection (d)(1)(A),
3 based on a 10-year repayment period;

4 “(iii) monthly payments under a re-
5 payment plan under subsection (d)(1) or
6 (g) of not less than the monthly amount
7 calculated under subsection (d)(1)(A),
8 based on a 10-year repayment period; or

9 “(iv) payments under an income con-
10 tingent repayment plan under subsection
11 (d)(1)(D); and

12 “(B)(i) is employed as a mental health or
13 behavioral health social worker, as defined by
14 the Secretary by regulation, at the time of such
15 forgiveness; and

16 “(ii) has been employed as such a mental
17 health or behavioral health social worker during
18 the period in which the borrower makes each of
19 the 120 payments as described in subparagraph
20 (A).

21 “(2) LOAN CANCELLATION AMOUNT.—After the
22 conclusion of the employment period described in
23 paragraph (1), the Secretary shall cancel the obliga-
24 tion to repay the balance of principal and interest
25 due as of the time of such cancellation, on the eligi-

1 ble Federal Direct Loans made to the borrower
2 under this part.

3 “(3) DEFINITION OF ELIGIBLE FEDERAL DI-
4 RECT LOAN.—In this subsection, the term ‘eligible
5 Federal Direct Loan’ means a Federal Direct Staf-
6 ford Loan, Federal Direct PLUS Loan, Federal Di-
7 rect Unsubsidized Stafford Loan, or a Federal Di-
8 rect Consolidation Loan.”.

9 **TITLE IV—IMPROVEMENT OF**
10 **HEALTH CARE SERVICES**
11 **Subtitle A—Health Empowerment**
12 **Zones**

13 **SEC. 401. SHORT TITLE.**

14 This subtitle may be cited as the “Health Empower-
15 ment Zone Act of 2011”.

16 **SEC. 402. FINDINGS.**

17 The Congress finds the following:

18 (1) Numerous studies and reports, including
19 the National Healthcare Disparities Report and Un-
20 equal Treatment, the 2002 Institute of Medicine Re-
21 port, document the extensiveness to which health
22 disparities exist across the country.

23 (2) These studies have found that, on average,
24 racial and ethnic minorities are disproportionately
25 afflicted with chronic and acute conditions—such as

1 cancer, diabetes, and hypertension—and suffer
2 worse health outcomes, worse health status, and
3 higher mortality rates than their White counter-
4 parts.

5 (3) Several recent studies also show that health
6 disparities are a function of not only access to health
7 care, but also the social determinants of health—in-
8 cluding the environment, the physical structure of
9 communities, nutrition and food options, educational
10 attainment, employment, race, ethnicity, geography,
11 and language preference—that directly and indi-
12 rectly affect the health, health care, and wellness of
13 individuals and communities.

14 (4) Integrally involving and fully supporting the
15 communities most affected by health inequities in
16 the assessment, planning, launch, and evaluation of
17 health disparity elimination efforts is among the
18 leading recommendations made to adequately ad-
19 dress and ultimately reduce health disparities.

20 (5) Recommendations also include supporting
21 the efforts of community stakeholders from a broad
22 crosssection—including, but not limited to local
23 businesses, local departments of commerce, edu-
24 cation, labor, urban planning, and transportation,
25 and community-based and other nonprofit organiza-

1 tions—to find areas of common ground around
2 health disparity elimination and collaborate to im-
3 prove the overall health and wellness of a community
4 and its residents.

5 **SEC. 403. DESIGNATION OF HEALTH EMPOWERMENT**
6 **ZONES.**

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

10 (b) ELIGIBILITY CRITERIA.—

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

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

20 (B) includes representatives of—

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

1 (ii) organizations, facilities, and insti-
2 tutions that have a history of working
3 within and serving such communities.

4 (2) ELIGIBLE AREA.—An area is eligible to be
5 designated as a health empowerment zone under this
6 section if one or more communities in the area expe-
7 rience disproportionate disparities in health status
8 and health care. In determining whether a commu-
9 nity experiences such disparities, the Secretary shall
10 consider the data collected by the Department of
11 Health and Human Services focusing on the fol-
12 lowing areas:

13 (A) Access to affordable high-quality
14 health services.

15 (B) Arthritis, osteoporosis, and chronic
16 back conditions.

17 (C) Cancer.

18 (D) Chronic kidney disease.

19 (E) Diabetes.

20 (F) Injury and violence prevention.

21 (G) Maternal, infant, and child health.

22 (H) Medical product safety.

23 (I) Mental health and mental disorders.

24 (J) Nutrition and overweight.

25 (K) Disability and secondary conditions.

1 (L) Educational and community-based
2 health programs.

3 (M) Environmental health.

4 (N) Family planning.

5 (O) Food safety.

6 (P) Health communication.

7 (Q) Health disease and stroke.

8 (R) HIV/AIDS.

9 (S) Immunization and infectious diseases.

10 (T) Occupational safety and health.

11 (U) Oral health.

12 (V) Physical activity and fitness.

13 (W) Public health infrastructure.

14 (X) Respiratory diseases.

15 (Y) Sexually transmitted diseases.

16 (Z) Substance abuse.

17 (AA) Tobacco use.

18 (BB) Vision and hearing.

19 (CC) The degree to which those who have
20 disabilities have access to health services, in-
21 cluding physical activity and fitness, including
22 the ability to physically access the locations
23 where such services are provided.

24 (c) PROCEDURE.—

1 (1) REQUEST.—A request under subsection (a)
2 shall—

3 (A) describe the bounds of the area to be
4 designated as a health empowerment zone and
5 the process used to select those bounds;

6 (B) demonstrate that the partnership sub-
7 mitting the request is an eligible community
8 partnership described in subsection (b)(1);

9 (C) demonstrate that the area is an eligible
10 area described in subsection (b)(2);

11 (D) include a comprehensive assessment of
12 disparities in health status and health care ex-
13 perience by one or more communities in the
14 area;

15 (E) set forth—

16 (i) a vision and a set of values for the
17 area; and

18 (ii) a comprehensive and holistic set of
19 goals to be achieved in the area through
20 designation as a health empowerment zone;
21 and

22 (F) include a strategic plan for achieving
23 the goals described in subparagraph (E)(ii).

24 (2) APPROVAL.—Not later than 60 days after
25 the receipt of a request for designation of an area

1 as a health empowerment zone under this section,
2 the Secretary shall approve or disapprove the re-
3 quest.

4 (d) MINIMUM NUMBER.—The Secretary—

5 (1) shall designate not more than 110 health
6 empowerment zones under this section; and

7 (2) shall designate at least one health empower-
8 ment zone in each of the several States, the District
9 of Columbia, and each territory or possession of the
10 United States.

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

12 At the request of any organization or entity seeking
13 to submit a request under section 403(a), the Secretary
14 shall provide technical assistance, and may award a grant,
15 to assist such organization or entity—

16 (1) to form an eligible community partnership
17 described in section 403(b)(1);

18 (2) to complete a health assessment, including
19 an assessment of health disparities under section
20 403(c)(1)(D); or

21 (3) to prepare and submit a request, including
22 a strategic plan, in accordance with section 403.

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

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

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

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

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

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

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

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

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

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

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

9 **SEC. 406. DEFINITION.**

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

18 **SEC. 407. AUTHORIZATION OF APPROPRIATIONS.**

19 To carry out this subtitle, there is authorized to be
20 appropriated \$100,000,000 for fiscal year 2012.

1 **Subtitle B—Other Improvements of**
2 **Health Care Services**

3 **CHAPTER 1—EXPANSION OF COVERAGE**

4 **SEC. 411. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
5 **ACT.**

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

9 **“Subtitle D—Reconstruction and**
10 **Improvement Grants for Public**
11 **Health Care Facilities Serving**
12 **Pacific Islanders and the Insu-**
13 **lar Areas**

14 **“SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
15 **INITIATIVES.**

16 “(a) IN GENERAL.—The Secretary, in collaboration
17 with the Administrator of the Health Resources and Serv-
18 ices Administration, the Director of the Agency for
19 Healthcare Research and Quality, and the Administrator
20 of the Centers for Medicare & Medicaid Services, shall
21 award grants to eligible entities for the conduct of dem-
22 onstration projects to improve the quality of and access
23 to health care.

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

1 “(1) be a health center, hospital, health plan,
2 health system, community clinic. or other health en-
3 tity determined appropriate by the Secretary—

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

7 “(B) that provides care or treatment for a
8 substantial number of patients who are unin-
9 sured, are receiving assistance under a State
10 program under title XIX of the Social Security
11 Act, or are members of vulnerable populations,
12 as determined by the Secretary; and

13 “(C)(i) with respect to which, not less than
14 50 percent of the entity’s patient population is
15 made up of racial and ethnic minorities; or

16 “(ii) that—

17 “(I) serves a disproportionate percent-
18 age of local, minority racial and ethnic pa-
19 tients, or that has a patient population, at
20 least 50 percent of which is limited-English
21 proficient; and

22 “(II) provides an assurance that
23 amounts received under the grant will be
24 used only to support quality improvement

1 activities in the racial and ethnic popu-
2 lation served; and

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

7 “(c) PRIORITY.—In awarding grants under sub-
8 section (a), the Secretary shall give priority to applicants
9 under subsection (b)(2) that—

10 “(1) demonstrate an intent to operate as part
11 of a health care partnership, network, collaborative,
12 coalition, or alliance where each member entity con-
13 tributes to the design, implementation, and evalua-
14 tion of the proposed intervention; or

15 “(2) intend to use funds to carry out system-
16 wide changes with respect to health care quality im-
17 provement, including—

18 “(A) improved systems for data collection
19 and reporting;

20 “(B) innovative collaborative or similar
21 processes;

22 “(C) group programs with behavioral or
23 self-management interventions;

24 “(D) case management services;

1 “(E) physician or patient reminder sys-
2 tems;

3 “(F) educational interventions; or

4 “(G) other activities determined appro-
5 priate by the Secretary.

6 “(d) USE OF FUNDS.—An entity shall use amounts
7 received under a grant under subsection (a) to support
8 the implementation and evaluation of health care quality
9 improvement activities or minority health and health care
10 disparity reduction activities that include—

11 “(1) with respect to health care systems, activi-
12 ties relating to improving—

13 “(A) patient safety;

14 “(B) timeliness of care;

15 “(C) effectiveness of care;

16 “(D) efficiency of care;

17 “(E) patient centeredness; and

18 “(F) health information technology; and

19 “(2) with respect to patients, activities relating
20 to—

21 “(A) staying healthy;

22 “(B) getting well;

23 “(C) living with illness or disability; and

24 “(D) coping with end-of-life issues.

1 “(e) COMMON DATA SYSTEMS.—The Secretary shall
2 provide financial and other technical assistance to grant-
3 ees under this section for the development of common data
4 systems.

5 “(f) 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 2010 through 2015.

9 **“SEC. 3452. CENTERS OF EXCELLENCE.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Administrator of the Health Resources and Services
12 Administration, shall designate centers of excellence at
13 public hospitals, and other health systems serving large
14 numbers of minority patients, that—

15 “(1) meet the requirements of section
16 3451(b)(1);

17 “(2) demonstrate excellence in providing care to
18 minority populations; and

19 “(3) demonstrate excellence in reducing dispari-
20 ties in health and health care.

21 “(b) REQUIREMENTS.—A hospital or health system
22 that serves as a Center of Excellence under subsection (a)
23 shall—

24 “(1) design, implement, and evaluate programs
25 and policies relating to the delivery of care in ra-

1 cially, ethnically, and linguistically diverse popu-
2 lations;

3 “(2) provide training and technical assistance
4 to other hospitals and health systems relating to the
5 provision of quality health care to minority popu-
6 lations; and

7 “(3) develop activities for graduate or con-
8 tinuing medical education that institutionalize a
9 focus on cultural competence training for health care
10 providers.

11 “(c) 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 2010 through 2015.

15 **“SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**
16 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
17 **ING PACIFIC ISLANDERS AND THE INSULAR**
18 **AREAS.**

19 “(a) IN GENERAL.—The Secretary shall provide di-
20 rect financial assistance to designated health care pro-
21 viders and community health centers in American Samoa,
22 Guam, the Commonwealth of the Northern Mariana Is-
23 lands, the United States Virgin Islands, Puerto Rico, and
24 Hawaii for the purposes of reconstructing and improving
25 health care facilities and services.

1 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
2 nancial assistance under subsection (a), an entity shall be
3 a public health facility or community health center located
4 in American Samoa, Guam, the Commonwealth of the
5 Northern Mariana Islands, the United States Virgin Is-
6 lands, Puerto Rico, or Hawaii that—

7 “(1) is owned or operated by—

8 “(A) the Government of American Samoa,
9 Guam, the Commonwealth of the Northern
10 Mariana Islands, the United States Virgin Is-
11 lands, Puerto Rico, or Hawaii or a unit of local
12 government; or

13 “(B) a nonprofit organization; and

14 “(2)(A) provides care or treatment for a sub-
15 stantial number of patients who are uninsured, re-
16 ceiving assistance under a State program under a
17 title XVIII of the Social Security Act, or a State
18 program under title XIX of such Act, or who are
19 members of a vulnerable population, as determined
20 by the Secretary; or

21 “(B) serves a disproportionate percentage of
22 local, minority racial and ethnic patients.

23 “(c) REPORT.—Not later than 180 days after the
24 date of enactment of this title and annually thereafter, the
25 Secretary shall submit to the Congress and the President

1 a report that includes an assessment of health resources
2 and facilities serving populations in American Samoa,
3 Guam, the Commonwealth of the Northern Mariana Is-
4 lands, the United States Virgin Islands, Puerto Rico, and
5 Hawaii. In preparing such report, the Secretary shall—

6 “(1) consult with and obtain information on all
7 health care facilities needs from the entities de-
8 scribed in subsection (b);

9 “(2) include all amounts of Federal assistance
10 received by each entity in the preceding fiscal year;

11 “(3) review the total unmet needs of each juris-
12 diction for health care facilities, including needs for
13 renovation and expansion of existing facilities; and

14 “(4) include a strategic plan for addressing the
15 needs of each jurisdiction identified in the report.

16 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated such sums as necessary
18 to carry out this section.”.

19 **SEC. 412. REMOVING BARRIERS TO UNSUBSIDIZED PUR-**
20 **CHASE OF PRIVATE INSURANCE IN AMER-**
21 **ICAN HEALTH BENEFIT EXCHANGES.**

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

1 (1) in the subsection heading, by striking the
2 semicolon and all that follows through “RESI-
3 DENTS”; and

4 (2) by striking paragraph (3).

5 (b) CONFORMING AMENDMENT.—Section 1411(a)(1)
6 of such Act (42 U.S.C. 18081(a)(1)) is amended by strik-
7 ing “1312(f)(3),”.

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

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services shall—

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

14 (2) predict, based on such study, the demo-
15 graphic characteristics of the population of individ-
16 uals who will not have health insurance coverage
17 after January 1, 2014.

18 (b) REPORTING REQUIREMENTS.—

19 (1) IN GENERAL.—Not later than 12 months
20 after the date of the enactment of this Act, the Sec-
21 retary shall submit to the Congress the results of
22 the study under subsection (a)(1) and the prediction
23 made under subsection (a)(2).

24 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
25 ISTICS.—The Secretary shall report the demographic

1 characteristics under paragraphs (1) and (2) of sub-
2 section (a) on the basis of racial and ethnic group,
3 and shall stratify the reporting on each racial and
4 ethnic group by other demographic characteristics
5 that can impact access to health insurance coverage,
6 such as sexual orientation, gender identity, primary
7 language, disability status, sex, socioeconomic sta-
8 tus, and citizenship and immigration status, in a
9 manner consistent with title I of this Act.

10 **SEC. 414. MEDICAID PAYMENT PARITY FOR THE TERRI-**
11 **TORIES.**

12 (a) **ELIMINATION OF FUNDING LIMITATIONS FOR**
13 **PUERTO RICO, THE UNITED STATES VIRGIN ISLANDS,**
14 **GUAM, THE COMMONWEALTH OF THE NORTHERN MAR-**
15 **IANA ISLANDS, AND AMERICAN SAMOA.—**

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

18 (A) in subsection (f), in the matter before
19 paragraph (1), by striking “subsection (g)” and
20 inserting “subsections (g) and (h)”;

21 (B) in subsection (g)(2), in the matter be-
22 fore subparagraph (A), by inserting “and sub-
23 section (h)” after “paragraphs (3) and (5)”;
24 and

1 (C) by adding at the end the following new
2 subsection:

3 “(h) SUNSET OF FUNDING LIMITATIONS FOR PUER-
4 TO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM,
5 THE COMMONWEALTH OF THE NORTHERN MARIANA IS-
6 LANDS, AND AMERICAN SAMOA.—Subsections (f) and (g)
7 shall not apply to Puerto Rico, the United States Virgin
8 Islands, Guam, the Commonwealth of the Northern Mar-
9 iana Islands, and American Samoa for any fiscal year
10 after fiscal year 2011.”.

11 (2) CONFORMING AMENDMENT.—Section
12 1903(u) of such Act (42 U.S.C. 1396c(u)) is amend-
13 ed by striking paragraph (4).

14 (3) EFFECTIVE DATE.—The amendments made
15 by this subsection shall apply beginning with fiscal
16 year 2012.

17 (b) PARITY IN FMAP.—

18 (1) IN GENERAL.—Section 1905(b)(2) of such
19 Act (42 U.S.C. 1396d(b)(2)) is amended by insert-
20 ing after “50 per centum” the following: “(except
21 that, beginning with fiscal year 2014, the Federal
22 medical assistance percentage for Puerto Rico, the
23 United States Virgin Islands, Guam, the Common-
24 wealth of the Northern Mariana Islands, and Amer-
25 ican Samoa shall be the Federal medical assistance

1 percentage determined by the Secretary in consulta-
2 tion (for the United States Virgin Islands, Guam,
3 the Commonwealth of the Northern Mariana Is-
4 lands, and American Samoa) with the Secretary of
5 the Interior”).

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

23 (3) PER CAPITA INCOME DATA.—

24 (A) REPORT TO CONGRESS.—Not later
25 than October 1, 2012, the Secretary of Health

1 and Human Services shall submit to Congress
2 a report that describes the per capita income
3 data used to promulgate the Federal medical
4 assistance percentage in the territories and how
5 such data differ from the per capita income
6 data used to promulgate Federal medical assist-
7 ance percentages for the 50 States and the Dis-
8 trict of Columbia. The report should include
9 recommendations on how the Federal medical
10 assistance percentages can be calculated for the
11 territories to ensure parity with the 50 States
12 and the District of Columbia.

13 (B) APPLICATION.—Section 1101(a)(8)(B)
14 of the Social Security Act (42 U.S.C.
15 1308(a)(8)(B)) is amended—

16 (i) by striking “(other than Puerto
17 Rico, the United States Virgin Islands, and
18 Guam)” and inserting “(including Puerto
19 Rico, the United States Virgin Islands,
20 Guam, the Commonwealth of the Northern
21 Mariana Islands, and American Samoa)”;
22 and

23 (ii) by inserting “(or, if such satisfac-
24 tory data are not available in the case of
25 the Virgin Islands, Guam, the Northern

1 Mariana Islands, or American Samoa, sat-
2 isfactory data available from the Depart-
3 ment of the Interior for the same period,
4 or if such satisfactory data are not avail-
5 able in the case of Puerto Rico, satisfac-
6 tory data available from the government of
7 the Commonwealth of Puerto Rico for the
8 same period)” after “Department of Com-
9 merce”.

10 (4) RELATION TO AMERICAN RECOVERY AND
11 REINVESTMENT ACT OF 2009.—For any period and
12 territory in which the provisions of this subsection
13 apply to a territory, the provisions of section
14 5001(b)(2) of division B of the American Recovery
15 and Reinvestment Act of 2009 (Public Law 111–5)
16 shall not apply (except as otherwise specifically pro-
17 vided in paragraph (2)).

18 **SEC. 415. CLARIFICATION OF MEDICAID COVERAGE FOR**
19 **CITIZENS OF FREELY ASSOCIATED STATES.**

20 (a) IN GENERAL.—Section 402(b)(2) of the Personal
21 Responsibility and Work Opportunity Reconciliation Act
22 of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at
23 the end the following:

24 “(G) MEDICAID EXCEPTION FOR CITIZENS
25 OF FREELY ASSOCIATED STATES.—With respect

1 to eligibility for benefits for the program de-
2 fined in paragraph (3)(C) (relating to the Med-
3 icaid program), paragraph (1) shall not apply
4 to any individual who lawfully resides in the
5 United States (including territories and posses-
6 sions of the United States) in accordance with
7 the Compacts of Free Association between the
8 Government of the United States and the Gov-
9 ernments of the Federated States of Micro-
10 nesia, the Republic of the Marshall Islands, and
11 the Republic of Palau.”.

12 (b) CONFORMING DEFINITION OF QUALIFIED
13 ALIEN.—Section 431(b) of such Act (8 U.S.C. 1641(b))
14 is amended—

15 (1) in paragraph (6), by striking “or” at the
16 end;

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

19 (3) by adding at the end the following:

20 “(8) an individual who lawfully resides in the
21 United States (including territories and possessions
22 of the United States) in accordance with a Compact
23 of Free Association referred to in section
24 402(b)(2)(G), but only with respect to the program

1 defined in section 402(b)(3)(C) (relating to the Med-
2 icaid program).”.

3 (c) **SETTING FMAP AT 100 PERCENT.**—The third
4 sentence of section 1905(b) of the Social Security Act (42
5 U.S.C. 1396d(b)) is amended by inserting before the pe-
6 riod at the end the following: “; with respect to medical
7 assistance for individuals described in section
8 402(b)(2)(G) of the Personal Responsibility and Work Op-
9 portunity Reconciliation Act of 1996”.

10 (d) **EFFECTIVE DATE.**—The amendments made by
11 this Act take effect on October 1, 2011, and apply to bene-
12 fits and assistance provided on or after that date.

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

14 (a) **IN GENERAL.**—Section 1862(b)(1)(C) of the So-
15 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
16 ed—

17 (1) in the last sentence, by inserting “, and be-
18 fore January 1, 2012” after “prior to such date”;
19 and

20 (2) by adding at the end the following new sen-
21 tence: “Effective for items and services furnished on
22 or after January 1, 2012 (with respect to periods
23 beginning on or after the date that is 42 months
24 prior to such date), clauses (i) and (ii) shall be ap-

1 plied by substituting ‘42-month’ for ‘12-month’ each
2 place it appears in the first sentence.”.

3 (b) **EFFECTIVE DATE.**—The amendments made by
4 this subsection shall take effect on the date of enactment
5 of this Act. For purposes of determining an individual’s
6 status under section 1862(b)(1)(C) of the Social Security
7 Act (42 U.S.C. 1395y(b)(1)(C)), as amended by para-
8 graph (1), an individual who is within the coordinating
9 period as of the date of enactment of this Act shall have
10 that period extended to the full 42 months described in
11 the last sentence of such section, as added by the amend-
12 ment made by paragraph (1)(B).

13 **SEC. 417. BORDER HEALTH GRANTS.**

14 (a) **ELIGIBLE ENTITY DEFINED.**—In this section,
15 the term “eligible entity” means a State, public institution
16 of higher education, local government, tribal government,
17 nonprofit health organization, community health center, or
18 community clinic receiving assistance under section 330
19 of the Public Health Service Act (42 U.S.C. 254b), that
20 is located in the border area.

21 (b) **AUTHORIZATION.**—From funds appropriated
22 under subsection (f), the Secretary of Health and Human
23 Services (in this section referred to as the “Secretary”),
24 acting through the United States members of the United
25 States-Mexico Border Health Commission, shall award

1 grants to eligible entities to address priorities and rec-
2 ommendations to improve the health of border area resi-
3 dents that are established by—

4 (1) the United States members of the United
5 States-Mexico Border Health Commission;

6 (2) the State border health offices; and

7 (3) the Secretary.

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

12 (d) USE OF FUNDS.—An eligible entity that receives
13 a grant under subsection (b) shall use the grant funds
14 for—

15 (1) programs relating to—

16 (A) maternal and child health;

17 (B) primary care and preventative health;

18 (C) public health and public health infra-
19 structure;

20 (D) health education and promotion;

21 (E) oral health;

22 (F) mental and behavioral health;

23 (G) substance abuse;

24 (H) health conditions that have a high
25 prevalence in the border area;

1 (I) medical and health services research;

2 (J) workforce training and development;

3 (K) community health workers or
4 promotoras;

5 (L) health care infrastructure problems in
6 the border area (including planning and con-
7 struction grants);

8 (M) health disparities in the border area;

9 (N) environmental health; and

10 (O) outreach and enrollment services with
11 respect to Federal programs (including pro-
12 grams authorized under titles XIX and XXI of
13 the Social Security Act (42 U.S.C. 1396 and
14 1397aa)); and

15 (2) other programs determined appropriate by
16 the Secretary.

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

22 (f) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section,
24 \$200,000,000 for fiscal year 2012, and such sums as may
25 be necessary for each succeeding fiscal year.

1 **SEC. 418. REMOVING MEDICARE BARRIER TO HEALTH**
2 **CARE.**

3 Section 1818(a)(3) of the Social Security Act (42
4 U.S.C. 1395i-2(a)(3)) is amended by amending subpara-
5 graph (B) to read as follows: “(B) an individual who is
6 lawfully present in the United States”.

7 **SEC. 419. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
8 **PROVIDED BY URBAN INDIAN HEALTH CEN-**
9 **TERS.**

10 (a) **IN GENERAL.**—Section 1905(b) of the Social Se-
11 curity Act (42 U.S.C. 1396(b)), as amended by section
12 415(c), is amended by inserting “or are received through
13 a program operated by an urban Indian organization
14 through a grant or contract under title V of such Act”.

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

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

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

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

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

12 **CHAPTER 2—EXPANSION OF ACCESS**

13 **SEC. 421. GRANTS FOR RACIAL AND ETHNIC APPROACHES** 14 **TO COMMUNITY HEALTH.**

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

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

1 driven sustainable strategies to eliminate racial and ethnic
2 health and health care disparities.

3 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
4 grant under this section, an entity shall—

5 (1) represent a coalition—

6 (A) whose principal purpose is to develop
7 and implement interventions to reduce or elimi-
8 nate a health or health care disparity in a tar-
9 geted racial or ethnic minority group in the
10 community served by the coalition; and

11 (B) that includes—

12 (i) members selected from among—

13 (I) public health departments;

14 (II) community-based organiza-
15 tions;

16 (III) university and research or-
17 ganizations;

18 (IV) American Indian tribal or-
19 ganizations, national American Indian
20 organizations, Indian Health Service,
21 or organizations serving Alaska Na-
22 tives; and

23 (V) interested public or private
24 health care providers or organizations

1 as deemed appropriate by the Sec-
2 retary; and

3 (ii) at least 1 member from a commu-
4 nity-based organization that represents the
5 targeted racial or ethnic minority group;
6 and

7 (2) submit to the Secretary an application at
8 such time, in such manner, and containing such in-
9 formation as the Secretary may require, which shall
10 include—

11 (A) a description of the targeted racial or
12 ethnic populations in the community to be
13 served under the grant;

14 (B) a description of at least 1 health dis-
15 parity that exists in the racial or ethnic tar-
16 geted populations, including health issues such
17 as infant mortality, breast and cervical cancer
18 screening and management, cardiovascular dis-
19 ease, diabetes, child and adult immunization
20 levels, or other health priority areas as des-
21 ignated by the Secretary; and

22 (C) a demonstration of a proven record of
23 accomplishment of the coalition members in
24 serving and working with the targeted commu-
25 nity.

1 (d) SUSTAINABILITY.—The Secretary shall give pri-
2 ority to an eligible entity under this section if the entity
3 agrees that, with respect to the costs to be incurred by
4 the entity in carrying out the activities for which the grant
5 was awarded, the entity (and each of the participating
6 partners in the coalition represented by the entity) will
7 maintain its expenditures of non-Federal funds for such
8 activities at a level that is not less than the level of such
9 expenditures during the fiscal year immediately preceding
10 the first fiscal year for which the grant is awarded.

11 (e) NONDUPLICATION.—Funds provided through this
12 grant program should supplement, not supplant, existing
13 Federal funding, and the funds should not be used to du-
14 plicate the activities of the other health disparity grant
15 programs in this Act.

16 (f) TECHNICAL ASSISTANCE.—The Secretary may,
17 either directly or by grant or contract, provide any entity
18 that receives a grant under this section with technical and
19 other nonfinancial assistance necessary to meet the re-
20 quirements of this section.

21 (g) DISSEMINATION.—The Secretary shall encourage
22 and enable grantees to share best practices, evaluation re-
23 sults, and reports with communities not affiliated with
24 grantees using the Internet, conferences, and other perti-
25 nent information regarding the projects funded by this

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

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

7 (i) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated such sums as may be
9 necessary to carry out this section.

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

11 (a) ELIMINATION OF ISOLATION TEST FOR COST-
12 BASED AMBULANCE REIMBURSEMENT.—

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

16 (A) in subparagraph (B)—

17 (i) by striking “owned and”; and

18 (ii) by inserting “(including when
19 such services are provided by the entity
20 under an arrangement with the hospital)”
21 after “hospital”; and

22 (B) by striking the comma at the end of
23 subparagraph (B) and all that follows and in-
24 serting a period.

1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply to services furnished
3 on or after January 1, 2012.

4 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
5 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
6 REQUIREMENT.—

7 (1) IN GENERAL.—Section 1820(c)(2) of the
8 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
9 amended—

10 (A) in subparagraph (B)(iii), by striking
11 “provides not more than” and inserting “sub-
12 ject to subparagraph (F), provides not more
13 than”; and

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

16 “(F) ALTERNATIVE TO 25 INPATIENT BED
17 LIMIT REQUIREMENT.—

18 “(i) IN GENERAL.—A State may elect
19 to treat a facility, with respect to the des-
20 ignation of the facility for a cost reporting
21 period, as satisfying the requirement of
22 subparagraph (B)(iii) relating to a max-
23 imum number of acute care inpatient beds
24 if the facility elects, in accordance with a
25 method specified by the Secretary and be-

1 fore the beginning of the cost reporting pe-
2 riod, to meet the requirement under clause
3 (ii).

4 “(ii) ALTERNATE REQUIREMENT.—
5 The requirement under this clause, with
6 respect to a facility and a cost reporting
7 period, is that the total number of inpa-
8 tient bed days described in subparagraph
9 (B)(iii) during such period will not exceed
10 7,300. For purposes of this subparagraph,
11 an individual who is an inpatient in a bed
12 in the facility for a single day shall be
13 counted as one inpatient bed day.

14 “(iii) WITHDRAWAL OF ELECTION.—
15 The option described in clause (i) shall not
16 apply to a facility for a cost reporting pe-
17 riod if the facility (for any two consecutive
18 cost-reporting periods during the previous
19 5 cost-reporting periods) was treated under
20 such option and had a total number of in-
21 patient bed days for each of such two cost-
22 reporting periods that exceeded the num-
23 ber specified in such clause.”.

24 (2) EFFECTIVE DATE.—The amendments made
25 by paragraph (1) shall apply to cost-reporting peri-

1 ods beginning on or after the date of the enactment
2 of this Act.

3 **SEC. 423. ESTABLISHMENT OF RURAL COMMUNITY HOS-
4 PITAL (RCH) PROGRAM.**

5 (a) IN GENERAL.—Section 1861 of the Social Secu-
6 rity Act (42 U.S.C. 1395x), as amended by section
7 203(b)(1)(A), is amended by adding at the end of the fol-
8 lowing new subsection:

9 “Rural Community Hospital; Rural Community Hospital
10 Services

11 “(jjj)(1) The term ‘rural community hospital’ means
12 a hospital (as defined in subsection (e)) that—

13 “(A) is located in a rural area (as defined in
14 section 1886(d)(2)(D)) or treated as being so lo-
15 cated pursuant to section 1886(d)(8)(E);

16 “(B) subject to paragraph (2), has less than 51
17 acute care inpatient beds, as reported in its most re-
18 cent cost report;

19 “(C) makes available 24-hour emergency care
20 services;

21 “(D) subject to paragraph (3), has a provider
22 agreement in effect with the Secretary and is open
23 to the public as of January 1, 2010; and

24 “(E) applies to the Secretary for such designa-
25 tion.

1 “(2) For purposes of paragraph (1)(B), beds in a
2 psychiatric or rehabilitation unit of the hospital which is
3 a distinct part of the hospital shall not be counted.

4 “(3) Paragraph (1)(D) shall not be construed to pro-
5 hibit any of the following from qualifying as a rural com-
6 munity hospital:

7 “(A) A replacement facility (as defined by the
8 Secretary in regulations in effect on January 1,
9 2012) with the same service area (as defined by the
10 Secretary in regulations in effect on such date).

11 “(B) A facility obtaining a new provider num-
12 ber pursuant to a change of ownership.

13 “(C) A facility which has a binding written
14 agreement with an outside, unrelated party for the
15 construction, reconstruction, lease, rental, or financ-
16 ing of a building as of January 1, 2012.

17 “(4) Nothing in this subsection shall be construed as
18 prohibiting a critical access hospital from qualifying as a
19 rural community hospital if the critical access hospital
20 meets the conditions otherwise applicable to hospitals
21 under subsection (e) and section 1866.

22 “(5) Nothing in this subsection shall be construed as
23 prohibiting a rural community hospital participating in
24 the demonstration program under section 410A of the
25 Medicare Prescription Drug, Improvement, and Mod-

1 ernization Act of 2003 (Public Law 108–173; 117 Stat.
2 2313) from qualifying as a rural community hospital if
3 the rural community hospital meets the conditions other-
4 wise applicable to hospitals under subsection (e) and sec-
5 tion 1866.”.

6 (b) PAYMENT.—

7 (1) INPATIENT HOSPITAL SERVICES.—Section
8 1814 of the Social Security Act (42 U.S.C. 1395f)
9 is amended by adding at the end the following new
10 subsection:

11 “Payment for Inpatient Services Furnished in Rural
12 Community Hospitals

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

19 “(1) 101 percent of the reasonable costs of pro-
20 viding such services, without regard to the amount
21 of the customary or other charge, or

22 “(2) the amount of payment provided for under
23 the prospective payment system for inpatient hos-
24 pital services under section 1886(d).”.

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

4 “(p) PAYMENT FOR OUTPATIENT SERVICES FUR-
5 NISHED IN RURAL COMMUNITY HOSPITALS.—The
6 amount of payment under this part for outpatient services
7 furnished in a rural community hospital is, at the election
8 of the hospital in the application referred to in section
9 1861(jjj)(1)(E)—

10 “(1) 101 percent of the reasonable costs of pro-
11 viding such services, without regard to the amount
12 of the customary or other charge and any limitation
13 under section 1861(v)(1)(U), or

14 “(2) the amount of payment provided for under
15 the prospective payment system for covered OPD
16 services under section 1833(t).”.

17 (3) EXEMPTION FROM 30-PERCENT REDUCTION
18 IN REIMBURSEMENT FOR BAD DEBT.—Section
19 1861(v)(1)(T) of such Act (42 U.S.C.
20 1395x(v)(1)(T)) is amended by inserting “(other
21 than for a rural community hospital)” after “In de-
22 termining such reasonable costs for hospitals”.

23 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
24 SERVICES.—Section 1834(p) of such Act (as added by
25 subsection (b)(2)) is amended—

1 (1) by redesignating paragraphs (1) and (2) as
2 subparagraphs (A) and (B), respectively;

3 (2) by inserting “(1)” after “(p)”; and

4 (3) by adding at the end the following:

5 “(2) The amounts of beneficiary costsharing for out-
6 patient services furnished in a rural community hospital
7 under this part shall be as follows:

8 “(A) For items and services that would have
9 been paid under section 1833(t) if provided by a
10 hospital, the amount of costsharing determined
11 under paragraph (8) of such section.

12 “(B) For items and services that would have
13 been paid under section 1833(h) if furnished by a
14 provider or supplier, no costsharing shall apply.

15 “(C) For all other items and services, the
16 amount of costsharing that would apply to the item
17 or service under the methodology that would be used
18 to determine payment for such item or service if pro-
19 vided by a physician, provider, or supplier, as the
20 case may be.”.

21 (d) CONFORMING AMENDMENTS.—

22 (1) PART A PAYMENT.—Section 1814(b) of
23 such Act (42 U.S.C. 1395f(b)) is amended in the
24 matter preceding paragraph (1) by inserting “other
25 than inpatient hospital services furnished by a rural

1 community hospital,” after “critical access hospital
2 services,”.

3 (2) PART B PAYMENT.—Section 1833(a) of
4 such Act (42 U.S.C. 1395l(a)), as amended by sec-
5 tion 203(b)(2), is amended—

6 (A) in paragraph (2), in the matter before
7 subparagraph (A), by striking “and (I)” and in-
8 serting “(I), and (K)”;

9 (B) by striking “and” at the end of para-
10 graph (9);

11 (C) by striking the period at the end of
12 paragraph (10) and inserting “; and”; and

13 (D) by adding at the end the following:

14 “(11) in the case of outpatient services fur-
15 nished by a rural community hospital, the amounts
16 described in section 1834(p).”.

17 (3) TECHNICAL AMENDMENTS.—

18 (A) CONSULTATION WITH STATE AGEN-
19 CIES.—Section 1863 of such Act (42 U.S.C.
20 1395z) is amended by striking “and (dd)(2)”
21 and inserting “(dd)(2), (mm)(1), and (jjj)(1)”.

22 (B) PROVIDER AGREEMENTS.—Section
23 1866(a)(2)(A) of such Act (42 U.S.C.
24 1395cc(a)(2)(A)) is amended by inserting “sec-
25 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, 2011.

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 Health care 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 2012
3 through 2016.

4 (2) AVAILABILITY.—

5 (A) IN GENERAL.—Funds appropriated
6 under paragraph (1) shall remain available for
7 expenditure through fiscal year 2016.

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 2017.

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, 2014,
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 2012, and such sums as may
15 be necessary for each of fiscal years 2013 through 2016.”.

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.—

24 “(A) IN GENERAL.—Nothing in this sec-
25 tion shall be construed to prevent a community

1 health center from contracting with a federally
2 certified rural health clinic (as defined by sec-
3 tion 1861(aa)(2) of the Social Security Act) for
4 the delivery of primary health care services that
5 are available at the rural health clinic to indi-
6 viduals who would otherwise be eligible for free
7 or reduced cost care if that individual were able
8 to obtain that care at the community health
9 center. Such services may be limited in scope to
10 those primary health care services available in
11 that rural health clinic.

12 “(B) ASSURANCES.—In order for a rural
13 health clinic to receive funds under this section
14 through a contract with a community health
15 center under paragraph (1), such rural health
16 clinic shall establish policies to ensure—

17 “(i) nondiscrimination based upon the
18 ability of a patient to pay; and

19 “(ii) the establishment of a sliding fee
20 scale for low-income patients.”.

21 **SEC. 428. FACILITATING THE PROVISION OF TELEHEALTH**
22 **SERVICES ACROSS STATE LINES.**

23 (a) IN GENERAL.—For purposes of expediting the
24 provision of telehealth services, for which payment is made
25 under the Medicare program, across State lines, the Sec-

1 retary of Health and Human Services shall, in consulta-
2 tion with representatives of States, physicians, health care
3 practitioners, and patient advocates, encourage and facili-
4 tate the adoption of provisions allowing for multistate
5 practitioner practice across State lines.

6 (b) DEFINITIONS.—In subsection (a):

7 (1) TELEHEALTH SERVICE.—The term “tele-
8 health service” has the meaning given that term in
9 subparagraph (F) of section 1834(m)(4) of the So-
10 cial Security Act (42 U.S.C. 1395m(m)(4)).

11 (2) PHYSICIAN, PRACTITIONER.—The terms
12 “physician” and “practitioner” have the meaning
13 given those terms in subparagraphs (D) and (E), re-
14 spectively, of such section.

15 (3) MEDICARE PROGRAM.—The term “Medicare
16 program” means the program of health insurance
17 administered by the Secretary of Health and Human
18 Services under title XVIII of the Social Security Act
19 (42 U.S.C. 1395 et seq.).

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

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

24 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

1 “(1) DETERMINATION BY THE DIRECTOR.—

2 Upon a request by the chairman or ranking minority
3 member of the Committee on the Budget of the Sen-
4 ate, or by the chairman or ranking minority member
5 of the Committee on the Budget of the House of
6 Representatives, the Director shall determine if a
7 proposed measure would result in reductions in
8 budget outlays in budgetary outyears through the
9 use of preventive health and preventive health serv-
10 ices.

11 “(2) PROJECTIONS.—If the Director determines
12 that a measure would result in substantial reduc-
13 tions in budget outlays as described in paragraph
14 (1), the Director—

15 “(A) shall include, in any projection pre-
16 pared by the Director, a description and esti-
17 mate of the reductions in budget outlays in the
18 budgetary outyears and a description of the
19 basis for such conclusions; and

20 “(B) may prepare a budget projection that
21 includes some or all of the budgetary outyears,
22 notwithstanding the time periods for projections
23 described in subsection (e) and sections 308,
24 402, and 424.

1 “(3) DEFINITIONS.—As used in this sub-
2 section—

3 “(A) the term ‘preventive health’ means an
4 action that focuses on the health of the public,
5 individuals, and defined populations in order to
6 protect, promote, and maintain health, wellness,
7 and functional ability, and prevent disease, dis-
8 ability, and premature death that is dem-
9 onstrated by credible and publicly available epi-
10 demiological projection models, incorporating
11 clinical trials or observational studies in hu-
12 mans, to avoid future health care costs; and

13 “(B) the term ‘budgetary outyears’ means
14 the 2 consecutive 10-year periods beginning
15 with the first fiscal year that is 10 years after
16 the budget year provided for in the most re-
17 cently agreed to concurrent resolution on the
18 budget.”.

19 **SEC. 430. SENSE OF CONGRESS.**

20 It is the sense of the Congress that—

21 (1) the maintenance of effort (MOE) provisions
22 added to sections 1902 and 2105(d) of the Social
23 Security Act by sections 2001(b) and 2101(b) of the
24 Patient Protection and Affordable Care Act were
25 written to maintain the eligibility standards for the

1 Medicaid program and Children’s Health Insurance
2 Program until the American Health Benefit Ex-
3 changes in the States are fully operational;

4 (2) it is imperative that the MOE provisions are
5 enforced to the strict standard intended by the Con-
6 gress;

7 (3) waiving the MOE provisions should not be
8 permitted, except in the case of a request for a waiv-
9 er that meets the explicit nonapplication require-
10 ments;

11 (4) the MOE provisions ensure the continued
12 success of the Medicaid program and CHIP and
13 were written deliberately to specifically protect vul-
14 nerable and disabled individuals, children, and senior
15 citizens, many of whom are also members of commu-
16 nities of color; and

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

20 **SEC. 431. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
21 **TION EVIDENCING CITIZENSHIP OR NATION-**
22 **ALITY UNDER THE MEDICAID PROGRAM.**

23 (a) REPEAL.—Subsections (i)(22) and (x) of section
24 1903 of the Social Security Act (42 U.S.C. 1396b), as

1 added by section 6036 of the Deficit Reduction Act of
2 2005, are each repealed.

3 (b) CONFORMING AMENDMENTS.—

4 (1) Section 1903 of the Social Security Act (42
5 U.S.C. 1396b) is amended—

6 (A) in subsection (i)—

7 (i) in paragraph (20), by adding “or”
8 after the semicolon at the end; and

9 (ii) in paragraph (21), by striking “;
10 or” and inserting a period;

11 (B) by redesignating subsection (y), as
12 added by section 6043(b) of the Deficit Reduc-
13 tion Act of 2005, as subsection (x); and

14 (C) by redesignating subsection (z), as
15 added by section 6081(a) of the Deficit Reduc-
16 tion Act of 2005, as subsection (y).

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

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

1 **SEC. 432. OFFICE OF MINORITY HEALTH IN VETERANS**
2 **HEALTH ADMINISTRATION OF DEPARTMENT**
3 **OF VETERANS AFFAIRS.**

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

7 **“§ 7309. Office of Minority Health**

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

12 “(b) HEAD.—The Director of the Office of Minority
13 Health shall be the head of the Office. The Director of
14 the Office of Minority Health shall be appointed by the
15 Under Secretary of Health from among individuals quali-
16 fied to perform the duties of the position.

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

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

1 “(2) To support research, demonstrations, and
2 evaluations to test new and innovative models for
3 the discharge of activities described in paragraph
4 (1).

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

8 “(4) To develop mechanisms that support bet-
9 ter health care information dissemination, education,
10 prevention, and services delivery to veterans from
11 disadvantaged backgrounds, including veterans who
12 are members of a racial or ethnic minority group.

13 “(5) To enter into contracts or agreements with
14 appropriate public and nonprofit private entities to
15 develop and carry out programs to provide bilingual
16 or interpretive services to assist veterans who are
17 members of a racial or ethnic minority group and
18 who lack proficiency in speaking the English lan-
19 guage in accessing and receiving health care services
20 through the Veterans Health Administration.

21 “(6) To carry out programs to improve access
22 to health care services through the Veterans Health
23 Administration for veterans with limited proficiency
24 in speaking the English language, including the de-

1 velopment and evaluation of demonstration and pilot
2 projects for that purpose.

3 “(7) To advise the Under Secretary of Health
4 on matters relating to the development, implementa-
5 tion, and evaluation of health professions education
6 in decreasing disparities in health care outcomes be-
7 tween veterans who are members of a racial or eth-
8 nic minority group and other veterans, including
9 cultural competency as a method of eliminating such
10 health disparities.

11 “(8) To perform such other functions and du-
12 ties as the Secretary or the Under Secretary for
13 Health considers appropriate.

14 “(d) DEFINITIONS.—In this section:

15 “(1) The term ‘racial or ethnic minority group’
16 means the following:

17 “(A) American Indians (including Alaska
18 Natives, Eskimos, and Aleuts).

19 “(B) Asian Americans.

20 “(C) Native Hawaiians and other Pacific
21 Islanders.

22 “(D) Blacks.

23 “(E) Hispanics.

24 “(2) The term ‘Hispanic’ means individuals
25 whose origin is Mexican, Puerto Rican, Cuban, Cen-

1 tral or South American, or any other Spanish-speak-
2 ing country.”.

3 **SEC. 433. ACCESS FOR NATIVE AMERICANS UNDER PPACA.**

4 (a) IN GENERAL.—Title I of the Patient Protection
5 and Affordable Care Act is amended—

6 (1) in section 1311(c)(6)(D), by striking “(as
7 defined in section 4 of the Indian Health Care Im-
8 provement Act)” and inserting “(as defined in sec-
9 tion 447.50(b)(1) of title 42 of the Code of Federal
10 Regulations, as in effect on July 1, 2010)”; and

11 (2) in section 1402(d)(1), by striking “(as de-
12 fined in section 4(d) of the Indian Self-Determina-
13 tion and Education Assistance Act (25 U.S.C.
14 450b(d)))” and inserting (f) “(as defined in section
15 447.50(b)(1) of title 42 of the Code of Federal Reg-
16 ulations, as in effect on July 1, 2010)”.

17 (b) INDIVIDUAL MANDATE.—In section 5000A(e)(3)
18 of the Internal Revenue Code of 1986, by striking “(as
19 defined in section 45A(c)(6))” and inserting “(as defined
20 in section 447.50(b)(1) of title 42 of the Code of Federal
21 Regulations, as in effect on July 1, 2010)”.

1 **TITLE V—IMPROVING HEALTH**
2 **OUTCOMES FOR WOMEN,**
3 **CHILDREN, AND FAMILIES**

4 **SEC. 501. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV-**
5 **IORES IN WOMEN AND CHILDREN.**

6 Part Q of title III of the Public Health Service Act
7 (42 U.S.C. 280g et seq.) is amended by adding at the end
8 the following:

9 **“SEC. 399Z–2. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
10 **HAVIORS IN WOMEN AND CHILDREN.**

11 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
12 laboration with the Director of the Centers for Disease
13 Control and Prevention and other Federal officials deter-
14 mined appropriate by the Secretary, is authorized to
15 award grants to eligible entities to promote positive health
16 behaviors for women and children in target populations,
17 especially racial and ethnic minority women and children
18 in medically underserved communities.

19 “(b) USE OF FUNDS.—Grants awarded pursuant to
20 subsection (a) may be used to support community health
21 workers—

22 “(1) to educate and provide outreach regarding
23 enrollment in health insurance including the State
24 Children’s Health Insurance Program under title
25 XXI of the Social Security Act, Medicare under title

1 XVIII of such Act, and Medicaid under title XIX of
2 such Act;

3 “(2) to educate, guide, and provide outreach in
4 a community setting regarding health problems prev-
5 alent among women and children and especially
6 among racial and ethnic minority women and chil-
7 dren;

8 “(3) to educate, guide, and provide experiential
9 learning opportunities that target behavioral risk
10 factors including—

11 “(A) poor nutrition;

12 “(B) physical inactivity;

13 “(C) being overweight or obese;

14 “(D) tobacco use;

15 “(E) alcohol and substance use;

16 “(F) injury and violence;

17 “(G) risky sexual behavior;

18 “(H) mental health problems;

19 “(I) musculoskeletal health;

20 “(J) dental and oral health problems; and

21 “(K) understanding informed consent;

22 “(4) to educate and guide regarding effective
23 strategies to promote positive health behaviors with-
24 in the family;

1 “(5) to promote community wellness and aware-
2 ness; and

3 “(6) to educate and refer target populations to
4 appropriate health care agencies and community-
5 based programs and organizations in order to in-
6 crease access to quality health care services, includ-
7 ing preventive health services.

8 “(c) APPLICATION.—

9 “(1) IN GENERAL.—Each eligible entity that
10 desires to receive a grant under subsection (a) shall
11 submit an application to the Secretary, at such time,
12 in such manner, and accompanied by such additional
13 information as the Secretary may require.

14 “(2) CONTENTS.—Each application submitted
15 pursuant to paragraph (1) shall—

16 “(A) describe the activities for which as-
17 sistance under this section is sought;

18 “(B) contain an assurance that with re-
19 spect to each community health worker pro-
20 gram receiving funds under the grant awarded,
21 such program provides training and supervision
22 to community health workers to enable such
23 workers to provide authorized program services;

24 “(C) contain an assurance that the appli-
25 cant will evaluate the effectiveness of commu-

1 nity health worker programs receiving funds
2 under the grant;

3 “(D) contain an assurance that each com-
4 munity health worker program receiving funds
5 under the grant will provide services in the cul-
6 tural context most appropriate for the individ-
7 uals served by the program;

8 “(E) contain a plan to document and dis-
9 seminate project description and results to
10 other States and organizations as identified by
11 the Secretary; and

12 “(F) describe plans to enhance the capac-
13 ity of individuals to utilize health services and
14 health-related social services under Federal,
15 State, and local programs by—

16 “(i) assisting individuals in estab-
17 lishing eligibility under the programs and
18 in receiving the services or other benefits
19 of the programs; and

20 “(ii) providing other services as the
21 Secretary determines to be appropriate,
22 that may include transportation and trans-
23 lation services.

1 “(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Secretary shall give priority to those appli-
3 cants—

4 “(1) who propose to target geographic areas—

5 “(A) with a high percentage of residents
6 who are eligible for health insurance but are
7 uninsured or underinsured; and

8 “(B) with a high percentage of families for
9 whom English is not their primary language;

10 “(2) with experience in providing health or
11 health-related social services to individuals who are
12 underserved with respect to such services; and

13 “(3) with documented community activity and
14 experience with community health workers.

15 “(e) COLLABORATION WITH ACADEMIC INSTITU-
16 TIONS.—The Secretary shall encourage community health
17 worker programs receiving funds under this section to col-
18 laborate with academic institutions, including minority-
19 serving institutions. Nothing in this section shall be con-
20 strued to require such collaboration.

21 “(f) QUALITY ASSURANCE AND
22 COSTEFFECTIVENESS.—The Secretary shall establish
23 guidelines for assuring the quality of the training and su-
24 pervision of community health workers under the pro-

1 grams funded under this section and for assuring the
2 costeffectiveness of such programs.

3 “(g) MONITORING.—The Secretary shall monitor
4 community health worker programs identified in approved
5 applications and shall determine whether such programs
6 are in compliance with the guidelines established under
7 subsection (f).

8 “(h) TECHNICAL ASSISTANCE.—The Secretary may
9 provide technical assistance to community health worker
10 programs identified in approved applications with respect
11 to planning, developing, and operating programs under the
12 grant.

13 “(i) REPORT TO CONGRESS.—

14 “(1) IN GENERAL.—Not later than 4 years
15 after the date on which the Secretary first awards
16 grants under subsection (a), the Secretary shall sub-
17 mit to Congress a report regarding the grant
18 project.

19 “(2) CONTENTS.—The report required under
20 paragraph (1) shall include the following:

21 “(A) A description of the programs for
22 which grant funds were used.

23 “(B) The number of individuals served.

24 “(C) An evaluation of—

1 “(i) the effectiveness of these pro-
2 grams;

3 “(ii) the cost of these programs; and

4 “(iii) the impact of the project on the
5 health outcomes of the community resi-
6 dents.

7 “(D) Recommendations for sustaining the
8 community health worker programs developed
9 or assisted under this section.

10 “(E) Recommendations regarding training
11 to enhance career opportunities for community
12 health workers.

13 “(j) DEFINITIONS.—In this section:

14 “(1) COMMUNITY HEALTH WORKER.—The term
15 ‘community health worker’ means an individual who
16 promotes health or nutrition within the community
17 in which the individual resides—

18 “(A) by serving as a liaison between com-
19 munities and health care agencies;

20 “(B) by providing guidance and social as-
21 sistance to community residents;

22 “(C) by enhancing community residents’
23 ability to effectively communicate with health
24 care providers;

1 “(D) by providing culturally and linguis-
2 tically appropriate health or nutrition edu-
3 cation;

4 “(E) by advocating for individual and com-
5 munity health, including dental, oral, mental,
6 and environmental health, or nutrition needs;
7 and

8 “(F) by providing referral and followup
9 services.

10 “(2) COMMUNITY SETTING.—The term ‘commu-
11 nity setting’ means a home or a community organi-
12 zation located in the neighborhood in which a partic-
13 ipant resides.

14 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
15 tity’ means—

16 “(A) a unit of State, territorial, local, or
17 tribal government (including a federally recog-
18 nized tribe or Alaska Native village); or

19 “(B) a community-based organization.

20 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
21 The term ‘medically underserved community’ means
22 a community—

23 “(A) that has a substantial number of in-
24 dividuals who are members of a medically un-

1 derserved population, as defined by section
2 330(b)(3); and

3 “(B) a significant portion of which is a
4 health professional shortage area as designated
5 under section 332.

6 “(5) SUPPORT.—The term ‘support’ means the
7 provision of training, supervision, and materials
8 needed to effectively deliver the services described in
9 subsection (b), reimbursement for services, and
10 other benefits.

11 “(6) TARGET POPULATION.—The term ‘target
12 population’ means women of reproductive age, re-
13 gardless of their current childbearing status and
14 children under 21 years of age.

15 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section
17 \$15,000,000 for each of fiscal years 2012 through 2016.”.

18 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
19 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
20 **NANT WOMEN, AND LAWFULLY PRESENT IN-**
21 **DIVIDUALS.**

22 (a) MEDICAID.—Section 1903(v) of the Social Secu-
23 rity Act (42 U.S.C. 1396b(v)) is amended by striking
24 paragraph (4) and inserting the following new paragraph:

1 “(4)(A) Notwithstanding sections 401(a),
2 402(b), 403, and 421 of the Personal Responsibility
3 and Work Opportunity Reconciliation Act of 1996,
4 payment shall be made under this section for care
5 and services that are furnished to aliens, including
6 those described in paragraph (1), if they otherwise
7 meet the eligibility requirements for medical assist-
8 ance under the State plan approved under this sub-
9 chapter (other than the requirement of the receipt of
10 aid or assistance under title IV, supplemental secu-
11 rity income benefits under title XVI, or a State sup-
12 plementary payment), and are—

13 “(i) lawfully present in the United
14 States;

15 “(ii) children under 21 years of age,
16 including any optional targeted low-income
17 child (as such term is defined in section
18 1905(u)(2)(B)); or

19 “(iii) pregnant women during preg-
20 nancy and during the 60-day period begin-
21 ning on the last day of the pregnancy.

22 “(B) No debt shall accrue under an affidavit of
23 support against any sponsor of such an alien on the
24 basis of provision of assistance to such alien under

1 this paragraph and the cost of such assistance shall
2 not be considered as an unreimbursed cost.”.

3 (b) SCHIP.—Section 2107(e)(1) of the Social Secu-
4 rity Act (42 U.S.C. 1397gg(e)(1)) is amended by amend-
5 ing subparagraph (J) to read as follows:

6 “(J) Paragraph (4) of section 1903(v) (re-
7 lating to individuals who, but for sections
8 401(a), 403, and 421 of the Personal Responsi-
9 bility and Work Opportunity Reconciliation Act
10 of 1996, would be eligible for medical assistance
11 under title XXI).”.

12 (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-
13 withstanding sections 401(a), 402(a), and 403(a) of the
14 Personal Responsibility and Work Opportunity Reconcili-
15 ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))
16 and section 6(f) of the Food and Nutrition Act of 2008
17 (7 U.S.C. 2015(f)), persons who are lawfully present in
18 the United States shall be not be ineligible for benefits
19 under the supplemental nutrition assistance program on
20 the basis of their immigration status or date of entry into
21 the United States.

22 (d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—
23 Section of the 421(d)(3) of the Personal Responsibility
24 and Work Opportunity Reconciliation Act of 1996 (8
25 U.S.C. 1631(d)(3)) is amended by striking “to the extent

1 that a qualified alien is eligible under section
2 402(a)(2)(J)” and inserting, “to the extent that a child
3 is a member of a household under the supplemental nutri-
4 tion assistance program”.

5 (e) ENSURING PROPER SCREENING.—Section
6 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7
7 U.S.C. 2020(e)(2)(B)) is amended—

8 (1) by redesignating clauses (vi) and (vii) as
9 clauses (vii) and (viii); and

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

11 “(vi) shall provide a method for imple-
12 menting section 421 of the Personal Re-
13 sponsibility and Work Opportunity Rec-
14 onciliation Act of 1996 (8 U.S.C. 1631)
15 that does not require any unnecessary in-
16 formation from persons who may be ex-
17 empt from that provision;”.

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

19 Section 115 of the Personal Responsibility and Work
20 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
21 is amended—

22 (1) in subsection (a) by striking paragraph (2);

23 (2) in subsection (b) by striking paragraph (2);

24 and

25 (3) in subsection (e) by striking paragraph (2).

1 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
2 **AND AWARENESS.**

3 (a) IN GENERAL.—The Secretary shall establish and
4 implement a birth defects prevention and public awareness
5 program, consisting of the activities described in sub-
6 sections (c) and (d).

7 (b) DEFINITIONS.—In this section:

8 (1) The term “pregnancy and breastfeeding in-
9 formation services” includes only—

10 (A) information services to provide accu-
11 rate, evidence-based, clinical information re-
12 garding maternal exposures during pregnancy
13 that may be associated with birth defects or
14 other health risks, such as exposures to medica-
15 tions, chemicals, infections, foodborne patho-
16 gens, illnesses, nutrition, or lifestyle factors;

17 (B) information services to provide accu-
18 rate, evidence-based, clinical information re-
19 garding maternal exposures during breast-
20 feeding that may be associated with health risks
21 to a breast-fed infant, such as exposures to
22 medications, chemicals, infections, foodborne
23 pathogens, illnesses, nutrition, or lifestyle fac-
24 tors;

25 (C) the provision of accurate, evidence-
26 based information weighing risks of exposures

1 during breastfeeding against the benefits of
2 breastfeeding; and

3 (D) the provision of information described
4 in subparagraph (A), (B), or (C) through coun-
5 selors, Web sites, fact sheets, telephonic or elec-
6 tronic communication, community outreach ef-
7 forts, or other appropriate means.

8 (2) The term “Secretary” means the Secretary
9 of Health and Human Services, acting through the
10 Director of the Centers for Disease Control and Pre-
11 vention.

12 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
13 subsection (a), the Secretary shall conduct or support a
14 nationwide media campaign to increase awareness among
15 health care providers and at-risk populations about preg-
16 nancy and breastfeeding information services.

17 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
18 INFORMATION SERVICES.—

19 (1) IN GENERAL.—In carrying out subsection
20 (a), the Secretary shall award grants to State or re-
21 gional agencies or organizations for any of the fol-
22 lowing:

23 (A) INFORMATION SERVICES.—The provi-
24 sion of, or campaigns to increase awareness

1 about, pregnancy and breastfeeding information
2 services.

3 (B) SURVEILLANCE AND RESEARCH.—The
4 conduct or support of—

5 (i) surveillance of or research on—

6 (I) maternal exposures and ma-
7 ternal health conditions that may in-
8 fluence the risk of birth defects, pre-
9 maturity, or other adverse pregnancy
10 outcomes; and

11 (II) maternal exposures that may
12 influence health risks to a breastfed
13 infant; or

14 (ii) networking to facilitate surveil-
15 lance or research described in this sub-
16 paragraph.

17 (2) PREFERENCE FOR CERTAIN STATES.—The
18 Secretary, in making any grant under this sub-
19 section, shall give preference to States, otherwise
20 equally qualified, that have or had a pregnancy and
21 breastfeeding information service in place on or after
22 January 1, 2006.

23 (3) MATCHING FUNDS.—The Secretary may
24 only award a grant under this subsection to a State
25 or regional agency or organization that agrees, with

1 respect to the costs to be incurred in carrying out
2 the grant activities, to make available (directly or
3 through donations from public or private entities)
4 non-Federal funds toward such costs in an amount
5 equal to not less than 25 percent of the amount of
6 the grant.

7 (4) COORDINATION.—The Secretary shall en-
8 sure that activities funded through a grant under
9 this subsection are coordinated, to the maximum ex-
10 tent practicable, with other birth defects prevention
11 and environmental health activities of the Federal
12 Government, including with respect to pediatric envi-
13 ronmental health specialty units and children’s envi-
14 ronmental health centers.

15 (e) EVALUATION.—In furtherance of the program
16 under subsection (a), the Secretary shall provide for an
17 evaluation of pregnancy and breastfeeding information
18 services to identify efficient and effective models of—

- 19 (1) providing information;
20 (2) raising awareness and increasing knowledge
21 about birth defects prevention measures;
22 (3) modifying risk behaviors; or
23 (4) other outcome measures as determined ap-
24 propriate by the Secretary.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 \$5,000,000 for fiscal year 2012, \$6,000,000 for fiscal year
4 2013, \$7,000,000 for fiscal year 2014, \$8,000,000 for fis-
5 cal year 2015, and \$9,000,000 for fiscal year 2016.

6 **SEC. 505. UNIFORM STATE MATERNAL MORTALITY REVIEW**
7 **COMMITTEES ON PREGNANCY-RELATED**
8 **DEATHS.**

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

14 **“SEC. 514. UNIFORM STATE MATERNAL MORTALITY RE-**
15 **VIEW COMMITTEES ON PREGNANCY-RE-**
16 **LATED DEATHS.**

17 “(a) GRANTS.—

18 “(1) IN GENERAL.—Notwithstanding any other
19 provision of this title, for each of fiscal years 2012
20 through 2018, in addition to payments from allot-
21 ments for States under section 502 for such year,
22 the Secretary shall, subject to paragraph (3) and in
23 accordance with the criteria established under para-
24 graph (2), award grants to States to—

1 “(A) carry out the activities described in
2 subsection (b)(1);

3 “(B) establish a State maternal mortality
4 review committee, in accordance with subsection
5 (b)(2), to carry out the activities described in
6 subsection (b)(2)(A), and to establish the proc-
7 esses described in subsection (b)(1);

8 “(C) ensure the State department of
9 health carries out the applicable activities de-
10 scribed in subsection (b)(3), with respect to
11 pregnancy-related deaths occurring within the
12 State during such fiscal year;

13 “(D) implement and use the comprehensive
14 case abstraction form developed under sub-
15 section (c), in accordance with such subsection;
16 and

17 “(E) provide for public disclosure of infor-
18 mation, in accordance with subsection (e).

19 “(2) CRITERIA.—The Secretary shall establish
20 criteria for determining eligibility for and the
21 amount of a grant awarded to a State under para-
22 graph (1). Such criteria shall provide that in the
23 case of a State that receives such a grant for a fiscal
24 year and is determined by the Secretary to have not
25 used such grant in accordance with this section,

1 such State shall not be eligible for such a grant for
2 any subsequent fiscal year.

3 “(3) AUTHORIZATION OF APPROPRIATIONS.—

4 For purposes of carrying out the grant program
5 under this section, including for administrative pur-
6 poses, there is authorized to be appropriated
7 \$10,000,000 for each of fiscal years 2012 through
8 2018.

9 “(b) PREGNANCY-RELATED DEATH REVIEW.—

10 “(1) REVIEW OF PREGNANCY-RELATED DEATH
11 AND PREGNANCY-ASSOCIATED DEATH CASES.—For
12 purposes of subsection (a), with respect to a State
13 that receives a grant under subsection (a), the fol-
14 lowing shall apply:

15 “(A) MANDATORY REPORTING OF PREG-
16 NANCY-RELATED DEATHS.—

17 “(i) IN GENERAL.—The State shall,
18 through the State maternal mortality re-
19 view committee, develop a process, sepa-
20 rate from any reporting process established
21 by the State department of health prior to
22 the date of the enactment of this section,
23 that provides for mandatory and confiden-
24 tial case reporting by individuals and enti-
25 ties described in clause (ii) of pregnancy-

1 related deaths to the State department of
2 health.

3 “(ii) INDIVIDUALS AND ENTITIES DE-
4 SCRIBED.—Individuals and entities de-
5 scribed in this clause include each of the
6 following:

7 “(I) Health care providers.

8 “(II) Medical examiners.

9 “(III) Medical coroners.

10 “(IV) Hospitals.

11 “(V) Free-standing birth centers.

12 “(VI) Other health care facilities.

13 “(VII) Any other individuals re-
14 sponsible for completing death certifi-
15 cates.

16 “(VIII) Any other appropriate in-
17 dividuals or entities specified by the
18 Secretary.

19 “(B) VOLUNTARY REPORTING OF PREG-
20 NANCY-RELATED AND PREGNANCY-ASSOCIATED
21 DEATHS.—

22 “(i) The State shall, through the
23 State maternal mortality review committee,
24 develop a process for and encourage, sepa-
25 rate from any reporting process established

1 by the State department of health prior to
2 the date of the enactment of this section,
3 voluntary and confidential case reporting
4 by individuals described in clause (ii) of
5 pregnancy-associated deaths to the State
6 department of health.

7 “(ii) The State shall, through the
8 State maternal mortality review committee,
9 develop a process for voluntary and con-
10 fidential reporting by family members of
11 the deceased and by other individuals on
12 possible pregnancy-related and pregnancy-
13 associated deaths to the State department
14 of health. Such process shall include—

15 “(I) making publicly available on
16 the Internet Web site of the State de-
17 partment of health a telephone num-
18 ber, Internet Web link, and email ad-
19 dress for such reporting; and

20 “(II) publicizing to local profes-
21 sional organizations, community orga-
22 nizations, and social services agencies
23 the availability of the telephone num-
24 ber, Internet Web link, and email ad-

1 dress made available under subclause
2 (I).

3 “(C) DEVELOPMENT OF CASE-FINDING.—
4 The State, through the vital statistics unit of
5 the State, shall annually identify pregnancy-re-
6 lated and pregnancy-associated deaths occur-
7 ring in such State during the year involved
8 by—

9 “(i) matching all death records, with
10 respect to such year, for women of child-
11 bearing age to live birth certificates and in-
12 fant death certificates to identify deaths of
13 women that occurred during pregnancy
14 and within one year after the end of a
15 pregnancy;

16 “(ii) identifying deaths reported dur-
17 ing such year as having an underlying or
18 contributing cause of death related to
19 pregnancy, regardless of the time that has
20 passed between the end of the pregnancy
21 and the death;

22 “(iii) collecting data from medical ex-
23 aminer and coroner reports; and

24 “(iv) any other methods the States
25 may devise to identify maternal deaths,

1 such as through review of a random sam-
2 ple of reported deaths of women of child-
3 bearing age to ascertain cases of preg-
4 nancy-related and pregnancy-associated
5 deaths that are not discernable from a re-
6 view of death certificates alone.

7 When feasible and for purposes of effectively
8 collecting and obtaining data on pregnancy-re-
9 lated and pregnancy-associated deaths, the
10 State shall adopt the most recent standardized
11 birth and death certificates, as issued by the
12 National Center for Vital Health Statistics, in-
13 cluding the recommended checkbox section for
14 pregnancy on the death certificates.

15 “(D) CASE INVESTIGATION AND DEVELOP-
16 MENT OF CASE SUMMARIES.—Following receipt
17 of reports by the State department of health
18 pursuant to subparagraph (A) or (B) and col-
19 lection by the vital statistics unit of the State
20 of possible cases of pregnancy-related and preg-
21 nancy-associated deaths pursuant to subpara-
22 graph (C), the State, through the State mater-
23 nal mortality review committee established
24 under subsection (a), shall investigate each
25 case, utilizing the case abstraction form de-

1 scribed in subsection (c), and prepare de-identi-
2 fied case summaries, which shall be reviewed by
3 the committee and included in applicable re-
4 ports. For purposes of subsection (a), under the
5 processes established under subparagraphs (A),
6 (B), and (C), a State department of health or
7 vital statistics unit of a State shall provide to
8 the State maternal mortality review committee
9 access to information collected pursuant to such
10 subparagraphs as necessary to carry out this
11 subparagraph. Data and information collected
12 for the case summary and review are for pur-
13 poses of public health activities, in accordance
14 with HIPAA privacy and security law (as de-
15 fined in section 3009(a)(2) of the Public Health
16 Service Act). Such case investigations shall in-
17 clude data and information obtained through—

18 “(i) medical examiner and autopsy re-
19 ports of the woman involved;

20 “(ii) medical records of the woman,
21 including such records related to health
22 care prior to pregnancy, prenatal and post-
23 natal care, labor and delivery care, emer-
24 gency room care, hospital discharge
25 records, and any care delivered up until

1 the time of death of the woman for pur-
 2 poses of public health activities, in accord-
 3 ance with HIPAA privacy and security law
 4 (as defined in section 3009(a)(2) of the
 5 Public Health Service Act);

6 “(iii) oral and written interviews of in-
 7 dividuals directly involved in the maternal
 8 care of the woman during and immediately
 9 following the pregnancy of the woman, in-
 10 cluding health care, mental health, and so-
 11 cial service providers, as applicable;

12 “(iv) optional oral or written inter-
 13 views of the family of the woman;

14 “(v) socioeconomic and other relevant
 15 background information about the woman;

16 “(vi) information collected in subpara-
 17 graph (C)(i); and

18 “(vii) other information on the cause
 19 of death of the woman, such as social serv-
 20 ices and child welfare reports.

21 “(2) STATE MATERNAL MORTALITY REVIEW
 22 COMMITTEES.—

23 “(A) DUTIES.—

24 “(i) REQUIRED COMMITTEE ACTIVI-
 25 TIES.—For purposes of subsection (a), a

1 maternal mortality review committee estab-
2 lished by a State pursuant to a grant
3 under such subsection shall carry out the
4 following pregnancy-related death and
5 pregnancy-associated death review activi-
6 ties and shall include all information rel-
7 evant to the death involved on the case ab-
8 straction form developed under subsection
9 (d):

10 “(I) With respect to a case of
11 pregnancy-related or pregnancy-asso-
12 ciated death of a woman, review the
13 case summaries prepared under sub-
14 paragraphs (A), (B), (C), and (D) of
15 paragraph (1).

16 “(II) Review aggregate statistical
17 reports developed by the vital statis-
18 tics unit of the State under paragraph
19 (1)(C) regarding pregnancy-related
20 and pregnancy-associated deaths to
21 identify trends, patterns, and dispari-
22 ties in adverse outcomes and address
23 medical, non-medical, and system-re-
24 lated factors that may have contrib-
25 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 multi-disciplinary, consisting of
9 health care and social service providers,
10 public health officials, other persons with
11 professional expertise on maternal health
12 and mortality, and patient and community
13 advocates who represent those communities
14 within such State that are the most af-
15 fected by maternal mortality. Membership
16 on such a committee of a State shall be re-
17 viewed annually by the State department
18 of health to ensure that membership rep-
19 resentation requirements are being fulfilled
20 in accordance with this paragraph.

21 “(ii) REQUIRED MEMBERSHIP.—Each
22 such review committee shall include—

23 “(I) representatives from medical
24 specialities providing care to pregnant
25 and postpartum patients, including

1 obstetricians (including generalists
2 and maternal fetal medicine special-
3 ists), and family practice physicians;

4 “(II) certified nurse midwives,
5 certified midwives, and advanced prac-
6 tice nurses;

7 “(III) hospital-based nurses;

8 “(IV) representatives of the State
9 department of health maternal and
10 child health department;

11 “(V) social service providers or
12 social workers;

13 “(VI) the chief medical exam-
14 iners or designees;

15 “(VII) facility representatives,
16 such as from hospitals or free-stand-
17 ing birth centers; and

18 “(VIII) community or patient ad-
19 vocates who represent those commu-
20 nities within the State that are the
21 most affected by maternal mortality.

22 “(iii) ADDITIONAL MEMBERS.—Each
23 such review committee may also include
24 representatives from other relevant aca-
25 demic, health, social service, or policy pro-

1 fessions, or community organizations, on
2 an ongoing basis, or as needed, as deter-
3 mined beneficial by the review committee,
4 including—

5 “(I) anesthesiologists;

6 “(II) emergency physicians;

7 “(III) pathologists;

8 “(IV) epidemiologists or biostat-
9 isticians;

10 “(V) intensivists;

11 “(VI) vital statistics officers;

12 “(VII) nutritionists;

13 “(VIII) mental health profes-
14 sionals;

15 “(IX) substance abuse treatment
16 specialists;

17 “(X) representatives of relevant
18 advocacy groups;

19 “(XI) academics;

20 “(XII) representatives of bene-
21 ficiaries of the State plan under the
22 Medicaid program under title XIX;

23 “(XIII) paramedics;

24 “(XIV) lawyers;

1 “(XV) risk management special-
2 ists;

3 “(XVI) representatives of the de-
4 partments of health or public health
5 of major cities in the State involved;
6 and

7 “(XVII) policy makers.

8 “(iv) DIVERSE COMMUNITY MEMBER-
9 SHIP.—The composition of such a com-
10 mittee, with respect to a State, shall in-
11 clude—

12 “(I) representatives from diverse
13 communities, particularly those com-
14 munities within such State most se-
15 verely affected by pregnancy-related
16 deaths or pregnancy-associated deaths
17 and by a lack of access to relevant
18 maternal care services, from commu-
19 nity maternal child health organiza-
20 tions, and from minority advocacy
21 groups;

22 “(II) members, including health
23 care providers, from different geo-
24 graphic regions in the State, including

1 any rural, urban, and tribal areas;
2 and

3 “(III) health care and social serv-
4 ice providers who work in commu-
5 nities that are diverse with regard to
6 race, ethnicity, immigration status,
7 Indigenous status, and English pro-
8 ficiency.

9 “(v) MATERNAL MORTALITY REVIEW
10 STAFF.—Staff of each such review com-
11 mittee shall include—

12 “(I) vital health statisticians, ma-
13 ternal child health statisticians, or
14 epidemiologists;

15 “(II) a coordinator of the State
16 maternal mortality review committee,
17 to be designated by the State; and

18 “(III) administrative staff.

19 “(C) OPTION FOR STATES TO FORM RE-
20 GIONAL MATERNAL MORTALITY REVIEWS.—
21 States with a low rate of occurrence of preg-
22 nancy-associated or pregnancy-related deaths
23 may choose to partner with one or more neigh-
24 boring States to fulfill the activities described in
25 paragraph (1)(C). In such a case, with respect

1 to States in such a partnership, any require-
2 ment under this section relating to the report-
3 ing of information related to such activities
4 shall be deemed to be fulfilled by each such
5 State if a single such report is submitted for
6 the partnership.

7 “(3) STATE DEPARTMENT OF HEALTH ACTIVI-
8 TIES.—For purposes of subsection (a), a State de-
9 partment of health of a State receiving a grant
10 under such subsection shall—

11 “(A) in consultation with the maternal
12 mortality review committee of the State and in
13 conjunction with relevant professional organiza-
14 tions, develop a plan for ongoing health care
15 provider education, based on the findings and
16 recommendations of the committee, in order to
17 improve the quality of maternal care; and

18 “(B) take steps to widely disseminate the
19 findings and recommendations of the State ma-
20 ternal mortality review committees of the State
21 and to implement the recommendations of such
22 committee.

23 “(c) CASE ABSTRACTION FORM.—

24 “(1) DEVELOPMENT.—The Director of the Cen-
25 ters for Disease Control and Prevention shall de-

1 velop a uniform, comprehensive case abstraction
2 form and make such form available to States for
3 State maternal mortality review committees for use
4 by such committees in order to—

5 “(A) ensure that the cases and information
6 collected and reviewed by such committees can
7 be pooled for review by the Department of
8 Health and Human Services and its agencies;
9 and

10 “(B) preserve the uniformity of the infor-
11 mation and its use for Federal public health
12 purposes.

13 “(2) PERMISSIBLE STATE MODIFICATION.—
14 Each State may modify the form developed under
15 paragraph (1) for implementation and use by such
16 State or by the State maternal mortality review com-
17 mittee of such State by including on such form addi-
18 tional information to be collected, but may not alter
19 the standard questions on such form, in order to en-
20 sure that the information can be collected and re-
21 viewed centrally at the Federal level.

22 “(d) TREATMENT AS PUBLIC HEALTH AUTHORITY
23 FOR PURPOSES OF HIPAA.—For purposes of applying
24 HIPAA privacy and security law (as defined in section
25 3009(a)(2) of the Public Health Service Act), a State ma-

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

10 “(e) PUBLIC DISCLOSURE OF INFORMATION.—

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

22 “(2) INFORMATION CLEARINGHOUSE.—The
23 Secretary of Health and Human Services shall es-
24 tablish an information clearinghouse, that shall be
25 administered by the Director of the Centers for Dis-

1 ease Control and Prevention, that will maintain find-
2 ings and recommendations submitted pursuant to
3 paragraph (1) and provide such findings and rec-
4 ommendations for public review and research pur-
5 poses by State health departments, maternal mor-
6 tality review committees, and health providers and
7 institutions.

8 “(3) CONFIDENTIALITY OF INFORMATION.—In
9 no case shall any individually identifiable health in-
10 formation be provided to the public, or submitted to
11 the information clearinghouse, under paragraph (1).

12 “(f) CONFIDENTIALITY OF REVIEW COMMITTEE
13 PROCEEDINGS.—

14 “(1) IN GENERAL.—All proceedings and activi-
15 ties of a State maternal mortality review committee
16 under this section, opinions of members of such a
17 committee formed as a result of such proceedings
18 and activities, and records obtained, created, or
19 maintained pursuant to this section, including
20 records of interviews, written reports, and state-
21 ments procured by the Department of Health and
22 Human Services or by any other person, agency, or
23 organization acting jointly with the Department, in
24 connection with morbidity and mortality reviews
25 under this section, shall be confidential, and not sub-

1 ject to discovery, subpoena, or introduction into evi-
2 dence in any civil, criminal, legislative, or other pro-
3 ceeding. Such records shall not be open to public in-
4 spection.

5 “(2) TESTIMONY OF MEMBERS OF COM-
6 MITTEE.—

7 “(A) IN GENERAL.—Members of a State
8 maternal mortality review committee under this
9 section may not be questioned in any civil,
10 criminal, legislative, or other proceeding regard-
11 ing information presented in, or opinions
12 formed as a result of, a meeting or communica-
13 tion of the committee.

14 “(B) CLARIFICATION.—Nothing in this
15 subsection shall be construed to prevent a mem-
16 ber of such a committee from testifying regard-
17 ing information that was obtained independent
18 of such member’s participation on the com-
19 mittee, or that is public information.

20 “(3) AVAILABILITY OF INFORMATION FOR RE-
21 SEARCH PURPOSES.—Nothing in this subsection
22 shall prohibit the publishing by such a committee or
23 the Department of Health and Human Services of
24 statistical compilations and research reports that—

1 “(A) are based on confidential information,
2 relating to morbidity and mortality review; and

3 “(B) do not contain identifying informa-
4 tion or any other information that could be
5 used to ultimately identify the individuals con-
6 cerned.

7 “(g) DEFINITIONS.—For purposes of this section:

8 “(1) The term ‘pregnancy-associated death’
9 means the death of a woman while pregnant or dur-
10 ing the one-year period following the date of the end
11 of pregnancy, irrespective of the cause of such death.

12 “(2) The term ‘pregnancy-related death’ means
13 the death of a woman while pregnant or during the
14 one-year period following the date of the end of
15 pregnancy, irrespective of the duration or site of the
16 pregnancy, from any cause related to or aggravated
17 by the pregnancy or its management, but not from
18 any accidental or incidental cause.

19 “(3) The term ‘woman of childbearing age’
20 means a woman who is at least 10 years of age and
21 not more than 54 years of age.”.

22 (b) INCLUSION OF FINDINGS OF REVIEW COMMIT-
23 TEES IN REQUIRED REPORTS.—

24 (1) STATE TRIENNIAL REPORTS.—Paragraph

25 (2) of section 506(a) of such Act (42 U.S.C. 706(a))

1 is amended by inserting after subparagraph (E) the
2 following new subparagraph:

3 “(F) In the case of a State receiving a
4 grant under section 514, beginning for the first
5 fiscal year beginning after 3 years after the
6 date of establishment of the State maternal
7 mortality review committee established by the
8 State pursuant to such grant and once every 3
9 years thereafter, information containing the
10 findings and recommendations of such com-
11 mittee and information on the implementation
12 of such recommendations during the period in-
13 volved.”.

14 (2) ANNUAL REPORTS TO CONGRESS.—Para-
15 graph (3) of such section is amended—

16 (A) in subparagraph (D), at the end, by
17 striking “and”;

18 (B) in subparagraph (E), at the end, by
19 striking the period and inserting “; and”; and

20 (C) by adding at the end the following new
21 subparagraph:

22 “(F) For fiscal year 2012 and each subse-
23 quent fiscal year, taking into account the find-
24 ings, recommendations, and implementation in-
25 formation submitted by States pursuant to

1 paragraph (2)(F), on the status of pregnancy-
2 related deaths and pregnancy-associated deaths
3 in the United States and including rec-
4 ommendations on methods to prevent such
5 deaths in the United States.”.

6 **SEC. 506. ELIMINATING DISPARITIES IN MATERNITY**
7 **HEALTH OUTCOMES.**

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

11 **“SEC. 317W. ELIMINATING DISPARITIES IN MATERNITY**
12 **HEALTH OUTCOMES.**

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

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

1 “(2) Expand access to services that have been
2 demonstrated to improve the quality and outcomes
3 of maternity care for vulnerable populations.

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

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

13 “(1) applications submitted by States, which
14 specify which regions and populations the State in-
15 volved will serve under the demonstration project;

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

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

1 “(4) criteria designed by the Secretary to as-
2 sure that the demonstration projects and models will
3 be carried out in consultation with local and regional
4 provider organizations, such as community health
5 centers, hospital systems, and medical societies rep-
6 resenting providers of maternity services.

7 “(c) DURATION OF DEMONSTRATION PROJECT.—
8 The demonstration project under subsection (a)(3) shall
9 begin on January 1, 2012, and end on December 31,
10 2016.

11 “(d) GRANTS FOR EVALUATION AND MONITORING.—
12 The Secretary may make grants to States and health care
13 providers participating in the demonstration project under
14 subsection (a)(3) for the purpose of collecting data nec-
15 essary for the evaluation and monitoring of such project.

16 “(e) REPORTS.—

17 “(1) STATE REPORTS.—Each State that par-
18 ticipates in the demonstration project under sub-
19 section (a)(3) shall report to the Secretary, in a
20 time, form, and manner specified by the Secretary,
21 the data necessary to—

22 “(A) monitor the—

23 “(i) outcomes of the project;

24 “(ii) costs of the project; and

1 “(iii) quality of maternity care pro-
2 vided under the project; and

3 “(B) evaluate the rationale for the selec-
4 tion of the items and services included in any
5 bundled payment made by the State under the
6 project.

7 “(2) FINAL REPORT.—Not later than December
8 31, 2017, the Secretary shall submit to Congress a
9 report on the results of the demonstration project
10 under subsection (a)(3).”.

11 **SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN**
12 **UNEXPECTED INFANT DEATH AND SUDDEN**
13 **UNEXPLAINED DEATH IN CHILDHOOD.**

14 (a) ESTABLISHMENT.—The Secretary of Health and
15 Human Services acting through the Administrator of the
16 Health Resources and Services Administration and in con-
17 sultation with the Director of the Centers for Disease Con-
18 trol and Prevention and the Director of the National Insti-
19 tutes of Health (in this section referred to as the “Sec-
20 retary”) shall establish and implement a culturally com-
21 petent public health awareness and education campaign
22 to provide information that is focused on decreasing the
23 risk factors for sudden unexpected infant death and sud-
24 den unexplained death in childhood, including educating
25 individuals about safe sleep environments, sleep positions,

1 and reducing exposure to smoking during pregnancy and
2 after birth.

3 (b) TARGETED POPULATIONS.—The campaign under
4 subsection (a) shall be designed to reduce health dispari-
5 ties through the targeting of populations with high rates
6 of sudden unexpected infant death and sudden unex-
7 plained death in childhood.

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

17 (d) GRANTS.—

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

1 (2) APPLICATION.—To be eligible to receive a
2 grant under paragraph (1), an entity shall submit to
3 the Secretary an application at such time, in such
4 manner, and containing such information as the Sec-
5 retary may require.

6 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
7 authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2012 through 2016.

10 **SEC. 508. REDUCING TEENAGE PREGNANCIES.**

11 Title III of the Public Health Service Act (42 U.S.C.
12 241 et seq.) is amended by adding at the end the following
13 new part:

14 **“PART W—YOUTH PREGNANCY PREVENTION**
15 **PROGRAMS**

16 **“SEC. 3990O. PURPOSE.**

17 “It is the purpose of this part to develop and carry
18 out research and demonstration projects on new and exist-
19 ing program interventions to provide youth in racial or
20 ethnic minority or immigrant communities the information
21 and skills needed to reduce teenage pregnancies, build
22 healthy relationships, and improve overall health and well-
23 being.

1 **“SEC. 39900-1. DEMONSTRATION GRANTS TO REDUCE**
2 **TEENAGE PREGNANCIES.**

3 “(a) IN GENERAL.—The Secretary shall award com-
4 petitive grants to eligible entities for establishing or ex-
5 panding programs to provide youth in racial or ethnic mi-
6 nority or immigrant communities the information and
7 skills needed to avoid teenage pregnancy and develop
8 healthy relationships.

9 “(b) PRIORITY.—In awarding grants under this sec-
10 tion, the Secretary shall give priority to applicants—

11 “(1) proposing to carry out projects in racial or
12 ethnic minority or immigrant communities;

13 “(2) that have a demonstrated history of effec-
14 tively working with such targeted communities; or

15 “(3) that have a demonstrated history of engag-
16 ing in a meaningful and significant partnership with
17 such targeted communities.

18 “(c) PROGRAM SETTINGS.—Programs funded
19 through a grant under subsection (a) shall be provided—

20 “(1) through classroom-based settings, such as
21 school health education, humanities, language arts,
22 or family and consumer science education; after-
23 school programs; community-based programs; work-
24 force development programs; and health care set-
25 tings; 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 39900–5(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. 39900-2. MULTIMEDIA CAMPAIGNS TO REDUCE**
4 **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 teenage pregnancy and
9 related social and emotional issues, such as violence pre-
10 vention.

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 racial or eth-
14 nic minority or immigrant communities.

15 “(c) INFORMATION TO BE PROVIDED.—As a condi-
16 tion of receipt of a grant under this section, an entity shall
17 agree to use the grant to carry out multimedia campaigns
18 described in subsection (a) that—

19 “(1) at a minimum, shall provide information
20 on—

21 “(A) the prevention of teenage pregnancy;

22 and

23 “(B) healthy relationship development; and

24 “(2) may provide information on the prevention
25 of dating violence.

1 **“SEC. 39900–3. RESEARCH ON REDUCING TEENAGE PREG-**
2 **NANCIES AND TEENAGE DATING VIOLENCE**
3 **AND IMPROVING HEALTHY RELATIONSHIPS.**

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Director of the Centers for Disease Control and Pre-
6 vention, shall make grants to public and private entities
7 to conduct, support, or coordinate research on teenage
8 pregnancy, dating violence, and healthy relationships
9 among racial or ethnic minority or immigrant communities
10 that—

11 “(1) improves data collection on—

12 “(A) sexual and reproductive health, in-
13 cluding teenage pregnancies and births, among
14 all minority communities and subpopulations in
15 which such data are not collected, including
16 American Indian and Alaska Native youth;

17 “(B) sexual behavior, sexual or reproduc-
18 tive coercion, and teenage contraceptive use
19 patterns at the State level, as appropriate; and

20 “(C) teenage pregnancies among youth in
21 and aging out of foster care or juvenile justice
22 systems and the underlying factors that lead to
23 teenage pregnancy among youth in foster care
24 or juvenile justice systems;

25 “(2) investigates—

1 “(A) the variance in the rates of teenage
2 pregnancy by—

3 “(i) racial and ethnic group (such as
4 Hispanic, Asian-American, African-Amer-
5 ican, Pacific Islander, American Indian,
6 and Alaska Native); and

7 “(ii) socioeconomic status, including
8 as based on the income of the family and
9 education attainment;

10 “(B) factors affecting the risk for youth of
11 teenage pregnancy or dating abuse, including
12 the physical and social environment, level of ac-
13 culturation, access to health care, aspirations
14 for the future, and history of physical or sexual
15 violence or abuse;

16 “(C) the role that violence and abuse play
17 in teenage sex, pregnancy, and childbearing;

18 “(D) strategies to address the dispropor-
19 tionate rates of teenage pregnancies and dating
20 violence in racial or ethnic minority or immi-
21 grant communities;

22 “(E) how effective interventions can be
23 replicated or adapted in other settings to serve
24 racial or ethnic minority or immigrant commu-
25 nities; and

1 “(F) the effectiveness of media campaigns
2 in addressing healthy relationship development,
3 dating violence prevention, and teenage preg-
4 nancy; and

5 “(3) tests research-based strategies for address-
6 ing high rates of unintended teenage pregnancy
7 through programs that emphasize healthy relation-
8 ships and violence prevention.

9 “(b) PRIORITY.—In carrying out this section, the
10 Secretary shall give priority to research that incor-
11 porates—

12 “(1) interdisciplinary approaches;

13 “(2) a strong emphasis on community-based
14 participatory research; or

15 “(3) translational research.

16 **“SEC. 39900-4. HHS ADOLESCENT HEALTH WORK GROUP.**

17 “(a) PURPOSE.—Not later than 30 days after the
18 date of the enactment of this part, the Secretary shall di-
19 rect the interagency adolescent health workgroup within
20 the Office of Adolescent Health of the Department of
21 Health and Human Services to—

22 “(1) include in the work of the group strategies
23 for teenage dating violence prevention and healthy
24 teenage relationships with a particular focus among

1 racial or ethnic minority or immigrant communities;
2 and

3 “(2) with respect to including such strategies,
4 consult, to the greatest extent possible, with the
5 Federal Interagency Workgroup on Teen Dating Vi-
6 olence formed under the leadership of the National
7 Institute of Justice of the Department of Justice.

8 “(b) REPORT REQUIREMENT.—The Secretary,
9 through the Office of Adolescent Health, shall periodically
10 submit to Congress a report that—

11 “(1) includes a review of the evidence-based
12 programs on preventing teenage pregnancy, which
13 are carried out and identified by the Office; and

14 “(2) identifies the programs of the Department
15 of Health and Human Services that include teenage
16 dating violence prevention and the promotion of
17 healthy teenage relationships as part of a strategy to
18 prevent teenage pregnancy.

19 **“SEC. 39900-5. GENERAL GRANT PROVISIONS.**

20 “(a) APPLICATIONS.—To seek a grant under this
21 part, an entity shall submit an application to the Secretary
22 in such form, in such manner, and containing such agree-
23 ments, assurances, and information as the Secretary may
24 require.

1 “(b) ADDITIONAL REQUIREMENTS.—A grant may be
2 made under this part only if the applicant involved agrees
3 that information, activities, and services provided under
4 the grant—

5 “(1) will be evidence-based or evidence in-
6 formed;

7 “(2) will be factually and medically accurate
8 and complete; and

9 “(3) if directed to a particular population
10 group, will be provided in an appropriate language
11 and cultural context.

12 “(c) TRAINING AND TECHNICAL ASSISTANCE.—

13 “(1) IN GENERAL.—Of the total amount made
14 available to carry out this part for a fiscal year, the
15 Secretary shall use 10 percent to provide, directly or
16 through a competitive grant process, training and
17 technical assistance to the grant recipients under
18 this part, including by disseminating research and
19 information regarding effective and promising prac-
20 tices, providing consultation and resources on a
21 broad array of teenage and unintended pregnancy
22 and violence prevention strategies, and developing
23 resources and materials.

24 “(2) COLLABORATION.—In carrying out this
25 subsection, the Secretary shall collaborate with enti-

1 ties that have expertise in the prevention of teenage
2 pregnancy, healthy relationship development, minor-
3 ity health and health disparities, and violence pre-
4 vention.

5 **“SEC. 39900-6. DEFINITIONS.**

6 “In this part:

7 “(1) **MEDICALLY ACCURATE AND COMPLETE.**—

8 The term ‘medically accurate and complete’ means,
9 with respect to information, activities, or services,
10 verified or supported by the weight of research con-
11 ducted in compliance with accepted scientific meth-
12 ods and—

13 “(A) published in peer-reviewed journals,
14 where applicable; or

15 “(B) comprising information that leading
16 professional organizations and agencies with
17 relevant expertise in the field recognize as accu-
18 rate, objective, and complete.

19 “(2) **RACIAL OR ETHNIC MINORITY OR IMMI-**
20 **GRANT COMMUNITIES.**—The term ‘racial or ethnic
21 minority or immigrant communities’ means commu-
22 nities with a substantial number of residents who
23 are members of racial or ethnic minority groups or
24 who are immigrants.

1 “(3) REPRODUCTIVE COERCION.—The term ‘re-
2 productive coercion’ means, with respect to a person,
3 coercive behavior that interferes with the ability of
4 such person to control the reproductive decision-
5 making of such person, such as intentionally expos-
6 ing such person to sexually transmitted infections; in
7 the case such person is a female, attempting to im-
8 pregnate such person against her will; intentionally
9 interfering with the person’s birth control; or threat-
10 ening or acting violent if the person does not comply
11 with the perpetrator’s wishes regarding contracep-
12 tion or the decision whether to terminate or continue
13 a pregnancy.

14 “(4) YOUTH.—The term ‘youth’ means individ-
15 uals who are 11 to 19 years of age.

16 **“SEC. 39900-7. REPORTS.**

17 “(a) REPORT ON USE OF FUNDS.—Not later than
18 1 year after the date of the enactment of this part, the
19 Secretary shall submit to Congress a report on the use
20 of funds provided pursuant to this part.

21 “(b) REPORT ON IMPACT OF PROGRAMS.—Not later
22 than March 1, 2016, the Secretary shall submit to Con-
23 gress a report on the impact that the programs under this
24 part had on reducing teenage pregnancies.

1 **“SEC. 39900–8. AUTHORIZATION OF APPROPRIATIONS.**

2 “(a) IN GENERAL.—There are authorized to be ap-
3 propriated to carry out this part such sums as may be
4 necessary for each of the fiscal years 2012 through 2016.

5 “(b) AVAILABILITY.—Amounts appropriated pursu-
6 ant to subsection (a)—

7 “(1) are authorized to remain available until ex-
8 pended; and

9 “(2) are in addition to amounts otherwise made
10 available for such purposes.”.

11 **SEC. 509. GESTATIONAL DIABETES.**

12 Part B of title III of the Public Health Service Act
13 (42 U.S.C. 243 et seq.) is amended by adding after section
14 317H the following:

15 **“SEC. 317H–1. GESTATIONAL DIABETES.**

16 “(a) UNDERSTANDING AND MONITORING GESTA-
17 TIONAL DIABETES.—

18 “(1) IN GENERAL.—The Secretary, acting
19 through the Director of the Centers for Disease
20 Control and Prevention, in consultation with the Di-
21 abetes Mellitus Interagency Coordinating Committee
22 established under section 429 and representatives of
23 appropriate national health organizations, shall de-
24 velop a multisite gestational diabetes research
25 project within the diabetes program of the Centers
26 for Disease Control and Prevention to expand and

1 enhance surveillance data and public health research
2 on gestational diabetes.

3 “(2) AREAS TO BE ADDRESSED.—The research
4 project developed under paragraph (1) shall ad-
5 dress—

6 “(A) procedures to establish accurate and
7 efficient systems for the collection of gestational
8 diabetes data within each State and common-
9 wealth, territory, or possession of the United
10 States;

11 “(B) the progress of collaborative activities
12 with the National Vital Statistics System, the
13 National Center for Health Statistics, and
14 State health departments with respect to the
15 standard birth certificate, in order to improve
16 surveillance of gestational diabetes;

17 “(C) postpartum methods of tracking
18 women with gestational diabetes after delivery
19 as well as targeted interventions proven to
20 lower the incidence of type 2 diabetes in that
21 population;

22 “(D) variations in the distribution of diag-
23 nosed and undiagnosed gestational diabetes,
24 and of impaired fasting glucose tolerance and

1 impaired fasting glucose, within and among
2 groups of women; and

3 “(E) factors and culturally sensitive inter-
4 ventions that influence risks and reduce the in-
5 cidence of gestational diabetes and related com-
6 plications during childbirth, including cultural,
7 behavioral, racial, ethnic, geographic, demo-
8 graphic, socioeconomic, and genetic factors.

9 “(3) REPORT.—Not later than 2 years after the
10 date of the enactment of this section, and annually
11 thereafter, the Secretary shall generate a report on
12 the findings and recommendations of the research
13 project including prevalence of gestational diabetes
14 in the multisite area and disseminate the report to
15 the appropriate Federal and non-Federal agencies.

16 “(b) EXPANSION OF GESTATIONAL DIABETES RE-
17 SEARCH.—

18 “(1) IN GENERAL.—The Secretary shall expand
19 and intensify public health research regarding gesta-
20 tional diabetes. Such research may include—

21 “(A) developing and testing novel ap-
22 proaches for improving postpartum diabetes
23 testing or screening and for preventing type 2
24 diabetes in women with a history of gestational
25 diabetes; and

1 “(B) conducting public health research to
2 further understanding of the epidemiologic,
3 socioenvironmental, behavioral, translation, and
4 biomedical factors and health systems that in-
5 fluence the risk of gestational diabetes and the
6 development of type 2 diabetes in women with
7 a history of gestational diabetes.

8 “(2) AUTHORIZATION OF APPROPRIATIONS.—
9 There is authorized to be appropriated to carry out
10 this subsection \$5,000,000 for each of fiscal years
11 2012 through 2016.

12 “(c) DEMONSTRATION GRANTS TO LOWER THE
13 RATE OF GESTATIONAL DIABETES.—

14 “(1) IN GENERAL.—The Secretary, acting
15 through the Director of the Centers for Disease
16 Control and Prevention, shall award grants, on a
17 competitive basis, to eligible entities for demonstra-
18 tion projects that implement evidence-based inter-
19 ventions to reduce the incidence of gestational diabe-
20 tes, the recurrence of gestational diabetes in subse-
21 quent pregnancies, and the development of type 2 di-
22 abetes in women with a history of gestational diabe-
23 tes.

1 “(2) PRIORITY.—In making grants under this
2 subsection, the Secretary shall give priority to
3 projects focusing on—

4 “(A) helping women who have 1 or more
5 risk factors for developing gestational diabetes;

6 “(B) working with women with a history of
7 gestational diabetes during a previous preg-
8 nancy;

9 “(C) providing postpartum care for women
10 with gestational diabetes;

11 “(D) tracking cases where women with a
12 history of gestational diabetes developed type 2
13 diabetes;

14 “(E) educating mothers with a history of
15 gestational diabetes about the increased risk of
16 their child developing diabetes;

17 “(F) working to prevent gestational diabe-
18 tes and prevent or delay the development of
19 type 2 diabetes in women with a history of ges-
20 tational diabetes; and

21 “(G) achieving outcomes designed to assess
22 the efficacy and cost-effectiveness of interven-
23 tions that can inform decisions on long-term
24 sustainability, including third-party reimburse-
25 ment.

1 “(3) APPLICATION.—An eligible entity desiring
2 to receive a grant under this subsection shall submit
3 to the Secretary—

4 “(A) an application at such time, in such
5 manner, and containing such information as the
6 Secretary may require; and

7 “(B) a plan to—

8 “(i) lower the rate of gestational dia-
9 betes during pregnancy; or

10 “(ii) develop methods of tracking
11 women with a history of gestational diabe-
12 tes and develop effective interventions to
13 lower the incidence of the recurrence of
14 gestational diabetes in subsequent preg-
15 nancies and the development of type 2 dia-
16 betes.

17 “(4) USES OF FUNDS.—An eligible entity re-
18 ceiving a grant under this subsection shall use the
19 grant funds to carry out demonstration projects de-
20 scribed in paragraph (1), including—

21 “(A) expanding community-based health
22 promotion education, activities, and incentives
23 focused on the prevention of gestational diabe-
24 tes and development of type 2 diabetes in
25 women with a history of gestational diabetes;

1 “(B) aiding State- and tribal-based diabe-
2 tes prevention and control programs to collect,
3 analyze, disseminate, and report surveillance
4 data on women with, and at risk for, gesta-
5 tional diabetes, the recurrence of gestational di-
6 abetes in subsequent pregnancies, and, for
7 women with a history of gestational diabetes,
8 the development of type 2 diabetes; and

9 “(C) training and encouraging health care
10 providers—

11 “(i) to promote risk assessment, high-
12 quality care, and self-management for ges-
13 tational diabetes and the recurrence of ges-
14 tational diabetes in subsequent preg-
15 nancies; and

16 “(ii) to prevent the development of
17 type 2 diabetes in women with a history of
18 gestational diabetes, and its complications
19 in the practice settings of the health care
20 providers.

21 “(5) REPORT.—Not later than 4 years after the
22 date of the enactment of this section, the Secretary
23 shall prepare and submit to the Congress a report
24 concerning the results of the demonstration projects

1 conducted through the grants awarded under this
2 subsection.

3 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
4 this subsection, the term ‘eligible entity’ means a
5 nonprofit organization (such as a nonprofit academic
6 center or community health center) or a State, trib-
7 al, or local health agency.

8 “(7) AUTHORIZATION OF APPROPRIATIONS.—
9 There is authorized to be appropriated to carry out
10 this subsection \$5,000,000 for each of fiscal years
11 2012 through 2016.

12 “(d) POSTPARTUM FOLLOW-UP REGARDING GESTA-
13 TIONAL DIABETES.—The Secretary, acting through the
14 Director of the Centers for Disease Control and Preven-
15 tion, shall work with the State- and tribal-based diabetes
16 prevention and control programs assisted by the Centers
17 to encourage postpartum follow-up after gestational diabe-
18 tes, as medically appropriate, for the purpose of reducing
19 the incidence of gestational diabetes, the recurrence of
20 gestational diabetes in subsequent pregnancies, the devel-
21 opment of type 2 diabetes in women with a history of ges-
22 tational diabetes, and related complications.”.

1 **SEC. 510. EMERGENCY CONTRACEPTION EDUCATION AND**
2 **INFORMATION PROGRAMS.**

3 (a) EMERGENCY CONTRACEPTION PUBLIC EDU-
4 CATION PROGRAM.—

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

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

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

21 (b) EMERGENCY CONTRACEPTION INFORMATION
22 PROGRAM FOR HEALTH CARE PROVIDERS.—

23 (1) IN GENERAL.—The Secretary, acting
24 through the Administrator of the Health Resources
25 and Services Administration and in consultation
26 with major medical and public health organizations,

1 shall develop and disseminate to health care pro-
2 viders information on emergency contraception.

3 (2) INFORMATION.—The information dissemi-
4 nated under paragraph (1) shall include, at a min-
5 imum—

6 (A) information describing the use, safety,
7 efficacy, and availability of emergency contra-
8 ception;

9 (B) a recommendation regarding the use of
10 such contraception in appropriate cases; and

11 (C) information explaining how to obtain
12 copies of the information developed under sub-
13 section (a) for distribution to the patients of
14 the providers.

15 (c) DEFINITIONS.—In this section:

16 (1) EMERGENCY CONTRACEPTION.—The term
17 “emergency contraception” means a drug or device
18 (as the terms are defined in section 201 of the Fed-
19 eral Food, Drug, and Cosmetic Act (21 U.S.C. 321))
20 or a drug regimen that—

21 (A) is used postcoitally;

22 (B) prevents pregnancy primarily by pre-
23 venting or delaying ovulation, and does not ter-
24 minate an established pregnancy; and

1 (C) is approved by the Food and Drug Ad-
2 ministration.

3 (2) HEALTH CARE PROVIDER.—The term
4 “health care provider” means an individual who is li-
5 censed or certified under State law to provide health
6 care services and who is operating within the scope
7 of such license. Such term shall include a phar-
8 macist.

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

13 (4) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services.

15 (d) 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 the fiscal years
18 2012 through 2016.

19 **SEC. 511. SUPPORTING HEALTHY ADOLESCENT DEVELOP-**
20 **MENT.**

21 (a) IN GENERAL.—The Secretary may award a grant
22 to each eligible State to conduct programs of sex education
23 described in subsection (b), including education on both
24 abstinence and contraception for the prevention of teenage

1 pregnancy and sexually transmitted diseases, including
2 HIV/AIDS.

3 (b) REQUIREMENTS FOR SEX EDUCATION PRO-
4 GRAMS.—A program of sex education described in this
5 subsection is a program that—

6 (1) is age appropriate and medically accurate;

7 (2) stresses the value of abstinence while not ig-
8 noring those young people who have been or are sex-
9 ually active;

10 (3) provides information about the health bene-
11 fits and side effects of contraceptive and barrier
12 methods used—

13 (A) as a means to prevent pregnancy; and

14 (B) to reduce the risk of contracting sexu-
15 ally transmitted disease, including HIV/AIDS;

16 (4) encourages family communication between
17 parent and child about sexuality;

18 (5) cultivates a respectful dialogue about sexu-
19 ality, including sexual orientation and gender iden-
20 tity, and embraces the principles of nondiscrimina-
21 tion based on sexual orientation and gender identity;

22 (6) counters the perpetuation of narrow gender
23 roles, including the sexualization of female children,
24 adolescents, and adults;

1 (7) teaches young people the skills to make re-
2 sponsible decisions about sexuality, including how to
3 avoid unwanted verbal, physical, and sexual ad-
4 vances and how to avoid making verbal, physical,
5 and sexual advances that are not wanted by the
6 other party;

7 (8) develops healthy relationships, including the
8 prevention of dating and sexual violence;

9 (9) teaches young people how alcohol and drug
10 use can affect responsible decisionmaking; and

11 (10) does not teach or promote religion.

12 (c) **ADDITIONAL ACTIVITIES.**—In carrying out a pro-
13 gram of sex education, a State may expend grant funds
14 awarded under subsection (a) to carry out educational and
15 motivational activities that help young people—

16 (1) gain knowledge about the physical, emo-
17 tional, biological, and hormonal changes of adoles-
18 cence and subsequent stages of human maturation;

19 (2) develop the knowledge and skills necessary
20 to ensure and protect their sexual and reproductive
21 health from unintended pregnancy and sexually
22 transmitted disease, including HIV/AIDS, through-
23 out their lifespan;

1 (3) gain knowledge about the specific involve-
2 ment and responsibility of each individual in sexual
3 decisionmaking;

4 (4) develop healthy attitudes and values about
5 adolescent growth and development, body image,
6 gender roles, racial and ethnic diversity, sexual ori-
7 entation and gender identity, and other subjects;

8 (5) develop and practice healthy life skills in-
9 cluding goal-setting, decisionmaking, negotiation,
10 communication, and stress management; and

11 (6) promote self-esteem and positive inter-
12 personal skills focusing on relationship dynamics, in-
13 cluding friendships, dating, romantic involvement,
14 marriage, and family interactions.

15 (d) MATCHING FUNDS.—The Secretary may not
16 make payments to a State under this section in an amount
17 exceeding Federal medical assistance percentage for such
18 State (as such term is defined in section 1905(b) of the
19 Social Security Act (42 U.S.C. 1396d(b))) of the costs of
20 the programs conducted by the State under this section.

21 (e) EVALUATION OF PROGRAMS.—

22 (1) IN GENERAL.—For the purpose of evalu-
23 ating the effectiveness of programs of sex education
24 carried out with a grant under this section, evalua-

1 tions shall be carried out in accordance with para-
2 graphs (2) and (3).

3 (2) NATIONAL EVALUATION.—

4 (A) METHOD.—The Secretary shall pro-
5 vide for a national evaluation of a representa-
6 tive sample of programs of sex education car-
7 ried out with grants under this section to deter-
8 mine—

9 (i) the effectiveness of such programs
10 in helping to delay the initiation of sexual
11 intercourse and other high-risk behaviors;

12 (ii) the effectiveness of such programs
13 in preventing adolescent pregnancy;

14 (iii) the effectiveness of such pro-
15 grams in preventing sexually transmitted
16 disease, including HIV/AIDS;

17 (iv) the effectiveness of such programs
18 in increasing contraceptive knowledge and
19 contraceptive behaviors when sexual inter-
20 course occurs; and

21 (v) a list of best practices based upon
22 essential programmatic components of
23 evaluated programs that have led to suc-
24 cess described in clauses (i) through (iv).

1 (B) GRANT CONDITION.—A condition for
2 the receipt of a grant to a State under this sec-
3 tion is that the State cooperate with the evalua-
4 tion under subparagraph (A).

5 (C) REPORT.—The Secretary shall submit
6 to the Congress—

7 (i) not later than the end of each fis-
8 cal year during the 5-year period beginning
9 with fiscal year 2012, an interim report on
10 the national evaluation under subpara-
11 graph (A); and

12 (ii) not later than March 31, 2017, a
13 final report providing the results of such
14 national evaluation.

15 (3) INDIVIDUAL STATE EVALUATIONS.—A con-
16 dition for the receipt of a grant under this section
17 is that the State evaluate of the programs of sex
18 education funded through such grant in accordance
19 with the following requirements:

20 (A) The evaluation will be conducted by an
21 external, independent entity.

22 (B) The purposes of the evaluation will be
23 the determination of—

1 (i) the effectiveness of such programs
2 in helping to delay the initiation of sexual
3 intercourse and other high-risk behaviors;

4 (ii) the effectiveness of such programs
5 in preventing adolescent pregnancy;

6 (iii) the effectiveness of such pro-
7 grams in preventing sexually transmitted
8 disease, including HIV/AIDS; and

9 (iv) the effectiveness of such programs
10 in increasing contraceptive and barrier
11 method knowledge and contraceptive be-
12 haviors when sexual intercourse occurs.

13 (f) LIMITATIONS ON USE OF FUNDS.—

14 (1) LIMITATIONS ON SECRETARY.—Of the
15 amounts appropriated for a fiscal year for purposes
16 of this section, the Secretary may not use more
17 than—

18 (A) 7 percent of such amounts for admin-
19 istrative expenses related to carrying out this
20 section for that fiscal year; and

21 (B) 10 percent of such amounts for the
22 national evaluation under subsection (e)(2).

23 (2) LIMITATIONS TO STATES.—Of amounts pro-
24 vided to an eligible State under this subsection, the
25 State may not use more than 10 percent of the

1 grant to conduct any evaluation under subsection
2 (e)(3).

3 (g) NONDISCRIMINATION REQUIRED.—Programs
4 funded under this section shall not discriminate on the
5 basis of sex, race, ethnicity, national origin, disability, reli-
6 gion, marital status, familial status, sexual orientation, or
7 gender identity. Nothing in this section shall be construed
8 to invalidate or limit rights, remedies, procedures, or legal
9 standards available to victims of discrimination under any
10 other Federal law or any law of a State or a political sub-
11 division of a State, including title VI of the Civil Rights
12 Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the
13 Education Amendments of 1972 (20 U.S.C. 1681 et seq.),
14 section 504 of the Rehabilitation Act of 1973 (29 U.S.C.
15 794), and the Americans with Disabilities Act of 1990 (42
16 U.S.C. 12101 et seq.).

17 (h) DEFINITIONS.—For purposes of this section:

18 (1) The term “age appropriate” means, with re-
19 spect to topics, messages, and teaching methods,
20 those suitable to particular ages or age groups of
21 children, adolescents, and adults, based on devel-
22 oping cognitive, emotional, and behavioral capacity
23 typical for the age or age group.

24 (2) The term “eligible State” means a State
25 that submits to the Secretary an application for a

1 grant under this section that is in such form, is
2 made in such manner, and contains such agree-
3 ments, assurances, and information as the Secretary
4 determines to be necessary to carry out this section.

5 (3) The term “HIV/AIDS” means the human
6 immunodeficiency virus, and includes acquired im-
7 mune deficiency syndrome.

8 (4) The term “medically accurate”, with respect
9 to information, means information that is supported
10 by research, recognized as accurate and objective by
11 leading medical, psychological, psychiatric, and pub-
12 lic health organizations and agencies, and, published
13 in journals that are peer reviewed.

14 (5) The term “State” means the 50 States, the
15 District of Columbia, the Commonwealth of Puerto
16 Rico, the Commonwealth of the Northern Mariana
17 Islands, American Samoa, Guam, the United States
18 Virgin Islands, and any other territory or possession
19 of the United States.

20 (i) AUTHORIZATION OF APPROPRIATIONS.—For the
21 purpose of carrying out this section, there is authorized
22 to be appropriated \$50,000,000 for each of the fiscal years
23 2012 through 2016.

TITLE VI—MENTAL HEALTH**SEC. 601. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.**

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (EE), by striking

“and” at the end;

(B) in subparagraph (FF), by inserting

“and” at the end; and

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

“(GG) marriage and family therapist services (as defined in subsection (kkk)(1)) and mental health counselor services (as defined in subsection (kkk)(3));”.

(2) DEFINITIONS.—Section 1861 of such Act (42 U.S.C. 1395x), as amended by sections 202(b)(1)(A) and 423(a), is amended by adding at the end the following new subsection:

1 “Marriage and Family Therapist Services; Marriage and
2 Family Therapist; Mental Health Counselor Serv-
3 ices; Mental Health Counselor

4 “(kkk)(1) The term ‘marriage and family therapist
5 services’ means services performed by a marriage and
6 family therapist (as defined in paragraph (2)) for the diag-
7 nosis and treatment of mental illnesses, which the mar-
8 riage and family therapist is legally authorized to perform
9 under State law (or the State regulatory mechanism pro-
10 vided by State law) of the State in which such services
11 are performed, as would otherwise be covered if furnished
12 by a physician or as an incident to a physician’s profes-
13 sional service, but only if no facility or other provider
14 charges or is paid any amounts with respect to the fur-
15 nishing of such services.

16 “(2) The term ‘marriage and family therapist’ means
17 an individual who—

18 “(A) possesses a master’s or doctoral degree
19 which qualifies for licensure or certification as a
20 marriage and family therapist pursuant to State
21 law;

22 “(B) after obtaining such degree has performed
23 at least 2 years of clinical supervised experience in
24 marriage and family therapy; and

1 “(C) in the case of an individual performing
2 services in a State that provides for licensure or cer-
3 tification of marriage and family therapists, is li-
4 censed or certified as a marriage and family thera-
5 pist in such State.

6 “(3) The term ‘mental health counselor services’
7 means services performed by a mental health counselor (as
8 defined in paragraph (4)) for the diagnosis and treatment
9 of mental illnesses which the mental health counselor is
10 legally authorized to perform under State law (or the
11 State regulatory mechanism provided by the State law) of
12 the State in which such services are performed, as would
13 otherwise be covered if furnished by a physician or as inci-
14 dent to a physician’s professional service, but only if no
15 facility or other provider charges or is paid any amounts
16 with respect to the furnishing of such services.

17 “(4) The term ‘mental health counselor’ means an
18 individual who—

19 “(A) possesses a master’s or doctor’s degree in
20 mental health counseling or a related field;

21 “(B) after obtaining such a degree has per-
22 formed at least 2 years of supervised mental health
23 counselor practice; and

24 “(C) in the case of an individual performing
25 services in a State that provides for licensure or cer-

1 tification of mental health counselors or professional
2 counselors, is licensed or certified as a mental health
3 counselor or professional counselor in such State.”.

4 (3) PROVISION FOR PAYMENT UNDER PART
5 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.
6 1395k(a)(2)(B)) is amended by adding at the end
7 the following new clause:

8 “(v) marriage and family therapist
9 services and mental health counselor serv-
10 ices;”.

11 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
12 of such Act (42 U.S.C. 1395l(a)(1)) is amended—

13 (A) by striking “and (Z)” and inserting
14 “(Z)”; and

15 (B) by inserting before the semicolon at
16 the end the following: “, and (AA) with respect
17 to marriage and family therapist services and
18 mental health counselor services under section
19 1861(s)(2)(GG), the amounts paid shall be 80
20 percent of the lesser of the actual charge for
21 the services or 75 percent of the amount deter-
22 mined for payment of a psychologist under sub-
23 paragraph (L)”.

24 (5) EXCLUSION OF MARRIAGE AND FAMILY
25 THERAPIST SERVICES AND MENTAL HEALTH COUN-

1 SELOR SERVICES FROM SKILLED NURSING FACILITY
2 PROSPECTIVE PAYMENT SYSTEM.—Section
3 1888(e)(2)(A)(ii) of such Act (42 U.S.C.
4 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
5 riage and family therapist services (as defined in
6 section 1861(kkk)(1)), mental health counselor serv-
7 ices (as defined in section 1861(kkk)(3)),” after
8 “qualified psychologist services,”.

9 (6) INCLUSION OF MARRIAGE AND FAMILY
10 THERAPISTS AND MENTAL HEALTH COUNSELORS AS
11 PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Sec-
12 tion 1842(b)(18)(C) of such Act (42 U.S.C.
13 1395u(b)(18)(C)) is amended by adding at the end
14 the following new clauses:

15 “(vii) A marriage and family therapist (as de-
16 fined in section 1861(kkk)(2)).

17 “(viii) A mental health counselor (as defined in
18 section 1861(kkk)(4)).”.

19 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
20 ICES PROVIDED IN CERTAIN SETTINGS.—

21 (1) RURAL HEALTH CLINICS AND FEDERALLY
22 QUALIFIED HEALTH CENTERS.—Section
23 1861(aa)(1)(B) of the Social Security Act (42
24 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
25 by a clinical social worker (as defined in subsection

1 (hh)(1)),” and inserting “, by a clinical social worker
2 (as defined in subsection (hh)(1)), by a marriage
3 and family therapist (as defined in subsection
4 (kkk)(2)), or by a mental health counselor (as de-
5 fined in subsection (kkk)(4)),”.

6 (2) HOSPICE PROGRAMS.—Section
7 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C.
8 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or
9 one marriage and family therapist (as defined in
10 subsection (kkk)(2))” after “social worker”.

11 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
12 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-
13 HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the So-
14 cial Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended
15 by inserting “marriage and family therapist (as defined
16 in subsection (kkk)(2)),” after “social worker,”.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section shall apply with respect to services furnished
19 on or after January 1, 2012.

20 **SEC. 602. COMMUNITY MENTAL HEALTH AND ADDICTION**
21 **SAFETY NET EQUITY ACT.**

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

1 (1) in subsection (a)(2)(A), by striking “com-
2 munity mental health services” and inserting “be-
3 havioral health services (of the type offered by feder-
4 ally qualified behavioral health centers consistent
5 with subsection (c)(3))”;

6 (2) in subsection (b)—

7 (A) by striking paragraph (1) and insert-
8 ing the following:

9 “(1) services under the plan will be provided
10 only through appropriate, qualified community pro-
11 grams (which may include federally qualified behav-
12 ioral health centers, child mental health programs,
13 psychosocial rehabilitation programs, mental health
14 peer-support programs, and mental health primary
15 consumer-directed programs); and”;

16 (B) in paragraph (2), by striking “commu-
17 nity mental health centers” and inserting “fed-
18 erally qualified behavioral health centers”; and

19 (3) by striking subsection (c) and inserting the
20 following:

21 “(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAV-
22 IORAL HEALTH CENTERS.—

23 “(1) IN GENERAL.—The Administrator shall
24 certify, and recertify at least every 5 years, federally

1 qualified behavioral health centers as meeting the
2 criteria specified in this subsection.

3 “(2) REGULATIONS.—Not later than 18 months
4 after the date of the enactment of this section, the
5 Administrator shall issue final regulations for certi-
6 fying nonprofit or local government centers as cen-
7 ters under paragraph (1).

8 “(3) CRITERIA.—The criteria referred to in
9 subsection (b)(2) are that the center performs each
10 of the following:

11 “(A) Provide services in locations that en-
12 sure services will be promptly available, be
13 physically accessible, provide reasonable policy
14 modifications, and be provided in a manner
15 which preserves human dignity and assures con-
16 tinuity of care.

17 “(B) Provide services in a mode of service
18 delivery appropriate for the target population.

19 “(C) Provide individuals with a choice of
20 service options where there is more than one ef-
21 ficacious treatment.

22 “(D) Employ a core staff of clinical staff
23 that is multidisciplinary and culturally and lin-
24 guistically competent.

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

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

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

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

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

1 apy and other such therapies which are
2 evidence-based).

3 “(iv) Outpatient clinic primary care
4 services, including screening and moni-
5 toring of key health indicators and health
6 risk (including screening for diabetes, hy-
7 pertension, and cardiovascular disease and
8 monitoring of weight, height, body mass
9 index (BMI), blood pressure, blood glucose
10 or HbA1C, and lipid profile).

11 “(v) Crisis mental health services, in-
12 cluding 24-hour mobile crisis teams, emer-
13 gency crisis intervention services, and cri-
14 sis stabilization.

15 “(vi) Targeted case management
16 (services to assist individuals gaining ac-
17 cess to needed medical, social, educational,
18 and other home- and community-based
19 services and applying for income security
20 and other benefits to which they may be
21 entitled).

22 “(vii) Psychiatric rehabilitation serv-
23 ices including skills training, assertive com-
24 munity treatment, family psychoeducation,
25 disability self-management, supported em-

1 ployment, supported housing services,
2 therapeutic foster care services, and such
3 other evidence-based practices as the Sec-
4 retary may require.

5 “(viii) Peer support and counselor
6 services and family supports.

7 “(G) Maintain linkages, and where possible
8 enter into formal contracts with the following:

9 “(i) Inpatient psychiatric facilities and
10 substance abuse detoxification and residen-
11 tial programs.

12 “(ii) Adult and youth peer support
13 and counselor services.

14 “(iii) Family support services for fam-
15 ilies of children with serious mental dis-
16 orders.

17 “(iv) Other home- and community-
18 based or regional services, supports, and
19 providers, including schools, child welfare
20 agencies, juvenile and criminal justice
21 agencies and facilities, housing agencies
22 and programs, employers, and other social
23 services.

24 “(v) Onsite or offsite access to pri-
25 mary care services.

1 “(vi) Enabling services, including out-
2 reach, transportation, and translation.

3 “(vii) Health and wellness services, in-
4 cluding services for tobacco cessation.”.

5 (b) MEDICAID COVERAGE AND PAYMENT FOR FED-
6 ERALLY QUALIFIED BEHAVIORAL HEALTH CENTER
7 SERVICES.—

8 (1) PAYMENT FOR SERVICES PROVIDED BY
9 FEDERALLY QUALIFIED BEHAVIORAL HEALTH CEN-
10 TERS.—Section 1902(bb) of the Social Security Act
11 (42 U.S.C. 1396a(bb)) is amended—

12 (A) in the heading, by striking “AND
13 RURAL HEALTH CLINICS” and inserting “,
14 FEDERALLY QUALIFIED BEHAVIORAL HEALTH
15 CENTERS, AND RURAL HEALTH CLINICS”;

16 (B) in paragraph (1), by inserting “(and
17 beginning with fiscal year 2012 with respect to
18 services furnished on or after January 1, 2012,
19 and each succeeding fiscal year, for services de-
20 scribed in section 1905(a)(2)(D) furnished by a
21 federally qualified behavioral health center)”
22 after “by a rural health clinic”;

23 (C) in paragraph (2)—

24 (i) by striking the heading and insert-
25 ing “INITIAL FISCAL YEAR”;

1 (ii) by inserting “(or, in the case of
2 services described in section 1905(a)(2)(D)
3 furnished by a federally qualified behav-
4 ioral health center, for services furnished
5 on and after January 1, 2012, during fis-
6 cal year 2012)” after “January 1, 2001,
7 during fiscal year 2001”;

8 (iii) by inserting “(or, in the case of
9 services described in section 1905(a)(2)(D)
10 furnished by a federally qualified behav-
11 ioral health center, during fiscal years
12 2010 and 2011)” after “1999 and 2000”;
13 and

14 (iv) by inserting “(or, in the case of
15 services described in section 1905(a)(2)(D)
16 furnished by a federally qualified behav-
17 ioral health center, during fiscal year
18 2012)” before the period;

19 (D) in paragraph (3)—

20 (i) in the heading, by striking “FIS-
21 CAL YEAR 2002 AND SUCCEEDING” and in-
22 serting “SUCCEEDING”; and

23 (ii) by inserting “(or, in the case of
24 services described in section 1905(a)(2)(D)
25 furnished by a federally qualified behav-

1 ioral health center, for services furnished
2 during fiscal year 2013 or a succeeding fis-
3 cal year)” after “2002 or a succeeding fis-
4 cal year”;

5 (E) in paragraph (4)—

6 (i) by inserting “(or as a federally
7 qualified behavioral health center after fis-
8 cal year 2011” after “or rural health clinic
9 after fiscal year 2000”;

10 (ii) by striking “furnished by the cen-
11 ter or” and inserting “furnished by the
12 federally qualified health center, services
13 described in section 1905(a)(2)(D) fur-
14 nished by the federally qualified behavioral
15 health center, or”;

16 (iii) in the second sentence, by strik-
17 ing “or rural health clinic” and inserting
18 “, federally qualified behavioral health cen-
19 ter, or rural health clinic”;

20 (F) in paragraph (5), in each of subpara-
21 graphs (A) and (B), by striking “or rural
22 health clinic” and inserting “, federally quali-
23 fied behavioral health center, or rural health
24 clinic”; and

1 (G) in paragraph (6), by striking “or to a
2 rural health clinic” and inserting “, to a feder-
3 ally qualified behavioral health center for serv-
4 ices described in section 1905(a)(2)(D), or to a
5 rural health clinic”.

6 (2) INCLUSION OF FEDERALLY QUALIFIED BE-
7 HAVIORAL HEALTH CENTER SERVICES IN THE TERM
8 MEDICAL ASSISTANCE.—Section 1905(a)(2) of the
9 Social Security Act (42 U.S.C. 1396d(a)(2)) is
10 amended—

11 (A) by striking “and” before “(C)”; and

12 (B) by inserting before the semicolon at
13 the end the following: “, and (D) federally
14 qualified behavioral health center services (as
15 defined in subsection (l)(4))”.

16 (3) DEFINITION OF FEDERALLY QUALIFIED BE-
17 HAVIORAL HEALTH CENTER SERVICES.—Section
18 1905(l) of the Social Security Act (42 U.S.C.
19 1396d(l)) is amended by adding at the end the fol-
20 lowing paragraph:

21 “(4)(A) The term ‘federally qualified behavioral
22 health center services’ means services furnished to
23 an individual at a federally qualified behavioral
24 health center (as defined by subparagraph (B)).

1 “(B) The term ‘federally qualified behavioral
2 health center’ means an entity that is certified under
3 section 1913(c) of the Public Health Service Act as
4 meeting the criteria described in paragraph (3) of
5 such section.”.

6 (c) MENTAL HEALTH AND ADDICTION SAFETY NET
7 STUDIES.—

8 (1) PAPERWORK REDUCTION STUDY.—

9 (A) IN GENERAL.—Not later than 12
10 months after the date of the enactment of this
11 Act, the Institute of Medicine shall submit to
12 the appropriate committees of Congress a re-
13 port that evaluates the combined paperwork
14 burden of federally qualified behavioral health
15 centers certified section 1913(c) of the Public
16 Health Service Act, as inserted by subsection
17 (a).

18 (B) SCOPE.—In preparing the report
19 under subparagraph (A), the Institute of Medi-
20 cine shall examine licensing, certification, serv-
21 ice definitions, claims payment, billing codes,
22 and financial auditing requirements utilized by
23 the Office of Management and Budget, the
24 Centers for Medicare & Medicaid Services, the
25 Health Resources and Services Administration,

1 the Substance Abuse and Mental Health Serv-
2 ices Administration, the Office of the Inspector
3 General, State Medicaid agencies, State depart-
4 ments of health, State departments of edu-
5 cation, and State and local juvenile justice and
6 social services agencies to—

7 (i) establish an estimate of the com-
8 bined nationwide cost of complying with
9 the requirements described in this subpara-
10 graph, in terms of both administrative
11 funding and staff time;

12 (ii) establish an estimate of the per
13 capita cost to each federally qualified be-
14 havioral health center certified under sec-
15 tion 1913(c) of the Public Health Service
16 Act to comply with the requirements de-
17 scribed in this subparagraph, in terms of
18 both administrative funding and staff time;
19 and

20 (iii) make administrative and statu-
21 tory recommendations to Congress, which
22 may include a uniform methodology, to re-
23 duce the paperwork burden experienced by
24 such federally qualified behavioral health
25 centers.

1 (C) AUTHORIZATION OF APPROPRIA-
2 TIONS.—There are authorized to be appro-
3 priated to carry out this subsection \$550,000
4 for each of the fiscal years 2012 and 2013.

5 (2) WAGE STUDY.—

6 (A) IN GENERAL.—Not later than 12
7 months after the date of the enactment of this
8 Act, the Institute of Medicine shall conduct a
9 nationwide analysis, and submit a report to the
10 appropriate committees of Congress, concerning
11 the compensation structure of professional and
12 paraprofessional personnel employed by feder-
13 ally qualified behavioral health centers certified
14 under section 1913(e) of the Public Health
15 Service Act, as inserted by subsection (a), as
16 compared with the compensation structure of
17 comparable health safety net providers and rel-
18 evant private sector health care employers.

19 (B) SCOPE.—In preparing the report
20 under subparagraph (A), the Institute of Medi-
21 cine shall examine compensation disparities, if
22 such disparities are determined to exist, by type
23 of personnel, type of provider or private sector
24 employer, and by geographic region.

1 (C) AUTHORIZATION OF APPROPRIA-
2 TIONS.—There are authorized to be appro-
3 priated to carry out this paragraph, \$550,000
4 for each of the fiscal years 2012 and 2013.

5 **SEC. 603. MINORITY FELLOWSHIP PROGRAM.**

6 Title V of the Public Health Service Act is amended
7 by inserting after section 506B of such Act (42 U.S.C.
8 290aa–5b) the following:

9 **“SEC. 506C. MINORITY FELLOWSHIP PROGRAM.**

10 “(a) FELLOWSHIPS.—The Administrator shall main-
11 tain a program, to be known as the Minority Fellowship
12 Program, under which the Administrator awards grants
13 or contracts to national associations or other appropriate
14 entities for the financial support of graduate students,
15 postdoctoral fellows, and residents in the professions of
16 psychology, psychiatry, social work, psychiatric advance-
17 practice nursing, and marriage and family therapy to stu-
18 dents who demonstrate a commitment to clinical or re-
19 search careers focused on racial and ethnic minority popu-
20 lations.

21 “(b) TERM OF FINANCIAL SUPPORT.—Financial sup-
22 port provided to an individual pursuant to subsection (a)
23 shall be for a term of not more than 12 months and may
24 be renewed thereafter.

1 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there is authorized to be appro-
3 priated \$10,000,000 for each of fiscal years 2012 through
4 2016”.

5 **SEC. 604. INTEGRATED HEALTH CARE DEMONSTRATION**
6 **PROGRAM.**

7 Part D of title V of the Public Health Service Act
8 (42 U.S.C. 290dd et seq.) is amended by adding at the
9 end the following:

10 **“SEC. 544. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
11 **PROVISION OF BEHAVIORAL HEALTH CARE**
12 **IN PRIMARY CARE SETTINGS.**

13 “(a) GRANTS.—The Secretary, acting through the
14 Director of the Office of Minority Health of the Adminis-
15 tration, shall award grants to eligible entities for the pur-
16 pose of providing technical assistance and training regard-
17 ing the effective development and implementation of inte-
18 grated interprofessional health care teams that provide be-
19 havioral health care.

20 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
21 a grant under this section, an entity shall be a federally
22 qualified health center (as defined in section 1861(aa) of
23 the Social Security Act) serving a high proportion of indi-
24 viduals from racial and ethnic minority groups (as defined
25 in section 1707(g)).

1 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there is authorized to be appro-
3 priated \$20,000,000 for each of fiscal years 2012 through
4 2014.”.

5 **SEC. 605. ADDRESSING RACIAL AND ETHNIC MINORITY**
6 **MENTAL HEALTH DISPARITIES RESEARCH**
7 **GAPS.**

8 Not later than 6 months after the date of the enact-
9 ment of this Act, the Director of the National Institute
10 on Minority Health and Health Disparities shall enter into
11 an arrangement with the Institute of Medicine (or, if the
12 Institute declines to enter into such an arrangement, an-
13 other appropriate entity)—

14 (1) to conduct a study with respect to mental
15 and behavioral health disparities in racial and ethnic
16 minority groups (as defined in section 1707(g) of
17 the Public Health Service Act (42 U.S.C. 300u-
18 6(g)); and

19 (2) to submit to the Congress a report on the
20 results of such study, including—

21 (A) a compilation of information on the dy-
22 namics of mental disorders in such racial and
23 ethnic minority groups;

24 (B) an identification of gaps in knowledge
25 and research needs; and

1 (C) recommendations for an interprofes-
2 sional research agenda at the National Insti-
3 tutes of Health aimed at reducing and ulti-
4 mately eliminating mental and behavioral health
5 disparities in such racial and ethnic minority
6 groups.

7 **TITLE VII—ADDRESSING HIGH**
8 **IMPACT MINORITY DISEASES**
9 **Subtitle A—Cancer**

10 **SEC. 701. LUNG CANCER MORTALITY REDUCTION.**

11 (a) SHORT TITLE.—This section may be cited as the
12 “Lung Cancer Mortality Reduction Act of 2011”.

13 (b) FINDINGS.—Congress makes the following find-
14 ings:

15 (1) Lung cancer is the leading cause of cancer
16 death for both men and women, accounting for 28
17 percent of all cancer deaths.

18 (2) Lung cancer kills more people annually
19 than breast cancer, prostate cancer, colon cancer,
20 liver cancer, melanoma, and kidney cancer combined.

21 (3) Since the National Cancer Act of 1971
22 (Public Law 92–218; 85 Stat. 778), coordinated and
23 comprehensive research has raised the 5-year sur-
24 vival rates for breast cancer to 88 percent, for pros-

1 tate cancer to 99 percent, and for colon cancer to
2 64 percent.

3 (4) However, the 5-year survival rate for lung
4 cancer is still only 15 percent and a similar coordi-
5 nated and comprehensive research effort is required
6 to achieve increases in lung cancer survivability
7 rates.

8 (5) Sixty percent of lung cancer cases are now
9 diagnosed nonsmokers or former smokers.

10 (6) Two-thirds of nonsmokers diagnosed with
11 lung cancer are women.

12 (7) Certain minority populations, such as Afri-
13 can-American males, have disproportionately high
14 rates of lung cancer incidence and mortality, not-
15 withstanding their similar smoking rate.

16 (8) Members of the baby boomer generation are
17 entering their sixties, the most common age at which
18 people develop lung cancer.

19 (9) Tobacco addiction and exposure to other
20 lung cancer carcinogens such as Agent Orange and
21 other herbicides and battlefield emissions are serious
22 problems among military personnel and war vet-
23 erans.

24 (10) Significant and rapid improvements in
25 lung cancer mortality can be expected through great-

1 er use and access to lung cancer screening tests for
2 at-risk individuals.

3 (11) Additional strategies are necessary to fur-
4 ther enhance the existing tests and therapies avail-
5 able to diagnose and treat lung cancer in the future.

6 (12) The August 2001 Report of the Lung
7 Cancer Progress Review Group of the National Can-
8 cer Institute stated that funding for lung cancer re-
9 search was “far below the levels characterized for
10 other common malignancies and far out of propor-
11 tion to its massive health impact”.

12 (13) The Report of the Lung Cancer Progress
13 Review Group identified as its “highest priority” the
14 creation of integrated, multidisciplinary, multi-insti-
15 tutional research consortia organized around the
16 problem of lung cancer rather than around specific
17 research disciplines.

18 (14) The United States must enhance its re-
19 sponse to the issues raised in the Report of the
20 Lung Cancer Progress Review Group, and this can
21 be accomplished through the establishment of a co-
22 ordinated effort designed to reduce the lung cancer
23 mortality rate by 50 percent by 2015 and targeted
24 funding to support this coordinated effort.

1 (c) SENSE OF CONGRESS CONCERNING INVESTMENT
2 IN LUNG CANCER RESEARCH.—It is the sense of the Con-
3 gress that—

4 (1) lung cancer mortality reduction should be
5 made a national public health priority; and

6 (2) a comprehensive mortality reduction pro-
7 gram coordinated by the Secretary of Health and
8 Human Services is justified and necessary to ade-
9 quately address and reduce lung cancer mortality.

10 (d) LUNG CANCER MORTALITY REDUCTION PRO-
11 GRAM.—

12 (1) IN GENERAL.—Subpart 1 of part C of title
13 IV of the Public Health Service Act (42 U.S.C. 285
14 et seq.) is amended by adding at the end the fol-
15 lowing:

16 **“SEC. 417H. LUNG CANCER MORTALITY REDUCTION PRO-**
17 **GRAM.**

18 “(a) IN GENERAL.—Not later than 6 months after
19 the date of the enactment of this section, the Secretary,
20 in consultation with the Secretary of Defense, the Sec-
21 retary of Veterans Affairs, the Director of the National
22 Institutes of Health, the Director of the Centers for Dis-
23 ease Control and Prevention, the Commissioner of Food
24 and Drugs, the Administrator of the Centers for Medicare
25 & Medicaid Services, the Director of the National Institute

1 on Minority Health and Health Disparities, and other
2 members of the Lung Cancer Advisory Board established
3 under section 546 of the Lung Cancer Mortality Reduc-
4 tion Act of 2011, shall implement a comprehensive pro-
5 gram, to be known as the Lung Cancer Mortality Reduc-
6 tion Program, to achieve a reduction of at least 25 percent
7 in the mortality rate of lung cancer by 2017.

8 “(b) REQUIREMENTS.—The Program shall include at
9 least the following:

10 “(1) With respect to the National Institutes of
11 Health—

12 “(A) a strategic review and prioritization
13 by the National Cancer Institute of research
14 grants to achieve the goal of the Lung Cancer
15 Mortality Reduction Program in reducing lung
16 cancer mortality;

17 “(B) the provision of funds to enable the
18 Airway Biology and Disease Branch of the Na-
19 tional Heart, Lung, and Blood Institute to ex-
20 pand its research programs to include pre-
21 dispositions to lung cancer, the interrelationship
22 between lung cancer and other pulmonary and
23 cardiac disease, and the diagnosis and treat-
24 ment of these interrelationships;

1 “(C) the provision of funds to enable the
2 National Institute of Biomedical Imaging and
3 Bioengineering to expedite the development of
4 computer assisted diagnostic, surgical, treat-
5 ment, and drug-testing innovations to reduce
6 lung cancer mortality, such as through expan-
7 sion of the Institute’s Quantum Grant Program
8 and Image-Guided Interventions programs; and

9 “(D) the provision of funds to enable the
10 National Institute of Environmental Health
11 Sciences to implement research programs rel-
12 ative to the lung cancer incidence.

13 “(2) With respect to the Food and Drug Ad-
14 ministration—

15 “(A) activities under section 529 of the
16 Federal Food, Drug, and Cosmetic Act; and

17 “(B) activities under section 561 of the
18 Federal Food, Drug, and Cosmetic Act to ex-
19 pand access to investigational drugs and devices
20 for the diagnosis, monitoring, or treatment of
21 lung cancer.

22 “(3) With respect to the Centers for Disease
23 Control and Prevention, the establishment of an
24 early disease research and management program
25 under section 1511.

1 “(4) With respect to the Agency for Healthcare
2 Research and Quality, the conduct of a biannual re-
3 view of lung cancer screening, diagnostic, and treat-
4 ment protocols, and the issuance of updated guide-
5 lines.

6 “(5) The cooperation and coordination of all
7 minority and health disparity programs within the
8 Department of Health and Human Services to en-
9 sure that all aspects of the Lung Cancer Mortality
10 Reduction Program under this section adequately
11 address the burden of lung cancer on minority and
12 rural populations.

13 “(6) The cooperation and coordination of all to-
14 bacco control and cessation programs within agen-
15 cies of the Department of Health and Human Serv-
16 ices to achieve the goals of the Lung Cancer Mor-
17 tality Reduction Program under this section with
18 particular emphasis on the coordination of drug and
19 other cessation treatments with early detection pro-
20 tocols.”.

21 (2) FEDERAL FOOD, DRUG, AND COSMETIC
22 ACT.—Subchapter B of chapter V of the Federal
23 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
24 seq.) is amended by adding at the end the following:

1 “DRUGS RELATING TO LUNG CANCER

2 “SEC. 529. (a) IN GENERAL.—The provisions of this
3 subchapter shall apply to a drug described in subsection
4 (b) to the same extent and in the same manner as such
5 provisions apply to a drug for a rare disease or condition.

6 “(b) QUALIFIED DRUGS.—A drug described in this
7 subsection is—

8 “(1) a chemoprevention drug for precancerous
9 conditions of the lung;

10 “(2) a drug for targeted therapeutic treat-
11 ments, including any vaccine, for lung cancer; and

12 “(3) a drug to curtail or prevent nicotine addic-
13 tion.

14 “(c) BOARD.—The Board established under the Lung
15 Cancer Mortality Reduction Act of 2011 shall monitor the
16 program implemented under this section.”.

17 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
18 tion 561(e) of the Federal Food, Drug, and Cos-
19 metic Act (21 U.S.C. 360bbb(e)) is amended by in-
20 sserting before the period the following: “and shall
21 include expanding access to drugs under section
22 529, with substantial consideration being given to
23 whether the totality of information available to the
24 Secretary regarding the safety and effectiveness of
25 an investigational drug, as compared to the risk of

1 morbidity and death from the disease, indicates that
2 a patient may obtain more benefit than risk if treat-
3 ed with the drug”.

4 (4) CDC.—Title XV of the Public Health Serv-
5 ice Act (42 U.S.C. 300k et seq.) is amended by add-
6 ing at the end the following:

7 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
8 **PROGRAM.**

9 “The Secretary shall establish and implement an
10 early disease research and management program targeted
11 at the high incidence and mortality rates of lung cancer
12 among minority and low-income populations.”.

13 (e) DEPARTMENT OF DEFENSE AND THE DEPART-
14 MENT OF VETERANS AFFAIRS.—The Secretary of Defense
15 and the Secretary of Veterans Affairs shall coordinate
16 with the Secretary of Health and Human Services—

17 (1) in the development of the Lung Cancer
18 Mortality Reduction Program under section 417H;

19 (2) in the implementation within the Depart-
20 ment of Defense and the Department of Veterans
21 Affairs of an early detection and disease manage-
22 ment research program for military personnel and
23 veterans whose smoking history and exposure to car-
24 cinogens during active duty service has increased
25 their risk for lung cancer; and

1 (3) in the implementation of coordinated care
2 programs for military personnel and veterans diag-
3 nosed with lung cancer.

4 (f) LUNG CANCER ADVISORY BOARD.—

5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services shall convene a Lung Cancer Advi-
7 sory Board (referred to in this section as the
8 “Board”)—

9 (A) to monitor the programs established
10 under this section (and the amendments made
11 by this section); and

12 (B) to provide annual reports to the Con-
13 gress concerning benchmarks, expenditures,
14 lung cancer statistics, and the public health im-
15 pact of such programs.

16 (2) COMPOSITION.—The Board shall be com-
17 posed of—

18 (A) the Secretary of Health and Human
19 Services;

20 (B) the Secretary of Defense;

21 (C) the Secretary of Veterans Affairs; and

22 (D) two representatives each from the
23 fields of clinical medicine focused on lung can-
24 cer, lung cancer research, imaging, drug devel-
25 opment, and lung cancer advocacy, to be ap-

1 pointed by the Secretary of Health and Human
2 Services.

3 (g) AUTHORIZATION OF APPROPRIATIONS.—

4 (1) IN GENERAL.—To carry out this section
5 (and the amendments made by this section), there
6 are authorized to be appropriated such sums as may
7 be necessary for each of fiscal years 2012 through
8 2016.

9 (2) LUNG CANCER MORTALITY REDUCTION PRO-
10 GRAM.—Of the amounts authorized to be appro-
11 priated by subsection (a), there are authorized to be
12 appropriated—

13 (A) \$25,000,000 for fiscal year 2012, and
14 such sums as may be necessary for each of fis-
15 cal years 2013 through 2016, for the activities
16 described in section 417H(b)(1)(B) of the Pub-
17 lic Health Service Act, as added by subsection
18 (d)(1);

19 (B) \$25,000,000 for fiscal year 2012, and
20 such sums as may be necessary for each of fis-
21 cal years 2013 through 2016, for the activities
22 described in section 417H(b)(1)(C) of such Act;

23 (C) \$10,000,000 for fiscal year 2012, and
24 such sums as may be necessary for each of fis-
25 cal years 2013 through 2016, for the activities

1 described in section 417H(b)(1)(D) of such Act;
2 and

3 (D) \$15,000,000 for fiscal year 2012, and
4 such sums as may be necessary for each of fis-
5 cal years 2013 through 2016, for the activities
6 described in section 417H(b)(3) of such Act.

7 **SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUT-**
8 **REACH, SCREENING, TESTING, ACCESS, AND**
9 **TREATMENT EFFECTIVENESS.**

10 (a) **SHORT TITLE.**—This section may be cited as the
11 “Prostate Research, Outreach, Screening, Testing, Access,
12 and Treatment Effectiveness Act of 2011” or the “PROS-
13 TATE Act”.

14 (b) **FINDINGS.**—Congress makes the following find-
15 ings:

16 (1) Prostate cancer is the second leading cause
17 of cancer death among men.

18 (2) In 2010, more than 217,730 new patients
19 were diagnosed with prostate cancer and more than
20 32,000 men died from this disease.

21 (3) Roughly 2,000,000 Americans are living
22 with a diagnosis of prostate cancer and its con-
23 sequences.

24 (4) While prostate cancer generally affects older
25 individuals, younger men are also at risk for the dis-

1 ease, and when prostate cancer appears in early
2 middle age it frequently takes on a more aggressive
3 form.

4 (5) There are significant racial and ethnic dis-
5 parities that demand attention, namely African-
6 Americans have prostate cancer mortality rates that
7 are more than double those in the White population.

8 (6) Underserved rural populations have higher
9 rates of mortality compared to their urban counter-
10 parts, and innovative and cost-efficient methods to
11 improve rural access to high quality care should take
12 advantage of advances in telehealth to diagnose and
13 treat prostate cancer when appropriate.

14 (7) Certain veterans populations may have
15 nearly twice the incidence of prostate cancer as the
16 general population of the United States.

17 (8) Urologists may constitute the specialists
18 who diagnose and treat the vast majority of prostate
19 cancer patients.

20 (9) Although much basic and translational re-
21 search has been completed and much is currently
22 known, there are still many unanswered questions.
23 For example, it is not fully understood how much of
24 known disparities are attributable to disease eti-

1 ology, access to care, or education and awareness in
2 the community.

3 (10) Causes of prostate cancer are not known.
4 There is not good information regarding how to dif-
5 ferentiate accurately, early on, between aggressive
6 and indolent forms of the disease. As a result, there
7 is significant overtreatment in prostate cancer.
8 There are no treatments that can durably arrest
9 growth or cure prostate cancer once it has metasta-
10 sized.

11 (11) A significant proportion (roughly 23 to 54
12 percent) of cases may be clinically indolent and
13 “overdiagnosed”, resulting in significant overtreat-
14 ment. More accurate tests will allow men and their
15 families to face less physical, psychological, financial,
16 and emotional trauma and billions of dollars could
17 be saved in private and public health care systems
18 in an area that has been identified by the Medicare
19 program as one of eight high-volume, high-cost areas
20 in the Resource Utilization Report program author-
21 ized by Congress under the Medicare Improvements
22 for Patients and Providers Act of 2008.

23 (12) Prostate cancer research and health care
24 programs across Federal agencies should be coordi-
25 nated to improve accountability and actively encour-

1 age the translation of research into practice, to iden-
2 tify and implement best practices, in order to foster
3 an integrated and consistent focus on effective pre-
4 vention, diagnosis, and treatment of this disease.

5 (c) PROSTATE CANCER COORDINATION AND EDU-
6 CATION.—

7 (1) INTERAGENCY PROSTATE CANCER COORDI-
8 NATION AND EDUCATION TASK FORCE.—Not later
9 than 180 days after the date of the enactment of
10 this section, the Secretary of Veterans Affairs, in co-
11 operation with the Secretary of Defense and the Sec-
12 retary of Health and Human Services, shall estab-
13 lish an Interagency Prostate Cancer Coordination
14 and Education Task Force (in this section referred
15 to as the “Prostate Cancer Task Force”).

16 (2) DUTIES.—The Prostate Cancer Task Force
17 shall—

18 (A) develop a summary of advances in
19 prostate cancer research supported or con-
20 ducted by Federal agencies relevant to the diag-
21 nosis, prevention, and treatment of prostate
22 cancer, including psychosocial impairments re-
23 lated to prostate cancer treatment, and compile
24 a list of best practices that warrant broader
25 adoption in health care programs;

1 (B) consider establishing, and advocating
2 for, a guidance to enable physicians to allow
3 screening of men who are over age 74, on a
4 case-by-case basis, taking into account quality
5 of life and family history of prostate cancer;

6 (C) share and coordinate information on
7 Federal research and health care program ac-
8 tivities, including activities related to—

9 (i) determining how to improve re-
10 search and health care programs, including
11 psychosocial impairments related to pros-
12 tate cancer treatment;

13 (ii) identifying any gaps in the overall
14 research inventory and in health care pro-
15 grams;

16 (iii) identifying opportunities to pro-
17 mote translation of research into practice;
18 and

19 (iv) maximizing the effects of Federal
20 efforts by identifying opportunities for col-
21 laboration and leveraging of resources in
22 research and health care programs that
23 serve those susceptible to or diagnosed
24 with prostate cancer;

1 (D) develop a comprehensive interagency
2 strategy and advise relevant Federal agencies in
3 the solicitation of proposals for collaborative,
4 multidisciplinary research and health care pro-
5 grams, including proposals to evaluate factors
6 that may be related to the etiology of prostate
7 cancer, that would—

8 (i) result in innovative approaches to
9 study emerging scientific opportunities or
10 eliminate knowledge gaps in research to
11 improve the prostate cancer research port-
12 folio of the Federal Government;

13 (ii) outline key research questions,
14 methodologies, and knowledge gaps; and

15 (iii) ensure consistent action, as out-
16 lined by section 402(b) of the Public
17 Health Service Act;

18 (E) develop a coordinated message related
19 to screening and treatment for prostate cancer
20 to be reflected in educational and beneficiary
21 materials for Federal health programs as such
22 documents are updated; and

23 (F) not later than 2 years after the date
24 of the establishment of the Prostate Cancer
25 Task Force, submit to the Expert Advisory

1 Panel to be reviewed and returned within 30
2 days, and then within 90 days submitted to
3 Congress recommendations—

4 (i) regarding any appropriate changes
5 to research and health care programs, in-
6 cluding recommendations to improve the
7 research portfolio of the Department of
8 Veterans Affairs, Department of Defense,
9 National Institutes of Health, and other
10 Federal agencies to ensure that scientif-
11 ically based strategic planning is imple-
12 mented in support of research and health
13 care program priorities;

14 (ii) designed to ensure that the re-
15 search and health care programs and ac-
16 tivities of the Department of Veterans Af-
17 fairs, the Department of Defense, the De-
18 partment of Health and Human Services,
19 and other Federal agencies are free of un-
20 necessary duplication;

21 (iii) regarding public participation in
22 decisions relating to prostate cancer re-
23 search and health care programs to in-
24 crease the involvement of patient advo-
25 cates, community organizations, and med-

1 ical associations representing a broad geo-
2 graphical area;

3 (iv) on how to best disseminate infor-
4 mation on prostate cancer research and
5 progress achieved by health care programs;

6 (v) about how to expand partnerships
7 between public entities, including Federal
8 agencies, and private entities to encourage
9 collaborative, cross-cutting research and
10 health care delivery;

11 (vi) assessing any cost savings and ef-
12 ficiencies realized through the efforts iden-
13 tified and supported in this section and
14 recommending expansion of those efforts
15 that have proved most promising while also
16 ensuring against any conflicts in directives
17 from other congressional or statutory man-
18 dates or enabling statutes;

19 (vii) identifying key priority action
20 items from among the recommendations;
21 and

22 (viii) with respect to the level of fund-
23 ing needed by each agency to implement
24 the recommendations contained in the re-
25 port.

1 (3) MEMBERS OF THE PROSTATE CANCER TASK
2 FORCE.—The Prostate Cancer Task Force described
3 in subsection (a) shall be composed of representa-
4 tives from such Federal agencies, as each Secretary
5 determines necessary, to coordinate a uniform mes-
6 sage relating to prostate cancer screening and treat-
7 ment where appropriate, including representatives of
8 the following:

9 (A) The Department of Veterans Affairs,
10 including representatives of each relevant pro-
11 gram areas of the Department of Veterans Af-
12 fairs.

13 (B) The Prostate Cancer Research Pro-
14 gram of the Congressionally Directed Medical
15 Research Program of the Department of De-
16 fense.

17 (C) The Department of Health and
18 Human Services, including at a minimum rep-
19 resentatives of the following:

20 (i) The National Institutes of Health.

21 (ii) National research institutes and
22 centers, including the National Cancer In-
23 stitute, the National Institute of Allergy
24 and Infectious Diseases, and the Office of
25 Minority Health.

1 (iii) The Centers for Medicare & Med-
2 icaid Services.

3 (iv) The Food and Drug Administra-
4 tion.

5 (v) The Centers for Disease Control
6 and Prevention.

7 (vi) The Agency for Healthcare Re-
8 search and Quality.

9 (vii) The Health Resources and Serv-
10 ices Administration.

11 (4) APPOINTING EXPERT ADVISORY PANELS.—

12 The Prostate Cancer Task Force shall appoint ex-
13 pert advisory panels, as determined appropriate, to
14 provide input and concurrence from individuals and
15 organizations from the medical, prostate cancer pa-
16 tient and advocate, research, and delivery commu-
17 nities with expertise in prostate cancer diagnosis,
18 treatment, and research, including practicing urolo-
19 gists, primary care providers, and others and indi-
20 viduals with expertise in education and outreach to
21 underserved populations affected by prostate cancer.

22 (5) MEETINGS.—The Prostate Cancer Task
23 Force shall convene not less than twice a year, or
24 more frequently as the Secretary determines to be
25 appropriate.

1 (6) SUBMISSION OF RECOMMENDATIONS TO
2 CONGRESS.—The Secretary of Veterans Affairs shall
3 submit to Congress any recommendations submitted
4 to the Secretary under paragraph (2)(E).

5 (7) FEDERAL ADVISORY COMMITTEE ACT.—

6 (A) IN GENERAL.—Except as provided in
7 subparagraph (B), the Federal Advisory Com-
8 mittee Act (5 U.S.C. App.) shall apply to the
9 Prostate Cancer Task Force.

10 (B) EXCEPTION.—Section 14(a)(2)(B) of
11 such Act (relating to the termination of advi-
12 sory committees) shall not apply to the Prostate
13 Cancer Task Force.

14 (8) SUNSET DATE.—The Prostate Cancer Task
15 Force shall terminate at the end of fiscal year 2016.

16 (d) PROSTATE CANCER RESEARCH.—

17 (1) RESEARCH COORDINATION.—The Secretary
18 of Veterans Affairs, in coordination with the Secre-
19 taries of Defense and of Health and Human Serv-
20 ices, shall establish and carry out a program to co-
21 ordinate and intensify prostate cancer research as
22 needed. Specifically, such research program shall—

23 (A) develop advances in diagnostic and
24 prognostic methods and tests, including bio-
25 markers and an improved prostate cancer

1 screening blood test, including improvements or
2 alternatives to the prostate specific antigen test
3 and additional tests to distinguish indolent from
4 aggressive disease;

5 (B) better understand the etiology of the
6 disease (including an analysis of lifestyle factors
7 proven to be involved in higher rates of prostate
8 cancer, such as obesity and diet, and in dif-
9 ferent ethnic, racial, and socioeconomic groups,
10 such as the African-American, Latin-American,
11 and American Indian populations and men with
12 a family history of prostate cancer) to improve
13 prevention efforts;

14 (C) expand basic research into prostate
15 cancer, including studies of fundamental molec-
16 ular and cellular mechanisms;

17 (D) identify and provide clinical testing of
18 novel agents for the prevention and treatment
19 of prostate cancer;

20 (E) establish clinical registries for prostate
21 cancer;

22 (F) use the National Institute of Bio-
23 medical Imaging and Bioengineering and the
24 National Cancer Institute for assessment of ap-
25 propriate imaging modalities; and

1 (G) address such other matters relating to
2 prostate cancer research as may be identified by
3 the Federal agencies participating in the pro-
4 gram under this section.

5 (2) PROSTATE CANCER ADVISORY BOARD.—

6 There is established in the Office of the Chief Sci-
7 entist of the Food and Drug Administration a Pros-
8 tate Cancer Scientific Advisory Board. Such board
9 shall be responsible for accelerating real-time shar-
10 ing of the latest research data and accelerating
11 movement of new medicines to patients.

12 (3) UNDERSERVED MINORITY GRANT PRO-
13 GRAM.—In carrying out such program, the Secretary
14 shall—

15 (A) award grants to eligible entities to
16 carry out components of the research outlined
17 in paragraph (1);

18 (B) integrate and build upon existing
19 knowledge gained from comparative effective-
20 ness research; and

21 (C) recognize and address—

22 (i) the racial and ethnic disparities in
23 the incidence and mortality rates of pros-
24 tate cancer and men with a family history
25 of prostate cancer;

1 (ii) any barriers in access to care and
2 participation in clinical trials that are spe-
3 cific to racial, ethnic, and other under-
4 served minorities and men with a family
5 history of prostate cancer;

6 (iii) needed outreach and educational
7 efforts to raise awareness in these commu-
8 nities; and

9 (iv) appropriate access and utilization
10 of imaging modalities.

11 (e) TELEHEALTH AND RURAL ACCESS PILOT
12 PROJECT.—

13 (1) IN GENERAL.—The Secretary of Veterans
14 Affairs, the Secretary of Defense, and the Secretary
15 of Health and Human Services (in this section re-
16 ferred to as the “Secretaries”) shall establish 4-year
17 telehealth pilot projects for the purpose of analyzing
18 the clinical outcomes and cost effectiveness associ-
19 ated with telehealth services in a variety of geo-
20 graphic areas that contain high proportions of medi-
21 cally underserved populations, including African-
22 Americans, Latin-Americans, American Indians, and
23 those in rural areas. Such projects shall promote ef-
24 ficient use of specialist care through better coordina-
25 tion of primary care and physician extender teams

1 in underserved areas and more effectively employ
2 tumor boards to better counsel patients.

3 (2) ELIGIBLE ENTITIES.—

4 (A) IN GENERAL.—The Secretaries shall
5 select eligible entities to participate in the pilot
6 projects under this section.

7 (B) PRIORITY.—In selecting eligible enti-
8 ties to participate in the pilot projects under
9 this section, the Secretaries shall give priority
10 to such entities located in medically under-
11 served areas, particularly those that include Af-
12 rican-Americans, Latin-Americans, and facili-
13 ties of the Indian Health Service, and those in
14 rural areas.

15 (3) EVALUATION.—The Secretaries shall,
16 through the pilot projects, evaluate—

17 (A) the effective and economic delivery of
18 care in diagnosing and treating prostate cancer
19 with the use of telehealth services in medically
20 underserved and tribal areas including collabo-
21 rative uses of health professionals and integra-
22 tion of the range of telehealth and other tech-
23 nologies;

24 (B) the effectiveness of improving the ca-
25 pacity of nonmedical providers and nonspecial-

1 ized medical providers to provide health services
2 for prostate cancer in medically underserved
3 and tribal areas, including the exploration of in-
4 novative medical home models with collabora-
5 tion between urologists, other relevant medical
6 specialists, including oncologists, radiologists,
7 and primary care teams and coordination of
8 care through the efficient use of primary care
9 teams and physician extenders; and

10 (C) the effectiveness of using telehealth
11 services to provide prostate cancer treatment in
12 medically underserved areas, including the use
13 of tumor boards to facilitate better patient
14 counseling.

15 (4) REPORT.—Not later than 12 months after
16 the completion of the pilot projects under this sub-
17 section, the Secretaries shall submit to Congress a
18 report describing the outcomes of such pilot projects,
19 including any cost savings and efficiencies realized,
20 and providing recommendations, if any, for expand-
21 ing the use of telehealth services.

22 (f) EDUCATION AND AWARENESS.—

23 (1) IN GENERAL.—The Secretary of Veterans
24 Affairs shall develop a national education campaign
25 for prostate cancer. Such campaign shall involve the

1 use of written educational materials and public serv-
2 ice announcements consistent with the findings of
3 the Prostate Cancer Task Force under subsection
4 (c), that are intended to encourage men to seek
5 prostate cancer screening when appropriate.

6 (2) RACIAL DISPARITIES AND THE POPULATION
7 OF MEN WITH A FAMILY HISTORY OF PROSTATE
8 CANCER.—In developing the national campaign
9 under paragraph (1), the Secretary shall ensure that
10 such educational materials and public service an-
11 nouncements are more readily available in commu-
12 nities experiencing racial disparities in the incidence
13 and mortality rates of prostate cancer and by men
14 of any race classification with a family history of
15 prostate cancer.

16 (3) GRANTS.—In carrying out the national
17 campaign under this section, the Secretary shall
18 award grants to nonprofit private entities to enable
19 such entities to test alternative outreach and edu-
20 cation strategies.

21 (g) AUTHORIZATION OF APPROPRIATIONS.—

22 (1) IN GENERAL.—There is authorized to be
23 appropriated to carry out this section for the period
24 of fiscal years 2012 through 2016 an amount equal
25 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 2012 through 2016 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 2012, 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), and
22 (3) of this subsection) to such commonwealth or ter-
23 ritory for such fiscal year.”.

1 (2) TECHNICAL AMENDMENT.—Such section is
2 further amended by striking “(3), and (4)” and in-
3 sserting “and (3)”.

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 2011.

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, and appropriate use of Medicare-
13 covered services and referral patterns among
14 those target individuals with cancer;

15 (C) eliminate disparities in the rate of pre-
16 ventive cancer screening measures, such as Pap
17 smears, prostate cancer screenings, and CT
18 scans for lung cancer among target individuals;

19 (D) promote collaboration with community-
20 based organizations to ensure cultural com-
21 petency of health care professionals and lin-
22 guistic access for persons with limited-English
23 proficiency; and

24 (E) encourage the incorporation of commu-
25 nity health workers to increase the efficiency

1 and appropriateness of cervical cancer pro-
2 grams.

3 (2) COMMUNITY HEALTH WORKER DEFINED.—

4 In this section, the term “community health worker”
5 includes a community health advocate, a lay health
6 worker, a community health representative, a peer
7 health promotor, a community health outreach work-
8 ers, and promotores de salud, who promotes health
9 or nutrition within the community in which the indi-
10 vidual resides.

11 (3) TARGET INDIVIDUAL DEFINED.—In this

12 section, the term “target individual” means an indi-
13 vidual of a racial and ethnic minority group, as de-
14 fined in section 1707(g)(1) of the Public Health
15 Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-
16 tled to benefits under part A, and enrolled under
17 part B, of title XVIII of the Social Security Act.

18 (b) PROGRAM DESIGN.—

19 (1) INITIAL DESIGN.—Not later than 1 year
20 after the date of the enactment of this Act, the Sec-
21 retary shall evaluate best practices in the private
22 sector, community programs, and academic research
23 of methods that reduce disparities among individuals
24 of racial and ethnic minority groups in the preven-

1 tion and treatment of cancer and shall design the
2 demonstration projects based on such evaluation.

3 (2) NUMBER AND PROJECT AREAS.—Not later
4 than 2 years after the date of the enactment of this
5 Act, the Secretary shall implement at least nine
6 demonstration projects, including the following:

7 (A) Two projects for each of the four fol-
8 lowing major racial and ethnic minority groups:

9 (i) American Indians and Alaska Na-
10 tives, Eskimos and Aleuts.

11 (ii) Asian-Americans.

12 (iii) Blacks/African-Americans.

13 (iv) Hispanic/Latin-Americans.

14 (v) Native Hawaiians and other Pa-
15 cific Islanders.

16 The two projects must target different ethnic
17 subpopulations.

18 (B) One project within the Pacific Islands
19 or United States insular areas.

20 (C) At least one project each in a rural
21 area and inner-city area.

22 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
23 TION OF DEMONSTRATION PROJECT RESULTS.—If
24 the initial report under subsection (c) contains an
25 evaluation that demonstration projects—

1 (A) reduce expenditures under the Medi-
2 care program under title XVIII of the Social
3 Security Act; or

4 (B) do not increase expenditures under the
5 Medicare program and reduce racial and ethnic
6 health disparities in the quality of health care
7 services provided to target individuals and in-
8 crease satisfaction of beneficiaries and health
9 care providers;

10 the Secretary shall continue the existing demonstra-
11 tion projects and may expand the number of dem-
12 onstration projects.

13 (c) REPORT TO CONGRESS.—

14 (1) IN GENERAL.—Not later than 2 years after
15 the date the Secretary implements the initial dem-
16 onstration projects, and biannually thereafter, the
17 Secretary shall submit to Congress a report regard-
18 ing the demonstration projects.

19 (2) CONTENTS OF REPORT.—Each report under
20 paragraph (1) shall include the following:

21 (A) A description of the demonstration
22 projects.

23 (B) An evaluation of—

24 (i) the cost effectiveness of the dem-
25 onstration projects;

1 (ii) the quality of the health care serv-
2 ices provided to target individuals under
3 the demonstration projects; and

4 (iii) beneficiary and health care pro-
5 vider satisfaction under the demonstration
6 projects.

7 (C) Any other information regarding the
8 demonstration projects that the Secretary de-
9 termines to be appropriate.

10 (d) WAIVER AUTHORITY.—The Secretary shall waive
11 compliance with the requirements of title XVIII of the So-
12 cial Security Act to such extent and for such period as
13 the Secretary determines is necessary to conduct dem-
14 onstration projects.

15 **SEC. 705. REDUCING CANCER DISPARITIES WITHIN MEDI-**
16 **CARE.**

17 (a) DEVELOPMENT OF MEASURES OF DISPARITIES
18 IN QUALITY OF CANCER CARE.—

19 (1) DEVELOPMENT OF MEASURES.—The Sec-
20 retary of Health and Human Services (in this sec-
21 tion referred to as the “Secretary”) shall enter into
22 an agreement with the National Quality Forum
23 under which the National Quality Forum shall de-
24 velop a uniform set of measures to evaluate dispari-
25 ties in the quality of cancer care, endorse such set

1 of measures through its multistakeholder consensus
2 development process, and annually update such set
3 of measures.

4 (2) MEASURES TO BE INCLUDED.—Such set of
5 measures shall include, with respect to the treatment
6 of cancer, measures of patient outcomes, the process
7 for delivering medical care related to such treat-
8 ment, patient counseling and engagement in deci-
9 sionmaking, patient experience of care, resource use,
10 and practice capabilities, such as care coordination.

11 (b) ESTABLISHMENT OF REPORTING PROCESS.—

12 (1) IN GENERAL.—The Secretary shall establish
13 a reporting process that provides for a method for
14 health care providers specified under paragraph (2)
15 to submit to the Secretary and make public data on
16 the performance of such providers during each re-
17 porting period through use of the measures devel-
18 oped pursuant to subsection (a). Such data shall be
19 submitted in a form and manner and at a time spec-
20 ified by the Secretary.

21 (2) SPECIFICATION OF PROVIDERS TO REPORT
22 ON MEASURES.—The Secretary shall specify the
23 classes of Medicare providers of services and sup-
24 pliers, including hospitals, cancer centers, physi-
25 cians, primary care providers, and specialty pro-

1 viders, that will be required under such process to
2 publicly report on the measures specified under sub-
3 section (a).

4 (3) ASSESSMENT OF CHANGES.—Within this re-
5 porting process, the Secretary shall also establish a
6 format that assesses changes in both the absolute
7 and relative disparities over time. These measures
8 shall be presented in an easily comprehensible for-
9 mat, such as those presented in the final publica-
10 tions relating to Healthy People 2010 or the Na-
11 tional Healthcare Disparities Report.

12 (4) INITIAL IMPLEMENTATION.—The Secretary
13 shall implement the reporting process under this
14 subsection for reporting periods beginning not later
15 than 6 months after the date that measures are first
16 established under subsection (a).

17 **Subtitle B—Viral Hepatitis and**
18 **Liver Cancer Control and Pre-**
19 **vention**

20 **SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL**
21 **AND PREVENTION.**

22 (a) SHORT TITLE.—This subtitle may be cited as the
23 “Viral Hepatitis and Liver Cancer Control and Prevention
24 Act of 2011”.

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

1 (1) Approximately 5,300,000 Americans are
2 chronically infected with the hepatitis B virus (re-
3 ferred to in this section as “HBV”), the hepatitis C
4 virus (referred to in this section as “HCV”), or
5 both.

6 (2) In the United States, chronic HBV and
7 HCV are the most common cause of liver cancer,
8 one of the most lethal and fastest growing cancers
9 in this country. It is the most common cause of
10 chronic liver disease, liver cirrhosis, and the most
11 common indication for liver transplantation. It is
12 also a leading cause of death in Americans living
13 with HIV/AIDS, many of whom are coinfecting with
14 chronic HBV, chronic HCV, or both. At least 15,000
15 deaths per year in the United States can be attrib-
16 uted to chronic HBV and HCV.

17 (3) According to the Centers for Disease Con-
18 trol and Prevention (referred to in this section as
19 the “CDC” “”), approximately 2 percent of the pop-
20 ulation of the United States is living with chronic
21 HBV, chronic HCV, or both. The CDC has recog-
22 nized HCV as the Nation’s most common chronic
23 bloodborne virus infection and HBV as the deadliest
24 vaccine-preventable disease.

1 (4) HBV is easily transmitted and is 100 times
2 more infectious than HIV. According to the CDC,
3 HBV is transmitted through percutaneous (i.e.,
4 puncture through the skin) or mucosal contact with
5 infectious blood or body fluids. HCV is transmitted
6 by percutaneous exposures to infectious blood.

7 (5) The CDC conservatively estimates that in
8 2008 approximately 18,000 Americans were newly
9 infected with HCV and more than 38,000 Americans
10 were newly infected with HBV.

11 (6) There were 6 outbreaks reported to CDC
12 for investigation in 2008 related to health care ac-
13 quired infection of HBV and HCV, potentially ex-
14 posing more than 52,000 Americans to the viruses,
15 in 2009–2010 there were 15 outbreaks in which
16 more than 30,000 people were potentially exposed.

17 (7) Chronic HBV and chronic HCV usually do
18 not cause symptoms early in the course of the dis-
19 ease, but after many years of a clinically “silent”
20 phase, more than 50 percent of infected individuals
21 will develop cirrhosis, end-stage liver disease, or liver
22 cancer. Since most of those with chronic HBV and
23 HCV are unaware of their infection, they do not
24 know to take precautions to prevent the spread of

1 their infection and can unknowingly exacerbate their
2 own disease progression.

3 (8) HBV and HCV disproportionately affect
4 certain populations in the United States. Although
5 representing only 5 percent of the population, Asian-
6 Americans and Pacific Islanders account for over
7 half of the 1,400,000 domestic chronic HBV cases.
8 Baby boomers (those born between 1946 and 1964)
9 account for more than half of domestic chronic hepa-
10 titis C cases. In addition, African-Americans, Latin-
11 Americans, and American Indian/Alaskan Natives
12 are among the groups which have disproportionately
13 high rates of HBV and/or HCV infections in the
14 United States.

15 (9) For both chronic HBV and chronic HCV,
16 behavioral changes can slow disease progression if
17 diagnosis is made early. Early diagnosis, which is
18 determined through simple blood tests, can reduce
19 the risk of transmission and disease progression
20 through education and vaccination of household
21 members and other susceptible persons at risk.

22 (10) For those chronically infected with HBV
23 or HCV, regular monitoring can lead to the early de-
24 tection of liver cancer at a stage where cure is still
25 possible. Liver cancer is the third deadliest cancer in

1 the United States however, liver cancer has received
2 little funding for research, prevention, or treatment.

3 (11) Treatment for chronic HCV can eradicate
4 the disease in approximately 75 percent of those cur-
5 rently treated. The treatment of chronic HBV can
6 effectively suppress viral replication in the over-
7 whelming majority (>80%) of those treated thereby
8 reducing the risk of transmission and progression to
9 liver scarring or liver cancer even though a complete
10 cure is much less common than for HCV.

11 (12) To combat the HBV and HCV epidemics
12 in the United States, in May 2011, the Department
13 of Health and Human Services released Combating
14 the Silent Epidemic of Viral Hepatitis: Action Plan
15 for the Prevention, Care & Treatment of Viral Hepa-
16 titis (hereafter referred to as the HHS Action Plan).
17 The Institute of Medicine (IOM) of the National
18 Academies 2010 reported on the Federal response to
19 HBV and HCV titled: Hepatitis and Liver Cancer:
20 A National Strategy for Prevention and Control of
21 Hepatitis B and C. These recommendations and
22 guidelines provide a framework for HBV and HCV
23 prevention, education, control, research, and medical
24 management programs.

1 (13) The annual health care costs attributable
2 to HBV and HCV in the United States are signifi-
3 cant. For HBV, it is estimated to be approximately
4 \$1,000,000,000 to 2,000,000,000 (\$1,000 to \$2,000
5 per infected person). More than \$1,000,000,000 is
6 spent each year for HBV-related hospitalizations.
7 The indirect costs of chronic HBV infection are
8 harder to measure, but include reduced physical and
9 emotional quality of life, reduced economic produc-
10 tivity, long-term disability, and premature death.
11 For HCV, medical costs for patients are expected to
12 increase from \$30,000,000,000 in 2009 to over
13 \$85,000,000,000 in 2024. Avoiding these costs by
14 screening and diagnosing individuals earlier—and
15 connecting them to appropriate treatment and care
16 will save lives and critical health care dollars. Cur-
17 rently, without a comprehensive screening, testing
18 and diagnosis program, most patients are diagnosed
19 too late when they need a liver transplant costing at
20 least \$314,000 for uncomplicated cases or when they
21 have liver cancer or end stage liver disease which
22 costs \$30,980 to \$110,576 per hospital admission.
23 As health care costs continue to grow, it is critical
24 that the Federal Government invests in effective
25 mechanisms to avoid documented cost drivers.

1 (14) According to the IOM report in 2010,
2 chronic HBV and HCV infections cause substantial
3 morbidity and mortality despite being preventable
4 and treatable. Deficiencies in the implementation of
5 established guidelines for the prevention, diagnosis,
6 and medical management of chronic HBV and HCV
7 infections perpetuate personal and economic bur-
8 dens. Existing grants are not sufficient for the scale
9 of the health burden presented by HBV and HCV.

10 (15) Screening and testing for HBV and HCV
11 is aligned with the Healthy People 2020 goal; In-
12 crease immunization rates and reduce preventable
13 infectious diseases. Awareness of disease and access
14 to prevention and treatment remain essential compo-
15 nents for reducing infectious disease transmission.

16 (16) Federal support is necessary to increase
17 knowledge and awareness of HBV and HCV and to
18 assist State and local prevention and control efforts
19 in reducing the morbidity and mortality of these
20 epidemics.

21 (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B
22 AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,
23 AND MEDICAL MANAGEMENT PLAN.—Title III of the
24 Public Health Service Act (42 U.S.C. 241 et seq.) is
25 amended—

1 (1) by striking section 317N (42 U.S.C. 247b–
2 15); and

3 (2) by adding at the end the following:

4 **“PART X—BIENNIAL ASSESSMENT OF HHS HEPA-**
5 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
6 **CATION, RESEARCH, AND MEDICAL MANAGE-**
7 **MENT PLAN**

8 **“SEC. 399NN. BIENNIAL UPDATE OF THE PLAN.**

9 “(a) IN GENERAL.—The Secretary shall conduct a bi-
10 ennial assessment of the Secretary’s plan for the preven-
11 tion, control, and medical management of, and education
12 and research relating to, hepatitis B and hepatitis C, for
13 the purposes of—

14 “(1) incorporating into such plan new knowl-
15 edge or observations relating to hepatitis B and hep-
16 atitis C (such as knowledge and observations that
17 may be derived from clinical, laboratory, and epide-
18 miological research and disease detection, preven-
19 tion, and surveillance outcomes);

20 “(2) addressing gaps in the coverage or effec-
21 tiveness of the plan; and

22 “(3) evaluating and, if appropriate, updating
23 recommendations, guidelines, or educational mate-
24 rials of the Centers for Disease Control and Preven-
25 tion or the National Institutes of Health for health

1 care providers or the public on viral hepatitis in
2 order to be consistent with the plan.

3 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—

4 Not later than October 1 of the first even-numbered year
5 beginning after the date of the enactment of this part,
6 and October 1 of each even-numbered year thereafter, the
7 Secretary shall publish in the Federal Register a notice
8 of the results of the assessments conducted under para-
9 graph (1). Such notice shall include—

10 “(1) a description of any revisions to the plan
11 referred to in subsection (a) as a result of the as-
12 sessment;

13 “(2) an explanation of the basis for any such
14 revisions, including the ways in which such revisions
15 can reasonably be expected to further promote the
16 original goals and objectives of the plan; and

17 “(3) in the case of a determination by the Sec-
18 retary that the plan does not need revision, an expla-
19 nation of the basis for such determination.

20 **“SEC. 399NN-1. ELEMENTS OF PROGRAM.**

21 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
22 Secretary, acting through the Director of the Centers for
23 Disease Control and Prevention, the Administrator of the
24 Health Resources and Services Administration, and the
25 Administrator of the Substance Abuse and Mental Health

1 Services Administration, and in accordance with the plan
2 referred to in section 399NN(a), shall implement pro-
3 grams to increase awareness and enhance knowledge and
4 understanding of hepatitis B and hepatitis C. Such pro-
5 grams shall include—

6 “(1) the conduct of culturally and language ap-
7 propriate health education in primary and secondary
8 schools, college campuses, public awareness cam-
9 paigns, and community outreach activities (especially
10 to the ethnic communities with high rates of chronic
11 hepatitis B and chronic hepatitis C and other high-
12 risk groups) to promote public awareness and knowl-
13 edge about the value of hepatitis A and hepatitis B
14 immunization, risk factors, the transmission and
15 prevention of hepatitis B and hepatitis C, the value
16 of screening for the early detection of hepatitis B
17 and hepatitis C, and options available for the treat-
18 ment of chronic hepatitis B and chronic hepatitis C;

19 “(2) the promotion of immunization programs
20 that increase awareness and access to hepatitis A
21 and hepatitis B vaccines for susceptible adults and
22 children;

23 “(3) the training of health care professionals
24 regarding the importance of vaccinating individuals
25 infected with hepatitis C and individuals who are at

1 risk for hepatitis C infection against hepatitis A and
2 hepatitis B;

3 “(4) the training of health care professionals
4 regarding the importance of vaccinating individuals
5 chronically infected with hepatitis B and individuals
6 who are at risk for chronic hepatitis B infection
7 against the hepatitis A virus;

8 “(5) the training of health care professionals
9 and health educators to make them aware of the
10 high rates of chronic hepatitis B and chronic hepa-
11 titis C in certain adult ethnic populations, and the
12 importance of prevention, detection, and medical
13 management of hepatitis B and hepatitis C and of
14 liver cancer screening;

15 “(6) the development and distribution of health
16 education curricula (including information relating
17 to the special needs of individuals infected with hep-
18 atitis B and hepatitis C, such as the importance of
19 prevention and early intervention, regular moni-
20 toring, the recognition of psychosocial needs, appro-
21 priate treatment, and liver cancer screening) for in-
22 dividuals providing hepatitis B and hepatitis C coun-
23 seling; and

1 “(7) support for the implementation curricula
2 described in paragraph (6) by State and local public
3 health agencies.

4 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
5 PROGRAMS.—

6 “(1) IN GENERAL.—The Secretary, acting
7 through the Director of the Centers for Disease
8 Control and Prevention, shall support the integra-
9 tion of activities described in paragraph (2) into ex-
10 isting clinical and public health programs at State,
11 local, territorial, and tribal levels (including commu-
12 nity health clinics, programs for the prevention and
13 treatment of HIV/AIDS, sexually transmitted dis-
14 eases, and substance abuse, and programs for indi-
15 viduals in correctional settings).

16 “(2) 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 “(3) 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 2012, \$90,000,000
16 for fiscal year 2013, \$110,000,000 for fiscal year 2014,
17 \$130,000,000 for fiscal year 2015, and \$150,000,000 for
18 fiscal year 2016.”.

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 2011”.

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 Hispanic/Latin-American 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 2012 through 2016.”.

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 2012
12 through 2016.

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 sup-
13 ported under section 1707(b)(8) (including by means
14 of the center’s Web site, through appropriate loca-
15 tions 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 2012 through 2016.”.

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 2012
18 through 2016.

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 (15) environmental and related health illnesses
24 and conditions;

25 (16) Sickle cell disease;

- 1 (17) violence and injury prevention and control;
2 (18) genetic and related conditions;
3 (19) heart disease and stroke;
4 (20) tuberculosis;
5 (21) chronic obstructive pulmonary disease; and
6 (22) other diseases determined appropriate by
7 the Secretary.

8 (d) DISSEMINATION.—Not later than 24 months
9 after the date of enactment of this title, the Secretary
10 shall publish and disseminate to health care provider orga-
11 nizations the guidelines developed under subsection (a).

12 (e) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section,
14 such sums as may be necessary for each of fiscal years
15 2012 through 2016.

16 **SEC. 732. COVERAGE OF THE SHINGLES VACCINE UNDER**
17 **THE MEDICARE PROGRAM.**

18 (a) IN GENERAL.—Section 1861 of the Social Secu-
19 rity Act (42 U.S.C. 1395x) is amended—

20 (1) in subsection (s)(10)(A), by inserting “,
21 shingles vaccine and its administration,” before
22 “and, subject to”; and

23 (2) in subsection (ww)(2)(A), by inserting
24 “shingles,” after “Pneumococcal,”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to shingles vaccine furnished on
3 or after January 1 of the first calendar year beginning
4 more than 60 days after the date of the enactment of this
5 Act.

6 **SEC. 733. CDC WISEWOMAN SCREENING PROGRAM.**

7 Section 1509 of the Public Health Service Act (42
8 U.S.C. 300n–4a) is amended—

9 (1) in subsection (a)—

10 (A) by striking the heading and inserting
11 “IN GENERAL.—”; and

12 (B) in the matter preceding paragraph (1),
13 by striking “may make grants” and all that fol-
14 lows through “purpose” and inserting the fol-
15 lowing: “may make grants to such States for
16 the purpose”; and

17 (2) in subsection (d)(1), by striking “there are
18 authorized” and all that follows through the period
19 and inserting “there are authorized to be appro-
20 priated \$23,000,000 for fiscal year 2012,
21 \$25,300,000 for fiscal year 2013, \$27,800,000 for
22 fiscal year 2014, \$30,800,000 for fiscal year 2015,
23 and \$34,000,000 for fiscal year 2016.”.

1 **SEC. 734. REPORT ON CARDIOVASCULAR CARE FOR WOMEN**
2 **AND MINORITIES.**

3 Part P of title III of the Public Health Service Act
4 (42 U.S.C. 280g et seq.) is amended by adding at the end
5 the following:

6 **“SEC. 399V-5. REPORT ON CARDIOVASCULAR CARE FOR**
7 **WOMEN AND MINORITIES.**

8 “Not later than September 30, 2014, and annually
9 thereafter, the Secretary shall prepare and submit to the
10 Congress a report on the quality of and access to care
11 for women and minorities with heart disease, stroke, and
12 other cardiovascular diseases. The report shall contain rec-
13 ommendations for eliminating disparities in, and improv-
14 ing the treatment of, heart disease, stroke, and other car-
15 diovascular diseases in women, racial and ethnic minori-
16 ties, those for whom English is not their primary lan-
17 guage, and individuals with disabilities.”.

18 **SEC. 735. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
19 **SATION SERVICES IN MEDICAID.**

20 (a) **REQUIRING COVERAGE OF COUNSELING AND**
21 **PHARMACOTHERAPY FOR CESSATION OF TOBACCO**
22 **USE.**—Section 1905 of the Social Security Act (42 U.S.C.
23 1396d) is amended—

24 (1) in subsection (a)(4)(D) is amended by strik-
25 ing “by pregnant women”; and

26 (2) in subsection (bb)—

1 (A) by striking “by pregnant women” each
2 place it appears;

3 (B) in paragraph (1), in the matter before
4 subparagraph (A), by inserting “by individuals”
5 before “who use tobacco”; and

6 (C) in paragraph (2)(A), by striking “with
7 respect to pregnant women”.

8 (b) EXCEPTION FROM OPTIONAL RESTRICTION
9 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
10 Section 1927(d)(2)(F) of the Social Security Act (42
11 U.S.C. 1396r–8(d)(2)(F)) is amended by striking “in the
12 case of pregnant women”.

13 (c) REMOVAL OF COST SHARING FOR COUNSELING
14 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
15 USE.—

16 (1) GENERAL COST SHARING LIMITATIONS.—
17 Section 1916 of the Social Security Act (42 U.S.C.
18 1396o) is amended—

19 (A) in subsections (a)(2)(B) and (b)(2)(B),
20 by striking “and counseling and pharmacothe-
21 rapy for cessation of tobacco use by pregnant
22 women (as defined in section 1905(bb)) and
23 covered outpatient drugs (as defined in sub-
24 section (k)(2) of section 1927 and including
25 nonprescription drugs described in subsection

1 (d)(2) of such section) that are prescribed for
2 purposes of promoting, and when used to pro-
3 mote, tobacco cessation by pregnant women in
4 accordance with the Guideline referred to in
5 section 1905(bb)(2)(A)” each place it appears;
6 and

7 (B) in each of subsections (a)(2)(D) and
8 (b)(2)(D) by inserting “and counseling and
9 pharmacotherapy for cessation of tobacco use
10 (as defined in section 1905(bb)) and covered
11 outpatient drugs (as defined in subsection
12 (k)(2) of section 1927 and including non-
13 prescription drugs described in subsection
14 (d)(2) of such section) that are prescribed for
15 purposes of promoting, and when used to pro-
16 mote, tobacco cessation in accordance with the
17 Guideline referred to in section
18 1905(bb)(2)(A),” after “section
19 1905(a)(4)(C),”.

20 (2) APPLICATION TO ALTERNATIVE
21 COSTSHARING.—Section 1916A(b)(3)(B) of such Act
22 (42 U.S.C. 1396o–1(b)(3)(B)) is amended—

23 (A) in clause (iii), by striking “, and coun-
24 seling and pharmacotherapy for cessation of to-

1 bacco use by pregnant women (as defined in
2 section 1905(bb))”); and

3 (B) by adding at the end the following:

4 “(xi) Counseling and
5 pharmacotherapy for cessation of tobacco
6 use (as defined in section 1905(bb)) and
7 covered outpatient drugs (as defined in
8 subsection (k)(2) of section 1927 and in-
9 cluding nonprescription drugs described in
10 subsection (d)(2) of such section) that are
11 prescribed for purposes of promoting, and
12 when used to promote, tobacco cessation in
13 accordance with the Guideline referred to
14 in section 1905(bb)(2)(A).”.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect on October 1, 2012.

17 **SEC. 736. CLINICAL RESEARCH FUNDING FOR ORAL**
18 **HEALTH.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services shall expand and intensify the conduct
21 and support of the research activities of the National In-
22 stitutes of Health and the National Institute of Dental
23 and Craniofacial Research to improve the oral health of
24 the population through the prevention and management
25 of oral diseases and conditions.

1 (b) INCLUDED RESEARCH ACTIVITIES.—Research
2 activities under subsection (a) shall include—

3 (1) comparative effectiveness research and clin-
4 ical disease management research addressing early
5 childhood caries and oral cancer; and

6 (2) awarding of grants and contracts to support
7 the training and development of health services re-
8 searchers, comparative effectiveness researchers, and
9 clinical researchers whose research improves the oral
10 health of the population.

11 **Subtitle E—HIV/AIDS**

12 **SEC. 741. FINDINGS.**

13 The Congress finds the following:

14 (1) Over one million people are estimated to be
15 living with HIV in the United States according to
16 the Centers for Disease Control and Prevention.

17 (2) Annually there are over 17,000 deaths in
18 people with an HIV diagnoses in 40 States and 5
19 dependent areas of the United States.

20 (3) The Centers for Disease Control and Pre-
21 vention estimates that in 2009 there were approxi-
22 mately 48,100 people newly infected with HIV.
23 Though this number seems to be staying relatively
24 stable, the number of new infections is rapidly in-
25 creasing among certain populations especially among

1 young African-American men who have sex with men
2 who had an overall 48 percent increase in new infec-
3 tions from 2006 to 2009.

4 (4) HIV disproportionately affects certain popu-
5 lations in the United States. Though African-Ameri-
6 cans represent less than 13 percent of the popu-
7 lation, African-Americans account for almost half
8 (46 percent) of all people living with HIV in the
9 United States. Men who have sex with men (MSM)
10 make up approximately 2 percent of the population,
11 but account for over half (53 percent) of individuals
12 living with HIV and are the only risk group in which
13 HIV infections continue to increase.

14 (5) Disparities exist among Latin-Americans;
15 they make up 15 percent of US population and 17
16 percent of new infections (2006).

17 (6) Though American Indians/Alaska Natives
18 represent less than 1 percent of the total number of
19 HIV/AIDS cases, American Indians and Alaska Na-
20 tives rank third in rates of HIV/AIDS diagnosis,
21 after African-Americans and Latin-Americans.

22 (7) While Asian-Americans, Native Hawaiians,
23 and Pacific Islanders HIV/AIDS cases account for
24 approximately 1 percent of cases nationally, Asian
25 Americans and Pacific Islanders were the only ra-

1 cial/ethnic groups with a statistically significant in-
2 crease in new HIV diagnoses between 2001 and
3 2008.

4 (8) The limited data available on transgender
5 individuals point to a disproportionate burden of
6 HIV infection.

7 (9) Stigma and discrimination contribute to
8 these disparities.

9 (10) For HIV, early detection and treatment
10 can have huge effects. New research suggests that
11 treatment of individuals not only slows disease pro-
12 gression, but can also greatly reduce the risk of
13 transmission to other individuals.

14 (11) To combat the HIV epidemic in the United
15 States, the National HIV/AIDS Strategy (NHAS)
16 from the White House Office of National AIDS Pol-
17 icy provides a framework of increasing access to
18 care, reducing new infections, and eliminating HIV-
19 related health disparities. The vision of NHAS is
20 “The United States will become a place where new
21 HIV infections are rare and when they do occur,
22 every person, regardless of age, gender, race/eth-
23 nicity, sexual orientation, gender identity, or socio-
24 economic circumstance, will have unfettered access

1 to high quality, life extending care, free from stigma
2 and discrimination.”.

3 (12) Although the cost of education, treatment
4 and care, and research are not inconsequential, they
5 are substantially less than the annual health care
6 cost attributable to HIV in the United States. The
7 lifetime cost of HIV care and treatment in 2004 was
8 estimated to be \$405,000 to \$648,000 dollars annu-
9 ally. Preventing 40,000 new infections in the United
10 States each year would save \$12.8 billion annually.

11 **SEC. 742. ADDRESSING HIV/AIDS IN COMMUNITIES OF**
12 **COLOR.**

13 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
14 of the Congress that national observance days highlighting
15 the impact of HIV/AIDS on communities of color include
16 the following:

17 (1) National Black HIV/AIDS Awareness Day.

18 (2) National Latino AIDS Awareness Day.

19 (3) National Asian and Pacific Islander HIV/
20 AIDS Awareness Day.

21 (4) National Native HIV/AIDS Awareness Day.

22 (5) Caribbean American HIV/AIDS Awareness
23 Day.

1 (b) CALL TO ACTION.—It is the sense of the Con-
2 gress that the President should call on members of com-
3 munities of color—

4 (1) to become involved at the local community
5 level in HIV/AIDS testing, policy, and advocacy;

6 (2) to become aware, engaged, and empowered
7 on the HIV/AIDS epidemic within their commu-
8 nities; and

9 (3) to urge members of their communities to re-
10 duce risk factors, practice safe sex and other preven-
11 tive measures, be tested for HIV/AIDS, and seek
12 care when appropriate.

13 **SEC. 743. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MI-**
14 **NORITY COMMUNITIES.**

15 (a) EXPANDED FUNDING.—The Secretary, in col-
16 laboration with the Deputy Assistant Secretary for Minor-
17 ity Health, the Director of the Centers for Disease Control
18 and Prevention, the Administrator of the Health Re-
19 sources and Services Administration, and the Adminis-
20 trator of the Substance Abuse and Mental Health Services
21 Administration, shall provide funds and carry out activi-
22 ties to expand the Minority HIV/AIDS Initiative.

23 (b) USE OF FUNDS.—The additional funds made
24 available under this section may be used, through the Mi-
25 nority AIDS Initiative, to support the following activities:

1 (1) Providing technical assistance and infra-
2 structure support to reduce HIV/AIDS in minority
3 populations.

4 (2) Increasing minority populations' access to
5 HIV/AIDS prevention and care services.

6 (3) Building strong community programs and
7 partnerships to address HIV prevention and the
8 health care needs of specific racial and ethnic minor-
9 ity populations.

10 (c) PRIORITY INTERVENTIONS.—Within the racial
11 and ethnic minority populations referred to in subsection
12 (b), priority in conducting intervention services shall be
13 given to—

14 (1) women;

15 (2) youth;

16 (3) men who have sex with men;

17 (4) persons who engage in intravenous drug
18 abuse;

19 (5) homeless individuals; and

20 (6) individuals incarcerated or in the penal sys-
21 tem.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
23 rying out this section, there are authorized to be appro-
24 priated \$610,000,000 for fiscal year 2012 and such sums

1 as may be necessary for each of fiscal years 2013 through
2 2016.

3 **SEC. 744. REPEALING INEFFECTIVE AND INCOMPLETE AB-**
4 **STINENCE-ONLY EDUCATION PROGRAM.**

5 (a) IN GENERAL.—Title V of the Social Security Act
6 (42 U.S.C. 701 et seq.) is amended by striking section
7 510.

8 (b) RESCISSION.—Amounts appropriated for each of
9 fiscal years 2010 and 2011 under section 510(d) of the
10 Social Security Act (42 U.S.C. 710(d)) (as in effect on
11 the day before the date of enactment of this Act) that are
12 unobligated as of the date of enactment of this Act are
13 rescinded.

14 (c) REPROGRAM OF ELIMINATED ABSTINENCE-ONLY
15 FUNDS FOR THE PERSONAL RESPONSIBILITY EDUCATION
16 PROGRAM (PREP).—Section 513(f) of the Social Security
17 Act (42 U.S.C. 713(f)) is amended by striking “for each
18 of fiscal years 2010 through 2014” and inserting “for fis-
19 cal year 2010, \$75,000,000 increased by an amount equal
20 to the unobligated portion of funds appropriated for each
21 of fiscal years 2010 and 2011 under section 510(d) that
22 are rescinded under subsection (b), and \$125,000,000 for
23 each of fiscal years 2012 through 2014”.

1 **SEC. 745. DENTAL EDUCATION LOAN REPAYMENT PRO-**
2 **GRAM.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services may enter into an agreement with any
5 dentist under which—

6 (1) the dentist agrees to serve as a dentist for
7 a period of not less than 2 years at a facility with
8 a critical shortage of dentists (as determined by the
9 Secretary) in an area with a high incidence of HIV/
10 AIDS; and

11 (2) the Secretary agrees to make payments in
12 accordance with subsection (b) on the dental edu-
13 cation loans of the dentist.

14 (b) MANNER OF PAYMENTS.—The payments de-
15 scribed in subsection (a) shall be made by the Secretary
16 as follows:

17 (1) Upon completion by the dentist for whom
18 the payments are to be made of the first year of the
19 service specified in the agreement entered into with
20 the Secretary under subsection (a), the Secretary
21 shall pay 30 percent of the principal of and the in-
22 terest on the dental education loans of the dentist.

23 (2) Upon completion by the dentist of the sec-
24 ond year of such service, the Secretary shall pay an-
25 other 30 percent of the principal of and the interest
26 on such loans.

1 (3) Upon completion by that individual of a
2 third year of such service, the Secretary shall pay
3 another 25 percent of the principal of and the inter-
4 est on such loans.

5 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
6 provisions of subpart III of part D of title III of the Public
7 Health Service Act (42 U.S.C. 2541 et seq.) shall, except
8 as inconsistent with this section, apply to the program car-
9 ried out under this section in the same manner and to
10 the same extent as such provisions apply to the National
11 Health Service Corps Loan Repayment Program.

12 (d) REPORTS.—Not later than 18 months after the
13 date of the enactment of this Act, and annually thereafter,
14 the Secretary shall prepare and submit to the Congress
15 a report describing the program carried out under this sec-
16 tion, including statements regarding the following:

17 (1) The number of dentists enrolled in the pro-
18 gram.

19 (2) The number and amount of loan repay-
20 ments.

21 (3) The placement location of loan repayment
22 recipients at facilities described in subsection (a)(1).

23 (4) The default rate and actions required.

24 (5) The amount of outstanding default funds.

1 (6) To the extent that it can be determined, the
2 reason for the default.

3 (7) The demographics of individuals partici-
4 pating in the program.

5 (8) An evaluation of the overall costs and bene-
6 fits of the program.

7 (e) DEFINITIONS.—In this section:

8 (1) The term “dental education loan”—

9 (A) means a loan that is incurred for the
10 cost of attendance (including tuition, other rea-
11 sonable educational expenses, and reasonable
12 living costs) at a school of dentistry; and

13 (B) includes only the portion of the loan
14 that is outstanding on the date the dentist in-
15 volved begins the service specified in the agree-
16 ment under subsection (a).

17 (2) The term “dentist” means a graduate of a
18 school of dentistry who has completed postgraduate
19 training in general or pediatric dentistry.

20 (3) The term “HIV/AIDS” means human im-
21 munodeficiency virus and acquired immune defi-
22 ciency syndrome.

23 (4) The term “school of dentistry” has the
24 meaning given to that term in section 799B of the
25 Public Health Service Act (42 U.S.C. 295p).

1 (5) The term “Secretary” means the Secretary
2 of Health and Human Services.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there are authorized to be appropriated
5 such sums as may be necessary for each of fiscal years
6 2012 through 2016.

7 **SEC. 746. REPORT ON THE IMPLEMENTATION OF THE NA-**
8 **TIONAL HIV/AIDS STRATEGY.**

9 (a) REPORT REQUIRED.—Not later than 6 months
10 after the date of the enactment of this Act, the President,
11 in consultation with the heads of all relevant agencies in-
12 cluding the Department of Education, the Department of
13 Health and Human Services, the Department of Housing
14 and Urban Development, the Department of Justice, the
15 Department of Labor, the Department of Veterans Af-
16 fairs, and the Social Security Administration, shall trans-
17 mit to the Congress and make publicly available a report
18 on the status of the implementation of the National HIV/
19 AIDS Strategy.

20 (b) CONTENTS.—The report required by subsection
21 (a) shall include a description, analysis, and evaluation
22 of—

23 (1) key steps taken by the Federal Government
24 towards the achievement of the goals of the National
25 HIV/AIDS Strategy, including the goals of—

1 (A) reducing the number of people who be-
2 come infected with HIV;

3 (B) increasing access to care and opti-
4 mizing health outcomes for people living with
5 HIV; and

6 (C) reducing HIV-related health dispari-
7 ties;

8 (2) the extent to which the National HIV/AIDS
9 Strategy has improved coordination of efforts to
10 maximize the effective delivery of HIV/AIDS preven-
11 tion, care, and treatment services at the community
12 level, including coordination—

13 (A) within and among Federal agencies
14 and departments;

15 (B) between the Federal Government and
16 State and local governments and health depart-
17 ments;

18 (C) between the Federal Government and
19 nonprofit foundations and civil society organiza-
20 tions, including community- and faith-based or-
21 ganizations focused on addressing the issue of
22 HIV/AIDS; and

23 (D) between the Federal Government and
24 private businesses;

1 (3) efforts by the Federal Government to edu-
2 cate, involve, and establish and strengthen partner-
3 ships with civil society organizations, including
4 community- and faith-based organizations, in order
5 to implement the National HIV/AIDS Strategy and
6 achieve its goals;

7 (4) how Federal resources are being deployed to
8 implement the Strategy, including—

9 (A) the amount of funding used to date, by
10 each Federal agency and department, to imple-
11 ment the National HIV/AIDS Strategy;

12 (B) a brief summary for each Federal
13 agency and department of the number and
14 function of all Federal employees assisting in
15 implementing the Strategy; and

16 (C) an estimate of the amount of funding
17 necessary to implement the National HIV/AIDS
18 Strategy, by each Federal agency and depart-
19 ment, for the next fiscal year; and

20 (5) what additional steps, if any, are necessary
21 to fully implement the National HIV/AIDS Strategy,
22 including—

23 (A) whether any existing statutory laws,
24 policies, or regulations are impeding the imple-
25 mentation of the National HIV/AIDS Strategy,

1 at the Federal, State, or local level, and wheth-
2 er any changes to such laws, policies, or regula-
3 tions are necessary or recommended; and

4 (B) whether any Federal agencies or de-
5 partments require additional statutory authority
6 to effectively carry out their duties as part of
7 the National HIV/AIDS Strategy.

8 (c) USE OF PREVIOUSLY APPROPRIATED FUNDS.—
9 Funding for the report required under subsection (a) shall
10 derive from discretionary funds of the departments and
11 agencies specified in such subsection.

12 **SEC. 747. ADDRESSING HIV/AIDS IN THE AFRICAN-AMER-**
13 **ICAN COMMUNITY.**

14 (a) SENSE OF CONGRESS ON NATIONAL BLACK
15 CLERGY HIV/AIDS AWARENESS SUNDAY.—It is the
16 sense of Congress that—

17 (1) there should be established a National
18 Black Clergy HIV/AIDS Awareness Sunday on
19 which the Congress and the President call on mem-
20 bers of the Black clergy—

21 (A) to become involved at the local commu-
22 nity level in HIV/AIDS testing, policy, and ad-
23 vocacy;

1 (B) to discuss the HIV/AIDS epidemic
2 with their congregations and the community at-
3 large; and

4 (C) to urge members of their congregations
5 to reduce risk factors, practice safe sex and
6 other preventive measures, be tested for HIV/
7 AIDS, and seek care when appropriate; and

8 (2) an appropriate Sunday should be selected
9 for this occasion.

10 (b) SENSE OF CONGRESS ON FEDERAL AGENCIES
11 WITH RESPONSIBILITY FOR PREVENTING, TESTING FOR,
12 AND TREATING HIV/AIDS.—It is the sense of Congress
13 that all Federal agencies with a responsibility for pre-
14 venting, testing for, and treating HIV/AIDS should—

15 (1) adopt policies for prevention, testing, and
16 treatment that are consistent with the guidelines
17 issued in 2006 by the Centers for Disease Control
18 and Prevention, entitled “Revised Recommendations
19 for HIV Testing of Adults, Adolescents, and Preg-
20 nant Women in Health-Care Settings”; and

21 (2) begin a systemic, aggressive approach to im-
22 plementing voluntary, routine testing as part of all
23 health exams, including in emergency rooms, clinics,
24 and private physician offices.

1 (c) SENSE OF CONGRESS ON FEDERAL BUREAU OF
2 PRISONS PROCEDURES FOR INMATES WITH HIV.—It is
3 the sense of Congress that the Federal Bureau of Prisons
4 should implement procedures for—

5 (1) voluntary HIV testing as a routine compo-
6 nent of inmate care; and

7 (2) referral to care as a routine component of
8 release planning for inmates with HIV/AIDS, includ-
9 ing referral to community-based care and faith-based
10 institutions.

11 **SEC. 748. NATIONAL BLACK CLERGY FOR THE ELIMI-**
12 **NATION OF HIV/AIDS.**

13 (a) SHORT TITLE.—This section may be cited as the
14 “National Black Clergy for the Elimination of HIV/AIDS
15 Act of 2011”.

16 (b) FINDINGS.—Congress finds the following:

17 (1) It has been estimated that more than
18 1,200,000 people in the United States are living
19 with HIV/AIDS, and approximately 500,000 of them
20 are Black. Blacks are 8 times more likely to have
21 AIDS than their White counterparts. Within the
22 Black community, the subpopulation most dispropor-
23 tionately impacted by HIV/AIDS is Black men who
24 have sex with men (MSM) with prevalence rates
25 twice those of White MSM. Black women account

1 for the majority of new AIDS cases among women
2 and are 23 times more likely to be living with AIDS
3 than White women and 4 times more likely than
4 Latinas.

5 (2) On October 7–8, 2007, 186 Black clergy,
6 consisting of Baptist, COGIC, Methodist, Protes-
7 tant, AME, and Pentecostal, together with, medical,
8 policy, and AIDS leaders, were brought together by
9 the National Black Leadership Commission on
10 AIDS (NBLCA), the oldest and largest Black AIDS
11 organization of its kind in America, hosted by Time
12 Warner, Inc., with other foundation support, to par-
13 ticipate in the National Black Clergy Conclave On
14 HIV/AIDS Policy.

15 (3) The attendees included faith leaders across
16 traditional, mega, and activist churches representing
17 millions of congregants: the National Medical Asso-
18 ciation (NMA) representing 30,000 African-Amer-
19 ican physicians; the National Conference of Black
20 Mayors; the National Caucus of Black State Legisla-
21 tors; and the Health Brain Trust of the Congres-
22 sional Black Caucus and key African-American HIV/
23 AIDS advocates from across the United States. This
24 group developed a plan of action that has become
25 the National Black Clergy for the Elimination of

1 HIV/AIDS Act of 2011 to respond to the “on the
2 ground” emergency in prevention, care, and treat-
3 ment for AIDS in Black America.

4 (4) In August 2007, the NMA, the oldest and
5 largest organization representing 30,000 African-
6 American physicians, released a consensus report en-
7 titled “Addressing The HIV/AIDS Crisis In The Af-
8 rican American Community: Fact, Fiction and Pol-
9 icy”; and specifically called on the next President of
10 the United States to declare HIV/AIDS in African-
11 American communities a public health emergency
12 and worked with NBLCA to organize clergy to advo-
13 cate for the specific needs of Black physicians, their
14 patients, and those at risk in African-American com-
15 munities; and have pledged to advocate and work
16 with clergy to develop, execute, and implement these
17 initiatives as a part of their rightful role of leader-
18 ship in African-American communities and culture.

19 (5) The National Conference of Black Mayors
20 has pledged to work with clergy, medical, and com-
21 munity leaders to develop and support these initia-
22 tives on a local level and to help them to continue
23 to develop a policy agenda leading to the elimination
24 of HIV/AIDS.

1 (6) The National Caucus of Black State Legis-
2 lators pledged to take the initiatives herein to their
3 body and develop plans of action for Black State
4 Legislators to work with local clergy, health depart-
5 ments, and CBOs to adopt and implement these ini-
6 tiatives on a national level.

7 (7) At their April 2008 annual meeting, the
8 National Policy Alliance (NPA), consisting of the
9 Joint Center For Political and Economic Studies
10 (secretariat) and the National Black Caucus of
11 School Board Members, National Black Caucus of
12 Local Elected Officials; the Judicial Council of the
13 National Bar Association; the National Association
14 of Black County Officials; Blacks in Government
15 and the CBC; NCBM; WCM, voted unanimously to
16 support, endorse, and encourage the passage of the
17 National Black Clergy for the Elimination of HIV/
18 AIDS Act of 2011 and to organize their respective
19 members to endorse and support the passage of this
20 bill.

21 (8) The World Conference of Black Mayors has
22 ratified its support of these initiatives and legisla-
23 tion, and pledged to assist the clergy to take them
24 internationally.

1 (9) The National Black Leadership Commission
2 on AIDS, the Balm in Gilead, and the Black AIDS
3 Institute have been recognized by the clergy for their
4 tradition and history of service and will work with
5 clergy to conduct community and policy develop-
6 ment, linkages to local departments of health and
7 other services, infrastructure development, education
8 media, and fund development activities.

9 (10) Bishop T.D. Jakes of the Potters House
10 in Dallas, Texas, and Rev. Calvin O. Butts of the
11 Abyssinian Baptist Church in Harlem, New York,
12 and chairman of the National Black Leadership
13 Commission on AIDS have been recognized as the
14 organizers of this group and will help guide and lead
15 the development efforts of fellow clergy through this
16 process.

17 (11) The National Conclave on HIV/AIDS for
18 Black Clergy calls upon the President, Congress,
19 and corporate America to declare the HIV/AIDS cri-
20 sis in the African-American community a “public
21 health emergency”.

22 (12) The Black clergy will aggressively seek to
23 have every person under the sphere of their influence
24 tested for HIV in order to know the person’s status.

1 (13) The Black clergy will promote HIV/AIDS
2 awareness to ensure that all Black clergy serving in
3 their denominations and other congregations are
4 equipped to address issues related to this disease in
5 a factual and scientifically sound manner.

6 (14) The Black clergy will use the ABC/D
7 model as a behavioral guideline for prevention initia-
8 tives:

9 (A) A—Abstain.

10 (B) B—Be Faithful.

11 (C) C—Use Condoms.

12 (D) D—Don't Engage in Risky Behaviors.

13 (c) DEFINITIONS APPLICABLE THROUGHOUT SEC-
14 TION.—In this section—

15 (1) the terms “HIV” and “HIV/AIDS” have
16 the meanings given to such terms in section 2689 of
17 the Public Health Service Act (42 U.S.C. 300ff–88);
18 and

19 (2) the term “Secretary” means the Secretary
20 of Health and Human Services.

21 (d) SERVICES TO REDUCE HIV/AIDS IN THE AFRI-
22 CAN-AMERICAN COMMUNITY.—

23 (1) IN GENERAL.—For the purpose of reducing
24 HIV/AIDS in the African-American community, the
25 Secretary, acting through the Deputy Assistant Sec-

1 retary for Minority Health, may make grants to
2 public health agencies and faith-based organizations
3 to conduct—

4 (A) outreach activities related to HIV/
5 AIDS prevention and testing activities;

6 (B) HIV/AIDS prevention activities; and

7 (C) HIV/AIDS testing activities.

8 (2) AUTHORIZATION OF APPROPRIATIONS.—To
9 carry out this section, there are authorized to be ap-
10 propriated \$50,000,000 for fiscal year 2012, and
11 such sums as may be necessary for fiscal years 2013
12 through 2016.

13 (e) GRANTS FOR SUBSTANCE ABUSE AND MENTAL
14 HEALTH SERVICES TO PUBLIC HEALTH AGENCIES AND
15 FAITH-BASED ORGANIZATIONS.—

16 (1) IN GENERAL.—The Secretary, acting
17 through the Administrator of the Substance Abuse
18 and Mental Health Services Administration, may
19 make grants to public health agencies and faith-
20 based organizations to—

21 (A) conduct HIV/AIDS and sexually trans-
22 mitted disease outreach, prevention, and testing
23 activities that are targeted to the African-Amer-
24 ican community; and

1 (B) in connection with such activities, pro-
2 vide substance abuse testing and mental health
3 services to members of such community.

4 (2) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this section, there are authorized to be ap-
6 propriated \$90,000,000 for fiscal year 2012 and
7 such sums as may be necessary for fiscal years 2013
8 through 2016.

9 (f) SERVICES FOR HIV/AIDS AFFECTED YOUTH
10 WHO ARE SEPARATED FROM THEIR FAMILIES.—

11 (1) IN GENERAL.—The Secretary, acting
12 through the Administrator of the Substance Abuse
13 and Mental Health Services Administration, may
14 make grants to faith- and community-based organi-
15 zations to provide family reunification services, men-
16 tal health counseling, HIV/AIDS and sexually trans-
17 mitted disease testing, and substance abuse testing
18 and treatment to youth who—

19 (A)(i) have run away from home;

20 (ii) are homeless; or

21 (iii) reside in a detention center or foster
22 care; and

23 (B) are HIV positive or at risk for HIV/
24 AIDS, including young men who have sex with
25 men.

1 (2) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there are authorized to be ap-
3 propriated \$5,000,000 for fiscal year 2012, and such
4 sums as may be necessary for fiscal years 2013
5 through 2016.

6 (g) PUBLIC HEALTH INTERVENTION AND PREVEN-
7 TION ACTIVITIES.—

8 (1) IN GENERAL.—For the purpose of reducing
9 HIV/AIDS, sexually transmitted diseases, tuber-
10 culosis, and viral hepatitis in African-American com-
11 munities, the Secretary, acting through the Director
12 of the Centers for Disease Control and Prevention,
13 may make grants to faith-based organizations for
14 public health intervention and prevention activities,
15 including the use of rapid testing in traditional and
16 nontraditional settings to increase the number of in-
17 dividuals who know their status at the point of care
18 and are put into treatment.

19 (2) PARTNERSHIPS.—In carrying out this sec-
20 tion, the Secretary shall encourage grantees to enter
21 into partnerships with public health agencies.

22 (3) AUTHORIZATION OF APPROPRIATIONS.—To
23 carry out this section, there are authorized to be ap-
24 propriated \$100,000,000 for fiscal year 2012, and

1 such sums as may be necessary for fiscal years 2013
2 through 2016.

3 (h) HIV/AIDS PREVENTION AND EDUCATION.—

4 (1) PREVENTION ACTIVITIES.—The Secretary,
5 acting through the Director of the Centers for Dis-
6 ease Control and Prevention, shall expand and inten-
7 sify HIV/AIDS prevention activities in African-
8 American communities. Such activities—

9 (A) shall be targeted to specific popu-
10 lations;

11 (B) shall be comprehensive and accurately
12 based on science and research; and

13 (C) shall include information on absti-
14 nence, the proper use of condoms, risks associ-
15 ated with unprotected sex, and the value of sex-
16 ual delay particularly among young adolescents
17 and teenagers.

18 (2) EDUCATION.—The Secretary, acting
19 through the Director of the Centers for Disease
20 Control and Prevention, shall expand and intensify
21 HIV/AIDS educational activities targeting Black
22 women, youth, and men who have sex with men.

23 (3) COORDINATION.—The Secretary shall carry
24 out this section in coordination with public schools
25 of all levels, Black organizations, historically Black

1 colleges and universities, and faith-based organiza-
2 tions and institutions.

3 (4) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out this section, there are authorized to be ap-
5 propriated \$90,000,000 for fiscal year 2012, and
6 such sums as may be necessary for fiscal years 2013
7 through 2016.

8 (i) BUILDING CAPACITY OF COMMUNITIES.—

9 (1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall expand funding to eli-
12 gible entities to build the capacity of African-Amer-
13 ican communities to respond to HIV/AIDS.

14 (2) EMPHASIS.—In carrying out this section,
15 the Secretary shall emphasize the provision of fund-
16 ing for policy development, education, technical as-
17 sistance, and training—

18 (A) to national and local faith-based orga-
19 nizations; and

20 (B) to organizations with a significant his-
21 tory of working within the African-American
22 community on HIV/AIDS issues, an inter-
23 denominational center of seminaries specializing
24 in the training of African-American clergy, and
25 historically Black colleges and universities.

1 (3) DEFINITION.—In this section, the term “el-
2 igible entity” means a national or community-based
3 organization with a history and tradition of service
4 to African-American communities.

5 (4) AUTHORIZATION OF APPROPRIATIONS.—To
6 carry out this section, there are authorized to be ap-
7 propriated \$25,000,000 for fiscal year 2012, and
8 such sums as may be necessary for fiscal years 2013
9 through 2016.

10 (j) NATIONAL MEDIA OUTREACH CAMPAIGN.—

11 (1) IN GENERAL.—The Secretary, acting
12 through the Director of the Centers for Disease
13 Control and Prevention, shall implement a national
14 media outreach campaign that urges all sexually ac-
15 tive individuals to be tested for and know their HIV/
16 AIDS status.

17 (2) REQUIREMENTS.—The national media out-
18 reach campaign under this subsection shall—

19 (A) be science-driven and targeted to Afri-
20 can-American men, women, and youth; and

21 (B) give special emphasis to Black women
22 and men who have sex with men.

23 (3) COORDINATION; CONSULTATION.—The Sec-
24 retary shall carry out this subsection—

1 (A) in coordination with Black media out-
2 lets for print, electronic, and Web-based media
3 and Black media associations, including the Na-
4 tional Association of Black Owned Broadcasters
5 and the National Newspaper Publishers Asso-
6 ciation; and

7 (B) in consultation with an advisory board
8 including representatives of the National Med-
9 ical Association, faith leaders, elected and ap-
10 pointed officials, social marketing experts, and
11 business and community stakeholders.

12 (4) AUTHORIZATION OF APPROPRIATIONS.—To
13 carry out this subsection, there are authorized to be
14 appropriated \$10,000,000 for fiscal year 2012, and
15 such sums as may be necessary for fiscal years 2013
16 through 2016.

17 (k) RESEARCH TO DEVELOP BEHAVIORAL STRATE-
18 GIES TO REDUCE TRANSMISSION OF HIV/AIDS.—

19 (1) IN GENERAL.—The Secretary, acting
20 through the Director of the National Institutes of
21 Health, may conduct or support culturally competent
22 research to develop evidence-based behavioral strate-
23 gies to reduce the transmission of HIV/AIDS within
24 the African-American community.

1 (2) PRIORITY.—In carrying out this section, the
2 Secretary shall prioritize research that focuses on
3 populations within the African-American community
4 that are at increased risk for HIV/AIDS, includ-
5 ing—

6 (A) men who have sex with men; and

7 (B) women.

8 (3) AUTHORIZATION OF APPROPRIATIONS.—To
9 carry out this section, there are authorized to be ap-
10 propriated \$10,000,000 for fiscal year 2012, and
11 such sums as may be necessary for fiscal years 2013
12 through 2016.

13 (1) STUDY OF BIOLOGICAL AND BEHAVIORAL FAC-
14 TORS.—

15 (1) IN GENERAL.—The Secretary, acting
16 through the Director of the National Institute on
17 Minority Health and Health Disparities, may make
18 grants for—

19 (A) the study of biological and behavioral
20 factors that lead to increased HIV/AIDS preva-
21 lence in the African-American community, to be
22 conducted by researchers with a history and
23 tradition of service to Black communities; and

24 (B) behavioral and structural network re-
25 search and interventions, in collaboration with

1 other institutes and centers of the National In-
2 stitutes of Health, indigenous faith and national
3 and community-based organizations with a his-
4 tory and tradition of conducting such research
5 for Black communities, with a special emphasis
6 on Black women and Black men who have sex
7 with men.

8 (2) AUTHORIZATION OF APPROPRIATIONS.—To
9 carry out this subsection, there are authorized to be
10 appropriated \$100,000,000 for fiscal year 2012, and
11 such sums as may be necessary for fiscal years 2013
12 through 2016.

13 (m) HEALTH CARE PROFESSIONALS TREATING INDI-
14 VIDUALS WITH HIV/AIDS.—Part E of title VII of the
15 Public Health Service Act (42 U.S.C. 294n et seq.) is
16 amended by adding at the end the following:

17 **“Subpart 4—Health Care Professionals Treating**
18 **Individuals With HIV/AIDS**

19 **“SEC. 781. BETTER CARE FOR INDIVIDUALS WITH HIV/AIDS.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration and in consultation with the African-
23 American church community, may award grants for any
24 of the following:

1 “(1) Development of curricula for training pri-
2 mary care providers in HIV/AIDS prevention and
3 care.

4 “(2) Training health care professionals with ex-
5 pertise in HIV/AIDS to provide care to individuals
6 with HIV/AIDS.

7 “(3) Development by grant recipients under
8 title XXVI and other persons of policies for pro-
9 viding culturally relevant and sensitive treatment to
10 individuals with HIV/AIDS, with particular empha-
11 sis on treatment to African-Americans and children
12 with HIV/AIDS.

13 “(4) Development and implementation of pro-
14 grams to increase the use of telemedicine to respond
15 to HIV/AIDS-specific health care needs in rural and
16 minority communities, with particular emphasis
17 given to medically underserved communities and the
18 southern States.

19 “(5) Creation of faith- and community-based
20 certification programs for providers in HIV/AIDS
21 care and support services.

22 “(6) Establishment of comfort care centers that
23 provide mental, emotional, and psychosocial coun-
24 seling for people with HIV/AIDS and implement ad-
25 ditional protocols to be carried out in the centers

1 that address the needs of children and young adults
2 who are infected with the disease and are
3 transitioning from childhood to adulthood.

4 “(7) Incentive payments to health care pro-
5 viders supported by the Health Resources and Serv-
6 ices Administration to implement HIV/AIDS testing
7 consistent with the guidelines issued in 2006 by the
8 Centers for Disease Control and Prevention entitled
9 ‘Revised Recommendations for HIV Testing of
10 Adults, Adolescents, and Pregnant Women in
11 Health-Care Settings’.

12 “(b) DEFINITION.—In this section, the term ‘HIV/
13 AIDS’ has the meaning given to such term in section
14 2689.

15 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
16 carry out this section, there are authorized to be appro-
17 priated \$100,000,000 for fiscal year 2012, and such sums
18 as may be necessary for fiscal years 2013 through 2016.”.

19 (n) REPORT ON IMPACT OF HIV/AIDS IN THE AFRI-
20 CAN-AMERICAN COMMUNITY.—

21 (1) IN GENERAL.—The Secretary shall submit
22 to Congress and the President an annual report on
23 the impact of HIV/AIDS in the African-American
24 community.

1 (2) CONTENTS.—The report under subsection
2 (a) shall include information on the—

3 (A) progress that has been made in reduc-
4 ing the impact of HIV/AIDS in such commu-
5 nity;

6 (B) opportunities that exist to make addi-
7 tional progress in reducing the impact of HIV/
8 AIDS in such community;

9 (C) challenges that may impede such addi-
10 tional progress; and

11 (D) Federal funding necessary to achieve
12 substantial reductions in HIV/AIDS in the Afri-
13 can-American community.

14 **SEC. 749. REDUCING THE SPREAD OF SEXUALLY TRANS-**
15 **MITTED INFECTIONS IN CORRECTIONAL FA-**
16 **CILITIES.**

17 (a) SHORT TITLE.—This section may be cited as the
18 “Justice for the Unprotected Against Sexually Trans-
19 mitted Infections among the Confined and Exposed Act”
20 or the “JUSTICE Act”.

21 (b) FINDINGS.—The Congress makes the following
22 findings:

23 (1) According to the Bureau of Justice Statis-
24 tics (BJS), 2,292,133 persons were incarcerated in
25 the United States as of the end of 2009. Between

1 1998 and 2008, the number of persons incarcerated
2 in Federal or State correctional facilities increased
3 by an average of 2.4 percent per year. One in every
4 32 United States residents was on probation, in jail
5 or prison, or on parole at the end of 2009.

6 (2) As of 2009, 66.8 percent of incarcerated
7 persons were racial or ethnic minorities. Based on
8 current incarceration rates, BJS estimates that Afri-
9 can-American males are 6 times more likely to be
10 held in custody than White males, while Hispanic
11 males are a little more than 2 times more likely to
12 be held in custody. Across all age categories, Afri-
13 can-American males were incarcerated at higher
14 rates than Hispanic or White males.

15 (3) There is a disproportionately high rate of
16 HIV/AIDS among incarcerated persons, especially
17 among minorities. Approximately 25 percent of the
18 HIV-positive population of the United States passes
19 through correctional facilities each year. BJS has
20 determined that the rate of confirmed AIDS cases is
21 2.4 times higher among incarcerated persons than in
22 the general population. Minorities account for the
23 majority of AIDS-related deaths among incarcerated
24 persons, with African-American incarcerated persons
25 2.8 times more likely than White incarcerated per-

1 sons and 1.4 times more likely than Hispanic incar-
2 cerated persons to die from AIDS-related causes.
3 Nearly two-thirds of AIDS-related deaths are among
4 Black, non-Hispanic males.

5 (4) Studies suggest that other sexually trans-
6 mitted infections (STIs), such as gonorrhea,
7 chlamydia, syphilis, genital herpes, viral hepatitis,
8 and human papillomavirus, also exist at a higher
9 rate among incarcerated persons than in the general
10 population. For instance, researchers have estimated
11 that the rate of hepatitis C (HCV) infection among
12 incarcerated persons is somewhere between 8 and 20
13 times higher than that of the general population.

14 (5) Correctional facilities lack a uniform system
15 of STI testing and reporting. Establishing a uniform
16 data collection system would assist in developing and
17 targeting counseling and treatment programs for in-
18 carcerated persons. Better developed and targeted
19 programs may reduce the spread of STIs.

20 (6) Although Congress has acted to reduce the
21 spread of sexual violence in correctional facilities by
22 enacting the National Prison Rape Elimination Act
23 (PREA) of 2003, BJS reported that approximately
24 4.4 percent of incarcerated persons in prisons and
25 3.1 percent of persons in jail reported experiencing

1 one or more incidents of sexual victimization by an-
2 other incarcerated person or correctional facility
3 staff in the previous year.

4 (7) Approximately 95 percent of all incarcer-
5 ated persons eventually return to society. According
6 to one study, every year approximately 100,000 per-
7 sons infected with both HIV and HCV are released
8 from correctional facilities. These individuals com-
9 prise approximately 50 percent of all persons with
10 both infections in the United States.

11 (8) According to the Centers for Disease Con-
12 trol and Prevention (CDC), latex condoms, when
13 used consistently and correctly, are highly effective
14 in preventing the transmission of HIV. Latex
15 condoms also reduce the risk of other STIs. Despite
16 the effectiveness of condoms in reducing the spread
17 of STIs, the Bureau of Prisons does not recommend
18 their use in correctional facilities.

19 (9) The distribution of condoms in correctional
20 facilities is currently legal in certain parts of the
21 United States and the world. The States of Vermont
22 and Mississippi and the District of Columbia allow
23 condom distribution programs in their correctional
24 facilities. The cities of New York, San Francisco,
25 Los Angeles, Washington DC, and Philadelphia also

1 allow condom distribution in their correctional facili-
2 ties. However, these States and cities operate fewer
3 than 1 percent of all correctional facilities.

4 (10) A 2007 report by the Massachusetts Gen-
5 eral Hospital Division of Infectious Diseases and the
6 University of California, San Francisco, found that
7 the proportion of European prison systems allowing
8 condoms rose from 53 percent in 1989 to 81 percent
9 in 1997. The same report also found that no prison
10 system allowing the distribution of condoms had re-
11 versed their decision, and no prison system reported
12 an increase in sexual activity among incarcerated
13 persons as a result of a decision to allow condom
14 distribution.

15 (11) In 2000 and 2001, researchers surveyed
16 300 incarcerated persons and 100 correctional offi-
17 cers at the Central Detention Facility, a correctional
18 facility operated by the District of Columbia at
19 which condoms are available. Researchers found that
20 both incarcerated persons and correctional officers
21 generally supported the condom distribution pro-
22 gram and considered it to be important. Further-
23 more, the researchers determined that the program
24 had not caused any major security infractions. In
25 Canada, the Expert Committee on AIDS and Pris-

1 ons surveyed more than 400 correctional officers in
2 the Federal prison system of Canada in 1995 and
3 reported that 82 percent of those responding indi-
4 cated that the availability of condoms had created no
5 problems at their facility.

6 (12) The American Public Health Association,
7 the United Nations Joint Program on HIV/AIDS,
8 and the World Health Organization have endorsed
9 the effectiveness of condom distribution programs in
10 correctional facilities.

11 (13) Many correctional facilities in the United
12 States do not provide comprehensive testing and
13 treatment programs to reduce the spread of STIs.
14 According to BJS surveys from 2005, only 996 of
15 the 1,821 Federal and State correctional facilities
16 (i.e. 54.7 percent) provided HIV/AIDS counseling
17 programs.

18 (14) Individuals who are enrolled in Medicaid
19 prior to incarceration face a suspension of their ben-
20 efits upon incarceration, and in some States a termi-
21 nation of their Medicaid eligibility. The Federal Gov-
22 ernment encourages States to automatically re-enroll
23 incarcerated persons on Medicaid upon their release
24 from a correctional facility, unless the State reaches

1 a determination that the individual is no longer eligi-
2 ble for reasons other than their prior incarceration.

3 (15) Formerly incarcerated individuals who are
4 newly released from correctional facilities often face
5 delays in the resumption of their Medicaid benefits
6 which may exacerbate any health issues which they
7 face.

8 (16) Incarcerated individuals living with HIV/
9 AIDS who are eligible for Medicaid would benefit
10 from prompt and automatic enrollment upon their
11 release in order to ensure their continued ability to
12 access health services, including antiretroviral treat-
13 ment.

14 (c) AUTHORITY TO ALLOW COMMUNITY ORGANIZA-
15 TIONS TO PROVIDE STI COUNSELING, STI PREVENTION
16 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-
17 VICES IN FEDERAL CORRECTIONAL FACILITIES.—

18 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not
19 later than 30 days after the date of enactment of
20 this Act, the Attorney General shall direct the Bu-
21 reau of Prisons to allow community organizations to
22 distribute sexual barrier protection devices and to
23 engage in STI counseling and STI prevention edu-
24 cation in Federal correctional facilities. These activi-
25 ties shall be subject to all relevant Federal laws and

1 regulations which govern visitation in correctional
2 facilities.

3 (2) INFORMATION REQUIREMENT.—Any com-
4 munity organization permitted to distribute sexual
5 barrier protection devices under paragraph (1) must
6 ensure that the persons to whom the devices are dis-
7 tributed are informed about the proper use and dis-
8 posal of sexual barrier protection devices in accord-
9 ance with established public health practices. Any
10 community organization conducting STI counseling
11 or STI prevention education under paragraph (1)
12 must offer comprehensive sexuality education.

13 (3) POSSESSION OF DEVICE PROTECTED.—No
14 Federal correctional facility may, because of the pos-
15 session or use of a sexual barrier protection device—

16 (A) take adverse action against an incar-
17 cerated person; or

18 (B) consider possession or use as evidence
19 of prohibited activity for the purpose of any
20 Federal correctional facility administrative pro-
21 ceeding.

22 (4) IMPLEMENTATION.—The Attorney General
23 and Bureau of Prisons shall implement this section
24 according to established public health practices in a
25 manner that protects the health, safety, and privacy

1 of incarcerated persons and of correctional facility
2 staff.

3 (d) SENSE OF CONGRESS REGARDING DISTRIBUTION
4 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
5 PRISON SYSTEMS.—It is the sense of Congress that States
6 should allow for the legal distribution of sexual barrier
7 protection devices in State correctional facilities to reduce
8 the prevalence and spread of STIs in those facilities.

9 (e) AUTOMATIC REINSTATEMENT OF MEDICAID BEN-
10 EFITS.—

11 (1) IN GENERAL.—Section 1902(e) of the So-
12 cial Security Act (42 U.S.C. 1396a(e)) is amended
13 by adding at the end the following:

14 “(15) ENROLLMENT OF EX-OFFENDERS.—

15 “(A) AUTOMATIC ENROLLMENT OR REIN-
16 STATEMENT.—

17 “(i) IN GENERAL.—The State plan
18 shall provide for the automatic enrollment
19 or reinstatement of enrollment of an eligi-
20 ble individual if—

21 “(I) such individual is scheduled
22 to be released from a public institu-
23 tion due to the completion of sen-
24 tence, not less than 30 days prior to
25 the scheduled date of the release; and

1 “(II) such individual is to be re-
2 leased from a public institution on pa-
3 role or on probation, as soon as pos-
4 sible after the date on which the de-
5 termination to release such individual
6 was made, and before the date such
7 individual is released.

8 “(ii) EXCEPTION.—If a State makes a
9 determination that an individual is not eli-
10 gible to be enrolled under the State plan—

11 “(I) on or before the date by
12 which the individual would be enrolled
13 under clause (i), such clause shall not
14 apply to such individual; or

15 “(II) after such date, the State
16 may terminate the enrollment of such
17 individual.

18 “(B) RELATIONSHIP OF ENROLLMENT TO
19 PAYMENT FOR SERVICES.—

20 “(i) IN GENERAL.—Subject to sub-
21 paragraph (A)(ii), an eligible individual
22 who is enrolled, or whose enrollment is re-
23 instated under subparagraph (A), shall be
24 eligible for medical assistance that is pro-
25 vided after the date that the eligible indi-

1 vidual is released from the public institu-
2 tion

3 “(ii) RELATIONSHIP TO PAYMENT
4 PROHIBITION FOR INMATES.—No provision
5 of this paragraph may be construed to per-
6 mit payment for care or services for which
7 payment is excluded under the subpara-
8 graph (A), following paragraph (29), of
9 section 1905(a).

10 “(C) TREATMENT OF CONTINUOUS ELIGI-
11 BILITY.—

12 “(i) SUSPENSION FOR INMATES.—Any
13 period of continuous eligibility under this
14 title shall be suspended on the date an in-
15 dividual enrolled under this title becomes
16 an inmate of a public institution (except as
17 a patient of a medical institution).

18 “(ii) DETERMINATION OF REMAINING
19 PERIOD.—Notwithstanding any changes to
20 State law related to continuous eligibility
21 during the time that an individual is an in-
22 mate of a public institution (except as a
23 patient of a medical institution), subject to
24 clause (iii), with respect to an eligible indi-
25 vidual who was subject to a suspension

1 under subclause (I), on the date that such
2 individual is released from a public institu-
3 tion the suspension of continuous eligibility
4 under such subclause shall be lifted for a
5 period that is equal to the time remaining
6 in the period of continuous eligibility for
7 such individual on the date that such pe-
8 riod was suspended under such subclause.

9 “(iii) EXCEPTION.—If a State makes
10 a determination that an individual is not
11 eligible to be enrolled under the State
12 plan—

13 “(I) on or before the date that
14 the suspension of continuous eligibility
15 is lifted under clause (ii), such clause
16 shall not apply to such individual; or

17 “(II) after such date, the State
18 may terminate the enrollment of such
19 individual.

20 “(D) AUTOMATIC ENROLLMENT OR REIN-
21 STATEMENT OF ENROLLMENT DEFINED.—For
22 purposes of this paragraph, the term ‘automatic
23 enrollment or reinstatement of enrollment’
24 means that the State determines eligibility for
25 medical assistance under the State plan without

1 a program application from, or on behalf of, the
2 eligible individual, but an individual can only be
3 automatically enrolled in the State Medicaid
4 plan if the individual affirmatively consents to
5 being enrolled through affirmation in writing,
6 by telephone, orally, through electronic signa-
7 ture, or through any other means specified by
8 the Secretary.

9 “(E) ELIGIBLE INDIVIDUAL DEFINED.—
10 For purposes of this paragraph, the term ‘eligi-
11 ble individual’ means an individual who is an
12 inmate of a public institution (except as a pa-
13 tient in a medical institution)—

14 “(i) who was enrolled under the State
15 plan for medical assistance immediately be-
16 fore becoming an inmate of such an insti-
17 tution; or

18 “(ii) is diagnosed with human im-
19 munodeficiency virus.”.

20 (2) SUPPLEMENTAL FUNDING FOR STATE IM-
21 PLEMENTATION OF AUTOMATIC REINSTATEMENT OF
22 MEDICAID BENEFITS.—

23 (A) IN GENERAL.—Subject to paragraph
24 (6), for each State for which the Secretary of
25 Health and Human Services has approved an

1 application under paragraph (3), the Federal
2 matching payments (including payments based
3 on the Federal medical assistance percentage)
4 made to such State under section 1903 of the
5 Social Security Act (42 U.S.C. 1396b) shall be
6 increased by 5.0 percentage points for pay-
7 ments to the State for the activities permitted
8 under paragraph (2) for a period of one year.

9 (B) USE OF FUNDS.—A State may only
10 use increased matching payments authorized
11 under paragraph (1)—

12 (i) to strengthen the State’s enroll-
13 ment and administrative resources for the
14 purpose of improving processes for enroll-
15 ing (or reinstating the enrollment of) eligi-
16 ble individuals (as such term is defined in
17 section 1902(e)(15)(E) of the Social Secu-
18 rity Act); and

19 (ii) for medical assistance (as such
20 term is defined in section 1905(a) of the
21 Social Security Act) provided to such eligi-
22 ble individuals.

23 (C) APPLICATION AND AGREEMENT.—The
24 Secretary may only make payments to a State
25 in the increased amount if—

1 (i) the State has amended the State
2 plan under section 1902 of the Social Se-
3 curity Act to incorporate the requirements
4 of subsection (e)(15) of such section;

5 (ii) the State has submitted an appli-
6 cation to the Secretary that includes a plan
7 for implementing the requirements of sec-
8 tion 1902(e)(15) of the Social Security Act
9 under the State's amended State plan be-
10 fore the end of the 90-day period begin-
11 ning on the date that the State receives in-
12 creased matching payments under para-
13 graph (1);

14 (iii) the State's application meets the
15 satisfaction of the Secretary; and

16 (iv) the State enters an agreement
17 with the Secretary that states that—

18 (I) the State will only use the in-
19 creased matching funds for the uses
20 permitted under paragraph (2); and

21 (II) at the end of the period
22 under paragraph (1), the State will
23 submit to the Secretary, and make
24 publicly available, a report that con-

1 tains the information required under
2 paragraph (4).

3 (D) REQUIRED REPORT INFORMATION.—

4 The information that is required in the report
5 under paragraph (3)(D)(ii) includes—

6 (i) the results of an evaluation of the
7 impact of the implementation of the re-
8 quirements of section 1902(e)(15) of the
9 Social Security Act on improving the
10 State's processes for enrolling of individ-
11 uals who are released for public institu-
12 tions into the Medicaid program;

13 (ii) the number of individuals who
14 were automatically enrolled (or whose en-
15 rollment is reinstated) under such section
16 1902(e)(15) during the period under para-
17 graph (1); and

18 (iii) any other information that is re-
19 quired by the Secretary.

20 (E) INCREASE IN CAP ON MEDICAID PAY-

21 MENTS TO TERRITORIES.—Subject to para-
22 graph (6), the amounts otherwise determined
23 for Puerto Rico, the United States Virgin Is-
24 lands, Guam, the Commonwealth of the North-
25 ern Mariana Islands, and American Samoa

1 under subsections (f) and (g) of section 1108 of
2 the Social Security Act (42 U.S.C. 1308) shall
3 each be increased by the necessary amount to
4 allow for the increase in the Federal matching
5 payments under paragraph (1), but only for the
6 period under such paragraph for such State. In
7 the case of such an increase for a territory, sub-
8 section (a)(1) of such section 1108 shall be ap-
9 plied without regard to any increase in payment
10 made to the territory under part E of title IV
11 of such Act that is attributable to the increase
12 in Federal medical assistance percentage ef-
13 fected under paragraph (1) for the territory.

14 (F) LIMITATIONS.—

15 (i) TIMING.—With respect to a State,
16 at the end of the period under paragraph
17 (1), no increased matching payments may
18 be made to such State under this sub-
19 section.

20 (ii) MAINTENANCE OF ELIGIBILITY.—

21 (I) IN GENERAL.—Subject to
22 clause (ii), a State is not eligible for
23 an increase in its Federal matching
24 payments under paragraph (1), or an
25 increase in a cap amount under para-

1 graph (5), if eligibility standards,
2 methodologies, or procedures under its
3 State plan under title XIX of the So-
4 cial Security Act (including any waiv-
5 er under such title or under section
6 1115 of such Act (42 U.S.C. 1315))
7 are more restrictive than the eligibility
8 standards, methodologies, or proce-
9 dures, respectively, under such plan
10 (or waiver) as in effect on the date of
11 enactment of this Act.

12 (II) STATE REINSTATEMENT OF
13 ELIGIBILITY PERMITTED.—A State
14 that has restricted eligibility stand-
15 ards, methodologies, or procedures
16 under its State plan under title XIX
17 of the Social Security Act (including
18 any waiver under such title or under
19 section 1115 of such Act (42 U.S.C.
20 1315)) after the date of enactment of
21 this Act, is no longer ineligible under
22 clause (i) beginning with the first cal-
23 endar quarter in which the State has
24 reinstated eligibility standards, meth-
25 odologies, or procedures that are no

1 more restrictive than the eligibility
2 standards, methodologies, or proce-
3 dures, respectively, under such plan
4 (or waiver) as in effect on such date.

5 (iii) NO WAIVER AUTHORITY.—The
6 Secretary may not waive the application of
7 this subsection under section 1115 of the
8 Social Security Act or otherwise.

9 (iv) LIMITATION OF MATCHING PAY-
10 MENTS TO 100 PERCENT.—In no case shall
11 an increase in Federal matching payments
12 under this subsection result in Federal
13 matching payments that exceed 100 per-
14 cent.

15 (3) EFFECTIVE DATE.—

16 (A) IN GENERAL.—Except as provided in
17 paragraph (2), the amendments made by sub-
18 section (a) shall take effect 180 days after the
19 date of the enactment of this Act and shall
20 apply to services furnished on or after such
21 date.

22 (B) RULE FOR CHANGES REQUIRING
23 STATE LEGISLATION.—In the case of a State
24 plan for medical assistance under title XIX of
25 the Social Security Act which the Secretary of

1 Health and Human Services determines re-
2 quires State legislation (other than legislation
3 appropriating funds) in order for the plan to
4 meet the additional requirement imposed by the
5 amendments made by this subsection, the State
6 plan shall not be regarded as failing to comply
7 with the requirements of such title solely on the
8 basis of its failure to meet this additional re-
9 quirement before the first day of the first cal-
10 endar quarter beginning after the close of the
11 first regular session of the State legislature that
12 begins after the date of the enactment of this
13 Act. For purposes of the previous sentence, in
14 the case of a State that has a 2-year legislative
15 session, each year of such session shall be
16 deemed to be a separate regular session of the
17 State legislature.

18 (f) SURVEY OF AND REPORT ON CORRECTIONAL FA-
19 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
20 STIs.—

21 (1) SURVEY.—The Attorney General, after con-
22 sulting with the Secretary of Health and Human
23 Services, State officials, and community organiza-
24 tions, shall, to the maximum extent practicable, con-
25 duct a survey of all Federal and State correctional

1 facilities, no later than 180 days after the date of
2 enactment of this Act and annually thereafter for 5
3 years, to determine the following:

4 (A) PREVENTION EDUCATION OFFERED.—

5 The type of prevention education, information,
6 or training offered to incarcerated persons and
7 correctional facility staff regarding sexual vio-
8 lence and the spread of STIs, including whether
9 such education, information, or training—

10 (i) constitutes comprehensive sexuality
11 education;

12 (ii) is compulsory for new incarcerated
13 persons and for new staff; and

14 (iii) is offered on an ongoing basis.

15 (B) ACCESS TO SEXUAL BARRIER PROTEC-
16 TION DEVICES.—Whether incarcerated persons
17 can—

18 (i) possess sexual barrier protection
19 devices;

20 (ii) purchase sexual barrier protection
21 devices;

22 (iii) purchase sexual barrier protection
23 devices at a reduced cost; and

24 (iv) obtain sexual barrier protection
25 devices without cost.

1 (C) INCIDENCE OF SEXUAL VIOLENCE.—

2 The incidence of sexual violence and assault
3 committed by incarcerated persons and by cor-
4 rectional facility staff.

5 (D) COUNSELING, TREATMENT, AND SUP-

6 PORTIVE SERVICES.—Whether the correctional
7 facility requires incarcerated persons to partici-
8 pate in counseling, treatment, and supportive
9 services related to STIs, or whether it offers
10 such programs to incarcerated persons.

11 (E) STI TESTING.—Whether the correc-

12 tional facility tests incarcerated persons for
13 STIs or gives them the option to undergo such
14 testing—

15 (i) at intake;

16 (ii) on a regular basis; and

17 (iii) prior to release.

18 (F) STI TEST RESULTS.—The number of

19 incarcerated persons who are tested for STIs
20 and the outcome of such tests at each correc-
21 tional facility, disaggregated to include results
22 for—

23 (i) the type of sexually transmitted in-
24 fection tested for;

1 (ii) the race and/or ethnicity of indi-
2 viduals tested;

3 (iii) the age of individuals tested; and

4 (iv) the gender of individuals tested.

5 (G) PRE-RELEASE REFERRAL POLICY.—

6 Whether incarcerated persons are informed
7 prior to release about STI-related services or
8 other health services in their communities, in-
9 cluding free and low-cost counseling and treat-
10 ment options.

11 (H) PRE-RELEASE REFERRALS MADE.—

12 The number of referrals to community-based
13 organizations or public health facilities offering
14 STI-related or other health services provided to
15 incarcerated persons prior to release, and the
16 type of counseling or treatment for which the
17 referral was made.

18 (I) REINSTATEMENT OF MEDICAID BENE-

19 FITS.—Whether the correctional facility assists
20 incarcerated persons that were enrolled in the
21 State Medicaid program prior to their incarcer-
22 ation, in reinstating their enrollment upon re-
23 lease and whether such individuals receive refer-
24 rals as provided by paragraph (8) to entities

1 that accept the State Medicaid program, includ-
2 ing if applicable—

3 (i) the number of such individuals, in-
4 cluding those diagnosed with the human
5 immunodeficiency virus, that have been re-
6 instated;

7 (ii) a list of obstacles to reinstating
8 enrollment or to making determinations of
9 eligibility for reinstatement, if any; and

10 (iii) the number of individuals denied
11 enrollment.

12 (J) OTHER ACTIONS TAKEN.—Whether the
13 correctional facility has taken any other action,
14 in conjunction with community organizations or
15 otherwise, to reduce the prevalence and spread
16 of STIs in that facility.

17 (2) PRIVACY.—In conducting the survey, the
18 Attorney General shall not request or retain the
19 identity of any person who has sought or been of-
20 fered counseling, treatment, testing, or prevention
21 education information regarding an STI (including
22 information about sexual barrier protection devices),
23 or who has tested positive for an STI.

24 (3) REPORT.—The Attorney General shall
25 transmit to Congress and make publicly available

1 the results of the survey required under paragraph
2 (1), both for the Nation as a whole and
3 disaggregated as to each State and each correctional
4 facility. To the maximum extent possible, the Attor-
5 ney General shall issue the first report no later than
6 1 year after the date of enactment of this Act and
7 shall issue reports annually thereafter for 5 years.

8 (g) STRATEGY.—

9 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
10 Attorney General, in consultation with the Secretary
11 of Health and Human Services, State officials, and
12 community organizations, shall develop and imple-
13 ment a 5-year strategy to reduce the prevalence and
14 spread of STIs in Federal and State correctional fa-
15 cilities. To the maximum extent possible, the strat-
16 egy shall be developed, transmitted to Congress, and
17 made publicly available no later than 180 days after
18 the transmission of the first report required under
19 subsection (h)(3).

20 (2) CONTENTS OF STRATEGY.—The strategy
21 shall include the following:

22 (A) PREVENTION EDUCATION.—A plan for
23 improving prevention education, information,
24 and training offered to incarcerated persons
25 and correctional facility staff, including infor-

1 mation and training on sexual violence and the
2 spread of STIs, and comprehensive sexuality
3 education.

4 (B) SEXUAL BARRIER PROTECTION DEVICE
5 ACCESS.—A plan for expanding access to sexual
6 barrier protection devices in correctional facili-
7 ties.

8 (C) SEXUAL VIOLENCE REDUCTION.—A
9 plan for reducing the incidence of sexual vio-
10 lence among incarcerated persons and correc-
11 tional facility staff, developed in consultation
12 with the National Prison Rape Elimination
13 Commission.

14 (D) COUNSELING AND SUPPORTIVE SERV-
15 ICES.—A plan for expanding access to coun-
16 seling and supportive services related to STIs in
17 correctional facilities.

18 (E) TESTING.—A plan for testing incarcer-
19 ated persons for STIs during intake, during
20 regular health exams, and prior to release, and
21 that—

22 (i) is conducted in accordance with
23 guidelines established by the Centers for
24 Disease Control and Prevention;

25 (ii) includes pre-test counseling;

1 (iii) requires that incarcerated persons
2 are notified of their option to decline test-
3 ing at any time;

4 (iv) requires that incarcerated persons
5 are confidentially notified of their test re-
6 sults in a timely manner; and

7 (v) ensures that incarcerated persons
8 testing positive for STIs receive post-test
9 counseling, care, treatment, and supportive
10 services.

11 (F) TREATMENT.—A plan for ensuring
12 that correctional facilities have the necessary
13 medicine and equipment to treat and monitor
14 STIs and for ensuring that incarcerated per-
15 sons living with or testing positive for STIs re-
16 ceive and have access to care and treatment
17 services.

18 (G) STRATEGIES FOR DEMOGRAPHIC
19 GROUPS.—A plan for developing and imple-
20 menting culturally appropriate, sensitive, and
21 specific strategies to reduce the spread of STIs
22 among demographic groups heavily impacted by
23 STIs.

24 (H) LINKAGES WITH COMMUNITIES AND
25 FACILITIES.—A plan for establishing and

1 strengthening linkages to local communities and
2 health facilities that—

3 (i) provide counseling, testing, care,
4 and treatment services;

5 (ii) may receive persons recently re-
6 leased from incarceration who are living
7 with STIs; and

8 (iii) accept payment through the State
9 Medicaid program.

10 (I) ENROLLMENT IN STATE MEDICAID
11 PROGRAMS.—Plans to ensure that incarcerated
12 persons who were—

13 (i) enrolled in their State Medicaid
14 program prior to incarceration in a correc-
15 tional facility are automatically re-enrolled
16 in such program upon their release; and

17 (ii) not enrolled in their State Med-
18 icaid program prior to incarceration, but
19 who are diagnosed with the human im-
20 munodeficiency virus while incarcerated in
21 a correctional facility, are automatically
22 enrolled in such program upon their re-
23 lease.

24 (J) OTHER PLANS.—Any other plans de-
25 veloped by the Attorney General for reducing

1 the spread of STIs or improving the quality of
2 health care in correctional facilities.

3 (K) MONITORING SYSTEM.—A monitoring
4 system that establishes performance goals re-
5 lated to reducing the prevalence and spread of
6 STIs in correctional facilities and which, where
7 feasible, expresses such goals in quantifiable
8 form.

9 (L) MONITORING SYSTEM PERFORMANCE
10 INDICATORS.—Performance indicators that
11 measure or assess the achievement of the per-
12 formance goals described in subparagraph (I).

13 (M) COST ESTIMATE.—A detailed estimate
14 of the funding necessary to implement the
15 strategy at the Federal and State levels for all
16 5 years, including the amount of funds required
17 by community organizations to implement the
18 parts of the strategy in which they take part.

19 (3) REPORT.—The Attorney General shall
20 transmit to Congress and make publicly available an
21 annual progress report regarding the implementation
22 and effectiveness of the strategy described in sub-
23 section (a). The progress report shall include an
24 evaluation of the implementation of the strategy
25 using the monitoring system and performance indi-

1 cators provided for in subparagraphs (I) and (J) of
2 paragraph (2).

3 (h) APPROPRIATIONS.—

4 (1) IN GENERAL.—There are authorized to be
5 appropriated such sums as may be necessary to
6 carry out this section for each of the fiscal years
7 2012 through 2018.

8 (2) AVAILABILITY OF FUNDS.—Amounts made
9 available under subsection (a) are authorized to re-
10 main available until expended.

11 (i) DEFINITIONS.—For the purposes of this section:

12 (1) COMMUNITY ORGANIZATION.—The term
13 “community organization” means a public health
14 care facility or a nonprofit organization which pro-
15 vides health- or STI-related services according to es-
16 tablished public health standards.

17 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
18 The term “comprehensive sexuality education”
19 means sexuality education that includes information
20 about abstinence and about the proper use and dis-
21 posal of sexual barrier protection devices and which
22 is—

23 (A) evidence-based;

24 (B) medically accurate;

25 (C) age and developmentally appropriate;

1 (D) gender and identity sensitive;

2 (E) culturally and linguistically appro-
3 priate; and

4 (F) structured to promote critical thinking,
5 self-esteem, respect for others, and the develop-
6 ment of healthy attitudes and relationships.

7 (3) CORRECTIONAL FACILITY.—The term “cor-
8 rectional facility” means any prison, penitentiary,
9 adult detention facility, juvenile detention facility,
10 jail, or other facility to which persons may be sent
11 after conviction of a crime or act of juvenile delin-
12 quency within the United States.

13 (4) INCARCERATED PERSON.—The term “incar-
14 cerated person” means any person who is serving a
15 sentence in a correctional facility after conviction of
16 a crime.

17 (5) SEXUALLY TRANSMITTED INFECTION.—The
18 term “sexually transmitted infection” or “STI”
19 means any disease or infection that is commonly
20 transmitted through sexual activity, including HIV/
21 AIDS, gonorrhea, chlamydia, syphilis, genital her-
22 pes, viral hepatitis, and human papillomavirus.

23 (6) SEXUAL BARRIER PROTECTION DEVICE.—
24 The term “sexual barrier protection device” means
25 any FDA-approved physical device which has not

1 been tampered with and which reduces the prob-
2 ability of STI transmission or infection between sex-
3 ual partners, including female condoms, male
4 condoms, and dental dams.

5 (7) STATE.—The term “State” includes the
6 District of Columbia, American Samoa, the Com-
7 monwealth of the Northern Mariana Islands, Guam,
8 Puerto Rico, and the United States Virgin Islands.

9 **SEC. 750. STOP AIDS IN PRISON.**

10 (a) SHORT TITLE.—This section may be cited as the
11 “Stop AIDS in Prison Act of 2011”.

12 (b) COMPREHENSIVE HIV/AIDS POLICY.—

13 (1) IN GENERAL.—The Bureau of Prisons
14 (hereinafter in this section referred to as the “Bu-
15 reau”) shall develop a comprehensive policy to pro-
16 vide HIV testing, treatment, and prevention for in-
17 mates within the correctional setting and upon re-
18 entry.

19 (2) PURPOSE.—The purposes of such policy are
20 the following:

21 (A) To stop the spread of HIV/AIDS
22 among inmates.

23 (B) To protect prison guards and other
24 personnel from HIV/AIDS infection.

1 (C) To provide comprehensive medical
2 treatment to inmates who are living with HIV/
3 AIDS.

4 (D) To promote HIV/AIDS awareness and
5 prevention among inmates.

6 (E) To encourage inmates to take personal
7 responsibility for their health.

8 (F) To reduce the risk that inmates will
9 transmit HIV/AIDS to other persons in the
10 community following their release from prison.

11 (3) CONSULTATION.—The Bureau shall consult
12 with appropriate officials of the Department of
13 Health and Human Services, the Office of National
14 Drug Control Policy, the Office of National AIDS
15 Policy, and the Centers for Disease Control regard-
16 ing the development of such policy.

17 (4) TIME LIMIT.—The Bureau shall draft ap-
18 propriate regulations to implement such policy not
19 later than 1 year after the date of the enactment of
20 this Act.

21 (c) REQUIREMENTS FOR POLICY.—The policy cre-
22 ated under subsection (b) shall provide for the following:

23 (1) TESTING AND COUNSELING UPON IN-
24 TAKE.—

1 (A)(i) Subject to clause (ii), health care
2 personnel shall provide routine HIV testing to
3 all inmates as a part of a comprehensive med-
4 ical examination immediately following admis-
5 sion to a facility.

6 (ii) Health care personnel shall not be re-
7 quired to provide routine HIV testing to an in-
8 mate who is transferred to a facility from an-
9 other facility if the inmate's medical records are
10 transferred with the inmate and indicate that
11 the inmate has been tested previously.

12 (B) To all inmates admitted to a facility
13 prior to the effective date of this policy, health
14 care personnel shall provide routine HIV testing
15 within no more than 6 months. HIV testing for
16 these inmates may be performed in conjunction
17 with other health services provided to these in-
18 mates by health care personnel.

19 (C) All HIV tests under this paragraph
20 shall comply with paragraph (9).

21 (2) PRE-TEST AND POST-TEST COUNSELING.—
22 Health care personnel shall provide confidential pre-
23 test and post-test counseling to all inmates who are
24 tested for HIV. Counseling may be included with

1 other general health counseling provided to inmates
2 by health care personnel.

3 (3) HIV/AIDS PREVENTION EDUCATION.—

4 (A) Health care personnel shall improve
5 HIV/AIDS awareness through frequent edu-
6 cational programs for all inmates. HIV/AIDS
7 educational programs may be provided by com-
8 munity based organizations, local health depart-
9 ments, and inmate peer educators. Such HIV/
10 AIDS educational programs shall include infor-
11 mation on modes of transmission, including
12 transmission through tattooing, sexual contact,
13 and intravenous drug use; prevention methods;
14 treatment; and disease progression. HIV/AIDS
15 educational programs shall be culturally sen-
16 sitive, conducted in a variety of languages, and
17 present scientifically accurate information in a
18 clear and understandable manner.

19 (B) HIV/AIDS educational materials shall
20 be made available to all inmates at orientation,
21 at health care clinics, at regular educational
22 programs, and prior to release. Both written
23 and audio-visual materials shall be made avail-
24 able to all inmates. These materials shall be

1 culturally sensitive, written for low literacy lev-
2 els, and available in a variety of languages.

3 (4) HIV TESTING UPON REQUEST.—

4 (A) Health care personnel shall allow in-
5 mates to obtain HIV tests upon request once
6 per year or whenever an inmate has a reason to
7 believe the inmate may have been exposed to
8 HIV. Health care personnel shall, both orally
9 and in writing, inform inmates, during orienta-
10 tion and periodically throughout incarceration,
11 of their right to obtain HIV tests.

12 (B) Health care personnel shall encourage
13 inmates to request HIV tests if the inmate is
14 sexually active, has been raped, uses intra-
15 venous drugs, receives a tattoo, or if the inmate
16 is concerned that the inmate may have been ex-
17 posed to HIV/AIDS.

18 (C) An inmate's request for an HIV test
19 shall not be considered an indication that the
20 inmate has put himself or herself at risk of in-
21 fection or committed a violation of prison rules.

22 (5) HIV TESTING OF PREGNANT WOMAN.—

23 (A) Health care personnel shall provide
24 routine HIV testing to all inmates who become
25 pregnant.

1 (B) All HIV tests under this paragraph
2 shall comply with paragraph (9).

3 (6) COMPREHENSIVE TREATMENT.—

4 (A) Health care personnel shall provide all
5 inmates who test positive for HIV—

6 (i) timely, comprehensive medical
7 treatment;

8 (ii) confidential counseling on man-
9 aging their medical condition and pre-
10 venting its transmission to other persons;
11 and

12 (iii) voluntary partner notification
13 services.

14 (B) Medical care provided under this para-
15 graph shall be consistent with current Depart-
16 ment of Health and Human Services guidelines
17 and standard medical practice. Health care per-
18 sonnel shall discuss treatment options, the im-
19 portance of adherence to antiretroviral therapy,
20 and the side effects of medications with inmates
21 receiving treatment.

22 (C) Health care personnel and pharmacy
23 personnel shall ensure that the facility for-
24 mulary contains all Food and Drug Administra-
25 tion-approved medications necessary to provide

1 comprehensive treatment for inmates living with
2 HIV/AIDS, and that the facility maintains ade-
3 quate supplies of such medications to meet in-
4 mates' medical needs. Health care personnel
5 and pharmacy personnel shall also develop and
6 implement automatic renewal systems for these
7 medications to prevent interruptions in care.

8 (D) Correctional staff, health care per-
9 sonnel, and pharmacy personnel shall develop
10 and implement distribution procedures to en-
11 sure timely and confidential access to medica-
12 tions.

13 (7) PROTECTION OF CONFIDENTIALITY.—

14 (A) Health care personnel shall develop
15 and implement procedures to ensure the con-
16 fidentiality of inmate tests, diagnoses, and
17 treatment. Health care personnel and correc-
18 tional staff shall receive regular training on the
19 implementation of these procedures. Penalties
20 for violations of inmate confidentiality by health
21 care personnel or correctional staff shall be
22 specified and strictly enforced.

23 (B) HIV testing, counseling, and treat-
24 ment shall be provided in a confidential setting
25 where other routine health services are provided

1 and in a manner that allows the inmate to re-
2 quest and obtain these services as routine med-
3 ical services.

4 (8) TESTING, COUNSELING, AND REFERRAL
5 PRIOR TO REENTRY.—

6 (A)(i) Subject to clauses (ii) and (iii),
7 health care personnel shall provide routine HIV
8 testing to all inmates no more than 3 months
9 prior to their release and reentry into the com-
10 munity.

11 (ii) Inmates who are already known to be
12 infected shall not be required to be tested
13 again.

14 (iii) The requirement under clause (i) may
15 be waived if an inmate's release occurs without
16 sufficient notice to the Bureau to allow health
17 care personnel to perform a routine HIV test
18 and notify the inmate of the results.

19 (B) All HIV tests under this paragraph
20 shall comply with paragraph (9).

21 (C) To all inmates who test positive for
22 HIV and all inmates who already are known to
23 have HIV/AIDS, health care personnel shall
24 provide—

1 (i) confidential prerelease counseling
2 on managing their medical condition in the
3 community, accessing appropriate treat-
4 ment and services in the community, and
5 preventing the transmission of their condi-
6 tion to family members and other persons
7 in the community;

8 (ii) referrals to appropriate health
9 care providers and social service agencies
10 in the community that meet the inmate's
11 individual needs, including voluntary part-
12 ner notification services and prevention
13 counseling services for people living with
14 HIV/AIDS; and

15 (iii) a 30-day supply of any medically
16 necessary medications the inmate is cur-
17 rently receiving.

18 (9) OPT-OUT PROVISION.—Inmates shall have
19 the right to refuse routine HIV testing. Inmates
20 shall be informed both orally and in writing of this
21 right. Oral and written disclosure of this right may
22 be included with other general health information
23 and counseling provided to inmates by health care
24 personnel. If an inmate refuses a routine test for
25 HIV, health care personnel shall make a note of the

1 inmate's refusal in the inmate's confidential medical
2 records. However, the inmate's refusal shall not be
3 considered a violation of prison rules or result in dis-
4 ciplinary action.

5 (10) EXCLUSION OF TESTS PERFORMED UNDER
6 SECTION 4014(b) FROM THE DEFINITION OF ROU-
7 TINE HIV TESTING.—HIV testing of an inmate
8 under section 4014(b) of title 18, United States
9 Code, is not routine HIV testing for the purposes of
10 paragraph (9). Health care personnel shall document
11 the reason for testing under section 4014(b) of title
12 18, United States Code, in the inmate's confidential
13 medical records.

14 (11) TIMELY NOTIFICATION OF TEST RE-
15 SULTS.—Health care personnel shall provide timely
16 notification to inmates of the results of HIV tests.

17 (d) CHANGES IN EXISTING LAW.—

18 (1) SCREENING IN GENERAL.—Section 4014(a)
19 of title 18, United States Code, is amended—

20 (A) by striking “for a period of 6 months
21 or more”;

22 (B) by striking “, as appropriate,”; and

23 (C) by striking “if such individual is deter-
24 mined to be at risk for infection with such virus
25 in accordance with the guidelines issued by the

1 Bureau of Prisons relating to infectious disease
2 management” and inserting “unless the indi-
3 vidual declines. The Attorney General shall also
4 cause such individual to be so tested before re-
5 lease unless the individual declines.”.

6 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
7 CIVIL AND CRIMINAL PROCEEDINGS.—Section
8 4014(d) of title 18, United States Code, is amended
9 by inserting “or under the Stop AIDS in Prison Act
10 of 2011” after “under this section”.

11 (3) SCREENING AS PART OF ROUTINE SCREEN-
12 ING.—Section 4014(e) of title 18, United States
13 Code, is amended by adding at the end the fol-
14 lowing: “Such rules shall also provide that the initial
15 test under this section be performed as part of the
16 routine health screening conducted at intake.”.

17 (e) REPORTING REQUIREMENTS.—

18 (1) REPORT ON HEPATITIS AND OTHER DIS-
19 EASES.—Not later than 1 year after the date of the
20 enactment of this Act, the Bureau shall provide a re-
21 port to the Congress on Bureau policies and proce-
22 dures to provide testing, treatment, and prevention
23 education programs for hepatitis and other diseases
24 transmitted through sexual activity and intravenous
25 drug use. The Bureau shall consult with appropriate

1 officials of the Department of Health and Human
2 Services, the Office of National Drug Control Policy,
3 the Office of National AIDS Policy, and the Centers
4 for Disease Control and Prevention regarding the
5 development of this report.

6 (2) ANNUAL REPORTS.—

7 (A) GENERALLY.—Not later than 2 years
8 after the date of the enactment of this Act, and
9 then annually thereafter, the Bureau shall re-
10 port to Congress on the incidence among in-
11 mates of diseases transmitted through sexual
12 activity and intravenous drug use.

13 (B) MATTERS PERTAINING TO VARIOUS
14 DISEASES.—Reports under subparagraph (A)
15 shall discuss—

16 (i) the incidence among inmates of
17 HIV/AIDS, hepatitis, and other diseases
18 transmitted through sexual activity and in-
19 travenous drug use; and

20 (ii) updates on Bureau testing, treat-
21 ment, and prevention education programs
22 for these diseases.

23 (C) MATTERS PERTAINING TO HIV/AIDS
24 ONLY.—Reports under subparagraph (A) shall
25 also include—

1 (i) the number of inmates who tested
2 positive for HIV upon intake;

3 (ii) the number of inmates who tested
4 positive prior to reentry;

5 (iii) the number of inmates who were
6 not tested prior to reentry because they
7 were released without sufficient notice;

8 (iv) the number of inmates who opted-
9 out of taking the test;

10 (v) the number of inmates who were
11 tested under section 4014(b) of title 18,
12 United States Code; and

13 (vi) the number of inmates under
14 treatment for HIV/AIDS.

15 (D) CONSULTATION.—The Bureau shall
16 consult with appropriate officials of the Depart-
17 ment of Health and Human Services, the Office
18 of National Drug Control Policy, the Office of
19 National AIDS Policy, and the Centers for Dis-
20 ease Control and Prevention regarding the de-
21 velopment of reports under subparagraph (A).

22 **SEC. 751. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
23 **ETHNIC MINORITY COMMUNITIES.**

24 (a) IN GENERAL.—For the purpose of reducing HIV/
25 AIDS in racial and ethnic minority communities, the Sec-

1 retary, acting through the Deputy Assistant Secretary for
2 Minority Health, may make grants to public health agen-
3 cies and faith-based organizations to conduct—

4 (1) outreach activities related to HIV/AIDS
5 prevention and testing activities;

6 (2) HIV/AIDS prevention activities; and

7 (3) HIV/AIDS testing activities.

8 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
9 out this section, there are authorized to be appropriated
10 \$50,000,000 for fiscal year 2012, and such sums as may
11 be necessary for fiscal years 2013 through 2016.

12 **SEC. 752. HEALTH CARE PROFESSIONALS TREATING INDI-**
13 **VIDUALS WITH HIV/AIDS.**

14 Part E of title VII of the Public Health Service Act
15 (42 U.S.C. 294n et seq.) is amended by adding at the end
16 the following:

17 **“Subpart 5—Health Care Professionals Treating**
18 **Individuals With HIV/AIDS**

19 **“SEC. 785. HEALTH CARE PROFESSIONALS TREATING INDI-**
20 **VIDUALS WITH HIV/AIDS.**

21 “(a) IN GENERAL.—The Secretary, acting through
22 the Administrator of the Health Resources and Services
23 Administration and in consultation with racial and ethnic
24 minority community organizations, may award grants for
25 any of the following:

1 “(1) Development of curricula for training pri-
2 mary care providers in HIV/AIDS prevention and
3 care.

4 “(2) Training health care professionals with ex-
5 pertise in HIV/AIDS to provide care to individuals
6 with HIV/AIDS.

7 “(3) Development by grant recipients under
8 title XXVI and other persons of policies for pro-
9 viding culturally relevant and sensitive treatment to
10 individuals with HIV/AIDS, with particular empha-
11 sis on treatment to racial and ethnic minorities, men
12 who have sex with men, and women and children
13 with HIV/AIDS.

14 “(4) Development and implementation of pro-
15 grams to increase the use of telemedicine to respond
16 to HIV/AIDS-specific health care needs in rural and
17 minority communities, with particular emphasis
18 given to medically underserved communities and in-
19 sular areas.

20 “(5) Creation of faith- and community-based
21 certification programs for providers in HIV/AIDS
22 care and support services.

23 “(6) Establishment of comfort care centers that
24 provide mental, emotional, and psychosocial coun-
25 seling for people with HIV/AIDS and implement ad-

1 ditional protocols to be carried out in the centers
2 that address the needs of children and young adults
3 who are infected with the disease and are
4 transitioning from childhood to adulthood.

5 “(7) Incentive payments to health care pro-
6 viders supported by the Health Resources and Serv-
7 ices Administration to implement HIV/AIDS testing
8 consistent with the guidelines issued in 2006 by the
9 Centers for Disease Control and Prevention entitled
10 ‘Revised Recommendations for HIV Testing of
11 Adults, Adolescents, and Pregnant Women in
12 Health-Care Settings’.

13 “(b) DEFINITION.—In this section, the term ‘HIV/
14 AIDS’ has the meaning given to such term in section
15 2689.

16 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
17 carry out this section, there are authorized to be appro-
18 priated \$100,000,000 for fiscal year 2012, and such sums
19 as may be necessary for fiscal years 2013 through 2016.”.

20 **SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN RACIAL AND**
21 **ETHNIC MINORITY COMMUNITIES.**

22 (a) IN GENERAL.—The Secretary shall submit to the
23 Congress and the President an annual report on the im-
24 pact of HIV/AIDS in racial and ethnic minority commu-
25 nities.

1 (b) CONTENTS.—The report under subsection (a)
2 shall include information on the—

3 (1) progress that has been made in reducing
4 the impact of HIV/AIDS in such communities;

5 (2) opportunities that exist to make additional
6 progress in reducing the impact of HIV/AIDS in
7 such communities;

8 (3) challenges that may impede such additional
9 progress; and

10 (4) Federal funding necessary to achieve sub-
11 stantial reductions in HIV/AIDS in racial and ethnic
12 minority communities.

13 **SEC. 754. STUDY ON STATUS OF HIV/AIDS EPIDEMIC AMONG**
14 **AFRICAN-AMERICANS.**

15 (a) IN GENERAL.—The Secretary shall—

16 (1) seek to enter into an agreement with the In-
17 stitute of Medicine to document, in collaboration
18 with an academic organization which specializes in
19 the identification and reduction of health disparities
20 within the African-American community, all aspects
21 of the HIV/AIDS epidemic among African-Ameri-
22 cans, including the role that historical racial or eth-
23 nic barriers play in sustaining the epidemic among
24 African-Americans;

1 (2) submit a report to the President, the Direc-
2 tor of the Office of National AIDS Policy Coordina-
3 tion, the Director of the White House Domestic Pol-
4 icy Council, the Director of White House Office of
5 Faith-Based and Neighborhood Partnerships, key
6 Federal agencies, and the relevant committees of the
7 Congress on the status of the HIV/AIDS epidemic
8 among African-Americans in the United States; and

9 (3) include in such report—

10 (A) specific recommendations on the imple-
11 mentation of Federal policies to reduce the bur-
12 den of HIV/AIDS in the African-American com-
13 munity; and

14 (B) a special focus on the Black clergy and
15 the church as a unique resource in the African-
16 American community.

17 (b) AUTHORIZATION OF APPROPRIATIONS.—

18 (1) IN GENERAL.—To carry out this section,
19 there is authorized to be appropriated \$2,000,000
20 for each of fiscal years 2012 and 2013.

21 (2) SPECIAL RULE.—Of the amount of funds
22 appropriated to carry out this section for a fiscal
23 year—

1 (A) 45 percent shall be allocated to the In-
 2 stitutes of Medicine pursuant to the agreement
 3 entered into under subsection (a)(1);

4 (B) 45 percent shall be allocated to an
 5 academic organization which specializes in the
 6 identification and reduction of health disparities
 7 within the African-American community pursu-
 8 ant to such agreement; and

9 (C) 10 percent shall be allocated for ad-
 10 ministrative costs and other activities under
 11 this subsection.

12 **Subtitle F—Diabetes**

13 **SEC. 755. TREATMENT OF DIABETES IN MINORITY COMMU-** 14 **NITIES.**

15 (a) SHORT TITLE.—This subtitle may be cited as the
 16 “Minority Diabetes Initiative Act”.

17 (b) GRANTS REGARDING TREATMENT OF DIABETES
 18 IN MINORITY COMMUNITIES.—Part D of title III of the
 19 Public Health Service Act (42 U.S.C. 254b et seq.) is
 20 amended by inserting after section 330L the following:

21 **“SEC. 330M. GRANTS REGARDING TREATMENT OF DIABE-** 22 **TES IN MINORITY COMMUNITIES.**

23 “(a) IN GENERAL.—The Secretary may make grants
 24 to public and nonprofit private health care providers for

1 the purpose of providing treatment for diabetes in minor-
2 ity communities.

3 “(b) RECIPIENTS OF GRANTS.—The public and non-
4 profit private health care providers to whom grants may
5 be made under subsection (a) include physicians, podia-
6 trists, community-based organizations, health care organi-
7 zations, community health centers, and State, local, and
8 tribal health departments.

9 “(c) SCOPE OF TREATMENT ACTIVITIES.—The Sec-
10 retary shall ensure that grants under subsection (a) cover
11 a variety of diabetes-related health care services, including
12 routine care for diabetic patients, public education on dia-
13 betes prevention and control, eye care, foot care, and
14 treatment for kidney disease and other complications of
15 diabetes.

16 “(d) APPROPRIATE CULTURAL CONTEXT.—A condi-
17 tion for the receipt of a grant under subsection (a) is that
18 the applicant involved agrees that, in the program carried
19 out with the grant, services will be provided in the lan-
20 guages most appropriate for, and with consideration for
21 the cultural backgrounds of, the individuals for whom the
22 services are provided.

23 “(e) OUTREACH SERVICES.—A condition for the re-
24 ceipt of a grant under subsection (a) is that the applicant
25 involved agrees to provide outreach activities to inform the

1 public of the services of the program, and to provide offsite
2 information on diabetes.

3 “(f) APPLICATION FOR GRANT.—A grant may be
4 made under subsection (a) only if an application for the
5 grant is submitted to the Secretary and the application
6 is in such form, is made in such manner, and contains
7 such agreements, assurances, and information as the Sec-
8 retary determines to be necessary to carry out this section.

9 “(g) AUTHORIZATION OF APPROPRIATIONS.—For the
10 purpose of carrying out this section, there are authorized
11 to be appropriated such sums as may be necessary for
12 each of the fiscal years 2012 through 2017.”.

13 **SEC. 756. ELIMINATING DISPARITIES IN DIABETES PREVEN-**
14 **TION ACCESS AND CARE.**

15 (a) RESEARCH, TREATMENT, AND EDUCATION.—

16 (1) IN GENERAL.—Subpart 3 of part C of title
17 IV of the Public Health Service Act (42 U.S.C. 285c
18 et seq.) is amended by adding at the end the fol-
19 lowing new section:

20 **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

21 “(a) IN GENERAL.—The Director of the National In-
22 stitutes of Health shall expand, intensify, and support on-
23 going research and other activities with respect to pre-dia-
24 betes and diabetes, particularly type 2, in minority popu-
25 lations, including research to identify clinical, socio-

1 economic, geographical, cultural, and organizational fac-
2 tors that contribute to type 2 diabetes in such populations.

3 “(b) CERTAIN ACTIVITIES.—Activities under sub-
4 section (a) regarding type 2 diabetes in minority popu-
5 lations shall include the following:

6 “(1) Continuing research on behavior and obe-
7 sity, including through the obesity research center
8 that is sponsored by the National Institutes of
9 Health.

10 “(2) Research on environmental factors that
11 may contribute to the increase in type 2 diabetes.

12 “(3) Support for new methods to identify envi-
13 ronmental triggers and genetic interactions that lead
14 to the development of type 2 diabetes in minority
15 newborns. Such research should follow the newborns
16 through puberty, an increasingly high-risk period for
17 developing type 2 diabetes.

18 “(4) Research to identify genes that predispose
19 individuals to the onset of developing type 1 and
20 type 2 diabetes and to the development of complica-
21 tions.

22 “(5) Research to prevent complications in indi-
23 viduals who have already developed diabetes, such as
24 research that attempts to identify the genes that

1 predispose individuals with diabetes to the develop-
2 ment of complications.

3 “(6) Research methods and alternative thera-
4 pies to control blood glucose.

5 “(7) Support of ongoing research efforts exam-
6 ining the level of glycemia at which adverse out-
7 comes develop during pregnancy and to address the
8 many clinical issues associated with minority moth-
9 ers and fetuses during diabetic and gestational dia-
10 betic pregnancies.

11 “(c) EDUCATION.—The Director of the National In-
12 stitutes of Health shall—

13 “(1) through the National Institute on Minority
14 Health and Health Disparities and the National Di-
15 abetes Education Program—

16 “(A) make grants to programs funded
17 under section 485F (relating to centers of ex-
18 cellence) for the purpose of establishing a men-
19 toring program for health care professionals to
20 be more involved in weight counseling, obesity
21 research, and nutrition; and

22 “(B) provide for the participation of mi-
23 nority health professionals in diabetes-focused
24 research programs; and

1 “(2) make grants for programs to establish a
2 pipeline from high school to professional school that
3 will increase minority representation in diabetes-fo-
4 cused health fields by expanding Minority Access to
5 Research Careers (MARC) program internships and
6 mentoring opportunities for recruitment.

7 “(d) DEFINITION.—For purposes of this section, the
8 term ‘minority population’ means a racial and ethnic mi-
9 nority group, as defined in section 1707(g).

10 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
11 purpose of carrying out this section, there are authorized
12 to be appropriated such sums as are necessary for fiscal
13 year 2012 and each subsequent fiscal year.”.

14 (2) DIABETES MELLITUS INTERAGENCY CO-
15 ORDINATING COMMITTEE.—Section 429 of the Pub-
16 lic Health Service Act (42 U.S.C. 285c–3) is amend-
17 ed by adding at the end the following new sub-
18 section:

19 “(c)(1) The Diabetes Mellitus Interagency Coordi-
20 nating Committee shall submit to the Secretary a biennial
21 report that shall include an assessment of the Federal ac-
22 tivities and programs related to diabetes in minority popu-
23 lations. Such assessment shall—

24 “(A) compile the current activities of all current
25 Federal health programs to allow for the assessment

1 of their adequacy as a systemic method of address-
2 ing the impact of diabetes mellitus on minority popu-
3 lations;

4 “(B) develop strategic planning activities to de-
5 velop an effective and comprehensive Federal plan to
6 address diabetes mellitus within minority popu-
7 lations which will involve all appropriate Federal
8 health programs and shall—

9 “(i) include steps to address issues includ-
10 ing type 1 and type 2 diabetes in children and
11 the disproportionate impact of diabetes mellitus
12 on minority populations; and

13 “(ii) remain consistent with the programs
14 and activities identified in section 3990, as well
15 as remaining consistent with the intent of the
16 Eliminating Disparities in Diabetes Prevention
17 Access and Care Act of 2010; and

18 “(C) assess the implementation of such a plan
19 throughout Federal health programs.

20 “(2) For the purposes of this subsection, the term
21 ‘minority population’ means a racial and ethnic minority
22 group, as defined in section 1707(g).

23 “(3) For the purpose of carrying out this subsection,
24 there are authorized to be appropriated such sums as are

1 necessary for fiscal year 2012 and each subsequent fiscal
2 year.”.

3 (b) RESEARCH, EDUCATION, AND OTHER ACTIVI-
4 TIES.—Part B of title III of the Public Health Service
5 Act (42 U.S.C. 243 et seq.) is amended by inserting after
6 section 317T the following section:

7 **“SEC. 317U. DIABETES IN MINORITY POPULATIONS.**

8 “(a) RESEARCH AND OTHER ACTIVITIES.—

9 “(1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall conduct and support
12 research and other activities with respect to diabetes
13 in minority populations.

14 “(2) CERTAIN ACTIVITIES.—Activities under
15 paragraph (1) regarding diabetes in minority popu-
16 lations shall include the following:

17 “(A) Expanding the National Diabetes
18 Laboratory capacity for translational research
19 and the identification of genetic and
20 immunological risk factors associated with dia-
21 betes.

22 “(B) Improving the understanding of dia-
23 betes prevalence among Asian-American, Native
24 Hawaiian and other Pacific Islanders by en-
25 hancing data in the National Health and Nutri-

1 tion Examination Survey by oversampling these
2 populations in appropriate geographic areas, or
3 by another method determined appropriate to
4 collect this data.

5 “(C) Within the Division of Diabetes
6 Translation, providing for prevention research
7 to better understand how to influence health
8 care systems changes to improve quality of care
9 being delivered to such populations, and within
10 the Division of Diabetes Translation, carrying
11 out model demonstration projects to design, im-
12 plement, and evaluate effective diabetes preven-
13 tion and control intervention for such popu-
14 lations.

15 “(D) Through the Division of Diabetes
16 Translation, carrying out culturally appropriate
17 community-based interventions designed to ad-
18 dress issues and problems experienced by such
19 populations.

20 “(E) Conducting applied research within
21 the Division of Diabetes Translation to reduce
22 health disparities within such populations with
23 diabetes.

24 “(F) Conducting applied research on pri-
25 mary prevention within the Division of Diabetes

1 Translation to specifically focus on such popu-
2 lations with pre-diabetes.

3 “(b) EDUCATION.—

4 “(1) IN GENERAL.—The Secretary, acting
5 through the Director of the Centers for Disease
6 Control and Prevention, shall direct the Division of
7 Diabetes Translation to conduct and support pro-
8 grams to educate the public on the causes and ef-
9 fects of diabetes in minority populations.

10 “(2) CERTAIN ACTIVITIES.—Programs under
11 paragraph (1) regarding education on diabetes in
12 minority populations shall include carrying out pub-
13 lic awareness campaigns directed toward such popu-
14 lations to aggressively emphasize the importance and
15 impact of physical activity and diet in regard to dia-
16 betes and diabetes-related complications through the
17 National Diabetes Education Program.

18 “(c) DIABETES; HEALTH PROMOTION, PREVENTION
19 ACTIVITIES, AND ACCESS.—

20 “(1) IN GENERAL.—The Secretary, acting
21 through the Director of the Centers for Disease
22 Control and Prevention, shall carry out culturally
23 appropriate diabetes health promotion and preven-
24 tion programs for minority populations.

1 “(2) CERTAIN ACTIVITIES.—Activities regard-
2 ing culturally appropriate diabetes health promotion
3 and prevention programs for minority populations
4 shall include the following:

5 “(A) Expanding the Diabetes Prevention
6 and Control Program (currently existing in all
7 the States and territories) and providing funds
8 for education and community outreach on dia-
9 betes.

10 “(B) Providing funds for an expansion of
11 the Diabetes Prevention Program Initiative that
12 focuses on physical inactivity and diet and its
13 relation to type 2 diabetes within such popu-
14 lations.

15 “(C) Providing funds to strengthen exist-
16 ing surveillance systems to improve the quality,
17 accuracy, and timeliness of morbidity and mor-
18 tality diabetes data for such populations.

19 “(d) DEFINITION.—For purposes of this section, the
20 term ‘minority population’ means a racial and ethnic mi-
21 nority group, as defined in section 1707(g).

22 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
23 purpose of carrying out this section, there are authorized
24 to be appropriated such sums as are necessary for fiscal
25 year 2012 and each subsequent fiscal year.”.

1 (c) RESEARCH, EDUCATION, AND OTHER ACTIVI-
2 TIES.—Part P of title III of the Public Health Service
3 Act is amended—

4 (1) by redesignating the section 399R inserted
5 by section 2 of Public Law 110–373 as section
6 399S;

7 (2) by redesignating the section 399R inserted
8 by section 3 of Public Law 110–374 as section
9 399T; and

10 (3) by adding at the end the following new sec-
11 tion:

12 **“SEC. 399V-6. PROGRAMS TO EDUCATE HEALTH PRO-**
13 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
14 **ABETES IN MINORITY POPULATIONS.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Director of the Health Resources and Services Admin-
17 istration, shall conduct and support programs described
18 in subsection (b) to educate health professionals on the
19 causes and effects of diabetes in minority populations.

20 “(b) PROGRAMS.—Programs described in this sub-
21 section, with respect to education on diabetes in minority
22 populations, shall include the following:

23 “(1) Making grants for diabetes-focused edu-
24 cation classes or training programs on cultural sen-

1 sitivity and patient care within such populations for
2 health care providers.

3 “(2) Providing funds to community health cen-
4 ters for programs that provide diabetes services and
5 screenings.

6 “(3) Providing additional funds for the Health
7 Careers Opportunity Program, Centers for Excel-
8 lence, and the Minority Faculty Fellowship Program
9 to partner with the Office of Minority Health under
10 section 1707 and the National Institutes of Health
11 to strengthen programs for career opportunities
12 within minority populations focused on diabetes
13 treatment and care.

14 “(4) Developing a diabetes focus within, and
15 providing additional funds for, the National Health
16 Service Corps Scholarship program to place individ-
17 uals in areas that are disproportionately affected by
18 diabetes and to provide health care services to such
19 areas.

20 “(5) Establishing a diabetes ambassador pro-
21 gram for recruitment efforts to increase the number
22 of underrepresented minorities currently serving in
23 student, faculty, or administrative positions in insti-
24 tutions of higher learning, hospitals, and community
25 health centers.

1 “(6) Establishing a loan repayment program
2 that focuses on diabetes care and prevention in mi-
3 nority populations.”.

4 (d) RESEARCH, EDUCATION, AND OTHER ACTIVI-
5 TIES.—Part P of title III of the Public Health Service
6 Act (42 U.S.C. 280g et seq.), as amended by subsection
7 (c), is further amended by adding at the end the following
8 section:

9 **“SEC. 399V-7. RESEARCH, EDUCATION, AND OTHER ACTIVI-
10 TIES REGARDING DIABETES IN MINORITY
11 POPULATIONS.**

12 “(a) RESEARCH AND OTHER ACTIVITIES.—

13 “(1) IN GENERAL.—In addition to activities
14 under sections 317U and 434B, the Secretary shall
15 conduct and support research and other activities
16 with respect to diabetes within minority populations.

17 “(2) CERTAIN ACTIVITIES.—Activities under
18 paragraph (1) regarding diabetes in minority popu-
19 lations shall include the following:

20 “(A) Through the National Center on Mi-
21 nority Health and Health Disparities, the Office
22 of Minority Health under section 1707, the
23 Health Resources and Services Administration,
24 the Centers for Disease Control and Prevention,
25 and the Indian Health Service, establishing

1 partnerships within minority populations to
2 conduct studies on cultural, familial, and social
3 factors that may influence health promotion, di-
4 abetes management, and prevention.

5 “(B) Through the Indian Health Service,
6 in collaboration with other appropriate Federal
7 agencies, coordinating the collection of data on
8 ethnic and culturally appropriate diabetes treat-
9 ment, care, prevention, and services by health
10 care professionals to the American Indian popu-
11 lation.

12 “(3) PROGRAMS RELATING TO CLINICAL RE-
13 SEARCH.—

14 “(A) EDUCATION REGARDING CLINICAL
15 TRIALS.—The Secretary shall carry out edu-
16 cation and awareness programs designed to in-
17 crease participation of minority populations in
18 clinical trials.

19 “(B) MINORITY RESEARCHERS.—The Sec-
20 retary shall carry out mentorship programs for
21 minority researchers who are conducting or in-
22 tend to conduct research on diabetes in minor-
23 ity populations.

24 “(C) SUPPLEMENTING CLINICAL RE-
25 SEARCH REGARDING CHILDREN.—The Sec-

1 retary shall make grants to supplement clinical
2 research programs to assist such programs in
3 obtaining the services of health professionals
4 and other resources to provide specialized care
5 for children with type 1 and type 2 diabetes.

6 “(4) ADDITIONAL PROGRAMS.—Activities under
7 paragraph (1) regarding education on diabetes shall
8 include providing funds for new and existing diabe-
9 tes-focused education grants and programs for
10 present and future students and clinicians in the
11 medical field from minority populations, including
12 for the following:

13 “(A) For Federal and State loan repay-
14 ment programs for health profession students
15 within communities of color.

16 “(B) For the Office of Minority Health
17 under section 1707 for training health profes-
18 sion students to focus on diabetes within such
19 populations.

20 “(b) DEFINITION.—For purposes of this section, the
21 term ‘minority population’ means a racial and ethnic mi-
22 nority group as defined in section 1707(g).

23 “(c) AUTHORIZATION OF APPROPRIATIONS.—For the
24 purpose of carrying out this section, there are authorized

1 to be appropriated such sums as are necessary for fiscal
2 year 2012 and each subsequent fiscal year.”.

3 (e) SENSE OF THE CONGRESS.—It is the sense of the
4 Congress that States and localities are encourage to recog-
5 nize established times of diabetes awareness, such as
6 American Diabetes Month (November), American Diabe-
7 tes Alert Day (annually on the 4th Tuesday of March),
8 and World Diabetes Day (November 14th).

9 **Subtitle G—Lung Disease**

10 **SEC. 761. 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. 762. 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 2012 through 2016 for
3 the purpose of carrying out this section.”.

4 **SEC. 763. 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 (2) the campaign uses targeted, culturally ap-
2 propriate messages and messengers to reach under-
3 served communities.

4 (c) **AUTHORIZATION OF APPROPRIATIONS.**—There
5 are authorized to be appropriated to carry out this section
6 such sums as may be necessary for each of fiscal years
7 2012 through 2016.

8 **SEC. 764. CHRONIC OBSTRUCTIVE PULMONARY DISEASE**
9 **ACTION PLAN.**

10 (a) **IN GENERAL.**—The Director of the Centers for
11 Disease Control and Prevention shall conduct, support,
12 and expand public health strategies, prevention, diagnosis,
13 surveillance, and public and professional awareness activi-
14 ties regarding chronic obstructive pulmonary disease.

15 (b) **NATIONAL ACTION PLAN.**—

16 (1) **DEVELOPMENT.**—Not later than 2 years
17 after the date of the enactment of this Act, the Di-
18 rector of the National Heart, Lung, and Blood Insti-
19 tute, in consultation with the Director of the Centers
20 for Disease Control and Prevention, shall develop a
21 national action plan to address chronic obstructive
22 pulmonary disease in the United States with partici-
23 pation from patients, caregivers, health profes-
24 sionals, patient advocacy organizations, researchers,

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 2012 through 2016.

15 **TITLE VIII—HEALTH**
16 **INFORMATION TECHNOLOGY**
17 **Subtitle A—Reducing Health**
18 **Disparities Through Health IT**

19 **SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR**
20 **PROMOTION OF HEALTH IT.**

21 The Secretary of Health and Human Services, acting
22 through the Administrator of the Health Resources and
23 Services Administration, shall expand and intensify the
24 programs and activities of the Administration (directly or
25 through grants or contracts) to provide technical assist-

1 ance and resources to health centers (as defined in section
2 330(a) of the Public Health Service Act (42 U.S.C.
3 254b(a)) to adopt and meaningfully use certified EHR
4 technology (as defined in section 3000(1) of such Act (42
5 U.S.C. 300jj(1)) for the management of chronic diseases
6 and health conditions.

7 **SEC. 802. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**
8 **CIAL AND ETHNIC MINORITY COMMUNITIES;**
9 **OUTREACH AND ADOPTION OF HEALTH IT IN**
10 **SUCH COMMUNITIES.**

11 Section 3001(c)(6)(C) of the Public Health Service
12 Act (42 U.S.C. 300jj–11(c)(6)(C)) is amended—

13 (1) in the heading by inserting “, RACIAL AND
14 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
15 DISPARITIES”;

16 (2) by inserting “, in communities with a high
17 proportion of individuals from racial and ethnic mi-
18 nority groups (as defined in section 1707(g)),” after
19 “communities with health disparities”; and

20 (3) by adding at the end the following new sen-
21 tence: “In any publication under the previous sen-
22 tence, the National Coordinator shall include best
23 practices for encouraging partnerships between the
24 Federal Government and private entities to expand
25 outreach for and the adoption of such technology in

1 communities with a high proportion of individuals
2 from racial and ethnic minority groups (as so de-
3 fined), while also maintaining the accessibility re-
4 quirements of section 508 of the Rehabilitation Act
5 to encourage patient involvement in their own health
6 care. The National Coordinator shall—

7 “(i) not later than 6 months after the
8 submission to the Congress of the reports
9 required by sections 832 and 833 of the
10 Health Equity and Accountability Act of
11 2011, establish criteria for evaluating the
12 impact of health information technology on
13 communities with a high proportion of in-
14 dividuals from racial and ethnic minority
15 groups (as so defined) taking into account
16 the findings in such reports; and

17 “(ii) not later than 12 months after
18 the submission to the Congress of such re-
19 ports, conduct and publish the results of
20 an evaluation of such impact.”.

1 **Subtitle B—Modifications to**
2 **Achieve Parity in Existing Pro-**
3 **grams**

4 **SEC. 811. EXTENDING FUNDING TO STRENGTHEN THE**
5 **HEALTH IT INFRASTRUCTURE IN RACIAL**
6 **AND ETHNIC MINORITY COMMUNITIES.**

7 Section 3011 of the Public Health Service Act (42
8 U.S.C. 300jj–31) is amended—

9 (1) in subsection (a), by adding at the end the
10 following new paragraph:

11 “(8) Activities described in the previous para-
12 graphs of this subsection with respect to commu-
13 nities with a high proportion of individuals from ra-
14 cial and ethnic minority groups (as defined in sec-
15 tion 1707(g)).”; and

16 (2) by adding at the end the following new sub-
17 section:

18 “(e) ANNUAL REPORT ON EXPENDITURES.—The
19 National Coordinator shall report annually to the Con-
20 gress on activities and expenditures under this section.”.

21 **SEC. 812. PRIORITIZING REGIONAL EXTENSION CENTER AS-**
22 **SISTANCE TO RACIAL AND ETHNIC MINORITY**
23 **GROUPS.**

24 (a) IN GENERAL.—Section 3012(c)(4)(C) of the Pub-
25 lic Health Service Act (42 U.S.C. 300jj–32(c)(4)(C)) is

1 amended by inserting “or individuals from racial and eth-
2 nic minority groups (as defined in section 1707(g))” after
3 “medically underserved individuals”.

4 (b) BIENNIAL EVALUATION.—Section 3012(c)(8) of
5 such Act (42 U.S.C. 300jj–32(c)(8)) is amended—

6 (1) by inserting: “Each evaluation panel shall
7 include at least one consumer advocate from a racial
8 and ethnic minority community served by the center
9 involved and at least one representative of a minor-
10 ity-serving institution.” after “and of Federal offi-
11 cials.”; and

12 (2) by inserting “and shall determine the de-
13 gree to which such center provides outreach and as-
14 sistance to providers predominantly serving racial
15 and ethnic minority groups (as defined in section
16 1707(g))” after “specified in paragraph (3)”.

17 **SEC. 813. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
18 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
19 **TATE ADOPTION OF CERTIFIED EHR TECH-**
20 **NOLOGY BY PROVIDERS SERVING RACIAL**
21 **AND ETHNIC MINORITY GROUPS.**

22 Section 3014(e) of the Public Health Service Act (42
23 U.S.C. 300jj–34(e)) is amended—

24 (1) in paragraph (3), by striking at the end
25 “or”;

1 (2) in paragraph (4), by striking the period at
2 the end and inserting “; or”; and

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

5 “(5) carry out any of the activities described in
6 a previous paragraph of this subsection with respect
7 to communities with a high proportion of individuals
8 from racial and ethnic minority groups (as defined
9 in section 1707(g)).”.

10 **Subtitle C—Additional Research** 11 **and Studies**

12 **SEC. 831. DATA COLLECTION AND ASSESSMENTS CON-** 13 **DUCTED IN COORDINATION WITH MINORITY-** 14 **SERVING INSTITUTIONS.**

15 Section 3001(c)(6) of the Public Health Service Act
16 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
17 end the following new subparagraph:

18 “(F) DATA COLLECTION AND ASSESS-

19 MENTS CONDUCTED IN COORDINATION WITH

20 MINORITY-SERVING INSTITUTIONS.—

21 “(i) IN GENERAL.—In carrying out

22 subparagraph (C) with respect to commu-

23 nities with a high proportion of individuals

24 from racial and ethnic minority groups (as

25 defined in section 1707(g)), the National

1 Coordinator shall, to the greatest extent
2 possible, coordinate with an entity de-
3 scribed in clause (ii).

4 “(ii) MINORITY-SERVING INSTITU-
5 TIONS.—For purposes of clause (i), an en-
6 tity described in this clause is a historically
7 Black college or university, an Hispanic-
8 serving institution, a tribal college or uni-
9 versity, or an Asian-American-, Native
10 American-, and Pacific Islander-serving in-
11 stitution with an accredited public health,
12 health policy, or health services research
13 program.”.

14 **SEC. 832. IOM STUDY AND REPORT ON PRIVACY CONCERNS**
15 **OF CERTAIN MINORITY POPULATIONS.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services shall seek to enter into an agreement
18 with the Institute of Medicine of the National Academies
19 to—

20 (1) complete a study—

21 (A) on the privacy concerns, relating to the
22 exchange of health information, of individuals
23 described in subsection (b);

24 (B) on how such concerns may create bar-
25 riers for such individuals to access health care

1 or participate in the exchange of health infor-
2 mation; and

3 (C) including recommendations for over-
4 coming such barriers for such individuals; and

5 (2) not later than 24 months after the date of
6 the enactment of this Act, submit to Congress a re-
7 port on the results of such study.

8 If such Institute declines to conduct the study and submit
9 the report, the Secretary shall enter into an agreement
10 with another appropriate public or nonprofit private entity
11 to conduct the study and submit the report.

12 (b) INDIVIDUALS DESCRIBED.—For purposes of sub-
13 section (a), the individuals described in this subsection are
14 individuals from racial and ethnic minority groups (as de-
15 fined in section 1707(g)), including such individuals
16 who—

17 (1) are immigrants, as well as citizens living
18 within immigrant households (“mixed-status” house-
19 holds) in the United States;

20 (2) are lesbian, gay, bisexual, or transgender; or

21 (3) have a mental health disability or a record
22 of a mental health disability or treatment for a men-
23 tal health disability.

1 **SEC. 833. STUDY OF HEALTH INFORMATION TECHNOLOGY**
2 **IN MEDICALLY UNDERSERVED COMMU-**
3 **NITIES.**

4 (a) STUDY.—The Secretary of Health and Human
5 Services shall seek to enter into an agreement with the
6 Institute of Medicine of the National Academies to con-
7 duct a study on the development and implementation of
8 health information technology in communities with a high
9 proportion of individuals from racial and ethnic minority
10 groups (as defined in section 1707(g)) and submit the re-
11 port under subsection (b). The study shall—

12 (1) identify barriers to successful implementa-
13 tion of health information technology in these com-
14 munities;

15 (2) examine the impact of health information
16 technology on providing quality care and reducing
17 the cost of care to these communities;

18 (3) examine urban and rural community health
19 systems and determine the impact that health infor-
20 mation technology may have on the capacity of pri-
21 mary health providers;

22 (4) identify specific best practices for using
23 health information technology to foster the con-
24 sistent provision of physical accessibility and reason-
25 able policy accommodations in health care to individ-
26 uals with disabilities in these communities; and

1 (5) assess the feasibility and the costs of associ-
2 ated with the use of health information technology
3 in these communities.

4 If such Institute declines to conduct the study, the Sec-
5 retary shall enter into an agreement with another appro-
6 priate public or nonprofit private entity to conduct the
7 study.

8 (b) REPORT.—The Secretary shall ensure that, not
9 later than 24 months after the date of the enactment of
10 this Act, the study required under subsection (a) is com-
11 pleted and a report on the study is submitted to Congress,
12 including any recommendations for legislation or adminis-
13 trative action.

14 **Subtitle D—Closing Gaps in**
15 **Funding To Adopt Certified EHRs**

16 **SEC. 841. APPLICATION OF MEDICARE HITECH PAYMENTS**
17 **TO HOSPITALS IN PUERTO RICO.**

18 (a) IN GENERAL.—Subsection (n)(6)(B) of section
19 1886 of the Social Security Act (42 U.S.C. 1395ww) is
20 amended by striking “subsection (d) hospital” and insert-
21 ing “hospital that is a subsection (d) hospital or a sub-
22 section (d) Puerto Rico hospital”.

23 (b) OFFSETTING REDUCTION.—Subsection (n)(2) of
24 such section is amended by adding at the end the following
25 new subparagraph:

1 “(H) BUDGET NEUTRALITY ADJUST-
2 MENT.—The Secretary shall reduce the applica-
3 ble amounts that would otherwise be deter-
4 mined under this subsection with respect to—

5 “(i) the first fiscal year to which this
6 subparagraph applies by an amount that
7 the Secretary estimates would ensure that
8 estimated aggregate payments under this
9 subsection for such fiscal year are not in-
10 creased as a result of the amendments
11 made by subsection (a) of section 841 of
12 the Health Equity and Accountability Act
13 of 2011; or

14 “(ii) a succeeding fiscal year by an
15 amount that the Secretary estimates would
16 ensure that estimated aggregate payments
17 under this subsection for such fiscal year
18 are not increased as a result of the amend-
19 ments made by subsections (a) and (c) of
20 such section.”.

21 (c) CONFORMING AMENDMENTS.—(1) Subsection
22 (b)(3)(B)(ix) of such section is amended—

23 (A) in subclause (I), by striking “(n)(6)(A)”
24 and inserting “(n)(6)(B)”; and

1 (B) in subclause (II), by striking “subsection
2 (d) hospital” and inserting “an eligible hospital”.

3 (2) Paragraphs (2) and (4)(A) of section 1853(m) of
4 the Social Security Act (42 U.S.C. 1395w–23(m)) are
5 each amended by striking “1886(n)(6)(A)” and inserting
6 “1886(n)(6)(B)”.

7 (d) IMPLEMENTATION.—Notwithstanding any other
8 provision of law, the Secretary of Health and Human
9 Services may implement the amendments made by sub-
10 sections (a), (b) and (c) by program instruction or other-
11 wise.

12 (e) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to payments for payment years for
14 fiscal years beginning after the date of the enactment of
15 this Act.

16 **SEC. 842. EXTENDING MEDICAID EHR INCENTIVE PAY-**
17 **MENTS TO LONG-TERM CARE FACILITIES AND**
18 **HOME HEALTH AGENCIES.**

19 Section 1903(t)(2)(B) of the Social Security Act (42
20 U.S.C. 1396b(t)(2)(B)) is amended—

21 (1) in clause (i), by striking “, or” and insert-
22 ing a semicolon;

23 (2) in clause (ii), by striking the period at the
24 end and inserting a semicolon; and

1 (3) by adding at the end the following new
2 clauses:

3 “(iii) a long-term care facility; or

4 “(iv) a home health agency (as defined in
5 section 1861(o)).”.

6 **SEC. 843. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**
7 **FOR MEDICAID ELECTRONIC HEALTH**
8 **RECORD INCENTIVE PAYMENTS.**

9 (a) **IN GENERAL.**—Section 1903(t)(3)(B)(v) of the
10 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is
11 amended by striking “insofar as the assistant is prac-
12 ticing” and all that follows through “so led”.

13 (b) **EFFECTIVE DATE.**—The amendment made by
14 subsection (a) shall apply with respect to amounts ex-
15 pended under 1903(a)(3)(F) of the Social Security Act
16 (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters begin-
17 ning on or after the date of the enactment of this Act.

1 **TITLE IX—ACCOUNTABILITY**
2 **AND EVALUATION**

3 **SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL**
4 **ASSISTED HEALTH CARE SERVICES AND RE-**
5 **SEARCH PROGRAMS ON THE BASIS OF SEX,**
6 **RACE, COLOR, NATIONAL ORIGIN, SEXUAL**
7 **ORIENTATION, GENDER IDENTITY, OR DIS-**
8 **ABILITY STATUS.**

9 No person in the United States shall, on the basis
10 of sex, race, color, national origin, sexual orientation, gen-
11 der identity, or disability status, be excluded from partici-
12 pation in, be denied the benefits of, or be subjected to dis-
13 crimination under any health care service or research pro-
14 gram or activity receiving Federal financial assistance.

15 **SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER**
16 **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

17 A payment to a provider of services, physician, or
18 other supplier under part B, C, or D of title XVIII of
19 the Social Security Act shall be deemed a grant, and not
20 a contract of insurance or guaranty, for the purposes of
21 title VI of the Civil Rights Act of 1964.

1 **SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
2 **THE DEPARTMENT OF HEALTH AND HUMAN**
3 **SERVICES.**

4 Title XXXIV of the Public Health Service Act, as
5 amended by titles I, II, and III of this Act, is further
6 amended by inserting after subtitle B the following:

7 **“Subtitle C—Strengthening**
8 **Accountability**

9 **“SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

10 “(a) IN GENERAL.—The Secretary shall establish
11 within the Office for Civil Rights an Office of Health Dis-
12 parities, which shall be headed by a director to be ap-
13 pointed by the Secretary.

14 “(b) PURPOSE.—The Office of Health Disparities
15 shall ensure that the health programs, activities, and oper-
16 ations of health entities which receive Federal financial as-
17 sistance are in compliance with title VI of the Civil Rights
18 Act, which prohibits discrimination on the basis of race,
19 color, or national origin. The activities of the Office shall
20 include the following:

21 “(1) The development and implementation of
22 an action plan to address racial and ethnic health
23 care disparities, which shall address concerns relat-
24 ing to the Office for Civil Rights as released by the
25 United States Commission on Civil Rights in the re-
26 port entitled ‘Health Care Challenge: Acknowledging

1 Disparity, Confronting Discrimination, and Ensuring
2 Equity’ (September 1999) in conjunction with
3 the reports by the Institute of Medicine entitled ‘Un-
4 equal Treatment: Confronting Racial and Ethnic
5 Disparities in Health Care’, ‘Crossing the Quality
6 Chasm: A New Health System for the 21st Cen-
7 tury’, and ‘In the Nation’s Compelling Interest: En-
8 suring Diversity in the Health Care Workforce’, and
9 ‘The National Partnership for Action to End Health
10 Disparities’, and other related reports by the Insti-
11 tute of Medicine. This plan shall be publicly dis-
12 closed for review and comment and the final plan
13 shall address any comments or concerns that are re-
14 ceived by the Office.

15 “(2) Investigative and enforcement actions
16 against intentional discrimination and policies and
17 practices that have a disparate impact on minorities.

18 “(3) The review of racial, ethnic, and primary
19 language health data collected by Federal health
20 agencies to assess health care disparities related to
21 intentional discrimination and policies and practices
22 that have a disparate impact on minorities.

23 “(4) Outreach and education activities relating
24 to compliance with title VI of the Civil Rights Act.

1 “(5) The provision of technical assistance for
2 health entities to facilitate compliance with title VI
3 of the Civil Rights Act.

4 “(6) Coordination and oversight of activities of
5 the civil rights compliance offices established under
6 section 3442.

7 “(7) Ensuring compliance with the 1997 Office
8 of Management and Budget Standards for Maintain-
9 ing, Collecting, and Presenting Federal Data on
10 Race, Ethnicity and the available language stand-
11 ards.

12 “(c) FUNDING AND STAFF.—The Secretary shall en-
13 sure the effectiveness of the Office of Health Disparities
14 by ensuring that the Office is provided with—

15 “(1) adequate funding to enable the Office to
16 carry out its duties under this section; and

17 “(2) staff with expertise in—

18 “(A) epidemiology;

19 “(B) statistics;

20 “(C) health quality assurance;

21 “(D) minority health and health dispari-
22 ties;

23 “(E) cultural and linguistic competency;

24 and

25 “(F) civil rights.

1 “(d) REPORT.—Not later than December 31, 2012,
2 and annually thereafter, the Secretary, in collaboration
3 with the Director of the Office for Civil Rights and the
4 Deputy Assistant Secretary for Minority Health, shall
5 submit a report to the Committee on Health, Education,
6 Labor, and Pensions of the Senate and the Committee on
7 Energy and Commerce of the House of Representatives
8 that includes—

9 “(1) the number of cases filed, broken down by
10 category;

11 “(2) the number of cases investigated and
12 closed by the office;

13 “(3) the outcomes of cases investigated;

14 “(4) the staffing levels of the office including
15 staff credentials;

16 “(5) the number of other lingering and emerg-
17 ing cases in which civil rights inequities can be dem-
18 onstrated; and

19 “(6) the number of cases remaining open and
20 an explanation for their open status.

21 “(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 2012 through 2017.

1 **“SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OF-**
2 **OFFICES FOR CIVIL RIGHTS WITHIN FEDERAL**
3 **HEALTH AND HUMAN SERVICES AGENCIES.**

4 “(a) IN GENERAL.—The Secretary shall establish
5 civil rights compliance offices in each agency within the
6 Department of Health and Human Services that admin-
7 isters health programs.

8 “(b) PURPOSE OF OFFICES.—Each office established
9 under subsection (a) shall ensure that recipients of Fed-
10 eral financial assistance under Federal health programs
11 administer their programs, services, and activities in a
12 manner that—

13 “(1) does not discriminate, either intentionally
14 or in effect, on the basis of race, national origin, lan-
15 guage, ethnicity, sex, age, disability, sexual orienta-
16 tion, and gender identity; and

17 “(2) promotes the reduction and elimination of
18 disparities in health and health care based on race,
19 national origin, language, ethnicity, sex, age, dis-
20 ability, sexual orientation, and gender identity.

21 “(c) POWERS AND DUTIES.—The offices established
22 in subsection (a) shall have the following powers and du-
23 ties:

24 “(1) The establishment of compliance and pro-
25 gram participation standards for recipients of Fed-
26 eral financial assistance under each program admin-

1 istered by an agency within the Department of
2 Health and Human Services including the establish-
3 ment of disparity reduction standards to encompass
4 disparities in health and health care related to race,
5 national origin, language, ethnicity, sex, age, dis-
6 ability, sexual orientation, and gender identity.

7 “(2) The development and implementation of
8 program-specific guidelines that interpret and apply
9 Department of Health and Human Services guid-
10 ance under title VI of the Civil Rights Act of 1964
11 and section 1557 of the Patient Protection and Af-
12 fordable Care Act to each Federal health program
13 administered by the agency.

14 “(3) The development of a disparity-reduction
15 impact analysis methodology that shall be applied to
16 every rule issued by the agency and published as
17 part of the formal rulemaking process under sections
18 555, 556, and 557 of title 5, United States Code.

19 “(4) Oversight of data collection, analysis, and
20 publication requirements for all recipients of Federal
21 financial assistance under each Federal health pro-
22 gram administered by the agency, and compliance
23 with the 1997 Office of Management and Budget
24 Standards for Maintaining, Collecting, and Pre-

1 sending Federal Data on Race and Ethnicity and the
2 available language standards.

3 “(5) The conduct of publicly available studies
4 regarding discrimination within Federal health pro-
5 grams administered by the agency as well as dis-
6 parity reduction initiatives by recipients of Federal
7 financial assistance under Federal health programs.

8 “(6) Annual reports to the Committee on
9 Health, Education, Labor, and Pensions and the
10 Committee on Finance of the Senate and the Com-
11 mittee on Energy and Commerce and the Committee
12 on Ways and Means of the House of Representatives
13 on the progress in reducing disparities in health and
14 health care through the Federal programs adminis-
15 tered by the agency.

16 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
17 IN THE DEPARTMENT OF JUSTICE.—

18 “(1) DEPARTMENT OF HEALTH AND HUMAN
19 SERVICES.—The Office for Civil Rights in the De-
20 partment of Health and Human Services shall pro-
21 vide standard-setting and compliance review inves-
22 tigation support services to the Civil Rights Compli-
23 ance Office for each agency.

24 “(2) DEPARTMENT OF JUSTICE.—The Office
25 for Civil Rights in the Department of Justice shall

1 continue to maintain the power to institute formal
2 proceedings when an agency Office for Civil Rights
3 determines that a recipient of Federal financial as-
4 sistance is not in compliance with the disparity re-
5 duction standards of the agency.

6 “(e) DEFINITION.—In this section, the term ‘Federal
7 health programs’ mean programs—

8 “(1) under the Social Security Act (42 U.S.C.
9 301 et seq.) that pay for health care and services;
10 and

11 “(2) under this Act that provide Federal finan-
12 cial assistance for health care, biomedical research,
13 health services research, and programs designed to
14 improve the public’s health.”.

15 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

16 (a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3 of the Civil Rights Commission Act of
17 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-
18 TIES.—Section 3 of the Civil Rights Commission Act of
19 1983 (42 U.S.C. 1975a) is amended—

20 (1) in paragraph (1), by striking “and” at the
21 end;

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

24 (3) by adding at the end the following:

1 “(3) shall, with respect to activities carried out
2 in health care and correctional facilities toward the
3 goal of eliminating health disparities between the
4 general population and members of racial or ethnic
5 minority groups, coordinate such activities of—

6 “(A) the Office for Civil Rights within the
7 Department of Justice;

8 “(B) the Office of Justice Programs within
9 the Department of Justice;

10 “(C) the Office for Civil Rights within the
11 Department of Health and Human Services;
12 and

13 “(D) the Office of Minority Health within
14 the Department of Health and Human Services
15 (headed by the Deputy Assistant Secretary for
16 Minority Health).”.

17 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
18 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
19 1975c) is amended by striking the first sentence and in-
20 serting the following: “For the purpose of carrying out
21 this Act, there are authorized to be appropriated
22 \$30,000,000 for fiscal year 2012, and such sums as may
23 be necessary for each of the fiscal years 2013 through
24 2017.”.

1 **SEC. 905. SENSE OF CONGRESS CONCERNING FULL FUND-**
2 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
3 **AND ETHNIC HEALTH DISPARITIES.**

4 (a) FINDINGS.—Congress makes the following find-
5 ings:

6 (1) The health status of the American populace
7 is declining and the United States currently ranks
8 below most industrialized nations in health status
9 measured by longevity, sickness, and mortality.

10 (2) Racial and ethnic minority populations tend
11 have the poorest health status and face substantial
12 cultural, social, and economic barriers to obtaining
13 quality health care.

14 (3) Efforts to improve minority health have
15 been limited by inadequate resources (funding, staff-
16 ing, and stewardship) and accountability.

17 (b) SENSE OF CONGRESS.—It is the sense of Con-
18 gress that—

19 (1) funding should be doubled by fiscal year
20 2013 for the National Institute for Minority Health
21 Disparities, the Office of Civil Rights in the Depart-
22 ment of Health and Human Services, the National
23 Institute of Nursing Research, and the Office of Mi-
24 nority Health;

25 (2) adequate funding by fiscal year 2013, and
26 subsequent funding increases, should be provided for

1 health professions training programs, the Racial and
2 Ethnic Approaches to Community Health (REACH)
3 at the Centers for Disease Control and Prevention,
4 the Minority HIV/AIDS Initiative, and the Excel-
5 lence Centers to Eliminate Ethnic/Racial Disparities
6 (EXCEED) Program at the Agency for Healthcare
7 Research and Quality;

8 (3) funding should be restored to the Racial
9 and Ethnic Approaches to Community Health
10 (REACH) program at the Centers for Disease Con-
11 trol and Prevention, which has been a successful
12 program at the community health level;

13 (4) current and newly created health disparity
14 elimination incentives, programs, agencies, and de-
15 partments under this Act (and the amendments
16 made by this Act) should receive adequate staffing
17 and funding by fiscal year 2013; and

18 (5) stewardship and accountability should be
19 provided to the Congress and the President for
20 measurable and sustainable progress toward health
21 disparity elimination.

22 **SEC. 906. GAO AND NIH REPORTS.**

23 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-
24 NIC DIVERSITY.—

1 (1) IN GENERAL.—The Comptroller General of
2 the United States shall conduct a study on the racial
3 and ethnic diversity among the following groups:

4 (A) All applicants for grants, contracts,
5 and cooperative agreements awarded by the Na-
6 tional Institutes of Health during the period be-
7 ginning January 1, 1990, and ending December
8 31, 2011.

9 (B) All recipients of such grants, con-
10 tracts, and cooperative agreements.

11 (C) All members of the peer review panels
12 of such applicants and recipients, respectively.

13 (2) REPORT.—Not later than six months after
14 the date of the enactment of this Act, the Comp-
15 troller General shall complete the study under para-
16 graph (1) and submit to Congress a report con-
17 taining the results of such study.

18 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
19 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
20 DISPARITIES.—Not later than six months after the date
21 of the enactment of this Act, and biennially thereafter, the
22 Director of the National Institutes of Health, in collabora-
23 tion with the Director of the National Institute on Minor-
24 ity Health and Health Disparities, shall submit to Con-
25 gress a report that details and evaluates—

1 (1) the steps taken during the applicable report
2 period by the Director of the National Institutes of
3 Health to enforce the expanded planning, coordina-
4 tion, review, and evaluation authority provided the
5 National Institute on Minority Health and Health
6 Disparities under section 464z-3(h) of the Public
7 Health Service Act (42 U.S.C. 285(h)), as added by
8 section 10334(c) of the Patient Protection and Af-
9 fordable Care Act, over all minority health and
10 health disparity research that is conducted or sup-
11 ported by the Institutes and Centers at the National
12 Institutes of Health; and

13 (2) the outcomes of such steps.

14 (c) GAO REPORT RELATED TO RECIPIENTS OF
15 PPACA FUNDING.—Not later than one year after the
16 date of the enactment of this Act and biennially thereafter
17 until 2020, the Comptroller General of the United States
18 shall submit to Congress a report that identifies, with re-
19 spect to minority community-based organizations that ap-
20 plied during the applicable report period for Federal fund-
21 ing provided pursuant to the provisions of (and amend-
22 ments made by) the Patient Protection and Affordable
23 Care Act for purposes of achieving health equity and elimi-
24 nating health disparities, the percentage of such organiza-
25 tions that were awarded such funding.

1 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
2 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
3 PARITIES.—The Director of the National Institute on Mi-
4 nority Health and Health Disparities shall prepare an an-
5 nual report on the activities carried out or to be carried
6 out by the Institute, and shall submit each such report
7 to the Committee on Health, Education, Labor, and Pen-
8 sions of the Senate, the Committee on Energy and Com-
9 merce of the House of Representatives, the Secretary of
10 Health and Human Services, and the Director of the Na-
11 tional Institutes of Health. With respect to the fiscal year
12 involved, the report shall—

13 (1) describe and evaluate the progress made in
14 health disparities research conducted or supported
15 by institutes and centers of the National Institutes
16 of Health;

17 (2) summarize and analyze expenditures made
18 for activities with respect to health disparities re-
19 search conducted or supported by the National Insti-
20 tutes of Health;

21 (3) include a separate statement applying the
22 requirements of paragraphs (1) and (2) specifically
23 to minority health disparities research; and

24 (4) contain such recommendations as the Direc-
25 tor of the Institute considers appropriate.

1 **TITLE X—ADDRESSING SOCIAL**
2 **DETERMINANTS AND IM-**
3 **PROVING ENVIRONMENTAL**
4 **JUSTICE**

5 **SEC. 1001. CODIFICATION OF EXECUTIVE ORDER 12898.**

6 (a) IN GENERAL.—The President of the United
7 States is authorized and directed to execute, administer,
8 and enforce as a matter of Federal law the provisions of
9 Executive Order 12898, dated February 11, 1994 (“Fed-
10 eral Actions To Address Environmental Justice In Minor-
11 ity Populations and Low-Income Populations”), with such
12 modifications as are provided in this section.

13 (b) DEFINITION OF ENVIRONMENTAL JUSTICE.—For
14 purposes of carrying out the provisions of Executive Order
15 12898, the following definitions shall apply:

16 (1) The term “environmental justice” means
17 the fair treatment and meaningful involvement of all
18 people regardless of race, color, national origin, edu-
19 cational level, or income with respect to the develop-
20 ment, implementation, and enforcement of environ-
21 mental laws and regulations in order to ensure
22 that—

23 (A) minority and low-income communities
24 have access to public information relating to

1 human health and environmental planning, reg-
2 ulations, and enforcement; and

3 (B) no minority or low-income population
4 is forced to shoulder a disproportionate burden
5 of the negative human health and environ-
6 mental impacts of pollution or other environ-
7 mental hazard.

8 (2) The term “fair treatment” means policies
9 and practices that ensure that no group of people,
10 including racial, ethnic, or socioeconomic groups
11 bear disproportionately high and adverse human
12 health or environmental effects resulting from Fed-
13 eral agency programs, policies, and activities.

14 (c) JUDICIAL REVIEW AND RIGHTS OF ACTION.—
15 The provisions of section 6–609 of Executive Order 12898
16 shall not apply for purposes of this Act.

17 **SEC. 1002. IMPLEMENTATION OF RECOMMENDATIONS BY**
18 **ENVIRONMENTAL PROTECTION AGENCY.**

19 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The
20 Administrator of the Environmental Protection Agency
21 shall, as promptly as practicable, carry out each of the
22 following recommendations of the Inspector General of the
23 agency as set forth in Report No. 2006–P–00034 entitled
24 “EPA needs to conduct environmental justice reviews of
25 its programs, policies and activities”:

1 (1) The recommendation that the Agency’s pro-
2 gram and regional offices identify which programs,
3 policies, and activities need environmental justice re-
4 views and require these offices to establish a plan to
5 complete the necessary reviews.

6 (2) The recommendation that the Administrator
7 of the Agency ensure that these reviews determine
8 whether the programs, policies, and activities may
9 have a disproportionately high and adverse health or
10 environmental impact on minority and low-income
11 populations.

12 (3) The recommendation that each program
13 and regional office develop specific environmental
14 justice review guidance for conducting environmental
15 justice reviews.

16 (4) The recommendation that the Administrator
17 designate a responsible office to compile results of
18 environmental justice reviews and recommend appro-
19 priate actions.

20 (b) GAO RECOMMENDATIONS.—In developing rules
21 under laws administered by the Environmental Protection
22 Agency, the Administrator of the Agency shall, as prompt-
23 ly as practicable, carry out each of the following rec-
24 ommendations of the Comptroller General of the United
25 States as set forth in GAO Report numbered GAO–05–

1 289 entitled “EPA Should Devote More Attention to En-
2 vironmental Justice when Developing Clean Air Rules”:

3 (1) The recommendation that the Administrator
4 ensure that workgroups involved in developing a rule
5 devote attention to environmental justice while draft-
6 ing and finalizing the rule.

7 (2) The recommendation that the Administrator
8 enhance the ability of such workgroups to identify
9 potential environmental justice issues through such
10 steps as providing workgroup members with guid-
11 ance and training to helping them identify potential
12 environmental justice problems and involving envi-
13 ronmental justice coordinators in the workgroups
14 when appropriate.

15 (3) The recommendation that the Administrator
16 improve assessments of potential environmental jus-
17 tice impacts in economic reviews by identifying the
18 data and developing the modeling techniques needed
19 to assess such impacts.

20 (4) The recommendation that the Administrator
21 direct appropriate Agency officers and employees to
22 respond fully when feasible to public comments on
23 environmental justice, including improving the Agen-
24 cy’s explanation of the basis for its conclusions, to-
25 gether with supporting data.

1 (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-
2 ministrator of the Environmental Protection Agency shall,
3 as promptly as practicable, carry out each of the following
4 recommendations of the Inspector General of the Agency
5 as set forth in the report entitled “EPA Needs to Consist-
6 ently Implement the Intent of the Executive Order on En-
7 vironmental Justice” (Report No. 2004–P–00007):

8 (1) The recommendation that the Agency clear-
9 ly define the mission of the Office of Environmental
10 Justice (OEJ) and provide Agency staff with an un-
11 derstanding of the roles and responsibilities of the
12 Office.

13 (2) The recommendation that the Agency estab-
14 lish (through issuing guidance or a policy statement
15 from the Administrator) specific time frames for the
16 development of definitions, goals, and measurements
17 regarding environmental justice and provide the re-
18 gions and program offices a standard and consistent
19 definition for a minority and low-income community,
20 with instructions on how the Agency will implement
21 and operationalize environmental justice into the
22 Agency’s daily activities.

23 (3) The recommendation that the Agency en-
24 sure the comprehensive training program currently
25 under development includes standard and consistent

1 definitions of the key environmental justice concepts
2 (such as “low-income”, “minority”, and “dispropor-
3 tionately impacted”) and instructions for implemen-
4 tation of those concepts.

5 The Administrator shall submit an initial report to Con-
6 gress within 6 months after the enactment of this Act re-
7 garding the Administrator’s strategy for implementing the
8 recommendations referred to in paragraphs (1), (2), and
9 (3). Thereafter, the Administrator shall provide semi-
10 annual reports to Congress regarding the Administrator’s
11 progress in implementing such recommendations and
12 modifying the Administrator’s emergency management
13 procedures to incorporate environmental justice in the
14 Agency’s Incident Command Structure (in accordance
15 with the December 18, 2006, letter from the Deputy Ad-
16 ministrator to the Acting Inspector General of the Agen-
17 cy).

18 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,
19 PROTECTING PEOPLE AND THEIR FAMILIES FROM
20 RADON.—

21 (1) IN GENERAL.—Because radon is a naturally
22 occurring radioactive gas that is recognized as the
23 leading cause of lung cancer among nonsmokers and
24 is a particular environmental threat for low-income
25 and minority individuals because of the lack of infor-

1 mation about radon levels in their own homes, the
2 Administrator of the Environmental Protection
3 Agency shall within 6 months after the date of the
4 enactment of this Act, implement the action plan en-
5 titled “Protecting People and Families from Radon:
6 A Federal Action Plan for Saving Lives” (June 20,
7 2011), working with the Secretary of Health and
8 Human Services acting through the Director of the
9 Centers for Disease Control and Prevention, and
10 with the other Federal agencies mentioned in and as
11 set forth in the action plan.

12 (2) SPECIFIC STEPS.—In carrying out para-
13 graph (1), the Administrator shall take steps to
14 achieve each of the following:

15 (A) The recommendation that the
16 workgroup comprised of the Federal agencies
17 participating in the development of the action
18 plan referred to in paragraph (1) implement
19 specific steps within the current authority and
20 activities of each Federal agency to reduce ex-
21 posure to radon.

22 (B) The recommendation that such
23 workgroup meet on the 1-year anniversary of
24 the plan to assess and recognize achievements
25 of the plan.

1 (3) REPORT.—The Administrator shall report
2 to the Congress on the 1-year assessment of the
3 plan’s implementation, including the challenges re-
4 maining and the progress in reducing radon expo-
5 sure particularly to low-income and minority fami-
6 lies.

7 **SEC. 1003. GRANT PROGRAM.**

8 (a) DEFINITIONS.—In this section:

9 (1) DIRECTOR.—The term “Director” means
10 the Director of the Centers for Disease Control and
11 Prevention, acting in collaboration with the Adminis-
12 trator of the Environmental Protection Agency and
13 the Director of the National Institute of Environ-
14 mental Health Sciences.

15 (2) ELIGIBLE ENTITY.—The term “eligible enti-
16 ty” means a State or local community that—

17 (A) bears a disproportionate burden of ex-
18 posure to environmental health hazards;

19 (B) has established a coalition—

20 (i) with not less than 1 community-
21 based organization; and

22 (ii) with not less than 1—

23 (I) public health entity;

24 (II) health care provider organi-
25 zation; or

1 (III) academic institution, includ-
2 ing any minority-serving institution
3 (including an Hispanic-serving institu-
4 tion, a historically Black college or
5 university, and a tribal college or uni-
6 versity);

7 (C) ensures planned activities and funding
8 streams are coordinated to improve community
9 health; and

10 (D) submits an application in accordance
11 with subsection (c).

12 (b) ESTABLISHMENT.—The Director shall establish a
13 grant program under which eligible entities shall receive
14 grants to conduct environmental health improvement ac-
15 tivities.

16 (c) APPLICATION.—To receive a grant under this sec-
17 tion, an eligible entity shall submit an application to the
18 Director at such time, in such manner, and accompanied
19 by such information as the Director may require.

20 (d) COOPERATIVE AGREEMENTS.—An eligible entity
21 may use a grant under this section—

22 (1) to promote environmental health; and

23 (2) to address environmental health disparities.

24 (e) AMOUNT OF COOPERATIVE AGREEMENT.—

1 (1) IN GENERAL.—The Director shall award
2 grants to eligible entities at the 2 different funding
3 levels described in this subsection.

4 (2) LEVEL 1 COOPERATIVE AGREEMENTS.—

5 (A) IN GENERAL.—An eligible entity
6 awarded a grant under this paragraph shall use
7 the funds to identify environmental health prob-
8 lems and solutions by—

9 (i) establishing a planning and
10 prioritizing council in accordance with sub-
11 paragraph (B); and

12 (ii) conducting an environmental
13 health assessment in accordance with sub-
14 paragraph (C).

15 (B) PLANNING AND PRIORITIZING COUN-
16 CIL.—

17 (i) IN GENERAL.—A prioritizing and
18 planning council established under sub-
19 paragraph (A)(i) (referred to in this para-
20 graph as a “PPC”) shall assist the envi-
21 ronmental health assessment process and
22 environmental health promotion activities
23 of the eligible entity.

24 (ii) MEMBERSHIP.—Membership of a
25 PPC shall consist of representatives from

1 various organizations within public health,
2 planning, development, and environmental
3 services and shall include stakeholders
4 from vulnerable groups such as children,
5 the elderly, disabled, and minority ethnic
6 groups that are often not actively involved
7 in democratic or decisionmaking processes.

8 (iii) DUTIES.—A PPC shall—

9 (I) identify key stakeholders and
10 engage and coordinate potential part-
11 ners in the planning process;

12 (II) establish a formal advisory
13 group to plan for the establishment of
14 services;

15 (III) conduct an in-depth review
16 of the nature and extent of the need
17 for an environmental health assess-
18 ment, including a local epidemiological
19 profile, an evaluation of the service
20 provider capacity of the community,
21 and a profile of any target popu-
22 lations; and

23 (IV) define the components of
24 care and form essential programmatic

1 linkages with related providers in the
2 community.

3 (C) ENVIRONMENTAL HEALTH ASSESS-
4 MENT.—

5 (i) IN GENERAL.—A PPC shall carry
6 out an environmental health assessment to
7 identify environmental health concerns.

8 (ii) ASSESSMENT PROCESS.—The
9 PPC shall—

10 (I) define the goals of the assess-
11 ment;

12 (II) generate the environmental
13 health issue list;

14 (III) analyze issues with a sys-
15 tems framework;

16 (IV) develop appropriate commu-
17 nity environmental health indicators;

18 (V) rank the environmental
19 health issues;

20 (VI) set priorities for action;

21 (VII) develop an action plan;

22 (VIII) implement the plan; and

23 (IX) evaluate progress and plan-
24 ning for the future.

1 (D) EVALUATION.—Each eligible entity
2 that receives a grant under this paragraph shall
3 evaluate, report, and disseminate program find-
4 ings and outcomes.

5 (E) TECHNICAL ASSISTANCE.—The Direc-
6 tor may provide such technical and other non-
7 financial assistance to eligible entities as the
8 Director determines to be necessary.

9 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—

10 (A) ELIGIBILITY.—

11 (i) IN GENERAL.—The Director shall
12 award grants under this paragraph to eli-
13 gible entities that have already—

14 (I) established broad-based col-
15 laborative partnerships; and

16 (II) completed environmental as-
17 sessments.

18 (ii) NO LEVEL 1 REQUIREMENT.—To
19 be eligible to receive a grant under this
20 paragraph, an eligible entity is not re-
21 quired to have successfully completed a
22 Level 1 Cooperative Agreement (as de-
23 scribed in paragraph (2)).

24 (B) USE OF GRANT FUNDS.—An eligible
25 entity awarded a grant under this paragraph

1 shall use the funds to further activities to carry
2 out environmental health improvement activi-
3 ties, including—

4 (i) addressing community environ-
5 mental health priorities in accordance with
6 paragraph (2)(C)(ii), including—

7 (I) air quality;

8 (II) water quality;

9 (III) solid waste;

10 (IV) land use;

11 (V) housing;

12 (VI) food safety;

13 (VII) crime;

14 (VIII) injuries; and

15 (IX) health care services;

16 (ii) building partnerships between
17 planning, public health, and other sectors,
18 to address how the built environment im-
19 pacts food availability and access and
20 physical activity to promote healthy behav-
21 iors and lifestyles and reduce overweight
22 and obesity, asthma, respiratory condi-
23 tions, dental, oral and mental health condi-
24 tions, poverty, and related co-morbidities;

1 (iii) establishing programs to ad-
2 dress—

3 (I) how environmental and social
4 conditions of work and living choices
5 influence physical activity and dietary
6 intake; or

7 (II) how those conditions influ-
8 ence the concerns and needs of people
9 who have impaired mobility and use
10 assistance devices, including wheel-
11 chairs and lower limb prostheses; and

12 (iv) convening intervention programs
13 that examine the role of the social environ-
14 ment in connection with the physical and
15 chemical environment in—

16 (I) determining access to nutri-
17 tional food; and

18 (II) improving physical activity to
19 reduce morbidity and increase quality
20 of life.

21 (f) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this sec-
23 tion—

24 (1) \$25,000,000 for fiscal year 2012; and

1 (2) such sums as may be necessary for fiscal
2 years 2013 through 2016.

3 **SEC. 1004. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
4 **BETWEEN THE BUILT ENVIRONMENT AND**
5 **THE HEALTH OF COMMUNITY RESIDENTS.**

6 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
7 section, the term “eligible institution” means a public or
8 private nonprofit institution that submits to the Secretary
9 of Health and Human Services (in this section referred
10 to as the “Secretary”) and the Administrator of the Envi-
11 ronmental Protection Agency (in this section referred to
12 as the “Administrator”) an application for a grant under
13 the grant program authorized under subsection (b)(2) at
14 such time, in such manner, and containing such agree-
15 ments, assurances, and information as the Secretary and
16 Administrator may require.

17 (b) RESEARCH GRANT PROGRAM.—

18 (1) DEFINITION OF HEALTH.—In this section,
19 the term “health” includes—

20 (A) levels of physical activity;

21 (B) consumption of nutritional foods;

22 (C) rates of crime;

23 (D) air, water, and soil quality;

24 (E) risk of injury;

1 (F) accessibility to health care services;
2 and

3 (G) other indicators as determined appro-
4 priate by the Secretary.

5 (2) GRANTS.—The Secretary, in collaboration
6 with the Administrator, shall provide grants to eligi-
7 ble institutions to conduct and coordinate research
8 on the built environment and its influence on indi-
9 vidual and population-based health.

10 (3) RESEARCH.—The Secretary shall support
11 research that—

12 (A) investigates and defines the causal
13 links between all aspects of the built environ-
14 ment and the health of residents;

15 (B) examines—

16 (i) the extent of the impact of the
17 built environment (including the various
18 characteristics of the built environment) on
19 the health of residents;

20 (ii) the variance in the health of resi-
21 dents by—

22 (I) location (such as inner cities,
23 inner suburbs, and outer suburbs);
24 and

1 (II) population subgroup (such as
2 children, the elderly, the disadvan-
3 tagged); or

4 (iii) the importance of the built envi-
5 ronment to the total health of residents,
6 which is the primary variable of interest
7 from a public health perspective;

8 (C) is used to develop—

9 (i) measures to address health and the
10 connection of health to the built environ-
11 ment; and

12 (ii) efforts to link the measures to
13 travel and health databases; and

14 (D) distinguishes carefully between per-
15 sonal attitudes and choices and external influ-
16 ences on observed behavior to determine how
17 much an observed association between the built
18 environment and the health of residents, versus
19 the lifestyle preferences of the people that
20 choose to live in the neighborhood, reflects the
21 physical characteristics of the neighborhood;
22 and

23 (E)(i) identifies or develops effective inter-
24 vention strategies to promote better health
25 among residents with a focus on behavioral

1 interventions and enhancements of the built en-
2 vironment that promote increased use by resi-
3 dents; and

4 (ii) in developing the intervention strate-
5 gies under clause (i), ensures that the interven-
6 tion strategies will reach out to high-risk popu-
7 lations, including racial and ethnic minorities
8 and low-income urban and rural communities.

9 (4) PRIORITY.—In providing assistance under
10 the grant program authorized under paragraph (2),
11 the Secretary and the Administrator shall give pri-
12 ority to research that incorporates—

13 (A) minority-serving institutions as grant-
14 ees;

15 (B) interdisciplinary approaches; or

16 (C) the expertise of the public health,
17 physical activity, urban planning, and transpor-
18 tation research communities in the United
19 States and abroad.

20 **SEC. 1005. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**
21 **TION.**

22 (a) FINDINGS.—

23 (1) GENERAL FINDINGS.—The Congress finds
24 as follows:

1 (A) As human beings, we share our envi-
2 ronment with a wide variety of habitats and
3 ecosystems that nurture and sustain a diversity
4 of species.

5 (B) The abundance of natural resources in
6 our environment forms the basis for our econ-
7 omy and has greatly contributed to human de-
8 velopment throughout history.

9 (C) The accelerated pace of human devel-
10 opment over the last several hundred years has
11 significantly impacted our natural environment
12 and its resources, the health and diversity of
13 plant and animal wildlife, the availability of
14 critical habitats, the quality of our air and our
15 water, and our global climate.

16 (D) The intervention of the Federal Gov-
17 ernment is necessary to minimize and mitigate
18 human impact on the environment for the ben-
19 efit of public health, to maintain air quality and
20 water quality, to sustain the diversity of plants
21 and animals, to combat global climate change,
22 and to protect the environment.

23 (E) Laws and regulations in the United
24 States have been created and promulgated to
25 minimize and mitigate human impact on the en-

1 vironment for the benefit of public health, to
2 maintain air quality and water quality, to sus-
3 tain wildlife, and to protect the environment.

4 (F) Such laws include the Antiquities Act
5 of 1906 (16 U.S.C. 431 et seq.) initiated by
6 President Theodore Roosevelt to create the na-
7 tional park system, the National Environmental
8 Policy Act of 1969 (42 U.S.C. 4321 et seq.),
9 the Clean Air Act (42 U.S.C. 7401 et seq.), the
10 Federal Water Pollution Control Act (33 U.S.C.
11 1251 et seq.), the Comprehensive Environ-
12 mental Response, Compensation, and Liability
13 Act of 1980 (Public Law 96–510), the Endan-
14 gered Species Act of 1973 (Public Law 93–
15 205), and the National Forest Management Act
16 of 1976 (Public Law 94–588).

17 (G) Attempts to repeal or weaken key envi-
18 ronmental safeguards pose dangers to the pub-
19 lic health, air quality, water quality, wildlife,
20 and the environment.

21 (2) FINDINGS ON CHANGES AND PROPOSED
22 CHANGES IN LAW.—The Congress finds that, since
23 2001, the following changes and proposed changes
24 to existing law or regulations have negatively im-

1 pacted or will negatively impact the environment and
2 public health:

3 (A) CLEAN WATER.—

4 (i) On May 9, 2002, the Environ-
5 mental Protection Agency (EPA) and the
6 Army Corps of Engineers put forth a final
7 rule that reconciled regulations imple-
8 menting section 404 of the Federal Water
9 Pollution Control Act by redefining the
10 term “fill material” and amending the def-
11 inition of the term “discharge of fill mate-
12 rial”, reversing a 25-year-old regulation.
13 The new rule fails to restrict the dumping
14 of hardrock mining waste, construction de-
15 bris, and other industrial wastes into riv-
16 ers, streams, lakes, and wetlands. The rule
17 further allows destructive mountaintop re-
18 moval coal mining companies to dump
19 waste into streams and lakes, polluting the
20 surrounding natural habitat and poisoning
21 plants and animals that depend on those
22 water sources.

23 (ii) On February 12, 2003, the Envi-
24 ronmental Protection Agency published the
25 rule “National Pollutant Discharge Elimini-

1 nation System Permit Regulation and Ef-
2 fluent Limitation Guidelines and Stand-
3 ards for Concentrated Animal Feeding Op-
4 erations”, new livestock waste regulations
5 that aimed to control factory farm pollu-
6 tion but which would severely undermine
7 existing protections under the Federal
8 Water Pollution Control Act. This regula-
9 tion allows large-scale animal factories to
10 foul the Nation’s waters with animal
11 waste, allows livestock owners to draft
12 their own pollution-management plans and
13 avoid ground water monitoring, legalizes
14 the discharge of contaminated runoff water
15 rich in nitrogen, phosphorus, bacteria, and
16 metals, and ensures that large factory
17 farms are not held liable for the environ-
18 mental damage they cause. In a 2005 Fed-
19 eral court decision (“Waterkeeper Alliance,
20 et al. v. Environmental Protection Agency”,
21 399 F.3d 486 (2nd Cir. 2005)), major
22 parts of the rule were upheld, others va-
23 cated, and still others remanded back to
24 the EPA. On November 20, 2008, the En-
25 vironmental Protection Agency published a

1 revised final rule which undermines envi-
2 ronmental protection provisions by remov-
3 ing mandatory permitting requirements
4 and allowing large animal farms to self-
5 certify the absence of pollutant discharge
6 activity.

7 (iii) On March 19, 2003, the Environ-
8 mental Protection Agency published a new
9 rule regarding the Total Maximum Daily
10 Load program of the Federal Water Pollu-
11 tion Control Act that regulates the max-
12 imum amount of a particular pollutant
13 that can be present in a body of water and
14 still meet water quality standards. The new
15 rule withdrew the existing regulation put
16 forth on July 13, 2000, and halted mo-
17 mentum in cleaning up polluted waterways
18 throughout the Nation. By abandoning the
19 existing rule, the Environmental Protection
20 Agency is undermining the effectiveness of
21 clean-up plans and is allowing States to
22 avoid cleaning polluted waters entirely by
23 dropping them from their clean-up lists.
24 Waterways play a crucial role in the lives
25 of the people of the United States and are

1 critical to the livelihood of fish and wildlife.
2 The result of dropping the July 2000 rule
3 is that the restoration of polluted rivers,
4 shorelines, and lakes will be delayed, harm-
5 ing more fish and wildlife and worsening
6 the quality of drinking water.

7 (iv) On December 2, 2008, the Envi-
8 ronmental Protection Agency and the
9 Army Corps of Engineers jointly issued a
10 guidance document in the form of a legal
11 memorandum, titled “Clean Water Act Ju-
12 risdiction Following the U.S. Supreme
13 Court’s Decision in *Rapanos v. United*
14 *States & Carabell v. United States*”. This
15 new guidance dictates enforcement actions
16 under the Federal Water Pollution Control
17 Act and calls for a complicated “case-by-
18 case” analysis to determine jurisdiction for
19 waterways that do not flow all year. Such
20 actions endanger small streams and wet-
21 lands that serve as important habitats for
22 aquatic life, which play a fundamental role
23 in safeguarding sources of clean drinking
24 water and mitigate the risks and effects of
25 floods and droughts. Further, the defini-

1 tion provided therein for “waters of the
2 United States” is applicable to the Federal
3 Water Pollution Control Act as a whole,
4 potentially affecting programs that control
5 industrial pollution and sewage levels, pre-
6 vent oil spills, and set water quality stand-
7 ards for all waters in the United States
8 protected under the Federal Water Pollu-
9 tion Control Act.

10 (B) FORESTS AND LAND MANAGEMENT.—

11 (i) On December 3, 2003, the Presi-
12 dent signed into law the Healthy Forests
13 Restoration Act of 2003 (Public Law 108-
14 148; 16 U.S.C. 6501 et seq.). Although the
15 law attempts to reduce the risk of cata-
16 strophic forest fires, it provides a boon to
17 timber companies by accelerating the ag-
18 gressive thinning of backcountry forests
19 that are far from at-risk communities. The
20 law allows for increased logging of large,
21 fire-resistant trees that are not in close
22 proximity of homes and communities; it
23 undermines critical protections for endan-
24 gered species by exempting Federal land
25 management agencies from consulting with

1 the United States Fish and Wildlife Serv-
2 ice before approving any action that could
3 harm endangered plants or wildlife; and it
4 limits public participation by reducing the
5 number of environmental project reviews.

6 (ii) On April 21, 2008, the Depart-
7 ment of Agriculture issued a Final Plan-
8 ning Rule and Record of Decision for Na-
9 tional Forest System Land Management
10 Planning. Similar to rules enacted by the
11 Administration on January 5, 2005, later
12 remanded back to the agency in Federal
13 district court for violating the National
14 Environmental Policy Act of 1969, the En-
15 dangered Species Act of 1973, and the Ad-
16 ministrative Procedure Act (“Citizens for
17 Better Forestry v. United States Depart-
18 ment of Agriculture”, 481 F. Supp. 2d
19 1059 (N.D. Cal. 2007)), this revised rule
20 eliminates strict forest planning standards
21 established in 1982, and opens millions of
22 acres of public lands to damaging and
23 invasive logging, mining, and drilling oper-
24 ations. These regulations would reverse
25 more than 20 years of protection for wild-

1 life and national forests by removing the
2 overall goal of ensuring ecological sustain-
3 ability in managing the national forest sys-
4 tem, weakening the National Forest Man-
5 agement Act of 1976, and effectively end-
6 ing the review of forest management plans
7 under the National Environmental Policy
8 Act of 1969.

9 (iii) On September 20, 2006, the Dis-
10 trict Court for the Northern District of
11 California vacated the Protection of Inven-
12 toried Roadless Areas rule, enacted on May
13 13, 2005, which gave State Governors 18
14 months to petition the Federal Government
15 to either restore the previous rule for their
16 States, or submit a new management and
17 development plan for national forest areas
18 inventoried under the rule. Despite the
19 enjoinder of the Administration's 2005
20 rule, and the subsequent restoration of the
21 original Roadless Area Conservation Rule,
22 the U.S. Forest Service has continued to
23 allow States to petition for a special rule
24 under the authority of the Administrative
25 Procedure Act, publishing a final special

1 rule for Idaho on October 16, 2008. As a
2 result, 58.5 million acres of wild national
3 forests are still vulnerable to logging, road
4 building, and other developments that may
5 fragment natural habitats and negatively
6 impact fish and wildlife.

7 (iv) On November 17, 2008, the De-
8 partment of the Interior's Bureau of Land
9 Management (BLM) signed the Record of
10 Decision (ROD) amending 12 resource
11 management plans in Colorado, Utah, and
12 Wyoming, opening 2,000,000 acres of pub-
13 lic lands to commercial tar sands and oil
14 shale exploration and development. On No-
15 vember 18, 2008, the BLM published a
16 final rule for Oil Shale Management set-
17 ting the policies and procedures for a com-
18 mercial leasing program for the manage-
19 ment of federally owned oil shale in those
20 three States. Previously barred by a con-
21 gressional moratorium on the commercial
22 leasing regulations for oil shale until Sep-
23 tember 30, 2008, the development of oil
24 shale on public lands poses a serious threat
25 to land conservation, endangered and

1 threatened species, and critical habitat.
2 Domestic shale oil production allowed by
3 these regulations is highly water and en-
4 ergy intensive, the impacts of which will in-
5 tensify existing water scarcity in the arid
6 Western Region and potentially degrade
7 air and water quality for surrounding pop-
8 ulations.

9 (C) SCIENTIFIC REVIEW.—On December
10 16, 2008, the United States Fish and Wildlife
11 Service of the Department of the Interior and
12 the National Oceanic and Atmospheric Admin-
13 istration of the Department of Commerce joint-
14 ly issued a new rule amending regulations gov-
15 erning interagency cooperation under section 7
16 of the Endangered Species Act of 1973 (ESA).
17 This rule undermines the intention of the ESA
18 to protect species and the ecosystems upon
19 which they depend by allowing Federal agencies
20 to carry out, permit, or fund an action without
21 proper environmental review and expert third-
22 party consultation from Federal wildlife ex-
23 perts. Under this new rule, Federal agencies
24 can unilaterally circumvent the formal review
25 process, eliminating longstanding and scientif-

1 ically grounded safeguards that serve to protect
2 the biodiversity of our Nation’s ecosystems and
3 avert harm to thousands of endangered and
4 threatened species.

5 (b) STATEMENT OF POLICY.—It is the policy of the
6 United States Government to work in conjunction with
7 States, territories, tribal governments, international orga-
8 nizations, and foreign governments in order to act as a
9 steward of the environment for the benefit of public
10 health, to maintain air quality and water quality, to sus-
11 tain the diversity of plant and animal species, to combat
12 global climate change, and to protect the environment for
13 future generations to enjoy.

14 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
15 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
16 TIONS, LAWS, OR PROPOSED LAWS.—

17 (1) STUDY.—Not later than 30 days after the
18 date of enactment of this Act, the President shall
19 enter into an arrangement under which the National
20 Academy of Sciences will conduct a study to deter-
21 mine the impact on public health, air quality, water
22 quality, wildlife, and the environment of the fol-
23 lowing regulations, laws, and proposed laws:

24 (A) CLEAN WATER.—

1 (i) Final revisions to the Federal
2 Water Pollution Control Act regulatory
3 definitions of “fill material” and “dis-
4 charge of fill material”, finalized and pub-
5 lished in the Federal Register on May 9,
6 2002 (67 FR 31129), amending part 232
7 of title 40, Code of Federal Regulations.

8 (ii) Revised National Pollutant Dis-
9 charge Elimination System Permit Regula-
10 tion and Effluent Limitation Guidelines
11 and Standards for Concentrated Animal
12 Feeding Operations in response to the
13 “Waterkeeper Alliance, et al. v.
14 Environmental Protection Agency” decision,
15 finalized and published in the Federal Reg-
16 ister on November 20, 2008 (73 FR 225),
17 amending parts 9, 122, and 412 of title
18 40, Code of Federal Regulations.

19 (iii) A March 19, 2003, rule published
20 in the Federal Register (68 FR 13608)
21 withdrawing a July 13, 2000, rule revising
22 the Total Maximum Daily Load program
23 of the Federal Water Pollution Control Act
24 (65 FR 43586), amending parts 9, 122,

1 123, 124, and 130 of title 40, Code of
2 Federal Regulations.

3 (iv) Official Guidance Document,
4 “Clean Water Act Jurisdiction Following
5 the United States Supreme Court’s Deci-
6 sion in *Rapanos v. United States &*
7 *Carabell v. United States*”, issued on De-
8 cember 2, 2008, relating to jurisdiction
9 under section 404 of the Federal Water
10 Pollution Control Act.

11 (B) FORESTS AND LAND MANAGEMENT.—

12 (i) Healthy Forests Restoration Act of
13 2003, signed into law on December 3,
14 2003 (Public Law 108–148; 16 U.S.C.
15 6501 et seq.).

16 (ii) National Forest System Land
17 Management Planning Rule, finalized and
18 published in the Federal Register on April
19 21, 2008 (73 FR 21468), replacing the
20 2005 final rule (70 FR 1022, Jan. 5,
21 2005), as amended March 3, 2006 (71 FR
22 10837) and the 2000 final rule adopted on
23 November 9, 2000 (65 FR 67514) as
24 amended on September 29, 2004 (69 FR

1 58055), amending title 36, Code of Fed-
2 eral Regulations, part 219.

3 (iii) The application of the Adminis-
4 trative Procedure Act (5 U.S.C. 551 to
5 559, 701 to 706, et seq.), such that States
6 may petition for a special rule for the
7 roadless areas in all or part of said State.

8 (iv) Record of Decision, “Oil Shale
9 and Tar Sands Resources Resource Man-
10 agement Plan Amendments”, issued on
11 November 17, 2008, along with the Final
12 Rule, Oil Shale Management-General, pub-
13 lished in the Federal Register on Novem-
14 ber 18, 2008 (73 FR 223), amending title
15 43, Code of Federal Regulations, parts
16 3900, 3910, 3920, and 3930.

17 (C) SCIENTIFIC REVIEW.—Final Rule,
18 Interagency Cooperation Under the Endangered
19 Species Act, published in the Federal Register
20 on December 16, 2008, amending title 50, Code
21 of Federal Regulations, part 402.

22 (2) METHOD.—In conducting the study under
23 paragraph (1), the National Academy of Sciences
24 may utilize and compare existing scientific studies

1 regarding the regulations, laws, and proposed laws
2 listed in paragraph (1).

3 (3) REPORT.—Under the arrangement entered
4 into under paragraph (1), not later than 270 days
5 after the date on which such arrangement is entered
6 into, the National Academy of Sciences shall make
7 publicly available and shall submit to the Congress
8 and to the head of each department and agency of
9 the Federal Government that issued, implements, or
10 would implement a regulation, law, or proposed law
11 listed in paragraph (1), a report containing—

12 (A) a description of the impact of all such
13 regulations, laws, and proposed laws on public
14 health, air quality, water quality, wildlife, and
15 the environment, compared to the impact of
16 preexisting regulations, or laws in effect, includ-
17 ing—

18 (i) any negative impacts to air quality
19 or water quality;

20 (ii) any negative impacts to wildlife;

21 (iii) any delays in hazardous waste
22 cleanup that are projected to be hazardous
23 to public health; and

24 (iv) any other negative impact on pub-
25 lic health or the environment; and

1 (B) any recommendations that the Na-
2 tional Academy of Sciences considers appro-
3 priate to maintain, restore, or improve in whole
4 or in part protections for public health, air
5 quality, water quality, wildlife, and the environ-
6 ment for each of the regulations, laws, and pro-
7 posed laws listed in paragraph (1), which may
8 include recommendations for the adoption of
9 any regulation or law in place or proposed prior
10 to January 1, 2001.

11 (d) DEPARTMENT AND AGENCY REVISION OF EXIST-
12 ING RULES, REGULATIONS, OR LAWS.—Not later than
13 180 days after the date on which the report is submitted
14 pursuant to subsection (c)(3), the head of each depart-
15 ment and agency that has issued or implemented a regula-
16 tion or law listed in subsection (c)(1) shall submit to the
17 Congress a plan describing the steps such department or
18 such agency will take, or has taken, to restore or improve
19 protections for public health and the environment in whole
20 or in part that were in existence prior to the issuance of
21 such regulation or law.

22 **SEC. 1006. HEALTHY FOOD FINANCING INITIATIVE.**

23 (a) IN GENERAL.—Subtitle D of the Department of
24 Agriculture Reorganization Act of 1994 (7 U.S.C. 6951)
25 is amended by adding at the end the following:

1 **“SEC. 242. HEALTHY FOOD FINANCING INITIATIVE.**

2 “(a) PURPOSE.—The purpose of this section is to es-
3 tablish a program to improve access to healthy foods in
4 underserved areas, to create and preserve quality jobs, and
5 to revitalize low-income communities by providing loans
6 and grants to eligible fresh, healthy food retailers to over-
7 come the higher costs and initial barriers to entry in un-
8 derserved, urban, suburban, and rural areas.

9 “(b) DEFINITIONS.—In this section:

10 “(1) COMMUNITY DEVELOPMENT FINANCIAL IN-
11 STITUTION.—The term ‘community development fi-
12 nancial institution’ has the meaning given the term
13 in section 103 of the Community Development
14 Banking and Financial Institutions Act of 1994 (12
15 U.S.C. 4702).

16 “(2) FOOD ACCESS ORGANIZATION.—The term
17 ‘food access organization’ means a nonprofit organi-
18 zation with expertise in improving access to healthy
19 food in underserved communities.

20 “(3) INITIATIVE.—The term ‘Initiative’ means
21 the Healthy Food Financing Initiative established in
22 the Department by subsection (c)(1).

23 “(4) LOCAL FUNDS.—The term ‘local funds’
24 means the allocation of national funds and any other
25 forms of financial assistance (including grants,
26 loans, and equity investments) that are raised by

1 partnerships to carry out the purposes of this sec-
2 tion.

3 “(5) NATIONAL FUNDS.—The term ‘national
4 funds’ means any Federal appropriation made to
5 carry out this section and any other forms of finan-
6 cial assistance (including grants, loans, and equity
7 investments) that are raised by the national fund
8 manager to carry out the purposes of this section.

9 “(6) NATIONAL FUND MANAGER.—The term
10 ‘national fund manager’ means a community devel-
11 opment financial institution in existence as of the
12 date of enactment of this section and certified by the
13 Community Development Financial Institutions
14 Fund of the Department of the Treasury that is des-
15 ignated by the Secretary to manage the Initiative for
16 purposes of—

17 “(A) raising private capital;

18 “(B) providing financial and technical as-
19 sistance to partnerships; and

20 “(C) funding eligible projects directly at
21 the request of partnerships to attract fresh,
22 healthy food retailers to underserved urban,
23 suburban, and rural areas, in accordance with
24 this section.

25 “(7) PARTNERSHIP.—

1 “(A) IN GENERAL.—The term ‘partner-
2 ship’ means a regional, State, or local public
3 and private partnership that is organized to im-
4 prove access to fresh, healthy foods by pro-
5 viding financial and technical assistance to eli-
6 gible projects.

7 “(B) INCLUSIONS.—The term ‘partnership’
8 includes—

9 “(i) an unit of State, local, or tribal
10 government or a quasi-public State or local
11 government agency;

12 “(ii) a food access or community
13 health organization committed to improv-
14 ing access to healthy foods;

15 “(iii) a community development finan-
16 cial institution or other organization that
17 is capable of administering a loan and
18 grant program in accordance with this sec-
19 tion; and

20 “(iv) other organizations interested in
21 improving access to healthy foods in under-
22 served areas.

23 “(c) ESTABLISHMENT.—

24 “(1) IN GENERAL.—There is established in the
25 Department a Healthy Food Financing Initiative.

1 “(2) MANAGEMENT.—Not later than 1 year
2 after the date of enactment of this section, the Sec-
3 retary shall select and enter into a grant agreement
4 with a national fund manager who shall be respon-
5 sible for the management of the Initiative nationally.

6 “(3) ELIGIBLE PROJECTS.—

7 “(A) IN GENERAL.—Subject to the re-
8 quirements of this paragraph, the national fund
9 manager shall establish the eligibility criteria
10 for projects to be assisted by the Initiative.

11 “(B) REQUIREMENTS.—To be eligible to
12 receive assistance through the Initiative, a
13 project shall—

14 “(i) include a supermarket, grocery
15 store, farmers market, or other fresh,
16 healthy food retailer;

17 “(ii) consist of a for-profit business
18 enterprise, a member- or worker-owned co-
19 operative, or a nonprofit organization;

20 “(iii) meet the eligibility criteria es-
21 tablished under this section;

22 “(iv) continue to be a viable business
23 enterprise with a financial viability plan;

1 “(v) require an investment of public
2 funding to move forward and be competi-
3 tive;

4 “(vi) operate on a self-service basis;

5 “(vii) in accordance with subpara-
6 graph (C), expand or preserve the avail-
7 ability of healthy, fresh, high quality un-
8 prepared and unprocessed foods, particu-
9 larly fresh fruits and vegetables, in under-
10 served areas; and

11 “(viii) agree to accept benefits under
12 the supplemental nutrition assistance pro-
13 gram established under the Food and Nu-
14 trition Act of 2008 (7 U.S.C. 2011 et
15 seq.).

16 “(C) REQUIREMENTS.—

17 “(i) DEFINITIONS.—In this subpara-
18 graph:

19 “(I) PERISHABLE FOOD.—

20 “(aa) IN GENERAL.—The
21 term ‘perishable food’ means food
22 that is fresh, refrigerated, or fro-
23 zen.

24 “(bb) EXCLUSION.—The
25 term ‘perishable food’ does not

1 include packaged or canned
2 goods.

3 “(II) STAPLE FOOD.—

4 “(aa) IN GENERAL.—The
5 term ‘staple food’ means food
6 that is a basic dietary item, in-
7 cluding bread, flour, fruits, vege-
8 tables, and meat.

9 “(bb) EXCLUSIONS.—The
10 term ‘staple food’ does not in-
11 clude snack or accessory food
12 (such as chips, soda, coffee, con-
13 diments, and spices) or ready-to-
14 eat, prepared food.

15 “(III) VARIETY.—The term ‘vari-
16 ety’ means an assortment of different
17 types of food items.

18 “(ii) IN GENERAL.—For purposes of
19 subparagraph (B)(vii), to expand or pre-
20 serve the availability of fresh fruits and
21 vegetables in underserved areas shall
22 mean, with respect to a project, that the
23 project maintains a store that—

24 “(I) carries a full line of fresh
25 produce, as defined by the national

1 fund manager to reflect differences in
2 project size and overall store size;

3 “(II) sells food for home prepara-
4 tion and consumption; and

5 “(III) at a minimum—

6 “(aa) offers for sale at least
7 3 different varieties of food in
8 each of the 4 staple food groups
9 (bread and grains, dairy, fruits
10 and vegetables, and meat, poul-
11 try, and fish), with perishable
12 food in at least 2 categories, on
13 a daily basis; or

14 “(bb) has a store at which
15 at least 50 percent of the total
16 sales of the store (including food
17 and nonfood items or services)
18 are from the sale of eligible sta-
19 ple food.

20 “(D) INCOME CRITERIA.—Each eligible
21 project shall be located in—

22 “(i) a low- or moderate-income census
23 tract, as determined by the Bureau of the
24 Census of the Department of Commerce;

1 “(ii) a population census tract that is
2 treated as a low-income community under
3 section 45D(e) of the Internal Revenue
4 Code of 1986; or

5 “(iii) an area that significantly serves
6 an adjacent area that meets the criteria
7 described in clause (i) or (ii), as approved
8 by the national fund manager.

9 “(E) UNDERSERVED CRITERIA.—

10 “(i) IN GENERAL.—Each eligible
11 project shall be located in an underserved
12 area, as determined by the partnerships
13 according to criteria established by the na-
14 tional fund manager.

15 “(ii) FACTORS.—In determining
16 whether an area is an underserved area,
17 the following factors shall be taken into
18 consideration:

19 “(I) Population density.

20 “(II) Below average supermarket
21 density or sales.

22 “(III) Car ownership.

23 “(IV) Geographical or physical
24 barriers, such as highways, moun-
25 tains, major parks, or bodies of water.

1 “(iii) LOCATIONS.—On an annual
2 basis, the national fund manager shall col-
3 lect data and publish maps that show the
4 location of underserved areas.

5 “(4) PRIORITY PROJECTS.—

6 “(A) IN GENERAL.—Priority shall be given
7 to projects that—

8 “(i) are located in severely distressed
9 low-income communities, as defined by the
10 Community Development Financial Insti-
11 tutions Fund of the Department of the
12 Treasury; and

13 “(ii) include 1 or more of the fol-
14 lowing characteristics:

15 “(I) The project will create or re-
16 tain quality jobs in the community, as
17 determined in accordance with sub-
18 paragraph (B).

19 “(II) The project has community
20 support in terms of store quality, af-
21 fordability, site location, and coordina-
22 tion with local community plans or
23 other programs promoting community
24 and economic development.

1 “(III) The project supports re-
2 gional food systems and locally grown
3 foods, to the extent available.

4 “(IV) In major metropolitan
5 areas, the project is associated with a
6 transit-oriented development project.

7 “(V) In areas with public transit,
8 the project is accessible by public
9 transit.

10 “(VI) The project involves the
11 reuse of a building that is listed in or
12 eligible for the National Register of
13 Historic Places.

14 “(VII) The project involves a
15 brownfield or grayfield (as those
16 terms are used in the Comprehensive
17 Environmental Response, Compensa-
18 tion, and Liability Act of 1980 (42
19 U.S.C. 9601 et seq.)).

20 “(VIII) The estimated energy
21 consumption of the project, calculated
22 using building energy software ap-
23 proved by the Department of Energy,
24 will qualify the project for designation
25 under the Energy Star program estab-

1 lished by section 324A of the Energy
2 Policy and Conservation Act (42
3 U.S.C. 6294a).

4 “(IX) The project involves
5 women- and minority-owned busi-
6 nesses.

7 “(B) QUALITY JOBS.—For purposes of
8 subparagraph (A)(ii)(I), a quality job is a job
9 that—

10 “(i) provides wages that are com-
11 parable to or better than similar positions
12 in existing businesses of similar size in
13 similar local economies;

14 “(ii) offers benefits that are com-
15 parable to or better than what is offered
16 for similar positions in existing local busi-
17 nesses of similar size in similar local econo-
18 mies; and

19 “(iii) is targeted for residents of
20 neighborhoods with a high proportion of
21 persons of low income (as that term is de-
22 fined in section 102(a) of the Housing and
23 Community Development Act of 1974 (42
24 U.S.C. 5302(a))) through local targeted
25 hiring programs.

1 “(d) DUTIES OF THE SECRETARY.—

2 “(1) IN GENERAL.—The Secretary shall—

3 “(A) designate a national fund manager to
4 manage national funds;

5 “(B) oversee the Initiative nationally;

6 “(C) work closely with the designated na-
7 tional fund manager—

8 “(i) to ensure that funds are used ap-
9 propriately and in the most effective man-
10 ner practicable; and

11 “(ii) to develop the program strategy
12 into a detailed work plan, program, and
13 operating budget;

14 “(D) review and approve the operating
15 budget for the national fund manager to ensure
16 that the administrative costs are—

17 “(i) reasonable (not more than 5 per-
18 cent of the total budget);

19 “(ii) connected to the costs of oper-
20 ations; and

21 “(iii) reflect efficient operations by the
22 national fund manager; and

23 “(E) make available to the public an an-
24 nual report, using data obtained from the De-
25 partment of Agriculture, the Department of

1 Health and Human Services, and the Commu-
2 nity Development Financial Institutions, that
3 describes the impacts of the Initiative, including
4 tracking health and economic development indi-
5 cators at the local, State, and national levels to
6 determine the impacts of individual projects
7 and the collective impact in local areas and
8 statewide of funded projects and the Initiative
9 overall.

10 “(2) NATIONAL FUND MANAGER.—The Sec-
11 retary shall—

12 “(A) select the national fund manager
13 through a competitive process from among com-
14 munity development financial institutions that
15 have a proven and recent track record of suc-
16 cess and effectiveness in—

17 “(i) attracting private capital;

18 “(ii) developing and managing pro-
19 grams that provide grants and loans to
20 support supermarkets and other fresh,
21 healthy food retail business enterprises in
22 low- and moderate-income communities, in-
23 cluding the development of grocery stores,
24 farmers markets, and other fresh, healthy
25 food retail models;

1 “(iii) making and servicing loans that
2 are similar to loans proposed in the Initia-
3 tive or having a record of otherwise suc-
4 cessfully investing in fresh, healthy food
5 retail development projects;

6 “(iv) effectively managing multiple
7 contracts and subcontractors;

8 “(v) effectively managing large capital
9 pools, of at least \$100,000,000; and

10 “(vi) providing or contracting for the
11 provision of technical assistance; and

12 “(B) administer the Initiative by approving
13 the disbursement of funds to the national fund
14 manager in a manner that facilitates the imple-
15 mentation of the overall Initiative.

16 “(3) COORDINATION.—

17 “(A) IN GENERAL.—Not later than 45
18 days after the date of receipt of an award, the
19 national fund manager shall develop, with guid-
20 ance from and in consultation with the Sec-
21 retary, and submit to the Secretary, a detailed
22 work plan.

23 “(B) APPROVAL REQUIRED.—The Sec-
24 retary shall review and approve the work plan,
25 program budget, and administrative costs under

1 subsection (e)(4)(C) prior to entering into an
2 agreement with the national fund manager to
3 administer the Initiative.

4 “(4) PERFORMANCE TARGETS.—

5 “(A) IN GENERAL.—The Secretary shall
6 conduct financial audits of, and establish per-
7 formance targets for, the national fund man-
8 ager, which shall include, at a minimum, the re-
9 quirements described in this paragraph.

10 “(B) GEOGRAPHIC SPREAD.—Partnerships
11 funded by the Initiative shall be geographically
12 diverse and representative of the underserved
13 areas across the United States.

14 “(C) FOCUS ON LOW-INCOME COMMU-
15 NITIES.—A substantial portion of the projects
16 funded by partnerships shall serve very low-
17 and low-income communities, as defined by the
18 Bureau of the Census of the Department of
19 Commerce.

20 “(D) FINANCIAL EFFECTIVENESS OF THE
21 NATIONAL FUND MANAGER.—The national fund
22 manager and any local financial institution in-
23 volved in a partnership shall demonstrate on-
24 going capacity and timeliness in raising private

1 capital and disbursing funds as required under
2 the Initiative.

3 “(E) TECHNICAL ASSISTANCE EFFECTIVE-
4 NESS OF THE NATIONAL FUND MANAGER.—The
5 provision of technical assistance by the national
6 fund manager shall be evaluated based on—

7 “(i) the responsiveness of the national
8 fund manager to requests for assistance;
9 and

10 “(ii) the ability of the national fund
11 manager to craft programs that develop
12 needed new capacities in partnerships.

13 “(F) IMPACT.—Performance targets shall
14 address the allocation of funds by the national
15 fund manager to partnerships and the tracking
16 and reporting of the impacts of the funds in im-
17 proving access to fresh, healthy foods and in
18 achieving other related impacts.

19 “(e) DUTIES OF THE NATIONAL FUND MANAGER.—

20 “(1) ALLOCATION OF FUNDS.—

21 “(A) IN GENERAL.—The national fund
22 manager shall—

23 “(i) allocate at least 70 percent of any
24 Federal appropriation made to carry out
25 this section to partnerships that are se-

1 lected based on the criteria described in
2 paragraph (3); and

3 “(ii) retain not more than 30 percent
4 of any Federal appropriation made to
5 carry out this section to undertake financ-
6 ing activities described in subparagraph
7 (C), including a reasonable amount for ad-
8 ministrative costs (not to exceed 5 percent)
9 approved by the Secretary in accordance
10 with paragraph (4)(C).

11 “(B) USE OF THE NATIONAL FUNDS BY
12 PARTNERSHIP PROGRAMS.—

13 “(i) IN GENERAL.—As a condition on
14 the receipt of funds, each partnership shall
15 use—

16 “(I) the national funds received
17 from the national fund manager under
18 subparagraph (A)(i) to create 1 or
19 more revolving loan programs or other
20 revolving pools of capital or other
21 products to facilitate financing of local
22 projects as determined by the agree-
23 ment between the partnership and the
24 national fund manager; and

1 “(II) any remaining funds for
2 grants, or, as approved, for innovative
3 financing mechanisms.

4 “(ii) LIMITATIONS.—

5 “(I) IN GENERAL.—Use of funds
6 for administrative costs and other
7 purposes shall be—

8 “(aa) limited in accordance
9 with the terms of the agreement
10 negotiated between the national
11 fund manager and partnerships;

12 “(bb) based on whether ad-
13 ministrative costs are reasonable,
14 connected to the costs of oper-
15 ation, and reflect efficient oper-
16 ations by the partnership; and

17 “(cc) determined using cri-
18 teria including geographic cov-
19 erage, program duration, and
20 total funding amount.

21 “(II) GOAL.—The goal of this
22 clause to limit administrative costs to
23 the maximum extent practicable, but
24 in no case may the amount used for

1 administrative costs exceed 10 percent
2 of the Federal funds allocated.

3 “(C) USE OF THE NATIONAL FUNDS BY
4 THE NATIONAL FUND MANAGER.—The national
5 fund manager shall use national funds de-
6 scribed in subparagraph (A)(ii) to undertake fi-
7 nancing and other activities to enhance and
8 maximize the effectiveness of the Initiative, as
9 determined by the agreement with the Sec-
10 retary, including—

11 “(i) attracting other forms of financial
12 assistance to match or leverage the na-
13 tional funds;

14 “(ii) awarding national funds to part-
15 nerships in accordance with paragraph (3);

16 “(iii) creating and managing pools of
17 grant or loan capital that blend or leverage
18 national funds with other forms of finan-
19 cial assistance, including capital in the
20 form of tax credits under section 45D of
21 the Internal Revenue Code of 1986, for the
22 benefit of partnerships;

23 “(iv) creating and managing pools of
24 grant or loan capital that blend or leverage
25 the national funds with other forms of fi-

1 nancial assistance, including capital in the
2 form of tax credits under section 45D of
3 the Internal Revenue Code of 1986, to fi-
4 nance eligible local projects identified by
5 partnerships or the national fund manager
6 that have special or unique characteristics;

7 “ (v) providing loans or grants directly
8 to eligible local projects as matching funds
9 if requested by a partnership;

10 “ (vi) providing credit enhancement or
11 other financial products and instruments
12 for the benefit of partnerships or eligible
13 local projects;

14 “ (vii) providing technical assistance;
15 and

16 “ (viii) funding reasonable administra-
17 tive costs approved by the Secretary in ac-
18 cordance with paragraph (4)(C).

19 “(2) RESPONSIBILITIES OF THE NATIONAL
20 FUND MANAGER.—The designated national fund
21 manager shall—

22 “(A) raise other forms of financial assist-
23 ance to match or leverage the national funds;

1 “(B) use administrative funds to develop
2 appropriate training programs and offer tech-
3 nical assistance services to—

4 “(i) partnerships;

5 “(ii) State, local, and tribal govern-
6 ments;

7 “(iii) the food retail industry; and

8 “(iv) food access and health advocacy
9 organizations to augment local capacities;

10 “(C) develop financial products such as
11 loans, grants, and credit enhancement tools
12 that can be used by partnerships to incentivize
13 and support the development and retention of
14 supermarkets and other fresh, healthy food re-
15 tail in underserved areas;

16 “(D) award Initiative funds to eligible
17 partnerships through an annual competitive
18 process in accordance with paragraph (3);

19 “(E) contract with a national food access
20 organization to assist in the review of applica-
21 tions from partnerships and to provide technical
22 assistance to local food access organizations in
23 the proposed partnerships;

1 “(F) award and disburse funds to partner-
2 ships or eligible local projects in a timely man-
3 ner;

4 “(G) create and meet performance bench-
5 marks and reporting guidelines, as approved by
6 the Secretary, including for—

7 “(i) the amount of capital raised and
8 leveraged from financial institutions, part-
9 nerships, and other resources;

10 “(ii) the geographic diversity of part-
11 nerships; and

12 “(iii) the proportion of projects fund-
13 ed by the partnership that are in severely
14 distressed low-income communities;

15 “(H) develop program guidelines and oper-
16 ating procedures for the Initiative, including—

17 “(i) maximum grant and loan
18 amounts for projects;

19 “(ii) eligible uses of funds;

20 “(iii) prudent underwriting criteria;

21 “(iv) performance targets;

22 “(v) reporting guidelines;

23 “(vi) limits on administrative costs;

24 and

25 “(vii) implementation milestones;

1 “(I) monitor the performance of partner-
2 ships; and

3 “(J) collect data, compile information, and
4 conduct such research studies as the national
5 fund manager determines to be relevant to the
6 successful implementation of the Initiative, in-
7 cluding—

8 “(i) to assess national and local mar-
9 ket conditions;

10 “(ii) to determine barriers to market
11 entry; and

12 “(iii) to identify opportunities for the
13 development or retention of supermarkets
14 and other fresh, healthy food retail enter-
15 prises in underserved communities.

16 “(3) CRITERIA FOR AWARDING NATIONAL
17 FUNDS TO PARTNERSHIPS.—

18 “(A) IN GENERAL.—The national fund
19 manager shall award national funds to partner-
20 ships through a competitive process on an an-
21 nual basis.

22 “(B) FIRST ROUND PRIORITY.—In the
23 first round of funding, the national fund man-
24 ager shall give priority to existing partnerships
25 that have demonstrable capacity to implement

1 fresh food financing programs in underserved
2 areas quickly.

3 “(C) ADDITIONAL ROUNDS.—Additional
4 rounds shall be designed to promote geographic
5 diversity.

6 “(D) CRITERIA.—In awarding national
7 funds to partnerships, the national fund man-
8 ager shall consider—

9 “(i) the amount of funds and other
10 resources pledged by a partnership to
11 match or leverage national funds;

12 “(ii) the degree of State, local, or trib-
13 al government support of the partnership
14 as evidenced by matching grant and loan
15 funds or other types of support, such as al-
16 location of tax-exempt bonds, loan guaran-
17 tees, and coordination of resources from
18 other State or local economic development
19 programs;

20 “(iii) the capacity of the partnership
21 to successfully develop and manage loan
22 and grant programs;

23 “(iv) the lack of supermarkets and
24 other fresh, healthy food retail enterprises

1 in low- and moderate-income areas that
2 would be served by the partnership;

3 “(v) the experience of the food access
4 or community health organization of the
5 partnership in outreach about access to
6 healthy foods and local healthy food access
7 issues;

8 “(vi) the degree of community engage-
9 ment and support in the development and
10 retention of supermarkets and other fresh,
11 healthy food retail enterprises; and

12 “(vii) the contribution of the program
13 of the partnership to the overall geographic
14 diversity of the Initiative.

15 “(4) ADMINISTRATIVE COSTS.—

16 “(A) IN GENERAL.—Not later than 45
17 days after the date of receipt of an award, the
18 national fund manager shall submit to the Sec-
19 retary for approval a 3-year program and oper-
20 ating budget and detailed work plan that shall
21 include—

22 “(i) costs for research and evaluation,
23 technical assistance, and training; and

24 “(ii) program and operating costs.

1 “(B) EARNED REVENUES.—Earned reve-
2 nues from loan fees and interest may be ex-
3 pended on program and operating costs in ac-
4 cordance with the budget approved by the Sec-
5 retary.

6 “(C) BASIS OF REVIEW.—The Secretary
7 shall base the review under subparagraph (A)
8 on—

9 “(i) the likelihood of the plan and ex-
10 penditures to further the purposes of this
11 section; and

12 “(ii) whether the administrative costs
13 are reasonable, connected to the costs of
14 operation, and reflect efficient operations
15 by the national fund manager.

16 “(f) PARTNERSHIPS.—

17 “(1) IN GENERAL.—Each partnership that re-
18 ceives assistance through the Initiative shall provide
19 financial and technical assistance to eligible fresh,
20 healthy food retail projects in underserved areas
21 within the defined communities of the partnership.

22 “(2) ADMINISTRATION.—Each partnership shall
23 designate a community development financial insti-
24 tution or other organization that is capable of ad-
25 ministering a loan and grant program—

1 “(A) to execute grant agreements with the
2 national fund manager; and

3 “(B) to serve as the manager of local
4 funds.

5 “(3) RESPONSIBILITIES OF PARTNERSHIPS.—A
6 partnership shall—

7 “(A) raise other forms of financial assist-
8 ance to match the national funds received by
9 the partnership;

10 “(B) provide marketing and outreach to
11 communities, the supermarket industry, other
12 fresh, healthy food retailers, State and local
13 government officials, and civic and public inter-
14 est organizations—

15 “(i) to solicit applications from under-
16 served areas from across the State or local-
17 ity to be served by the partnership; and

18 “(ii) to inform the communities and
19 other persons about the availability of
20 grants, loans, training, and technical as-
21 sistance;

22 “(C) review and underwrite projects to de-
23 termine whether—

1 “(i) a proposed project meets the cri-
2 teria for eligible projects under subsection
3 (c)(3); and

4 “(ii) a proposed project meets the cri-
5 teria for priority projects under subsection
6 (c)(4);

7 “(D) provide technical assistance services
8 to eligible fresh, healthy food retail operators
9 and developers;

10 “(E) track and report outcomes, includ-
11 ing—

12 “(i) the number of jobs created or re-
13 tained;

14 “(ii) the quantity of fresh, healthy
15 food retail space created or retained; and

16 “(iii) such other health and economic
17 indicators as are required by the national
18 fund manager;

19 “(F) monitor and audit funded projects to
20 ensure compliance with the Initiative, the na-
21 tional fund manager, and partnership program
22 requirements for a period of at least 3 years;

23 “(G) submit an annual report to the na-
24 tional fund manager that describes—

25 “(i) the activities of the partnership;

1 “(ii) the expenditure of local funds;
2 and

3 “(iii) success in meeting performance
4 targets and satisfying such other terms
5 and conditions as are specified in the
6 agreement between the partnership and the
7 national fund manager; and

8 “(H) coordinate with the national fund
9 manager for the smooth operation of the Initia-
10 tive.

11 “(4) ADMINISTRATIVE COSTS.—

12 “(A) IN GENERAL.—As a condition on the
13 receipt of assistance under this section, each
14 partnership shall submit to the national fund
15 manager for approval a 3-year budget and plan
16 for all program and operating costs, includ-
17 ing—

18 “(i) costs for research and evaluation,
19 technical assistance, and training; and

20 “(ii) administrative and operating
21 costs.

22 “(B) EARNED REVENUES.—Earned reve-
23 nues from loan fees and interest may be ex-
24 pended on program and operating costs in ac-

1 cordance with the budget approved by the na-
2 tional fund manager.

3 “(C) BASIS OF REVIEW.—The national
4 fund manager shall base the review under sub-
5 paragraph (A) on the likelihood of the budget
6 and plan to further the purposes of this section.

7 “(g) EVALUATION AND MONITORING.—

8 “(1) IN GENERAL.—Program evaluation and fi-
9 nancial audits shall occur at all levels of the Initia-
10 tive to ensure that—

11 “(A) national and local funds are used
12 properly; and

13 “(B) the objectives of the Initiative are
14 met.

15 “(2) PROGRAM EVALUATION AND FINANCIAL
16 AUDITS.—

17 “(A) IN GENERAL.—The Secretary shall—

18 “(i) conduct periodic program evalua-
19 tions and financial audits of the national
20 fund manager, partnerships, and projects
21 funded by the Initiative; and

22 “(ii) share with the national fund
23 manager the results of the evaluations and
24 audits.

1 “(B) FUNDED PROJECTS.—The Secretary
2 or the national fund manager shall evaluate
3 partnerships to assess the health and economic
4 impacts of projects funded by the Initiative.

5 “(C) OTHER IMPACTS.—

6 “(i) SECRETARY OF HEALTH AND
7 HUMAN SERVICES.—The Secretary of
8 Health and Human Services shall conduct
9 research studies and evaluate the health
10 impacts of the Initiative.

11 “(ii) COMMUNITY DEVELOPMENT FI-
12 NANCIAL INSTITUTIONS.—Representatives
13 of the Community Development Financial
14 Institutions shall conduct research studies
15 and evaluate the economic impacts of the
16 Initiative.

17 “(D) PARTNERSHIPS.—

18 “(i) IN GENERAL.—Each partnership
19 shall—

20 “(I) conduct periodic administra-
21 tive and financial audits of projects
22 funded by the Initiative; and

23 “(II) share with the national
24 fund manager the results of the au-
25 dits.

1 “(ii) FAILURE OF PARTNERSHIP.—In
2 a case in which a partnership fails, the na-
3 tional fund manager shall take over the
4 portfolio of the failed partnership.

5 “(h) ADMINISTRATIVE PROVISIONS.—Not later than
6 180 days after the date of enactment of this section, the
7 Secretary shall promulgate such regulations as may be
8 necessary to carry out this section, including regulations—

9 “(1) for the conduct of a performance evalua-
10 tion at the end of the initial 5-year period;

11 “(2) to terminate the contract for cause; and

12 “(3) to extend the contract for an additional 5-
13 year period.

14 “(i) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to the Secretary to carry
16 out this section \$500,000,000, to remain available until
17 expended.”.

18 (b) CONFORMING AMENDMENT.—Section 296(b) of
19 the Department of Agriculture Reorganization Act of
20 1994 (7 U.S.C. 7014(b)) is amended—

21 (1) in paragraph (6)(C), by striking “or” at the
22 end;

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

25 (3) by adding at the end the following:

1 “(8) the authority of the Secretary to establish
2 in the Department the Healthy Food Financing Ini-
3 tiative in accordance with section 242.”.

4 **SEC. 1007. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
5 **WATER HORIZON OIL RIG EXPLOSION IN THE**
6 **GULF COAST.**

7 (a) **STUDY.**—The Comptroller General of the United
8 States shall conduct a study on the type and scope of
9 health care services administered through the Department
10 of Health and Human Services addressing the provision
11 of health care to racial and ethnic minorities (whether
12 residents, clean-up workers, or volunteers) affected by the
13 explosion of the mobile offshore drilling unit Deepwater
14 Horizon that occurred on April 20, 2010.

15 (b) **SPECIFIC COMPONENTS; REPORTING.**—In car-
16 rying out subsection (a), the Comptroller General shall—

17 (1) assess the type, size, and scope of programs
18 administered by the Department of Health and
19 Human Services that focus on provision of health
20 care to communities in the Gulf Coast;

21 (2) identify the merits and disadvantages asso-
22 ciated with each the programs;

23 (3) perform an analysis of the costs and bene-
24 fits of the programs;

1 (4) determine whether there is any duplication
2 of programs; and

3 (5) not later than 180 days after the date of
4 the enactment of this Act, report findings and rec-
5 ommendations for improving access to health care
6 for racial and ethnic minorities to the Congress.

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