

113TH CONGRESS
2^D SESSION

S. 2841

To provide for a study by the Institute of Medicine on health disparities, to direct the Secretary of Health and Human Services to develop guidelines on reducing health disparities, and for other purposes.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 17 (legislative day, SEPTEMBER 16), 2014

Mr. BOOKER introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To provide for a study by the Institute of Medicine on health disparities, to direct the Secretary of Health and Human Services to develop guidelines on reducing health disparities, 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 “Reducing Disparities
5 Using Care Models and Education Act of 2014”.

6 **SEC. 2. FINDINGS.**

7 The Congress finds as follows:

1 (1) The infant death rate among African-Amer-
2 icans is more than double that of Whites.

3 (2) The death rate for all cancers is 30 percent
4 higher for African-Americans than for Whites; for
5 prostate cancer, it is more than double that for
6 Whites.

7 (3) Black women have a higher death rate from
8 breast cancer despite having a mammography
9 screening rate that is nearly the same as the rate for
10 White women.

11 (4) Diabetes incidence is highest among Native
12 Americans, at 15.9 percent, followed by 13.2 percent
13 for African-Americans, 12.8 percent for Hispanics,
14 9.0 percent for Asians, and 7.6 percent for Whites.

15 (5) New cases of hepatitis and tuberculosis are
16 higher in Asians and Pacific Islanders living in the
17 United States than in Whites.

18 (6) Individuals in same-sex couples were more
19 likely than individuals in different-sex couples to re-
20 port a delay in getting necessary prescriptions.

21 (7) Infants born to Black women are 1.5 to 3
22 times more likely to die than those born to women
23 of other races or ethnicities, and American Indian
24 and Alaska Native infants die from sudden infant

1 death syndrome (SIDS) at nearly 2.5 times the rate
2 of White infants.

3 (8) Low-income children have higher rates of
4 mortality (even with the same condition), have high-
5 er rates of disability, and are more likely to have
6 multiple conditions.

7 (9) White children are half as likely as Black
8 and Latino children not to be in excellent or very
9 good health.

10 (10) As of 2012, 38.9 percent of United States
11 adults were obese, with the highest rate among Afri-
12 can-Americans at 47.9 percent, followed by His-
13 panics at 42.5 percent, Whites at 32.6 percent, and
14 Asians at 10.8 percent.

15 (11) The risk of stroke is twice as high for Af-
16 rican-Americans as for Whites, and African-Ameri-
17 cans are more likely to die of stroke. Other ethnic
18 minorities also have higher risk than Whites. Over-
19 all, strokes are most prevalent in the Southeast
20 United States, and less so in the Northeast.

21 (12) African-Americans accounted for 44 per-
22 cent of all those infected with HIV, despite being
23 only 12 percent of the United States population.

1 (13) Black men who have sex with men (MSM)
2 ages 13 to 24 had the most new infections among
3 youth.

4 (14) One study found that among heterosexuals
5 living in the same urban community, those below the
6 poverty line were twice as likely to contract human
7 immunodeficiency virus (HIV).

8 (15) Persons with less than a high school di-
9 ploma (6.7 percent) and high school graduates (4.0
10 percent) were more likely to report major depression
11 than those with at least some college education (2.5
12 percent).

13 (16) Only about 10 percent of physicians prac-
14 tice in rural America despite the fact that nearly
15 one-fourth of the population lives in these areas.

16 (17) Rural residents are less likely to have em-
17 ployer-provided health care coverage or prescription
18 drug coverage, and the rural poor are less likely to
19 be covered by Medicaid benefits than their urban
20 counterparts.

21 (18) Twenty percent of nonmetropolitan coun-
22 ties lack mental health services versus 5 percent of
23 metropolitan counties.

1 (19) Fifteen percent of persons with disabilities
2 report not seeing a doctor due to cost in comparison
3 to 6 percent of the general population.

4 **SEC. 3. INSTITUTE OF MEDICINE STUDY.**

5 (a) IN GENERAL.—Not later than 60 days after the
6 date of the enactment of this Act, the Secretary shall enter
7 into an arrangement with the Institute of Medicine under
8 which the Institute agrees to study—

9 (1) the extent of health disparities in the type
10 and quality of preventive interventions, health serv-
11 ices, and outcomes in the United States;

12 (2) the factors that may contribute to inequities
13 in such disparities;

14 (3) existing programs and policies intended to
15 reduce such disparities;

16 (4) best practices and successful strategies in
17 programs that aim to reduce such disparities;

18 (5) priorities for successful intervention pro-
19 grams targeting such disparities; and

20 (6) potential opportunities for expanding or
21 replicating such programs.

22 (b) REPORT.—The arrangement under subsection (a)
23 shall provide for submission by the Institute of Medicine
24 to the Secretary and Congress, not later than 20 months

1 after the date of enactment of this Act, of a report on
2 the results of the study.

3 **SEC. 4. GUIDELINES FOR DEVELOPMENT AND IMPLEMEN-**
4 **TATION OF HEALTH DISPARITIES REDUC-**
5 **TION PROGRAMS AND ACTIVITIES.**

6 (a) GUIDELINES.—Not later than 90 days after the
7 submission of the report described in section 3(b), and
8 taking such report into consideration, the Secretary shall
9 develop guidelines for entities to develop and implement
10 programs and activities to reduce health disparities.

11 (b) USE BY HHS.—The Secretary shall, where ap-
12 propriate, incorporate the use of the guidelines developed
13 under subsection (a) into the programs and activities of
14 the Department of Health and Human Services.

15 (c) GRANTS FOR DISPARITIES REDUCTION ACTIVI-
16 TIES.—

17 (1) IN GENERAL.—The Secretary may award
18 grants to entities for the development and implemen-
19 tation of programs and activities to reduce health
20 disparities in accordance with the guidelines de-
21 scribed in subparagraph (a).

22 (2) APPLICATIONS.—To seek a grant under this
23 subsection, an entity shall submit an application to
24 the Secretary at such time, in such manner, and

1 containing such information as the Secretary may
2 require.

3 (3) MINIMUM CONTENTS.—The Secretary shall
4 require that an application for a grant under this
5 subsection contains at a minimum—

6 (A) a description of the population and
7 public health concern the program will target
8 and an outreach plan to ensure that the most
9 in need populations will benefit;

10 (B) a description of the strategies the enti-
11 ty will use—

12 (i) to develop and implement its pro-
13 grams and activities in accordance with the
14 guidelines developed under subsection (a);
15 and

16 (ii) to make the interventions sustain-
17 able; and

18 (C) an agreement by the entities to peri-
19 odically provide data with respect to—

20 (i) the population served;

21 (ii) improvements in reducing health
22 disparities; and

23 (iii) effectiveness of the interventions
24 used.

1 (d) APPROPRIATIONS.—To carry out this section,
2 there are authorized to be appropriated \$5,000,000 for fis-
3 cal year 2016 and such sums as may be necessary for each
4 of fiscal years 2017 through 2020.

5 **SEC. 5. TESTING ALTERNATIVE PAYMENT AND DELIVERY**
6 **MODELS TO REDUCE HEALTH DISPARITIES.**

7 (a) IN GENERAL.—The Secretary acting through the
8 Centers for Medicare and Medicaid Innovation under sec-
9 tion 1115A of the Social Security Act (42 U.S.C. 1315a)
10 shall provide for the testing of a payment and service de-
11 livery model that includes incentives for reducing health
12 disparities consistent with the cost and quality criteria
13 otherwise applicable to the testing of models under such
14 section.

15 (b) DOCUMENTATION REQUIREMENT FOR MODEL
16 TESTING.—In carrying out subsection (a), the Secretary
17 shall require that an application to conduct such testing
18 of such a model include at least—

19 (1) documentation of at least one health dis-
20 parity targeted for reduction;

21 (2) a root-cause analysis of the health disparity
22 targeted for reduction;

23 (3) identification and selection of performance
24 targets for such reduction;

1 (4) a proposal to make payments in some way
2 contingent on a reduction in health disparities; and

3 (5) a reliable method for monitoring progress in
4 achieving such a reduction.

5 **SEC. 6. DEFINITIONS.**

6 In this Act:

7 (1) The term “health disparity” means signifi-
8 cant disparity in the overall rate of disease inci-
9 dence, prevalence, morbidity, mortality, or survival
10 rates in a population as compared to the health sta-
11 tus of the general population.

12 (2) The term “intervention” means an activity
13 taken by an entity on behalf of individuals or popu-
14 lations to reduce health disparities.

15 (3) The term “Secretary” means the Secretary
16 of Health and Human Services.

○