

115TH CONGRESS
2D SESSION

S. 3660

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

IN THE SENATE OF THE UNITED STATES

NOVEMBER 27, 2018

Ms. HIRONO (for herself, Ms. DUCKWORTH, Mr. CARDIN, Ms. HARRIS, Mr. BOOKER, Mr. MERKLEY, Mr. KAINE, Mr. BLUMENTHAL, Mrs. GILLIBRAND, and Mr. BROWN) introduced the following bill; which was read twice and referred to the Committee on Finance

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 2018”.

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

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

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- Sec. 2. Table of contents.
- Sec. 3. Findings.

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- Sec. 104. Revision of HIPAA claims standards.
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- Sec. 106. Disparities data collected by the Federal Government.
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1 SEC. 3. FINDINGS.

2 The Congress finds as follows:

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

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

18 (3) By 2020, the United States will face a
19 shortage of health care providers and allied health
20 workers. This shortage will disproportionately affect
21 health professional shortage areas where many racial
22 and ethnic minority populations reside.

23 (4) All efforts to reduce health disparities and
24 barriers to quality health services require better and
25 more consistent data.

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

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

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

14 (8) In 2011, the Department of Health and
15 Human Services developed the HHS Action Plan to
16 Reduce Racial and Ethnic Health Disparities and
17 the National Stakeholder Strategy for Achieving
18 Health Equity, which are 2 strategic plans that rep-
19 resent the first coordinated roadmap in the United
20 States to reducing health disparities. These com-
21 prehensive plans, along with the National Prevention
22 Strategy issued by the National Prevention Council
23 of the Department of Health and Human Services,
24 Healthy People 2020, and the National Quality
25 Strategy of the Agency for Healthcare Research and

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

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

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

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

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

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

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

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

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

20 “(a) REQUIREMENTS.—

21 “(1) IN GENERAL.—Each health-related pro-
 22 gram shall—

23 “(A) require the collection, by the agency
 24 or program involved, of data on the race, eth-
 25 nicity, sex, primary language, sexual orienta-

1 tion, disability status, gender identity, and so-
2 cioeconomic status of each applicant for and re-
3 cipient of health-related assistance under such
4 program, including—

5 “(i) using, at a minimum, standards
6 for data collection on race, ethnicity, sex,
7 primary language, sexual orientation, gen-
8 der identity, socioeconomic status, and dis-
9 ability status as each are developed under
10 section 3101;

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

16 “(iii) using, where practicable, the
17 standards developed by the Health and
18 Medicine Division of the National Acad-
19 emies of Sciences, Engineering, and Medi-
20 cine (formerly known as the ‘Institute of
21 Medicine’) in the 2009 publication, entitled
22 ‘Race, Ethnicity, and Language Data:
23 Standardization for Health Care Quality
24 Improvement’; and

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

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

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

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

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

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

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

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

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

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

20 “(B) diminish any requirements, including
21 such requirements in effect on or after the date
22 of enactment of this section, on health care pro-
23 viders to collect data.

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

25 This title does not authorize any health care pro-

1 vider, Federal official, or other entity to compel the
2 disclosure of any data collected under this title. The
3 disclosure of any such data by an individual pursu-
4 ant to this title shall be strictly voluntary.

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

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

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

21 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
22 Secretary shall develop and implement a national plan to
23 ensure the collection of data in a culturally and linguis-
24 tically appropriate manner, to improve the collection, anal-
25 ysis, and reporting of racial, ethnic, sex, primary lan-

1 guage, sexual orientation, disability status, gender iden-
2 tity, and socioeconomic status data at the Federal, State,
3 territorial, Tribal, and local levels, including data to be
4 collected under subsection (a), and to ensure that data col-
5 lection activities carried out under this section are in com-
6 pliance with standards developed under section 3101. The
7 Data Council of the Department of Health and Human
8 Services, in consultation with the National Committee on
9 Vital Health Statistics, the Office of Minority Health, Of-
10 fice on Women’s Health, and other appropriate public and
11 private entities, shall make recommendations to the Sec-
12 retary concerning the development, implementation, and
13 revision of the national plan. Such plan shall include rec-
14 ommendations on how to—

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

18 “(2) expand knowledge among Federal agen-
19 cies, States, territories, Indian Tribes, counties, mu-
20 nicipalities, health providers, health plans, and the
21 general public that data collection, analysis, and re-
22 porting by race, ethnicity, sex, primary language,
23 sexual orientation, gender identity, socioeconomic
24 status, and disability status is legal and necessary to

1 assure equity and nondiscrimination in the quality of
2 health care services;

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

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

18 “(5) provide researchers with greater access to
19 racial, ethnic, primary language, sex, sexual orienta-
20 tion, gender identity, socioeconomic status data, and
21 disability status data, subject to all applicable pri-
22 vacy and confidentiality requirements, including
23 HIPAA privacy and security law as defined in sec-
24 tion 3009; and

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

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

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

20 “(1) identifying appropriate quality assurance
21 mechanisms to monitor for health disparities;

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

24 “(3) developing new quality measures relating
25 to racial and ethnic disparities and their overlap

1 with other disparity factors in health and health
2 care;

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

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

7 “(f) DEFINITIONS.—In this section—

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

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

15 “(B) for providing federal financial assist-
16 ance for health care, biomedical research, or
17 health services research or for otherwise im-
18 proving the health of the public;

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

21 “(3) the term ‘primary language data collection
22 activities’ includes identifying, collecting, storing,
23 tracking, and analyzing primary language data and
24 information on the methods used to meet the lan-

1 guage access needs of individuals with limited-
2 English proficiency.

3 “(g) 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 2019 through 2024.

7 **“SEC. 3432. ESTABLISHING GRANTS FOR DATA COLLECTION**
8 **IMPROVEMENT ACTIVITIES.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Director of the Agency for Healthcare Research and
11 Quality and in consultation with the Deputy Assistant
12 Secretary for Minority Health, the Director of the Na-
13 tional Institutes of Health, the Assistant Secretary for
14 Planning and Evaluation, and the Director of the National
15 Center for Health Statistics, shall establish a technical as-
16 sistance program under which the Secretary provides
17 grants to eligible entities to assist such entities in com-
18 plying with section 3431.

19 “(b) TYPES OF ASSISTANCE.—A grant provided
20 under this section may be used to—

21 “(1) enhance or upgrade computer technology
22 that will facilitate collection, analysis, and reporting
23 of racial, ethnic, primary language, sexual orienta-
24 tion, sex, gender identity, socioeconomic status, and
25 disability status data;

1 “(2) improve methods for health data collection
2 and analysis, including additional population groups
3 if such groups can be aggregated into the race and
4 ethnicity categories outlined by standards developed
5 under section 3101;

6 “(3) develop mechanisms for submitting col-
7 lected data subject to any applicable privacy and
8 confidentiality regulations; and

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

16 “(c) ELIGIBLE ENTITY.—To be eligible for grants
17 under this section, an entity shall be a State, territory,
18 Indian Tribe, municipality, county, health provider, health
19 care organization, or health plan making a demonstrated
20 effort to bring data collections into compliance with sec-
21 tion 3431.

22 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2019 through 2024.

1 **“SEC. 3433. OVERSAMPLING OF UNDERREPRESENTED**
2 **GROUPS IN FEDERAL HEALTH SURVEYS.**

3 “(a) NATIONAL STRATEGY.—

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

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

24 “(A) consult with representatives of com-
25 munity groups, nonprofit organizations, non-
26 governmental organizations, and government

1 agencies working with underrepresented popu-
2 lations;

3 “(B) solicit the participation of representa-
4 tives from other Federal departments and agen-
5 cies, including subagencies of the Department
6 of Health and Human Services; and

7 “(C) consult on, and use as models, the
8 2014 National Health Interview Survey over-
9 sample of Native Hawaiian and Pacific Islander
10 populations and the 2017 Behavioral Risk Fac-
11 tor Surveillance System oversample of American
12 Indian and Alaska Native communities.

13 “(b) PROGRESS REPORT.—Not later than 2 years
14 after the date of the enactment of this section, the Sec-
15 retary shall submit to the Congress a progress report,
16 which shall include the national strategy described in sub-
17 section (a)(1).

18 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
19 carry out this section, there are authorized to be appro-
20 priated such sums as may be necessary for fiscal years
21 2019 through 2024.”.

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

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

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

7 (2) by redesignating subsection (i) as subsection
8 (h).

9 **SEC. 103. COLLECTION OF RACE AND ETHNICITY DATA BY**
10 **THE SOCIAL SECURITY ADMINISTRATION.**

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

14 “COLLECTION OF RACE AND ETHNICITY DATA BY THE
15 SOCIAL SECURITY ADMINISTRATION

16 “SEC. 1150C. (a) REQUIREMENT.—

17 “(1) IN GENERAL.—The Commissioner of So-
18 cial Security, in consultation with the Administrator
19 of the Centers for Medicare & Medicaid Services,
20 shall collect data on the race, ethnicity, primary lan-
21 guage, and disability status of all applicants for So-
22 cial Security account numbers or benefits under title
23 II or part A of title XVIII and all individuals with
24 respect to whom the Commissioner maintains
25 records of wages and self-employment income.

1 “(2) DATA COLLECTION STANDARDS.—In col-
2 lecting data under paragraph (1), the Commissioner
3 of Social Security shall use standards for data col-
4 lection on race, ethnicity, primary language, and dis-
5 ability status developed under section 3101 of the
6 Public Health Service Act and, where practicable,
7 the standards developed by the Institute of Medicine
8 in ‘Race, Ethnicity, and Language Data: Standard-
9 ization for Health Care Quality Improvement’ (re-
10 leased August 31, 2009).

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

18 “(4) COLLECTION OF DATA FOR MINORS AND
19 LEGALLY INCAPACITATED INDIVIDUALS.—With re-
20 spect to the collection of the data described in para-
21 graph (1) of applicants who are under 18 years of
22 age or otherwise legally incapacitated, the Commis-
23 sioner of Social Security shall require that—

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

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

4 “(5) ADDITIONAL REQUIREMENTS.—With re-
5 spect to data collected under paragraph (1), the
6 Commissioner of Social Security shall—

7 “(A) require that such data be uniformly
8 analyzed and that such analysis be reported at
9 least annually to the Commissioner;

10 “(B) be responsible for storing the data re-
11 ported under subparagraph (A);

12 “(C) ensure transmission to the Centers
13 for Medicare & Medicaid Services and other
14 agencies within the Department of Health and
15 Human Services, as determined appropriate by
16 the Secretary;

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

19 “(E) ensure that the provision of assist-
20 ance or benefits to an applicant is not denied
21 or otherwise adversely affected because of the
22 failure of the applicant to provide race, eth-
23 nicity, primary language, and disability status
24 data.

1 “(b) PROTECTION OF DATA.—The Commissioner of
2 Social Security shall ensure (through the promulgation of
3 regulations or otherwise) that all data collected pursuant
4 to subsection (a) is protected—

5 “(1) under the same privacy protections as the
6 Secretary applies to health data under the regula-
7 tions promulgated under section 264(c) of the
8 Health Insurance Portability and Accountability Act
9 of 1996 (relating to the privacy of individually iden-
10 tifiable health information and other protections);
11 and

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

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

23 “(d) TECHNICAL ASSISTANCE.—The Secretary may,
24 either directly or by grant or contract, provide technical
25 assistance to enable any entity to comply with the require-

1 ments of this section or with regulations implementing this
2 section.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2019 through 2024.”.

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

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

15 (1) the use, at a minimum, of standards for
16 data collection on race, ethnicity, primary language,
17 disability, sex, sexual orientation, gender identity,
18 and socioeconomic status developed under section
19 3101 of the Public Health Service Act (42 U.S.C.
20 300kk); and

21 (2) in consultation with the Office of the Na-
22 tional Coordinator for Health Information Tech-
23 nology, the designation of the appropriate racial,
24 ethnic, primary language, disability, sex, and other
25 code sets as required for claims and enrollment data.

1 (b) DISSEMINATION.—The Secretary of Health and
2 Human Services shall disseminate the new standards de-
3 veloped under subsection (a) to all entities that are subject
4 to the regulations described in such subsection and provide
5 technical assistance with respect to the collection of the
6 data involved.

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

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

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

15 (1) in paragraph (1), by striking “2003” and
16 inserting “2022”;

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

19 (3) in paragraph (3), by striking “2002” and
20 inserting “2022”.

21 **SEC. 106. DISPARITIES DATA COLLECTED BY THE FEDERAL**
22 **GOVERNMENT.**

23 (a) REPOSITORY OF GOVERNMENT DATA.—The Sec-
24 retary of Health and Human Services, in coordination
25 with the departments, agencies, or offices described in

1 subsection (b), shall establish a centralized electronic re-
2 pository of Government data on factors related to the
3 health and well-being of the population of the United
4 States.

5 (b) COLLECTION; SUBMISSION.—Not later than 180
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 data on race, ethnicity, sex, primary language, sexual ori-
10 entation, disability status, gender identity, or socio-
11 economic status during the preceding calendar year shall
12 submit such data to the repository of Government data
13 established under subsection (a).

14 (c) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
15 Not later than April 30, 2019, and April 30 of each year
16 thereafter, the Secretary of Health and Human Services,
17 acting through the Assistant Secretary for Planning and
18 Evaluation, the Assistant Secretary for Health, the Direc-
19 tor of the Agency for Healthcare Research and Quality,
20 the Director of the National Center for Health Statistics,
21 the Administrator of the Centers for Medicare & Medicaid
22 Services, the Director of the National Institute on Minor-
23 ity Health and Health Disparities, and the Deputy Assist-
24 ant Secretary for Minority Health, shall—

1 (1) prepare and make available datasets for
2 public use that relate to disparities in health status,
3 health care access, health care quality, health out-
4 comes, public health, and other areas of health and
5 well-being by factors that include race, ethnicity,
6 sex, primary language, sexual orientation, disability
7 status, gender identity, and socioeconomic status;

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

11 (3) submit a report to the Congress on the
12 availability and use of such data by public stake-
13 holders.

14 **SEC. 107. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**
15 **NORITY-SERVING INSTITUTIONS.**

16 (a) **AUTHORITY.**—The Secretary of Health and
17 Human Services, acting through the Director of the Na-
18 tional Institute on Minority Health and Health Disparities
19 and the Deputy Assistant Secretary for Minority Health,
20 shall award grants to eligible entities to access and analyze
21 racial and ethnic data on disparities in health and health
22 care, and where possible other data on disparities in health
23 and health care, to monitor and report on progress to re-
24 duce and eliminate disparities in health and health care.

1 (b) ELIGIBLE ENTITY.—In this section, the term “el-
2 ible entity” means an entity that has an accredited pub-
3 lic health, health policy, or health services research pro-
4 gram and is any of the following:

5 (1) A part B institution, as defined in section
6 322 of the Higher Education Act of 1965 (20
7 U.S.C. 1061).

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

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

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

15 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
16 out this section, there are authorized to be appropriated
17 such sums as may be necessary for fiscal years 2019
18 through 2024.

19 **SEC. 108. STANDARDS FOR MEASURING SEXUAL ORIENTA-**
20 **TION, GENDER IDENTITY, AND SOCIO-**
21 **ECONOMIC STATUS IN COLLECTION OF**
22 **HEALTH DATA.**

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

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

4 (2) in paragraph (1)(C), by inserting “sexual
5 orientation, gender identity, socioeconomic status,”
6 before “and disability status”; and

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

10 **SEC. 109. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
11 **RESPECT TO RACIAL AND ETHNIC BACK-**
12 **GROUND.**

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

16 **“SEC. 505G. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
17 **RESPECT TO RACIAL AND ETHNIC BACK-**
18 **GROUND.**

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

23 “(1)(A) in the case of a drug, the investigations
24 required under section 505(b)(1)(A) shall include

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

3 “(B) in the case of a biological product, the evi-
4 dence required under section 351(a) of the Public
5 Health Service Act for approval of a biologics license
6 application for the biological product shall include
7 adequate and well-controlled investigations of the
8 disparity; and

9 “(2) if the investigations described in subpara-
10 graph (A) or (B) of paragraph (1) confirm that
11 there is such a disparity, the labeling of the drug or
12 biological product shall include appropriate informa-
13 tion 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 of this Act or of a biological prod-
20 uct for which there is an approved license under sec-
21 tion 351 of the Public Health Service Act, the Sec-
22 retary may by order require the holder of the ap-
23 proved application or license to conduct, by a date
24 specified by the Secretary, postmarket studies to in-
25 vestigate the disparity.

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 or biological product shall include appro-
5 priate information about the disparity.

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

13 “(4) MODIFICATIONS OF STUDY DESIGN.—The
14 Secretary may, by order and as necessary, modify
15 any aspect of the design of a postmarket study re-
16 quired in an order under paragraph (1) after issuing
17 such order.

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

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

23 “(1) IN GENERAL.—A drug for which an appli-
24 cation has been submitted or approved under section
25 505(j) shall not be considered ineligible for approval

1 under that section or misbranded under section 502
2 on the basis that the labeling of the drug omits in-
3 formation relating to a disparity on the basis of ra-
4 cial or ethnic background as to the safety or effec-
5 tiveness of the drug, whether derived from investiga-
6 tions or studies required under this section or de-
7 rived from other sources, when the omitted informa-
8 tion is protected by patent or by exclusivity under
9 section 505(j)(5)(F).

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

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

23 “(1) evidence that there is a disparity on the
24 basis of racial or ethnic background as to safety or
25 effectiveness of a drug or biological product in the

1 same chemical class as the drug or biological prod-
2 uct;

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

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

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

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

16 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
17 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
18 379h(a)(1)(A)(ii)) is amended by inserting after “are not
19 required” the following: “, including postmarket studies
20 required under section 505G”.

21 **SEC. 110. IMPROVING HEALTH DATA REGARDING NATIVE**
22 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

23 Part B of title III of the Public Health Service Act
24 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
25 tion 317T the following:

1 **“SEC. 317U. NATIVE HAWAIIAN AND OTHER PACIFIC IS-**
2 **LANDER HEALTH DATA.**

3 “(a) DEFINITIONS.—In this section:

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

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

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

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

1 “(5) NATIVE HAWAIIANS AND OTHER PACIFIC
2 ISLANDERS (NHOPI).—The term ‘Native Hawaiians
3 and Other Pacific Islanders’ or ‘NHOPI’ means peo-
4 ple having origins in any of the original peoples of
5 American Samoa, the Commonwealth of the North-
6 ern Mariana Islands, the Federated States of Micro-
7 nesia, Guam, Hawaii, the Republic of the Marshall
8 Islands, the Republic of Palau, or any other Pacific
9 Island.

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

16 “(b) NATIONAL STRATEGY.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Director of the National Center for
19 Health Statistics (referred to in this section as
20 ‘NCHS’) of the Centers for Disease Control and
21 Prevention, and other agencies within the Depart-
22 ment of Health and Human Services as the Sec-
23 retary determines appropriate, shall develop and im-
24 plement an ongoing and sustainable national strat-
25 egy for identifying and evaluating the health status

1 and health care needs of NHOPI populations living
2 in the continental United States, Hawaii, American
3 Samoa, the Commonwealth of the Northern Mariana
4 Islands, the Federated States of Micronesia, Guam,
5 the Republic of Palau, and the Republic of the Mar-
6 shall Islands.

7 “(2) CONSULTATION.—In developing and imple-
8 menting a national strategy, as described in para-
9 graph (1), not later than 180 days after the date of
10 enactment of the Health Equity and Accountability
11 Act of 2018, the Secretary—

12 “(A) shall consult with representatives of
13 community groups, designated organizations,
14 and nonprofit, nongovernmental organizations
15 and with government representatives of NHOPI
16 populations; and

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

19 “(c) PRELIMINARY HEALTH SURVEY.—

20 “(1) IN GENERAL.—The Secretary, acting
21 through the Director of NCHS, shall conduct a pre-
22 liminary health survey in order to identify the major
23 areas and regions in the continental United States,
24 Hawaii, American Samoa, the Commonwealth of the
25 Northern Mariana Islands, the Federated States of

1 Micronesia, Guam, the Republic of Palau, and the
2 Republic of the Marshall Islands in which NHOPI
3 people reside.

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

7 “(A) useful in determining health status
8 and health care needs; or

9 “(B) required for developing or imple-
10 menting a national strategy.

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

19 “(4) TIMEFRAME.—The survey required under
20 this subsection shall be completed not later than 18
21 months after the date of enactment of the Health
22 Equity and Accountability Act of 2018.

23 “(d) PROGRESS REPORT.—Not later than 2 years
24 after the date of enactment of the Health Equity and Ac-
25 countability Act of 2018, the Secretary shall submit to

1 Congress a progress report, which shall include the na-
2 tional strategy described in subsection (b)(1).

3 “(e) STUDY AND REPORT BY THE HEALTH AND
4 MEDICINE DIVISION.—

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

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

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

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

22 “(D) The progress toward implementation
23 of recommendations of the Committee on
24 Health Care Services in the United States—As-
25 sociated Pacific Basin that are set forth in the

1 1998 report entitled ‘Pacific Partnerships for
2 Health: Charting a New Course’.

3 “(2) REPORT.—An agreement described in
4 paragraph (1) shall require the Health and Medicine
5 Division to submit to the Secretary and to Congress,
6 not later than 2 years after the date of the enact-
7 ment of the Health Equity and Accountability Act of
8 2018, a report containing a description of the results
9 of the study conducted under paragraph (1), includ-
10 ing the conclusions and recommendations of the
11 Health and Medicine Division for each of the items
12 described in subparagraphs (A) through (D) of such
13 paragraph.

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
15 carry out this section, there are authorized to be appro-
16 priated such sums as may be necessary for fiscal years
17 2019 through 2024.”.

18 **SEC. 111. CLARIFICATION OF SIMPLIFIED ADMINISTRATIVE**
19 **REPORTING REQUIREMENT.**

20 Section 11(a) of the Food and Nutrition Act of 2008
21 (7 U.S.C. 2020(a)) is amended by adding at the end the
22 following:

23 “(5) SIMPLIFIED ADMINISTRATIVE REPORTING
24 REQUIREMENT.—With respect to any obligation of a
25 State agency to comply with the notification require-

1 ment under paragraph (2) of section 421(e) of the
2 Personal Responsibility and Work Opportunity Rec-
3 onciliation Act of 1996 (8 U.S.C. 1631(e)), notwith-
4 standing the requirement to include in that notifica-
5 tion the names of the sponsor and the sponsored
6 alien involved, the State agency shall be considered
7 to have complied with the notification requirement if
8 the State agency submits to the Attorney General a
9 report that includes the aggregate number of excep-
10 tions granted by the State agency under paragraph
11 (1) of that section.”.

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

15 **SEC. 201. DEFINITIONS; FINDINGS.**

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

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

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

23 (2) Research indicates that the lack of appro-
24 priate language services creates language barriers
25 that result in increased risk of misdiagnosis, ineffec-

1 tive treatment plans, and poor health outcomes for
2 individuals with limited-English proficiency and indi-
3 viduals with communication disabilities such as hear-
4 ing, vision, or print impairments.

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

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

18 (5) Title VI of the Civil Rights Act of 1964 (42
19 U.S.C. 2000d et seq.) prohibits discrimination based
20 on the grounds of race, color, or national origin by
21 any entity receiving Federal financial assistance. In
22 order to avoid discrimination on the grounds of na-
23 tional origin, all programs or activities administered
24 by the Federal Government must take adequate
25 steps to ensure that their policies and procedures do

1 not deny or have the effect of denying individuals
2 with limited-English proficiency with equal access to
3 benefits and services for which such persons qualify.

4 (6) Both the Americans with Disabilities Act of
5 1990 (42 U.S.C. 12101 et seq.) and the Rehabilita-
6 tion Act of 1973 (29 U.S.C. 701 et seq.) prohibit
7 discrimination on the basis of disability and require
8 the provision of appropriate auxiliary aids and serv-
9 ices necessary to ensure effective communication
10 with individuals with disabilities. The type of auxil-
11 iary aid or service necessary to ensure effective com-
12 munication will vary in accordance with the method
13 of communication used by the individual; the nature,
14 length, and complexity of the communication in-
15 volved; and the context in which the communication
16 is taking place. A public accommodation should con-
17 sult with individuals with disabilities whenever pos-
18 sible to determine what type of auxiliary aid is need-
19 ed to ensure effective communication, but the ulti-
20 mate decision as to what measures to take rests with
21 the public accommodation, provided that the method
22 chosen results in effective communication. In order
23 to be effective, auxiliary aids and services must be
24 provided in accessible formats, in a timely manner,

1 and in such a way as to protect the privacy and
2 independence of the individual with a disability.

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

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

16 (9) Access to English as a second language, and
17 sign language instructions, readers, and other auxil-
18 iary aids and services, are essential to ensure effec-
19 tive communication and eliminate the language bar-
20 riers that impede access to health care.

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

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

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

7 (1) to improve Federal agency performance re-
8 garding access to federally conducted and federally
9 assisted programs and activities for individuals with
10 limited-English proficiency;

11 (2) to require each Federal agency to examine
12 the services it provides and develop and implement
13 a system by which individuals with limited-English
14 proficiency can obtain cultural competence and
15 meaningful access to those services consistent with,
16 and without substantially burdening, the funda-
17 mental mission of the agency;

18 (3) to require each Federal agency to ensure
19 that recipients of Federal financial assistance pro-
20 vide cultural competence and meaningful access to
21 applicants and beneficiaries that are individuals with
22 limited-English proficiency;

23 (4) to ensure that recipients of Federal finan-
24 cial assistance take reasonable steps, consistent with
25 the guidelines set forth in the “Guidance to Federal
26 Financial Assistance Recipients Regarding Title VI

1 Prohibition Against National Origin Discrimination
2 Affecting Limited English Proficient Persons (67
3 Fed. Reg. 41455 (June 18, 2002))”, to ensure cul-
4 turally and linguistically appropriate access to their
5 programs and activities by individuals with limited-
6 English proficiency; and

7 (5) to ensure compliance with title VI of the
8 Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
9 and that health care providers and organizations do
10 not discriminate in the provision of services.

11 (b) FEDERALLY CONDUCTED PROGRAMS AND AC-
12 TIVITIES.—

13 (1) IN GENERAL.—Not later than 120 days
14 after the date of enactment of this Act, each Federal
15 agency providing financial assistance to, or admin-
16 istering, a health program or activity described in
17 section 203(a) shall prepare a plan to improve cul-
18 turally and linguistically appropriate access to such
19 program or activity with respect to individuals with
20 limited-English proficiency. Not later than 1 year
21 after the date of enactment of this title, each such
22 Federal agency shall ensure that such plan is fully
23 implemented.

24 (2) PLAN REQUIREMENT.—Each plan under
25 paragraph (1) shall include—

1 (A) the steps the agency will take to en-
2 sure that individuals with limited-English pro-
3 ficiency have access to each health program or
4 activity supported or administered by the agen-
5 cy;

6 (B) the policies and procedures for identi-
7 fying, assessing, and meeting the culturally and
8 linguistically appropriate language needs of its
9 beneficiaries that are individuals with limited-
10 English proficiency served by such program or
11 activity;

12 (C) the steps the agency will take for such
13 program or activity to be culturally and linguis-
14 tically appropriate by providing a range of lan-
15 guage assistance options, notice to individuals
16 with limited-English proficiency of the right to
17 competent language services, periodic training
18 of staff, monitoring and quality assessment of
19 the language services and, in appropriate cir-
20 cumstances, the translation of written mate-
21 rials;

22 (D) the steps the agency will take to en-
23 sure that applications, forms, and other rel-
24 evant documents for such program or activity
25 are competently translated into the primary

1 language of a client that is an individual with
2 limited-English proficiency where such mate-
3 rials are needed to improve access of such client
4 to such program or activity;

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

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

16 (G) the resources the agency will provide
17 to ensure that family, particularly minor chil-
18 dren, and friends are not used to provide inter-
19 pretation services, except as permitted under
20 regulations implementing section 1557 of the
21 Patient Protection and Affordable Care Act (42
22 U.S.C. 18116).

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

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

3 (4) RULE OF CONSTRUCTION.—Paragraph
4 (2)(G) shall not be construed to mean that emer-
5 gency rooms or similar entities that regularly pro-
6 vide health care services in medical emergencies are
7 exempt from legal or regulatory requirements related
8 to competent interpreter services.

9 **SEC. 203. NATIONAL STANDARDS FOR CULTURALLY AND**
10 **LINGUISTICALLY APPROPRIATE SERVICES IN**
11 **HEALTH CARE.**

12 (a) APPLICABILITY.—This section shall apply to any
13 health program or activity, any part of which is receiving
14 Federal financial assistance, including credits, subsidies,
15 or contracts of insurance, or any program or activity that
16 is administered by an executive agency or any entity estab-
17 lished under title I of the Patient Protection and Afford-
18 able Care Act (or amendments made thereby), as such
19 programs, activities, agencies, and entities are described
20 in section 1557(a) of the Patient Protection and Afford-
21 able Care Act (42 U.S.C. 18116(a)).

22 (b) STANDARDS.—Each program or activity de-
23 scribed in subsection (a)—

24 (1) shall implement strategies to recruit, retain,
25 and promote individuals at all levels to maintain a

1 diverse staff and leadership that can provide cul-
2 turally and linguistically appropriate health care to
3 patient populations of the service area of the pro-
4 gram or activity;

5 (2) shall educate and train governance, leader-
6 ship, and workforce at all levels and across all dis-
7 ciplines of the program or activity in culturally and
8 linguistically appropriate policies and practices on an
9 ongoing basis;

10 (3) shall offer and provide language assistance,
11 including trained bilingual staff and interpreter serv-
12 ices, to individuals with limited-English proficiency
13 or who have other communication needs, at no cost
14 to the individual at all points of contact, and during
15 all hours of operation, to facilitate timely access to
16 health care services and health-care-related services;

17 (4) shall for each language group consisting of
18 individuals with limited-English proficiency that con-
19 stitutes 5 percent or 500 individuals, whichever is
20 less, of the population of persons eligible to be
21 served or likely to be affected or encountered in the
22 service area of the program or activity, make avail-
23 able—

1 (A) easily understood patient-related mate-
2 rials, including print and multimedia materials,
3 in the language of such language group;

4 (B) information or notices about termi-
5 nation of benefits in such language; and

6 (C) signage;

7 (5) shall develop and implement clear goals,
8 policies, operational plans, and management, ac-
9 countability, and oversight mechanisms to provide
10 culturally and linguistically appropriate services and
11 infuse them throughout the planning and operations
12 of the program or activity;

13 (6) shall conduct initial and ongoing organiza-
14 tional assessments of culturally and linguistically ap-
15 propriate services-related activities and integrate
16 valid linguistic, competence-related National Stand-
17 ards for Culturally and Linguistically Appropriate
18 Services (CLAS) measures into the internal audits,
19 performance improvement programs, patient satis-
20 faction assessments, continuous quality improvement
21 activities, and outcomes-based evaluations of the
22 program or activity and develop ways to standardize
23 the assessments;

24 (7) shall ensure that, consistent with the pri-
25 vacy protections provided for under the regulations

1 promulgated under section 264(c) of the Health In-
2 surance Portability and Accountability Act of 1996
3 (42 U.S.C. 1320–2 note), data on an individual re-
4 quired to be collected pursuant to section 3101, in-
5 cluding the individual’s alternative format pref-
6 erences and policy modification needs, are—

7 (A) collected in health records;

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

10 (C) periodically updated;

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

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

1 (10) shall ensure that conflict and grievance
2 resolution processes are culturally and linguistically
3 appropriate and capable of identifying, preventing,
4 and resolving cross-cultural conflicts or complaints
5 by patients;

6 (11) shall regularly make available to the public
7 information about their progress and successful in-
8 novations in implementing the standards under this
9 section and provide public notice in their commu-
10 nities about the availability of this information; and

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

17 (c) COMMENTS ACCEPTED THROUGH NOTICE AND
18 COMMENT RULEMAKING.—An agency carrying out a pro-
19 gram described in subsection (a) shall ensure that com-
20 ments with respect to such program that are accepted
21 through notice and comment rulemaking be accepted in
22 all languages and may not require such comments to be
23 submitted only in English.

1 **SEC. 204. CULTURALLY AND LINGUISTICALLY APPRO-**
 2 **PRIATE HEALTH CARE IN THE PUBLIC**
 3 **HEALTH SERVICE ACT.**

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

6 **“TITLE XXXIV—CULTURALLY**
 7 **AND LINGUISTICALLY APPRO-**
 8 **PRIATE HEALTH CARE**

9 **“SEC. 3400. DEFINITIONS.**

10 “(a) IN GENERAL.—In this title:

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

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

22 “(3) CULTURALLY AND LINGUISTICALLY AP-
 23 PROPRIATE.—The term ‘culturally and linguistically
 24 appropriate’ means being respectful of and respon-
 25 sive to the cultural and linguistic needs of all indi-
 26 viduals.

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

11 “(5) GRIEVANCE RESOLUTION PROCESS.—The
12 term ‘grievance resolution process’ means all aspects
13 of dispute resolution including filing complaints,
14 grievance and appeal procedures, and court action.

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

1 “(7) HEALTH CARE SERVICES.—The term
2 ‘health care services’ means services that address
3 physical as well as mental health conditions in all
4 care settings.

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

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

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

19 “(11) INDIVIDUAL WITH A DISABILITY.—The
20 term ‘individual with a disability’ means any indi-
21 vidual who has a disability as defined for the pur-
22 pose of section 504 of the Rehabilitation Act of
23 1973.

24 “(12) INDIVIDUAL WITH LIMITED-ENGLISH
25 PROFICIENCY.—The term ‘individual with limited-

1 English proficiency’ means an individual whose pri-
2 mary language for communication is not English
3 and who has a limited ability to read, write, speak,
4 or understand English.

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

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

22 “(15) LANGUAGE ACCESS.—The term ‘language
23 access’ means the provision of language services to
24 an individual with limited-English proficiency or an
25 individual with communication disabilities designed

1 to enhance that individual's access to, understanding
2 of, or benefit from health care services or health-
3 care-related services.

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

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

13 “(B) written translation, performed by a
14 qualified translator, of written content in paper
15 or electronic form into languages other than
16 English; and

17 “(C) taglines.

18 “(17) MINORITY.—

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

22 “(B) POPULATIONS.—The term ‘minority’,
23 with respect to populations, refers to racial and
24 ethnic minority groups, members of sexual and

1 gender minority groups, and individuals with a
2 disability.

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

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

14 “(20) QUALIFIED INTERPRETER FOR AN INDI-
15 VIDUAL WITH LIMITED-ENGLISH PROFICIENCY.—
16 The term ‘qualified interpreter for an individual with
17 limited-English proficiency’ means an interpreter
18 who via a remote interpreting service or an on-site
19 appearance—

20 “(A) adheres to generally accepted inter-
21 preter ethics principles, including client con-
22 fidentiality;

23 “(B) has demonstrated proficiency in
24 speaking and understanding both spoken

1 English and one or more other spoken lan-
2 guages; and

3 “(C) is able to interpret effectively, accu-
4 rately, and impartially, both receptively and ex-
5 pressly, to and from such languages and
6 English, using any necessary specialized vocab-
7 ulary, terminology, and phraseology.

8 “(21) QUALIFIED TRANSLATOR.—The term
9 ‘qualified translator’ means a translator who—

10 “(A) adheres to generally accepted trans-
11 lator ethics principles, including client confiden-
12 tiality;

13 “(B) has demonstrated proficiency in writ-
14 ing and understanding both written English
15 and one or more other written non-English lan-
16 guages; and

17 “(C) is able to translate effectively, accu-
18 rately, and impartially to and from such lan-
19 guages and English, using any necessary spe-
20 cialized vocabulary, terminology, and phrase-
21 ology.

22 “(22) RACIAL AND ETHNIC MINORITY GROUP.—
23 The term ‘racial and ethnic minority group’ means
24 Indians and Alaska Natives, African Americans (in-
25 cluding Caribbean Blacks, Africans, and other

1 Blacks), Asian Americans, Hispanics (including
2 Latinos), and Native Hawaiians and other Pacific
3 Islanders.

4 “(23) SEXUAL AND GENDER MINORITY
5 GROUP.—The term ‘sexual and gender minority
6 group’ encompasses lesbian, gay, bisexual, and
7 transgender populations, as well as those whose sex-
8 ual orientation, gender identity and expression, or
9 reproductive development varies from traditional, so-
10 cietal, cultural, or physiological norms.

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

16 “(25) STATE.—Notwithstanding section 2, the
17 term ‘State’ means each of the several States, the
18 District of Columbia, the Commonwealth of Puerto
19 Rico, the United States Virgin Islands, Guam,
20 American Samoa, and the Commonwealth of the
21 Northern Mariana Islands.

22 “(26) TELEPHONIC INTERPRETATION.—The
23 term ‘telephonic interpretation’ (also known as ‘over
24 the phone interpretation’ or ‘OPI’) means, with re-
25 spect to interpretation for an individual with limited-

1 English proficiency, a method of interpretation in
2 which the interpreter is not in the physical presence
3 of the provider of health care services or health-care-
4 related services and such individual receiving such
5 services, but the interpreter is connected via tele-
6 phone.

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

13 “(28) VIDEO REMOTE INTERPRETING SERV-
14 ICES.—The term ‘video remote interpreting services’
15 means the provision, in health care services or
16 health-care-related services, through a qualified in-
17 terpreter for an individual with limited-English pro-
18 ficiency, of video remote interpreting services that
19 are—

20 “(A) in real-time, full-motion video, and
21 audio over a dedicated high-speed, wide-band-
22 width video connection or wireless connection
23 that delivers high quality video images that do
24 not produce lags, choppy, blurry, or grainy im-
25 ages, or irregular pauses in communication; and

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

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

18 “(b) REFERENCE.—In any reference in this title to
19 a regulatory provision applicable to a ‘handicapped indi-
20 vidual’, the term ‘handicapped individual’ in such provi-
21 sion shall have the same meaning as the term ‘individual
22 with a disability’ as defined in subsection (a).

1 **“Subtitle A—Resources and Innova-**
 2 **tion for Culturally and Linguis-**
 3 **tically Appropriate Health Care**

4 **“SEC. 3401. ROBERT T. MATSUI CENTER FOR CULTURALLY**
 5 **AND LINGUISTICALLY APPROPRIATE HEALTH**
 6 **CARE.**

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

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

18 “(2) TRANSLATION OF WRITTEN MATERIAL.—
 19 “(A) VITAL DOCUMENTS.—The Center
 20 shall provide, directly or through contract, vital
 21 documents from competent translation services
 22 for providers of health care services and health-
 23 care-related services at no cost to such pro-
 24 viders. Such documents may be submitted for
 25 translation into non-English languages. Such

1 translation services shall be provided in a timely
2 and reasonable manner. The quality of such
3 translation services shall be monitored and re-
4 ported publicly.

5 “(B) FORMS.—For each form developed or
6 revised by the Secretary that will be used by in-
7 dividuals with limited-English proficiency in
8 health care or health-care-related settings, the
9 Center shall translate the form, at a minimum,
10 into the top 15 non-English languages in the
11 United States according to the most recent data
12 from the American Community Survey or its re-
13 placement. The translation shall be completed
14 within 45 days of the Secretary receiving final
15 approval of the form from the Office of Man-
16 agement and Budget.

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

21 “(A) to obtain information about federally
22 conducted or funded health programs, including
23 the Medicare program under title XVIII of the
24 Social Security Act, the Medicaid program
25 under title XIX of such Act, and the State Chil-

1 dren’s Health Insurance Program under title
2 XXI of such Act;

3 “(B) to obtain assistance with applying for
4 or accessing these programs and understanding
5 Federal notices written in English; and

6 “(C) to learn how to access language serv-
7 ices.

8 “(4) HEALTH INFORMATION CLEARING-
9 HOUSE.—

10 “(A) IN GENERAL.—The Center shall de-
11 velop and maintain an information clearing-
12 house to facilitate the provision of language
13 services by providers of health care services and
14 health-care-related services to reduce medical
15 errors, improve medical outcomes, improve cul-
16 tural competence, reduce health care costs
17 caused by miscommunication with individuals
18 with limited-English proficiency, and reduce or
19 eliminate the duplication of efforts to translate
20 materials. The clearinghouse shall include the
21 information described in subparagraphs (B)
22 through (F) and make such information avail-
23 able on the internet and in print.

24 “(B) DOCUMENT TEMPLATES.—The Cen-
25 ter shall collect and evaluate for accuracy, de-

1 velop, and make available templates for stand-
2 ard documents that are necessary for patients
3 and consumers to access and make educated de-
4 cisions about their health care, including tem-
5 plates for each of the following:

6 “(i) Administrative and legal docu-
7 ments, including—

8 “(I) intake forms;

9 “(II) forms related to the Medi-
10 care program under title XVIII of the
11 Social Security Act, the Medicaid pro-
12 gram under title XIX of such Act,
13 and the State Children’s Health In-
14 surance Program under title XXI of
15 such Act, including eligibility informa-
16 tion for such programs;

17 “(III) forms informing patients
18 of the compliance and consent re-
19 quirements pursuant to the regula-
20 tions under section 264(c) of the
21 Health Insurance Portability and Ac-
22 countability Act of 1996 (42 U.S.C.
23 1320–2 note); and

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

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

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

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

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

17 “(i) ensure that the documents posted
18 in English and non-English languages are
19 culturally and linguistically 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 and linguistically ap-
24 propriate for the target 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 individuals with limited-English proficiency, in-
17 cluding case studies using de-identified patient
18 information, program summaries, and program
19 evaluations.

20 “(E) CULTURALLY AND LINGUISTICALLY
21 APPROPRIATE MATERIALS.—The Center shall
22 provide information relating to culturally and
23 linguistically appropriate health care for minor-
24 ity populations residing in the United States to
25 all 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 appropriate care;

5 “(ii) culturally and linguistically ap-
6 propriate self-assessment tools;

7 “(iii) culturally and linguistically ap-
8 propriate training tools;

9 “(iv) strategic plans to increase cul-
10 tural and linguistic appropriateness in dif-
11 ferent types of providers of health care
12 services and health-care-related services,
13 including regional collaborations among
14 health care organizations; and

15 “(v) culturally and linguistically ap-
16 propriate 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 3402 regarding successful innovations in
23 implementing the obligations under this sub-
24 section and provide public notice in the entities’

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

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

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

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

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

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

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

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

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section
7 \$5,000,000 for each of fiscal years 2019 through 2023.

8 **“SEC. 3402. INNOVATIONS IN CULTURALLY AND LINGUIS-**
9 **TICALLY APPROPRIATE HEALTH CARE**
10 **GRANTS.**

11 “(a) IN GENERAL.—

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

20 “(2) COORDINATION.—The Director of the
21 Agency for Healthcare Research and Quality shall
22 coordinate with, and ensure the participation of,
23 other agencies including the Health Resources and
24 Services Administration, the National Institute on
25 Minority Health and Health Disparities at the Na-

1 tional Institutes of Health, and the Office of Minor-
2 ity Health, regarding the design and evaluation of
3 the grants program.

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

6 “(1) be—

7 “(A) a city, county, Indian Tribe, State, or
8 subdivision thereof;

9 “(B) an organization described in section
10 501(c)(3) of the Internal Revenue Code of 1986
11 and exempt from tax under section 501(a) of
12 such Code;

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

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

16 “(E) an integrated health care delivery
17 system;

18 “(F) a public hospital;

19 “(G) a health care group, university, or
20 college; or

21 “(H) any other entity designated by the
22 Secretary; and

23 “(2) prepare and submit to the Secretary an
24 application, at such time, in such manner, and con-

1 taining such additional information as the Secretary
2 may reasonably require.

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

5 “(1) develop, implement, and evaluate models of
6 providing competent interpretation services through
7 onsite interpretation, telephonic interpretation, or
8 video remote interpreting services;

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

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

19 “(4) develop a strategic plan to implement lan-
20 guage services;

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

1 “(6) develop and implement grievance resolu-
2 tion processes that are culturally and linguistically
3 appropriate and capable of identifying, preventing,
4 and resolving complaints by individuals with limited-
5 English proficiency;

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

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

16 “(9) provide staff language training instruction,
17 which shall include information on the practical limi-
18 tations of such instruction for nonnative 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 bilingual 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, including cultural

1 competence programs for community health workers;
2 and

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

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

18 “(e) EVALUATION.—

19 “(1) BY GRANTEES.—An entity that receives a
20 grant under this section shall submit to the Sec-
21 retary an evaluation that describes, in the manner
22 and to the extent required by the Secretary, the ac-
23 tivities carried out with funds received under the
24 grant, and how such activities improved access to
25 health care services and health-care-related services

1 and the quality of health care for individuals with
2 limited-English proficiency. Such evaluation shall be
3 collected and disseminated through the Robert T.
4 Matsui Center for Culturally and Linguistically Ap-
5 propriate Health Care established under section
6 3401. The Director of the Agency for Healthcare
7 Research and Quality shall notify grantees of the
8 availability of technical assistance for the evaluation
9 and provide such assistance upon request.

10 “(2) BY SECRETARY.—The Director of the
11 Agency for Healthcare Research and Quality shall
12 evaluate or arrange with other individuals or organi-
13 zations to evaluate projects funded under this sec-
14 tion.

15 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
16 is authorized to be appropriated to carry out this section,
17 \$5,000,000 for each of fiscal years 2019 through 2023.

18 **“SEC. 3403. RESEARCH ON CULTURAL AND LANGUAGE COM-**

19 **PETENCE.**

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

24 “(b) ELIGIBILITY.—The Director of the Agency for
25 Healthcare Research and Quality may conduct the re-

1 search described in subsection (a) or enter into contracts
2 with other individuals or organizations to conduct such re-
3 search.

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

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

10 “(2) To identify health care providers’ and
11 health administrators’ attitudes, knowledge, and
12 awareness of the barriers to quality health care serv-
13 ices that are faced by individuals with limited-
14 English proficiency.

15 “(3) To identify optimal approaches for deliv-
16 ering language access.

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

19 “(A) the collection by providers of health
20 care services and health-care-related services of
21 data on the race, ethnicity, and primary lan-
22 guage of recipients of such services, taking into
23 account existing research conducted by the Gov-
24 ernment or private sector;

1 “(B) the development and implementation
2 of data collection and reporting systems; and

3 “(C) effective privacy safeguards for col-
4 lected data.

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

7 “(6) To evaluate the most effective ways in
8 which the Secretary can create or coordinate, and
9 subsidize or otherwise fund, telephonic interpretation
10 services for health care providers, taking into consid-
11 eration, among other factors, the flexibility necessary
12 for such a system to accommodate variations in—

13 “(A) provider type;

14 “(B) languages needed and their frequency
15 of use;

16 “(C) type of encounter;

17 “(D) time of encounter, including regular
18 business hours and after hours; and

19 “(E) location of encounter.

20 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 \$5,000,000 for each of fiscal years 2019 through 2023.”.

1 **SEC. 205. PILOT PROGRAM FOR IMPROVEMENT AND DE-**
2 **VELOPMENT OF STATE MEDICAL INTER-**
3 **PRETING SERVICES.**

4 (a) GRANTS AUTHORIZED.—The Secretary shall
5 award 1 grant in accordance with this section to each of
6 3 States (to be selected by the Secretary) to assist each
7 such State in designing, implementing, and evaluating a
8 statewide program to provide onsite interpreter services
9 under the State Medicaid plan.

10 (b) GRANT PERIOD.—A grant awarded under this
11 section is authorized for the period of 3 fiscal years begin-
12 ning on October 1, 2019, and ending on September 30,
13 2022.

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

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

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

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

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

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

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

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

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

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

19 (i) procuring and scheduling inter-
20 preter services for qualified LEP enrollees;

21 (ii) procuring and scheduling inter-
22 preter services for individuals with limited-
23 English proficiency seeking to enroll in the
24 State Medicaid plan;

1 (iii) ensuring that interpreters receive
2 payment for interpreter services rendered
3 under the system; and

4 (iv) consulting regularly with organi-
5 zations representing consumers, inter-
6 preters, and health care providers; and

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

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

16 (1) A description of the language access needs
17 of individuals in the State enrolled in the State Med-
18 icaid plan.

19 (2) A description of the extent to which the
20 program will—

21 (A) use the grant funds for the purposes
22 described in subsection (d);

23 (B) meet the health care needs of rural
24 populations of the State; and

1 (C) collect information that accurately
2 tracks the language services requested by con-
3 sumers as compared to the language services
4 provided by health care providers in the State
5 participating in the State Medicaid plan.

6 (3) A description of how the program will be
7 evaluated, including a proposal for collaboration with
8 organizations representing interpreters, consumers,
9 and individuals with limited-English proficiency.

10 (f) DEFINITIONS.—In this section:

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

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

14 (B) who is enrolled in a State Medicaid
15 plan.

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

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

24 (4) UNITED STATES.—The term “United
25 States” has the meaning given the term in section

1 1101(a)(2) of the Social Security Act (42 U.S.C.
2 1301(a)(2)), for purposes of title XIX of such Act.

3 (g) FUNDING.—

4 (1) AUTHORIZATION OF APPROPRIATIONS.—

5 There is authorized to be appropriated \$5,000,000
6 to carry out this section.

7 (2) AVAILABILITY OF FUNDS.—Amounts appro-
8 priated pursuant to the authorization in paragraph
9 (1) are authorized to remain available without fiscal
10 year limitation.

11 (3) INCREASED FEDERAL FINANCIAL PARTICI-
12 PATION.—Section 1903(a)(2)(E) of the Social Secu-
13 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended by
14 inserting “(or, in the case of a State that was
15 awarded a grant under section 203 of the Health
16 Equity and Accountability Act of 2018, 100 percent
17 for each quarter occurring during the grant period
18 specified in subsection (b) of such section)” after
19 “75 percent”.

20 (h) LIMITATION.—No Federal funds awarded under
21 this section may be used to provide interpreter services
22 from a location outside the United States.

1 **SEC. 206. TRAINING TOMORROW'S DOCTORS FOR CUL-**
 2 **TURALLY AND LINGUISTICALLY APPRO-**
 3 **PRIATE CARE: GRADUATE MEDICAL EDU-**
 4 **CATION.**

5 (a) DIRECT GRADUATE MEDICAL EDUCATION.—Sec-
 6 tion 1886(h)(4) of the Social Security Act (42 U.S.C.
 7 1395ww(h)(4)) is amended by adding at the end the fol-
 8 lowing new subparagraph:

9 “(L) TREATMENT OF CULTURALLY AND
 10 LINGUISTICALLY APPROPRIATE TRAINING.—In
 11 determining a hospital’s number of full-time
 12 equivalent residents for purposes of this sub-
 13 section, all the time that is spent by an intern
 14 or resident in an approved medical residency
 15 training program for education and training in
 16 culturally and linguistically appropriate service
 17 delivery shall be counted toward the determina-
 18 tion of full-time equivalency.”.

19 (b) INDIRECT MEDICAL EDUCATION.—Section
 20 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
 21 1395ww(d)(5)(B)) is amended—

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

25 (2) by adding at the end the following new
 26 clause:

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

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

9 **SEC. 207. FEDERAL REIMBURSEMENT FOR CULTURALLY**
10 **AND LINGUISTICALLY APPROPRIATE SERV-**
11 **ICES UNDER THE MEDICARE, MEDICAID, AND**
12 **STATE CHILDREN’S HEALTH INSURANCE**
13 **PROGRAMS.**

14 (a) LANGUAGE ACCESS GRANTS FOR MEDICARE
15 PROVIDERS.—

16 (1) ESTABLISHMENT.—

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

1 munication between such providers and Medi-
2 care beneficiaries who are English learners, in-
3 cluding beneficiaries who live in diverse and un-
4 derserved communities.

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

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

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

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

21 (A) MEDICARE PROVIDER.—The entity
22 must be—

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

1 (ii) a provider of services under part
2 B of such title;

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

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

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

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

20 (D) REPORTING.—In the case of a grantee
21 that received a grant under this subsection in
22 a previous year, such grantee is only eligible for
23 continued payments under a grant under this
24 subsection if the grantee met the reporting re-
25 quirements under paragraph (9) for such year.

1 If a grantee fails to meet the requirement of
2 such paragraph for the first year of a grant, the
3 Secretary may terminate the grant and solicit
4 applications from new grantees to participate in
5 the demonstration program.

6 (3) DISTRIBUTION.—To the extent feasible, the
7 Secretary shall award—

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

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

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

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

16 (4) CONSIDERATIONS IN AWARDING GRANTS.—

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

20 (i) The grantees provide many dif-
21 ferent types of language services.

22 (ii) The grantees serve Medicare bene-
23 ficiaries who speak different languages,
24 and who, as a population, have differing
25 needs for language services.

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

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

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

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

17 (i) a community organization; or

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

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

24 (A) IN GENERAL.—Subject to subpara-
 25 graph (E), a grantee may only use grant funds

1 received under this subsection to pay for the
2 provision of competent language services to
3 Medicare beneficiaries who are English learn-
4 ers.

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

8 (i) interpreter and translation services
9 that—

10 (I) subject to the exceptions
11 under subparagraph (C)—

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

17 (bb) if the grantee operates
18 in a State that does not have
19 statewide health care interpreter
20 standards, utilizes competent in-
21 terpreters who follow the Na-
22 tional Council on Interpreting in
23 Health Care’s Code of Ethics and
24 Standards of Practice; and

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

4 (aa) onsite interpretation;

5 (bb) telephonic interpreta-
6 tion; or

7 (cc) video interpretation;

8 and

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

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

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

18 (I) such beneficiary has been in-
19 formed, in the beneficiary's primary
20 language, of the availability of free in-
21 terpreter and translation services and
22 the beneficiary instead requests that a
23 family member, friend, or other per-
24 son provide such services; and

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

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

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

17 (D) MEDICARE ADVANTAGE ORGANIZA-
18 TIONS AND PDP SPONSORS.—If a grantee is a
19 Medicare Advantage organization offering a
20 Medicare Advantage plan under part C of title
21 XVIII of the Social Security Act or a PDP
22 sponsor offering a prescription drug plan under
23 part D of such title, such entity must provide
24 at least 50 percent of the grant funds that the
25 entity receives under this subsection directly to

1 the entity's network providers (including all
2 health providers and pharmacists) for the pur-
3 pose of providing support for such providers to
4 provide competent language services to Medi-
5 care beneficiaries who are English learners.

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

12 (6) DETERMINATION OF AMOUNT OF GRANT
13 PAYMENTS.—

14 (A) IN GENERAL.—Payments to grantees
15 under this subsection shall be calculated based
16 on the estimated numbers of Medicare bene-
17 ficiaries who are English learners in a grantee's
18 service area utilizing—

19 (i) data on the numbers of English
20 learners who speak English less than “very
21 well” from the most recently available data
22 from the Bureau of the Census or other
23 State-based study the Secretary determines
24 likely to yield accurate data regarding the

1 number of such individuals in such service
2 area; or

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

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

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

22 (7) ASSURANCES.—Grantees under this sub-
23 section shall, as a condition of receiving a grant
24 under this subsection—

1 (A) ensure that clinical and support staff
2 receive appropriate ongoing education and
3 training in linguistically appropriate service de-
4 livery;

5 (B) ensure the linguistic competence of bi-
6 lingual providers;

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

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

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

18 (F) ensure that—

19 (i) primary language data are col-
20 lected for recipients of language services
21 and such data are consistent with stand-
22 ards developed under title XXXIV of the
23 Public Health Service Act, as added by
24 section 202 of this Act, to the extent such

1 standards are available upon the initiation
2 of the demonstration program; and

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

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

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

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

24 (B) The primary languages of those Medi-
25 care beneficiaries.

1 (C) The types of language services pro-
2 vided to such beneficiaries.

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

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

11 (F) The costs of providing competent lan-
12 guage services.

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

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

23 (A) An analysis of the patient outcomes
24 and the costs of furnishing care to the Medicare
25 beneficiaries who are English learners partici-

1 participating in the project as compared to such out-
2 comes and costs for such Medicare beneficiaries
3 not participating, based on the data provided
4 under paragraph (9) and any other information
5 available to the Secretary.

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

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

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

12 (iii) patient satisfaction;

13 (iv) health outcomes; and

14 (v) the provision of culturally appro-
15 priate services provided to such bene-
16 ficiaries.

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

1 panded pursuant to section 1115A(c) of the So-
2 cial Security Act (42 U.S.C. 1315a(c)).

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

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

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

21 (b) LANGUAGE ASSISTANCE SERVICES UNDER THE
22 MEDICARE PROGRAM.—

23 (1) INCLUSION AS RURAL HEALTH CLINIC
24 SERVICES.—Section 1861 of the Social Security Act
25 (42 U.S.C. 1395x) is amended—

1 (A) in subsection (aa)(1)—

2 (i) in subparagraph (B), by striking

3 “and” at the end;

4 (ii) by adding “and” at the end of
5 subparagraph (C); and

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

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

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

12 “Language Assistance Services and Related Terms

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

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

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

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

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

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

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

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

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

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

18 (C) by inserting after paragraph (9) the
19 following new paragraph:

20 “(10) in the case of language assistance serv-
21 ices (as defined in section 1861(jjj)(1)), 100 percent
22 of the reasonable charges for such services, as deter-
23 mined in consultation with the Medicare Payment
24 Advisory Commission.”.

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

8 (c) MEDICARE PARTS C AND D.—

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

17 (2) MEDICARE ADVANTAGE PLANS AND PRE-
18 SCRIPTION DRUG PLANS REPORTING REQUIRE-
19 MENT.—Section 1857(e) of the Social Security Act
20 (42 U.S.C. 1395w-27(e)) is amended by adding at
21 the end the following new paragraph:

22 “(5) REPORTING REQUIREMENTS RELATING TO
23 EFFECTIVE LANGUAGE SERVICES.—A contract under
24 this part shall require a Medicare Advantage organi-
25 zation (and, through application of section 1860D-

1 12(b)(3)(D), a contract under section 1860D–12
2 shall require a PDP sponsor) to annually submit
3 (for each year of the contract) a report that contains
4 information on the internal policies and procedures
5 of the organization (or sponsor) related to recruit-
6 ment and retention efforts directed to workforce di-
7 versity and linguistically and culturally appropriate
8 provision of services in each of the following con-
9 texts:

10 “(A) The collection of data in a manner
11 that meets the requirements of title I of the
12 Health Equity and Accountability Act of 2018,
13 regarding the enrollee population.

14 “(B) Education of staff and contractors
15 who have routine contact with enrollees regard-
16 ing the various needs of the diverse enrollee
17 population.

18 “(C) Evaluation of the language services
19 programs and services offered by the organiza-
20 tion (or sponsor) with respect to the enrollee
21 population, such as through analysis of com-
22 plaints or satisfaction survey results.

23 “(D) Methods by which the plan provides
24 to the Secretary information regarding the eth-
25 nic diversity of the enrollee population.

1 “(E) The periodic provision of educational
2 information to plan enrollees on the language
3 services and programs offered by the organiza-
4 tion (or sponsor).”.

5 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID
6 AND CHIP.—

7 (1) PAYMENTS TO STATES.—Section
8 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
9 1396b(a)(2)(E)), as amended by section 203(g)(3),
10 is further amended by—

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

12 (B) striking “translation or interpretation
13 services” and inserting “language assistance
14 services”; and

15 (C) striking “children of families” and in-
16 serting “individuals”.

17 (2) STATE PLAN REQUIREMENTS.—Section
18 1902(a)(10)(A) of the Social Security Act (42
19 U.S.C. 1396a(a)(10)(A)) is amended by striking
20 “and (28)” and inserting “(28), and (29)”.

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

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

1 (B) by redesignating paragraph (29) as
2 paragraph (30); and

3 (C) by inserting after paragraph (28) the
4 following new paragraph:

5 “(29) language assistance services, as such
6 term is defined in section 1861(jjj)(1), provided in
7 a timely manner to individuals with limited-English
8 proficiency as defined in section 3400 of the Public
9 Health Service Act; and”.

10 (4) USE OF DEDUCTIONS AND COST SHAR-
11 ING.—Section 1916(a)(2) of the Social Security Act
12 (42 U.S.C. 1396o(a)(2)) is amended by—

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

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

17 (C) by adding at the end the following new
18 subparagraph:

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

21 (5) CHIP COVERAGE REQUIREMENTS.—Section
22 2103 of the Social Security Act (42 U.S.C. 1397cc)
23 is amended—

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

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

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

14 (C) in subsection (e)(2)—

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

17 (ii) by inserting “or subsection (c)(9)”
18 after “subsection (c)(1)(D)”.

19 (6) DEFINITION OF CHILD HEALTH ASSIST-
20 ANCE.—Section 2110(a)(27) of the Social Security
21 Act (42 U.S.C. 1397jj(a)(27)) is amended by strik-
22 ing “translation” and inserting “language assistance
23 services as described in section 2103(c)(9)”.

24 (7) STATE DATA COLLECTION.—Pursuant to
25 the reporting requirement described in section

1 2107(b)(1) of the Social Security Act (42 U.S.C.
 2 1397gg(b)(1)), the Secretary of Health and Human
 3 Services shall require that States collect data on—

4 (A) the primary language of individuals re-
 5 ceiving child health assistance under title XXI
 6 of the Social Security Act (42 U.S.C. 1397aa et
 7 seq.); and

8 (B) in the case of such individuals who are
 9 minors or incapacitated, the primary language
 10 of the individual’s parent or guardian.

11 (8) CHIP PAYMENTS TO STATES.—Section
 12 2105 of the Social Security Act (42 U.S.C. 1397ee)
 13 is amended—

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

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

21 (e) FUNDING LANGUAGE ASSISTANCE SERVICES
 22 FURNISHED BY PROVIDERS OF HEALTH CARE AND
 23 HEALTH-CARE-RELATED SERVICES THAT SERVE HIGH
 24 RATES OF UNINSURED LEP INDIVIDUALS.—

25 (1) PAYMENT OF COSTS.—

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

10 (B) FUNDING.—Out of any funds in the
11 Treasury not otherwise appropriated, there are
12 appropriated to the Secretary of Health and
13 Human Services such sums as may be nec-
14 essary for each of fiscal years 2019 through
15 2023.

16 (C) RELATION TO MEDICAID DSH.—Pay-
17 ments under this subsection shall not offset or
18 reduce payments under section 1923 of the So-
19 cial Security Act (42 U.S.C. 1396r-4), nor
20 shall payments under such section be consid-
21 ered when determining uncompensated costs as-
22 sociated with the provision of language assist-
23 ance services for the purposes of this section.

24 (2) METHODOLOGY FOR PAYMENT OF
25 CLAIMS.—

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

4 (B) DIFFERENT ENTITIES.—In estab-
5 lishing such methodology, the Secretary may es-
6 tablish different methodologies for different
7 types of eligible entities.

8 (C) NO INDIVIDUAL CLAIMS.—The Sec-
9 retary may not require eligible entities to sub-
10 mit individual claims for language assistance
11 services for individual patients as a requirement
12 for payment under this subsection.

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

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

24 (5) REPORTING REQUIREMENTS.—

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

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

15 (6) DEFINITIONS.—In this subsection:

16 (A) ELIGIBLE COSTS.—The term “eligible
17 costs” means, with respect to an eligible entity
18 that provides language assistance services to
19 English learners, the product of—

20 (i) the average per person cost of lan-
21 guage assistance services, determined ac-
22 cording to the methodology devised under
23 paragraph (2); and

24 (ii) the number of English learners
25 who are provided language assistance serv-

1 ices by the entity and for whom no reim-
2 bursement is available for such services
3 under the amendments made by sub-
4 sections (a), (b), (c), or (d) or by private
5 health insurance.

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

8 (i) is a Medicaid provider that is—

9 (I) a physician;

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

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

19 (ii) not later than 6 months after the
20 date of the enactment of this Act, provides
21 language assistance services to not less
22 than 8 percent of the entity’s total number
23 of patients; and

24 (iii) prepares and submits an applica-
25 tion to the Secretary, at such time, in such

1 manner, and accompanied by such infor-
2 mation as the Secretary may require, to
3 ascertain the entity's eligibility for funding
4 under this subsection.

5 (C) ENGLISH LEARNER.—The term
6 “English learner” has the meaning given such
7 term in section 8101(20) of the Elementary
8 and Secondary Education Act of 1965, except
9 that subparagraphs (A), (B), and (D) of such
10 section shall not apply.

11 (D) LANGUAGE ASSISTANCE SERVICES.—
12 The term “language assistance services” has
13 the meaning given such term in section
14 1861(jjj)(1) of the Social Security Act, as
15 added by subsection (b).

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

22 (g) EFFECTIVE DATE.—

23 (1) IN GENERAL.—Except as otherwise pro-
24 vided and subject to paragraph (2), the amendments

1 made by this section shall take effect on January 1,
2 2019.

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

22 **SEC. 208. 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 with respect to grants under subsection (c)(1) and
2 through the Administrator of the Health Resources and
3 Services Administration with respect to grants under sub-
4 section (c)(2), in consultation with the Director of the Na-
5 tional Institute on Minority Health and Health Disparities
6 and the Deputy Assistant Secretary for Minority Health,
7 shall award grants to eligible entities to improve health
8 care for patient populations that have low functional
9 health literacy.

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

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

15 (2) prepare and submit to the Secretary an ap-
16 plication at such time, in such manner, and con-
17 taining such information as the Secretary may rea-
18 sonably require.

19 (c) USE OF FUNDS.—

20 (1) AGENCY FOR HEALTHCARE RESEARCH AND
21 QUALITY.—A grant awarded under subsection (a)
22 through the Director of the Agency for Healthcare
23 Research and Quality shall be used—

24 (A) to define and increase the under-
25 standing of health literacy;

1 (B) to investigate the correlation between
2 low health literacy and health and health care;

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

5 (D) for any other activity determined ap-
6 propriate by the Director.

7 (2) HEALTH RESOURCES AND SERVICES ADMIN-
8 ISTRATION.—A grant awarded under subsection (a)
9 through the Administrator of the Health Resources
10 and Services Administration shall be used to conduct
11 demonstration projects for interventions for patients
12 with low health literacy that may include—

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

16 (B) the tailoring of disease management
17 programs addressing mental, physical, oral, and
18 behavioral health conditions for patients with
19 low health literacy;

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

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

1 (E) the conduct of educational campaigns
2 for patients and providers about low health lit-
3 eracy; and

4 (F) other activities determined appropriate
5 by the Administrator.

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

10 (e) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section,
12 such sums as may be necessary for each of fiscal years
13 2019 through 2023.

14 **SEC. 209. REQUIREMENTS FOR HEALTH PROGRAMS OR AC-**
15 **TIVITIES RECEIVING FEDERAL FUNDS.**

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

18 (1) the term “covered entity” means an entity
19 carrying out a covered program or activity; and

20 (2) the term “covered program or activity”
21 means any health program or activity, any part of
22 which is receiving Federal financial assistance, in-
23 cluding credits, subsidies, or contracts of insurance,
24 and any program or activity that is administered by
25 an executive agency or any entity established under

1 title I of the Patient Protection and Affordable Care
2 Act (or amendments made thereby), as such pro-
3 grams, activities, agencies, and entities are described
4 in section 1557(a) of the Patient Protection and Af-
5 fordable Care Act (42 U.S.C. 18116(a)).

6 (b) REQUIREMENTS.—A covered entity, in order to
7 ensure the right of individuals with limited-English pro-
8 ficiency to receive access to quality health care through
9 the covered program or activity, shall—

10 (1) ensure that appropriate clinical and support
11 staff receive ongoing education and training in cul-
12 turally and linguistically appropriate service delivery;

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

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

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

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

1 (1) When a patient requests the use of family,
2 friends, or other persons untrained in interpretation
3 or translation if each of the following conditions are
4 met:

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

7 (B) The covered entity informs the patient
8 in the primary language of the patient that he
9 or she has the option of having the entity pro-
10 vide to the patient an interpreter and trans-
11 lation services without charge.

12 (C) The covered entity informs the patient
13 that the entity may not require an individual
14 with a limited-English proficiency to use a fam-
15 ily member or friend as an interpreter.

16 (D) The covered entity evaluates whether
17 the person the patient wishes to use as an in-
18 terpreter is competent. If the covered entity has
19 reason to believe that such person is not com-
20 petent as an interpreter, the entity provides its
21 own interpreter to protect the covered entity
22 from liability if the patient's interpreter is later
23 found not competent.

24 (E) If the covered entity has reason to be-
25 lieve that there is a conflict of interest between

1 the interpreter and patient, the covered entity
2 may not use the patient's interpreter.

3 (F) The covered entity has the patient sign
4 a waiver, witnessed by at least 1 individual not
5 related to the patient, that includes the infor-
6 mation stated in subparagraphs (A) through
7 (E) and is translated into the patient's primary
8 language.

9 (2) When a medical emergency exists and the
10 delay directly associated with obtaining competent
11 interpreter or translation services would jeopardize
12 the health of the patient, but only until a competent
13 interpreter or translation service is available.

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

20 **SEC. 210. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
21 **TURALLY AND LINGUISTICALLY APPRO-**
22 **PRIATE HEALTH CARE SERVICES.**

23 (a) REPORT.—Not later than 1 year after the date
24 of enactment of this Act and annually thereafter, the Sec-
25 retary of Health and Human Services shall enter into a

1 contract with the National Academy of Medicine for the
2 preparation and publication of a report that describes
3 Federal efforts to ensure that all individuals with limited-
4 English proficiency have meaningful access to health care
5 services and health-care-related services that are culturally
6 and linguistically appropriate. Such report shall include—

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

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

13 (3) recommendations on the development and
14 implementation of policies and practices by providers
15 of health care services and health-care-related serv-
16 ices for individuals with limited-English proficiency;

17 (4) recommend guidelines or standards for
18 health literacy and plain language, informed consent,
19 discharge instructions, and written communications,
20 and for improvement of health care access;

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

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

1 (b) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2019 through 2023.

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

6 (a) GRANTS AUTHORIZED.—The Secretary of Edu-
7 cation is authorized to provide grants to eligible entities
8 for the provision of English as a second language (in this
9 section referred to “ESL”) instruction and shall deter-
10 mine, after consultation with appropriate stakeholders, the
11 mechanism for administering and distributing such
12 grants.

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

17 (c) APPLICATION.—An eligible entity may apply for
18 a grant under this section by submitting such information
19 as the Secretary of Education may require and in such
20 form and manner as the Secretary may require.

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

23 (1) develop and implement a plan for assuring
24 the availability of ESL instruction that effectively
25 integrates information about the nature of the

1 United States health care system, how to access
2 care, and any special language skills that may be re-
3 quired for individuals to access and regularly nego-
4 tiate the system effectively;

5 (2) develop a plan, including, where appro-
6 priate, public-private partnerships, for making ESL
7 instruction progressively available to all individuals
8 seeking instruction; and

9 (3) maintain current ESL instruction efforts by
10 using funds available under this section to supple-
11 ment rather than supplant any funds expended for
12 ESL instruction in the State as of January 1, 2019.

13 (e) ADDITIONAL DUTIES OF THE SECRETARY.—The
14 Secretary of Education shall—

15 (1) collect and publicize annual data on how
16 much Federal, State, and local governments spend
17 on ESL instruction;

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

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

24 (B) the extent of waiting lists for ESL in-
25 struction, including how many programs main-

1 tain waiting lists and, for programs that do not
2 have waiting lists, the reasons why not;

3 (C) the availability of programs to geo-
4 graphically isolated communities;

5 (D) the impact of course enrollment poli-
6 cies, including open enrollment, on the avail-
7 ability of ESL instruction;

8 (E) the number individuals in the State
9 and each participating locality;

10 (F) the effectiveness of the instruction in
11 meeting the needs of individuals receiving in-
12 struction and those needing instruction;

13 (G) as assessment of the need for pro-
14 grams that integrate job training and ESL in-
15 struction, to assist individuals to obtain better
16 jobs; and

17 (H) the availability of ESL slots by State
18 and locality;

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

22 (4) not later than 1 year after the date of en-
23 actment of this Act, issue a report to Congress that
24 assesses the information collected in paragraphs (1),
25 (2), and (3) and makes recommendations on steps

1 that should be taken to progressively realize the goal
2 of making ESL instruction available to all English
3 language learners seeking instruction.

4 (f) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to the Secretary of Edu-
6 cation \$250,000,000 for each of fiscal years 2019 through
7 2022 to carry out this section.

8 **SEC. 212. IMPLEMENTATION.**

9 (a) GENERAL PROVISIONS.—

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

15 (2) REMEDIES.—In a suit against a State for
16 a violation of this title (including an amendment
17 made by this title), remedies (including remedies
18 both at law and in equity) are available for such a
19 violation to the same extent as such remedies are
20 available for such a violation in a suit against any
21 public or private entity other than a State.

22 (b) RULE OF CONSTRUCTION.—Nothing in this title
23 shall be construed to limit otherwise existing obligations
24 of recipients of Federal financial assistance under title VI

1 of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
2 or any other Federal statute.

3 **SEC. 213. LANGUAGE ACCESS SERVICES.**

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

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

10 (b) **EMPLOYER-SPONSORED MINIMUM ESSENTIAL**
11 **COVERAGE.**—

12 (1) **IN GENERAL.**—Section 36B(e)(2)(C) of the
13 Internal Revenue Code of 1986 is amended by redesi-
14 gnating clauses (iii) and (iv) as clauses (iv) and (v),
15 respectively, and by inserting after clause (ii) the fol-
16 lowing new clause:

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

1 guage access services, including oral inter-
2 pretation and written translations.”.

3 (2) CONFORMING AMENDMENTS.—

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

8 (B) Section 36B(e)(2)(C)(iv) of such Code,
9 as redesignated by this subsection, is amended
10 by striking “(i) and (ii)” and inserting “(i), (ii),
11 and (iii)”.

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

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

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

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

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

24 (d) REGULATIONS REGARDING INTERNAL CLAIMS
25 AND APPEALS AND EXTERNAL REVIEW PROCESSES FOR

1 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—
2 The Secretary of the Treasury, the Secretary of Labor,
3 and the Secretary of Health and Human Services shall
4 amend the regulations in section 54.9815–2719(e) of title
5 26, Code of Federal Regulations, section 2590.715–
6 2719(e) of title 29, Code of Federal Regulations, and sec-
7 tion 147.136(e) of title 45, Code of Federal Regulations,
8 respectively, to require group health plans and health in-
9 surance issuers offering group or individual health insur-
10 ance coverage to which such sections apply—

11 (1) to provide oral interpretation services with-
12 out any threshold requirements;

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

18 (3) with respect to the requirements for pro-
19 viding relevant notices in a culturally and linguis-
20 tically appropriate manner in the applicable non-
21 English languages, to apply a threshold that 5 per-
22 cent of the population, or not less than 500 individ-
23 uals, in the county is literate only in the same non-
24 English language in order for the language to be
25 considered an applicable non-English language.

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

3 (1) amend the single streamlined application
4 form developed pursuant to section 1413 of the Pa-
5 tient Protection and Affordable Care Act (42 U.S.C.
6 18083) to collect the preferred spoken and written
7 language for each household member applying for
8 coverage under a qualified health plan through an
9 Exchange under title I of the Patient Protection and
10 Affordable Care Act;

11 (2) require navigators, certified application
12 counselors, and other individuals assisting with en-
13 rollment to collect and report requests for language
14 assistance; and

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

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

4 **TITLE III—HEALTH WORKFORCE**
5 **DIVERSITY**

6 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
7 **ACT.**

8 Title XXXIV of the Public Health Service Act, as
9 added by section 204, is amended by adding at the end
10 the following:

11 **“Subtitle B—Diversifying the**
12 **Health Care Workplace**

13 **“SEC. 3411. NATIONAL WORKING GROUP ON WORKFORCE**
14 **DIVERSITY.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Bureau of Health Workforce of the Health Resources
17 and Services Administration, shall award a grant to an
18 entity determined appropriate by the Secretary for the es-
19 tablishment of a national working group on workforce di-
20 versity.

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

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

1 “(A) The Health Resources and Services
2 Administration.

3 “(B) The Department of Health and
4 Human Services Data Council.

5 “(C) The Office of Minority Health of the
6 Department of Health and Human Services.

7 “(D) The Substance Abuse and Mental
8 Health Services Administration.

9 “(E) The Bureau of Labor Statistics of
10 the Department of Labor.

11 “(F) The National Institute on Minority
12 Health and Health Disparities.

13 “(G) The Agency for Healthcare Research
14 and Quality.

15 “(H) The Institute of Medicine Study
16 Committee for the 2004 workforce diversity re-
17 port.

18 “(I) The Indian Health Service.

19 “(J) The Department of Education.

20 “(K) Minority-serving academic institu-
21 tions.

22 “(L) Consumer organizations.

23 “(M) Health professional associations, in-
24 cluding those that represent underrepresented
25 minority populations.

1 “(N) Researchers in the area of health
2 workforce.

3 “(O) Health workforce accreditation enti-
4 ties.

5 “(P) Private (including nonprofit) founda-
6 tions that have sponsored workforce diversity
7 initiatives.

8 “(Q) Local and State health departments.

9 “(R) Representatives of community mem-
10 bers to be included on admissions committees
11 for health profession schools pursuant to sub-
12 section (c)(9).

13 “(S) National community-based organiza-
14 tions that serve as a national intermediary to
15 their urban affiliate members and have dem-
16 onstrated capacity to train health care profes-
17 sionals.

18 “(T) The Veterans Health Administration.

19 “(U) Other entities determined appropriate
20 by the Secretary.

21 “(2) The grantee shall ensure that, in addition
22 to the representatives under paragraph (1), the
23 working group has not less than 5 health professions
24 students representing various health profession fields
25 and levels of training.

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

4 “(1) Review public and private health workforce
5 diversity initiatives.

6 “(2) Identify successful health workforce diver-
7 sity programs and practices.

8 “(3) Examine challenges relating to the devel-
9 opment and implementation of health workforce di-
10 versity initiatives.

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

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

17 “(6) Develop recommended standards for work-
18 force diversity that could be applicable to all health
19 professions programs and programs funded under
20 this Act.

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

23 “(8) Develop a workforce data collection or
24 tracking system to identify where racial and ethnic
25 minority health professionals practice.

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

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

6 “(11) Other activities determined appropriate
 7 by 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 2019 through 2024.

20 **“SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH
 21 WORKFORCE DIVERSITY.**

22 “(a) IN GENERAL.—The Secretary, acting through
 23 the Deputy Assistant Secretary for Minority Health, and
 24 in collaboration with the Bureau of Health Workforce
 25 within the Health Resources and Services Administration

1 and the National Institute on Minority Health and Health
2 Disparities, shall establish a technical clearinghouse on
3 health workforce diversity within the Office of Minority
4 Health and coordinate current and future clearinghouses
5 related to health workforce diversity.

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

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

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

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

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

19 “(5) Retainment policies that promote comple-
20 tion of health profession degrees for underserved
21 populations.

22 “(6) Lists of scholarship, loan repayment, and
23 loan cancellation grants as well as fellowship infor-
24 mation for underserved populations for health pro-
25 fessions schools.

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

3 “(c) CONSULTATION.—In carrying out this section,
4 the Secretary shall consult with non-Federal entities which
5 may include minority health professional associations and
6 minority sections of major health professional associations
7 to ensure the adequacy and accuracy of information.

8 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2019 through 2024.

12 **“SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO**
13 **WORKFORCE DIVERSITY, EQUITY, AND IN-**
14 **CLUSION.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Administrator of the Health Resources and Services
17 Administration and the Centers for Disease Control and
18 Prevention, shall award grants to eligible entities that
19 demonstrate a commitment to health workforce diversity.

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

22 “(1) be an educational institution or entity that
23 historically produces or trains meaningful numbers
24 of underrepresented minority health professionals,
25 including—

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

3 “(B) Hispanic-serving health professions
4 schools;

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

7 “(D) Tribal colleges or universities, as de-
8 fined in section 316 of such Act;

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

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

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

20 “(H) institutions, including national and
21 regional community-based organizations with
22 demonstrated commitment to a diversified
23 workforce—

1 “(i) located in communities with pre-
2 dominantly underrepresented minority pop-
3 ulations;

4 “(ii) with whom partnerships have
5 been formed for the purpose of increasing
6 workforce diversity; and

7 “(iii) in which at least 20 percent of
8 the enrolled participants are underrep-
9 resented minorities; and

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

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

22 “(1) educational outreach programs relating to
23 opportunities in the health professions;

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

1 “(3) postbaccalaureate programs;

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

5 “(5) supporting workforce diversity in kinder-
6 garten through 12th grade and other health pipeline
7 programs;

8 “(6) mentoring programs;

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

12 “(8) community partnership development for
13 purposes relating to workforce diversity; or

14 “(9) leadership training.

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

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section,
22 such sums as may be necessary for each of fiscal years
23 2019 through 2024.

1 **“SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND**
2 **RESEARCHERS.**

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

13 “(b) RESEARCH FUNDING.—The head of each agency
14 listed in subsection (a) shall establish or expand existing
15 programs to provide research funding to scientists and re-
16 searchers in training. Under such programs, the head of
17 each such entity shall give priority in allocating research
18 funding to support health research in traditionally under-
19 served communities, including underrepresented minority
20 communities, and research classified as community or
21 participatory.

22 “(c) DATA COLLECTION.—The head of each agency
23 listed in subsection (a) shall collect data on the number
24 (expressed as an absolute number and a percentage) of
25 underrepresented minority and nonminority applicants
26 who receive and are denied agency funding at every stage

1 of review. Such data shall be reported annually to the Sec-
2 retary and the appropriate committees of Congress.

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

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

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated to carry out this section,
21 such sums as may be necessary for each of fiscal years
22 2019 through 2024.

1 **“SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH**
2 **PROFESSIONALS.**

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

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

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

20 “(2) 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.—An individual shall use
24 amounts received under a grant under this section to—

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

4 “(2) support health-related career advancement
5 activities;

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

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

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

1 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 2 is authorized to be appropriated to carry out this section
 3 such sums as may be necessary for each of fiscal years
 4 2019 through 2024.

5 **“SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
 6 **VERSITY ON QUALITY.**

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

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

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

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

22 “(c) USE OF FUNDS.—Amounts received under a
 23 grant awarded under subsection (a) shall be used to sup-
 24 port research that investigates the effect of health work-
 25 force diversity on—

- 1 “(1) language access;
- 2 “(2) cultural competence;
- 3 “(3) patient satisfaction;
- 4 “(4) timeliness of care;
- 5 “(5) safety of care;
- 6 “(6) effectiveness of care;
- 7 “(7) efficiency of care;
- 8 “(8) patient outcomes;
- 9 “(9) community engagement;
- 10 “(10) resource allocation;
- 11 “(11) organizational structure;
- 12 “(12) compliance of care; or
- 13 “(13) other topics determined appropriate by
- 14 the Director.

15 “(d) PRIORITY.—In awarding grants under sub-
16 section (a), the Director shall give individualized consider-
17 ation to all relevant aspects of the applicant’s background.

18 Consideration of prior research experience involving the
19 health of underserved communities shall be such a factor.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2019 through 2024.

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

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

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

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

1 fronting Racial and Ethnic Disparities in Health
2 Care’, as well as the impact of disparities related to
3 age, disability status, socioeconomic status, sex, gen-
4 der identity, and sexual orientation on racial and
5 ethnic minorities;

6 “(2) disseminate new research findings to
7 health care providers and patients to assist them in
8 understanding, reducing, and eliminating health and
9 health care disparities;

10 “(3) disseminate information about the impact
11 of linguistic and cultural barriers on health care
12 quality and the obligation of health providers who
13 receive Federal financial assistance to ensure that
14 individuals with limited-English proficiency have ac-
15 cess to language access services;

16 “(4) disseminate information about the impor-
17 tance and legality of racial, ethnic, disability status,
18 socioeconomic status, sex, gender identity, and sex-
19 ual orientation, and primary language data collec-
20 tion, analysis, and reporting;

21 “(5) design and implement specific educational
22 initiatives to health care providers relating to health
23 and health care disparities;

24 “(6) assess the impact of the programs estab-
25 lished under this section in raising awareness of

1 health and health care disparities and providing in-
2 formation on available resources; and

3 “(7) design and implement specific educational
4 initiatives to educate the health care workforce relat-
5 ing to unconscious bias.

6 “(c) 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 2019 through 2024.”.

10 **SEC. 302. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
11 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
12 **AND TRIBAL COLLEGES.**

13 (a) IN GENERAL.—Part B of title VII of the Public
14 Health Service Act (42 U.S.C. 293 et seq.) is amended
15 by adding at the end the following:

16 **“SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
17 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
18 **AND TRIBAL COLLEGES.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Administrator of the Health Resources and Services
21 Administration and in consultation with the Secretary of
22 Education, shall award grants to hispanic-serving institu-
23 tions, historically black colleges and universities, Tribal
24 Colleges or Universities, regional community based organi-
25 zations, and national minority medical associations, for

1 scholarships and counseling services to prepare underrep-
2 resented minority individuals to enroll in and graduate
3 from health professional schools and to increase services
4 for underrepresented minority students including—

5 “(1) mentoring with underrepresented health
6 professionals; and

7 “(2) providing financial assistance information
8 for continued education and applications to health
9 professional schools.

10 “(b) DEFINITIONS.—In this section:

11 “(1) HISPANIC SERVING INSTITUTION.—The
12 term ‘hispanic-serving institution’ means an entity
13 that—

14 “(A) is a school or program for which
15 there is a definition under 799B;

16 “(B) has an enrollment of full-time equiva-
17 lent students that is made up of at least 9 per-
18 cent Hispanic students;

19 “(C) has been effective in carrying out pro-
20 grams to recruit Hispanic individuals to enroll
21 in and graduate from the school;

22 “(D) has been effective in recruiting and
23 retaining Hispanic faculty members;

24 “(E) has a significant number of graduates
25 who are providing health services to medically

1 underserved populations or to individuals in
2 health professional shortage areas; and

3 “(F) is a Hispanic Center of Excellence in
4 Health Professions Education designated under
5 section 736(d)(2) of the Public Health Service
6 Act (42 U.S.C. 293(d)(2)).

7 “(2) HISTORICALLY BLACK COLLEGES AND
8 UNIVERSITY.—The term ‘historically black college
9 and university’ has the meaning given the term ‘part
10 B institution’ as defined in section 322 of the High-
11 er Education Act of 1965.

12 “(3) TRIBAL COLLEGE OR UNIVERSITY.—The
13 term ‘Tribal College or University’ has the meaning
14 given such term in section 316(b) of such Act.

15 “(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In
16 carrying out the National Health Service Corps Loan Re-
17 payment Program established under subpart III of part
18 D of title III and the loan repayment program under sec-
19 tion 317F, the Secretary shall ensure, notwithstanding
20 such subpart or section, that loan repayments of not less
21 than \$50,000 per year per person are awarded for repay-
22 ment of loans incurred for enrollment or participation of
23 underrepresented minority individuals in health profes-
24 sional schools and other health programs described in this
25 section.”.

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 at the end the
7 following: “, \$750,000 for fiscal year 2019, and such
8 sums as may be necessary for each of the fiscal
9 years 2020 through 2024”.

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 enter into cooperative agreements with
25 schools of public health and schools of allied health to de-
26 sign and implement online degree programs.

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

6 “(c) REQUIREMENTS.—As a condition of entering
7 into a cooperative agreement with the Secretary under this
8 section, a school of public health or school of allied health
9 shall agree to design and implement an online degree pro-
10 gram that meets the following restrictions:

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

14 “(2) Maintaining a significant enrollment of
15 underrepresented minority or disadvantaged stu-
16 dents.

17 “(3) Achieving a high completion rate of en-
18 rolled underrepresented minority or disadvantaged
19 students.

20 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2019 through 2024.”.

1 **SEC. 305. SENSE OF CONGRESS ON THE MISSION OF THE**
2 **NATIONAL HEALTH CARE WORKFORCE COM-**
3 **MISSION.**

4 It is the sense of Congress that the National Health
5 Care Workforce Commission established by section 5101
6 of the Patient Protection and Affordable Care Act (42
7 U.S.C. 294q) should, in carrying out its assigned duties
8 under that section, give attention to the needs of racial
9 and ethnic minorities, individuals with lower socio-
10 economic status, individuals with mental, developmental,
11 and physical disabilities, lesbian, gay, bisexual,
12 transgender, queer, and questioning populations, and indi-
13 viduals who are members of multiple minority or special
14 population groups.

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

16 Subtitle B of title XXXIV of the Public Health Serv-
17 ice Act, as added by section 301, is further amended by
18 inserting after section 3417 the following:

19 **“SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
20 **SERVICES CORPS.**

21 “(a) IN GENERAL.—The Director of the Centers for
22 Disease Control and Prevention, in collaboration with the
23 Administrator of the Health Resources and Services Ad-
24 ministration and the Deputy Assistant Secretary for Mi-
25 nority Health, shall award grants to eligible entities to in-

1 crease awareness among secondary and postsecondary stu-
2 dents of career opportunities in the health professions.

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

5 “(1) be a clinical, public health, or health serv-
6 ices organization, community-based or nonprofit en-
7 tity, or other entity determined appropriate by the
8 Director of the Centers for Disease Control and Pre-
9 vention;

10 “(2) serve a health professional shortage area,
11 as determined by the Secretary;

12 “(3) work with students, including those from
13 racial and ethnic minority backgrounds, that have
14 expressed an interest in the health professions; and

15 “(4) submit to the Secretary an application at
16 such time, in such manner, and containing such in-
17 formation as the Secretary may require.

18 “(c) USE OF FUNDS.—Grant awards under sub-
19 section (a) shall be used to support internships that will
20 increase awareness among students of non-research-based,
21 career opportunities in the following health professions:

22 “(1) Medicine.

23 “(2) Nursing.

24 “(3) Public health.

25 “(4) Pharmacy.

- 1 “(5) Health administration and management.
- 2 “(6) Health policy.
- 3 “(7) Psychology.
- 4 “(8) Dentistry.
- 5 “(9) International health.
- 6 “(10) Social work.
- 7 “(11) Allied health.
- 8 “(12) Psychiatry.
- 9 “(13) Hospice care.
- 10 “(14) Community health, patient navigation,
11 and peer support.
- 12 “(15) Other professions determined appropriate
13 by the Director of the Centers for Disease Control
14 and Prevention.
- 15 “(d) PRIORITY.—In awarding grants under sub-
16 section (a), the Director of the Centers for Disease Con-
17 trol and Prevention shall give priority to those entities
18 that—
- 19 “(1) serve a high proportion of individuals from
20 disadvantaged backgrounds;
- 21 “(2) have experience in health disparity elimi-
22 nation programs;
- 23 “(3) facilitate the entry of disadvantaged indi-
24 viduals into institutions of higher education; and

1 “(4) provide counseling or other services de-
2 signed to assist disadvantaged individuals in success-
3 fully completing their education at the postsecondary
4 level.

5 “(e) STIPENDS.—

6 “(1) IN GENERAL.—Subject to paragraph (2),
7 an entity receiving a grant under this section may
8 use the funds made available through such grant to
9 award stipends for educational and living expenses
10 to students participating in the internship supported
11 by the grant.

12 “(2) LIMITATIONS.—A stipend awarded under
13 paragraph (1) to an individual—

14 “(A) may not be provided for a period that
15 exceeds 6 months; and

16 “(B) may not exceed \$20 per day for an
17 individual (notwithstanding any other provision
18 of law regarding the amount of a stipend).

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2019 through 2024.

1 **“SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
2 **PROGRAM.**

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

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

10 “(1) have interest, knowledge, or skill in public
11 health research or public health practice, or other
12 health professions as determined appropriate by the
13 Director of the Centers for Disease Control and Pre-
14 vention;

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

17 “(3) demonstrate promise for becoming a leader
18 in public health;

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

21 “(5) 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 an
25 award under subsection (a) shall be used to support oppor-
26 tunities for students to become public health professionals.

1 “(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Director shall give priority to those stu-
3 dents that—

4 “(1) are from disadvantaged backgrounds;

5 “(2) have secured admissions to a minority-
6 serving institution; and

7 “(3) have identified a health professional as a
8 mentor at their school or institution and an aca-
9 demic advisor to assist in the completion of their
10 baccalaureate degree.

11 “(e) SCHOLARSHIPS.—The Secretary may approve
12 payment of scholarships under this section for such indi-
13 viduals for any period of education in student under-
14 graduate tenure, except that such a scholarship may not
15 be provided to an individual for more than 4 years, and
16 such a scholarship may not exceed \$10,000 per academic
17 year for an individual (notwithstanding any other provi-
18 sion of law regarding the amount of a scholarship).

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2019 through 2024.

1 **“SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH**
2 **FELLOWSHIP PROGRAM.**

3 “(a) IN GENERAL.—The Director of the Centers for
4 Disease Control and Prevention, in collaboration with the
5 Deputy Assistant Secretary for Minority Health, the As-
6 sistant Secretary for Mental Health and Substance Use,
7 and the Director of the Indian Health Services, shall
8 award research fellowships to eligible individuals under
9 subsection (b) to conduct research that will examine gen-
10 der and health disparities and to pursue a career in the
11 health professions.

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

14 “(1) have experience in health research or pub-
15 lic health practice;

16 “(2) reside in a health professional shortage
17 area as designated by the Secretary under section
18 332;

19 “(3) have expressed an interest in the health
20 professions;

21 “(4) demonstrate promise for becoming a leader
22 in the field of women’s health;

23 “(5) secure admission to a health professions
24 school or graduate program with an emphasis in
25 gender studies; and

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

4 “(c) USE OF FUNDS.—A fellowship awarded under
5 subsection (a) to an eligible individual shall be used to
6 support an opportunity for the individual to become a re-
7 searcher and advance the research base on the intersection
8 between gender and health.

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

13 “(1) are from disadvantaged backgrounds; and

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

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

1 individual (notwithstanding any other provision of law re-
2 garding the amount of a fellowship).

3 “(f) 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 2019 through 2024.

7 **“SEC. 3420A. PAUL DAVID WELLSTONE INTERNATIONAL**
8 **HEALTH FELLOWSHIP PROGRAM.**

9 “(a) IN GENERAL.—The Director of the Agency for
10 Healthcare Research and Quality, in collaboration with
11 the Deputy Assistant Secretary for Minority Health, shall
12 award research fellowships to eligible individuals under
13 subsection (b) to advance their understanding of inter-
14 national health.

15 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
16 ship under subsection (a), an individual shall—

17 “(1) have educational experience in the field of
18 international health;

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

21 “(3) demonstrate promise for becoming a leader
22 in the field of international health;

23 “(4) be a college senior or recent graduate of
24 a 4-year institution of higher education; and

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

4 “(c) USE OF FUNDS.—A fellowship awarded under
5 subsection (a) to an eligible individual shall be used to
6 support an opportunity for the individual to become a
7 health professional and to advance the knowledge of the
8 individual about international issues relating to health
9 care access and quality.

10 “(d) PRIORITY.—In awarding fellowships under sub-
11 section (a), the Director shall give priority to eligible indi-
12 viduals that—

13 “(1) are from a disadvantaged background; and

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

23 “(e) FELLOWSHIPS.—A fellowship awarded under
24 this section may not—

1 “(1) be provided to an eligible individual for
2 more than a period of 6 months;

3 “(2) be awarded to a graduate of a 4-year insti-
4 tution of higher education that has not been enrolled
5 in such institution for more than 1 year; and

6 “(3) exceed \$4,000 per academic year (notwith-
7 standing any other provision of law regarding the
8 amount of a fellowship).

9 “(f) **AUTHORIZATION OF APPROPRIATIONS.**—There
10 is authorized to be appropriated to carry out this section,
11 such sums as may be necessary for each of fiscal years
12 2019 through 2024.

13 **“SEC. 3420B. EDWARD R. ROYBAL HEALTH SCHOLAR PRO-**
14 **GRAM.**

15 “(a) **IN GENERAL.**—The Director of the Agency for
16 Healthcare Research and Quality, the Director of the Cen-
17 ters for Medicare & Medicaid Services, and the Adminis-
18 trator of the Health Resources and Services Administra-
19 tion, in collaboration with the Deputy Assistant Secretary
20 for Minority Health, shall award grants to eligible entities
21 to expose entering graduate students to the health profes-
22 sions.

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 organization, community-based, academic, or
3 nonprofit entity, or other entity determined appro-
4 priate by the Director of the Agency for Healthcare
5 Research and Quality;

6 “(2) serve in a health professional shortage
7 area as designated by the Secretary under section
8 332;

9 “(3) work with students obtaining a degree in
10 the health professions; and

11 “(4) submit to the Secretary an application at
12 such time, in such manner, and containing such in-
13 formation as the Secretary may require.

14 “(c) USE OF FUNDS.—Amounts received under a
15 grant awarded under subsection (a) shall be used to sup-
16 port opportunities that expose students to non-research-
17 based health professions, including—

18 “(1) public health policy;

19 “(2) health care and pharmaceutical policy;

20 “(3) health care administration and manage-
21 ment;

22 “(4) health economics; and

23 “(5) other professions determined appropriate
24 by the Director of the Agency for Healthcare Re-
25 search and Quality, the Director of the Centers for

1 Medicare & Medicaid Services, or the Administrator
2 of the Health Resources and Services Administra-
3 tion.

4 “(d) PRIORITY.—In awarding grants under sub-
5 section (a), the Director of the Agency for Healthcare Re-
6 search and Quality, the Director of the Centers for Medi-
7 care & Medicaid Services, and the Administrator of the
8 Health Resources and Services Administration, in collabo-
9 ration with the Deputy Assistant for Secretary for Minor-
10 ity Health, shall give priority to those entities that—

11 “(1) have experience with health disparity elimi-
12 nation programs;

13 “(2) facilitate training in the fields described in
14 subsection (c); and

15 “(3) provide counseling or other services de-
16 signed to assist students in successfully completing
17 their education at the postsecondary level.

18 “(e) STIPENDS.—

19 “(1) IN GENERAL.—Subject to paragraph (2),
20 an entity receiving a grant under this section may
21 use the funds made available through such grant to
22 award stipends for educational and living expenses
23 to students participating in the opportunities sup-
24 ported by the grant.

1 “(2) LIMITATIONS.—A stipend awarded under
2 paragraph (1) to an individual—

3 “(A) may not be provided for a period that
4 exceeds 2 months; and

5 “(B) may not exceed \$100 per day (not-
6 withstanding any other provision of law regard-
7 ing the amount of a stipend).

8 “(f) 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 2019 through 2024.

12 **“SEC. 3420C. LEADERSHIP FELLOWSHIP PROGRAMS.**

13 “(a) IN GENERAL.—The Secretary shall award
14 grants to national minority medical or health professional
15 associations to develop leadership fellowship programs for
16 underrepresented health professionals in order to—

17 “(1) assist such professionals in becoming fu-
18 ture leaders in public health and health care delivery
19 institutions; and

20 “(2) increase diversity in decision-making posi-
21 tions that can improve the health of underserved
22 communities.

23 “(b) USE OF FUNDS.—A leadership fellowship pro-
24 gram supported under this section shall—

1 “(1) focus on training mid-career physicians
2 and health care executives who have documented
3 leadership experience and a commitment to public
4 health services in underserved communities; and

5 “(2) support Federal public health policy and
6 budget programs, and priorities that impact health
7 equity, through activities such as didactic lectures
8 and leader site visits.

9 “(c) PERIOD OF GRANTS.—The period during which
10 payments are made under a grant awarded under sub-
11 section (a) may not exceed 1 year.”.

12 **SEC. 307. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
13 **PROGRAM.**

14 Section 402E of the Higher Education Act of 1965
15 (20 U.S.C. 1070a–15) is amended by striking subsection
16 (g) and inserting the following:

17 “(g) COLLABORATION IN HEALTH PROFESSION DI-
18 VERSITY TRAINING PROGRAMS.—The Secretary shall co-
19 ordinate with the Secretary of Health and Human Serv-
20 ices to ensure that there is collaboration between the goals
21 of the program under this section and programs of the
22 Health Resources and Services Administration that pro-
23 mote health workforce diversity. The Secretary of Edu-
24 cation shall take such measures as may be necessary to

1 encourage students participating in projects assisted
2 under this section to consider health profession careers.

3 “(h) FUNDING.—From amounts appropriated pursu-
4 ant to the authority of section 402A(g), the Secretary
5 shall, to the extent practicable, allocate funds for projects
6 authorized by this section in an amount which is not less
7 than \$31,000,000 for each of the fiscal years 2019
8 through 2025.”.

9 **SEC. 308. RULES FOR DETERMINATION OF FULL-TIME**
10 **EQUIVALENT RESIDENTS FOR COST-REPORT-**
11 **ING PERIODS.**

12 (a) DGME DETERMINATIONS.—Section 1886(h)(4)
13 of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as
14 amended by section 204(a), is amended—

15 (1) in subparagraph (E), by striking “Subject
16 to subparagraphs (J) and (K), such rules” and in-
17 serting “Subject to subparagraphs (J), (K), and
18 (M), such rules”;

19 (2) in subparagraph (J), by striking “Such
20 rules” and inserting “Subject to subparagraph (M),
21 such rules”;

22 (3) in subparagraph (K), by striking “In deter-
23 mining” and inserting “Subject to subparagraph
24 (M), in determining”; and

1 (4) by adding at the end the following new sub-
 2 paragraph:

3 “(M) TREATMENT OF CERTAIN RESIDENTS
 4 AND INTERNS.—For purposes of cost-reporting
 5 periods beginning on or after October 1, 2019,
 6 in determining the hospital’s number of full-
 7 time equivalent residents for purposes of this
 8 paragraph, all the time spent by an intern or
 9 resident in an approved medical residency train-
 10 ing program shall be counted toward the deter-
 11 mination of full-time equivalency if the hos-
 12 pital—

13 “(i) is recognized as a subsection (d)
 14 hospital;

15 “(ii) is recognized as a subsection (d)
 16 Puerto Rico hospital;

17 “(iii) is reimbursed under a reim-
 18 bursement system authorized under section
 19 1814(b)(3); or

20 “(iv) is a provider-based hospital out-
 21 patient department.”.

22 (b) IME DETERMINATIONS.—Section
 23 1886(d)(5)(B)(xi) of the Social Security Act (42 U.S.C.
 24 1395ww(d)(5)(B)(xi)), as redesignated by section 204(b),
 25 is amended—

1 (1) in subclause (II), by striking “In deter-
2 mining” and inserting “Subject to subclause (IV), in
3 determining”;

4 (2) in subclause (III), by striking “In deter-
5 mining” and inserting “Subject to subclause (IV), in
6 determining”; and

7 (3) by inserting after subclause (III) the fol-
8 lowing new subclause:

9 “(IV) For purposes of cost-reporting peri-
10 ods beginning on or after October 1, 2019, the
11 provisions of subparagraph (M) of subsection
12 (h)(4) shall apply under this subparagraph in
13 the same manner as they apply under such sub-
14 section.”.

15 **SEC. 309. DEVELOPING AND IMPLEMENTING STRATEGIES**
16 **FOR LOCAL HEALTH EQUITY.**

17 (a) GRANTS.—The Secretary of Health and Human
18 Services, acting jointly with the Secretary of Education
19 and the Secretary of Labor, shall make grants to institu-
20 tions of higher education for the purposes of—

21 (1) in accordance with subsection (b), devel-
22 oping capacity—

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

1 (B) to serve as national models of driving
2 local health equity;

3 (2) in accordance with subsection (c), devel-
4 oping a strategic partnership with the community in
5 which the institution is located; and

6 (3) collecting data on, and periodically evalu-
7 ating, the effectiveness of the institution's programs
8 funded through this section to enable the institution
9 to adapt accordingly for maximum efficiency and
10 success.

11 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
12 HEALTH EQUITY.—As a condition on receipt of a grant
13 under subsection (a), an institution of higher education
14 shall agree to use the grant to build an evidence base for
15 successful strategies for increasing local health equity, and
16 to serve as a national model of driving local health equity,
17 by supporting—

18 (1) resources to strengthen institutional metrics
19 and capacity to execute institution-wide health work-
20 force goals that can serve as models for increasing
21 health equity in communities across the United
22 States;

23 (2) collaborations among a cohort of institu-
24 tions in implementing systemic change, partnership
25 development, and programmatic efforts supportive of

1 health equity goals across disciplines and popu-
2 lations; and

3 (3) enhanced or newly developed data systems
4 and research infrastructure capable of informing
5 current and future workforce efforts and building a
6 foundation for a broader research agenda targeting
7 urban health disparities.

8 (c) STRATEGIC PARTNERSHIPS.—As a condition on
9 receipt of a grant under subsection (a), an institution of
10 higher education shall agree to use the grant to develop
11 a strategic partnership with the community in which the
12 institution is located for the purposes of—

13 (1) strengthening connections between the insti-
14 tution and the community—

15 (A) to improve evaluation of and address
16 the community's health and health workforce
17 needs; and

18 (B) to engage the community in health
19 workforce development;

20 (2) developing, enhancing, or accelerating inno-
21 vative undergraduate and graduate programs in the
22 biomedical sciences and health professions; and

23 (3) strengthening pipeline programs in the bio-
24 medical sciences and health professions, including by
25 developing partnerships between institutions of high-

1 er education and elementary schools and secondary
 2 schools to recruit the next generation of health pro-
 3 fessionals earlier in the pipeline to a health care ca-
 4 reer.

5 **SEC. 310. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**
 6 **IORAL HEALTH SOCIAL WORKERS.**

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

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

12 “(1) IN GENERAL.—The Secretary shall cancel
 13 the balance of interest and principal due, in accord-
 14 ance with paragraph (2), on any eligible Federal Di-
 15 rect Loan not in default for a borrower who—

16 “(A) has made 120 monthly payments on
 17 the eligible Federal Direct Loan after October
 18 1, 2016, pursuant to any one or a combination
 19 of the following—

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

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

1 “(iii) monthly payments under a re-
2 payment plan under subsection (d)(1) or
3 (g) of not less than the monthly amount
4 calculated under subsection (d)(1)(A),
5 based on a 10-year repayment period; or

6 “(iv) payments under an income con-
7 tingent repayment plan under subsection
8 (d)(1)(D); and

9 “(B)(i) is employed as a mental health or
10 behavioral health social worker, as defined by
11 the Secretary by regulation, at the time of such
12 forgiveness; and

13 “(ii) has been employed as such a mental
14 health or behavioral health social worker during
15 the period in which the borrower makes each of
16 the 120 payments as described in subparagraph
17 (A).

18 “(2) LOAN CANCELLATION AMOUNT.—After the
19 conclusion of the employment period described in
20 paragraph (1), the Secretary shall cancel the obliga-
21 tion to repay the balance of principal and interest
22 due as of the time of such cancellation, on the eligi-
23 ble Federal Direct Loans made to the borrower
24 under this part.

1 “(3) INELIGIBILITY FOR DOUBLE BENEFITS.—
 2 No borrower may, for the same employment as a
 3 mental health or behavioral health social worker, re-
 4 ceive a reduction of loan obligations under both this
 5 subsection and subsection (m), 428J, 428K, 428L,
 6 or 460.

7 “(4) DEFINITION OF ELIGIBLE FEDERAL DI-
 8 RECT LOAN.—In this subsection, the term ‘eligible
 9 Federal Direct Loan’ means a Federal Direct Staf-
 10 ford Loan, Federal Direct PLUS Loan, Federal Di-
 11 rect Unsubsidized Stafford Loan, or a Federal Di-
 12 rect Consolidation Loan.”.

13 **SEC. 311. HEALTH PROFESSIONS WORKFORCE FUND.**

14 (a) ESTABLISHMENT.—There is established in the
 15 Health Resources and Services Administration of the De-
 16 partment of Health and Human Services a Health Profes-
 17 sions Workforce Fund to provide for expanded and sus-
 18 tained national investment in the health professions and
 19 nursing workforce development programs under title VII
 20 and title VIII of the Public Health Service Act (42 U.S.C.
 21 292 et seq; 42 U.S.C. 296 et seq).

22 (b) FUNDING.—

23 (1) IN GENERAL.—There is authorized to be
 24 appropriated, and there is appropriated, out of any

1 monies in the Treasury not otherwise appropriated,
2 to the Health Professions Workforce Fund—

3 (A) \$355,000,000 for fiscal year 2019;

4 (B) \$375,000,000 for fiscal year 2020;

5 (C) \$392,000,000 for fiscal year 2021;

6 (D) \$412,000,000 for fiscal year 2022;

7 (E) \$432,000,000 for fiscal year 2023;

8 (F) \$454,000,000 for fiscal year 2024;

9 (G) \$476,000,000 for fiscal year 2025;

10 (H) \$500,000,000 for fiscal year 2026;

11 (I) \$525,000,000 for fiscal year 2027; and

12 (J) \$552,000,000 for fiscal year 2028.

13 (2) HEALTH PROFESSIONS EDUCATION PRO-
14 GRAMS.—For the purpose of carrying out health
15 professions education programs authorized under
16 title VII of the Public Health Service Act, in addi-
17 tion to any other amounts authorized to be appro-
18 priated for such purpose, there is authorized to be
19 appropriated out of any monies in the Health Pro-
20 fessions Workforce Fund, the following:

21 (A) \$240,000,000 for fiscal year 2019.

22 (B) \$253,000,000 for fiscal year 2020.

23 (C) \$265,000,000 for fiscal year 2021.

24 (D) \$278,000,000 for fiscal year 2022.

25 (E) \$292,000,000 for fiscal year 2023.

1 (F) \$307,000,000 for fiscal year 2024.

2 (G) \$322,000,000 for fiscal year 2025.

3 (H) \$338,000,000 for fiscal year 2026.

4 (I) \$355,000,000 for fiscal year 2027.

5 (J) \$373,000,000 for fiscal year 2028.

6 (3) NURSING WORKFORCE DEVELOPMENT PRO-
7 GRAMS.—For the purpose of carrying out nursing
8 workforce development programs authorized under
9 Title VIII of the Public Health Service Act, in addi-
10 tion to any other amounts authorized to be appro-
11 priated for such purpose, there is authorized to be
12 appropriated out of any monies in the Health Pro-
13 fessions Workforce Fund, the following:

14 (A) \$115,000,000 for fiscal year 2019.

15 (B) \$122,000,000 for fiscal year 2020.

16 (C) \$127,000,000 for fiscal year 2021.

17 (D) \$134,000,000 for fiscal year 2022.

18 (E) \$140,000,000 for fiscal year 2023.

19 (F) \$147,000,000 for fiscal year 2024.

20 (G) \$154,000,000 for fiscal year 2025.

21 (H) \$162,000,000 for fiscal year 2026.

22 (I) \$170,000,000 for fiscal year 2027.

23 (J) \$179,000,000 for fiscal year 2028.

1 **SEC. 312. FINDINGS; SENSE OF CONGRESS RELATING TO**
2 **GRADUATE MEDICAL EDUCATION.**

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

4 (1) Projections by the Association of American
5 Medical Colleges and other expert entities, such as
6 the Health Resources and Services Administration,
7 have indicated a nationwide shortage of up to
8 104,900 physicians, split evenly between primary
9 care and specialists, by 2030.

10 (2) Primarily due to the growing and aging
11 population, over the next decade, physician demand
12 is expected to grow up to 17 percent.

13 (3) The United States Census Bureau estimates
14 that the United States population will grow from
15 321 million in 2015 to 347 million in 2025. Further,
16 the number of Medicare beneficiaries is estimated to
17 increase from 47,800,000 in 2015 to approximately
18 66,000,000 in 2025.

19 (4) Approximately 36 percent of practicing phy-
20 sicians are over the age of 55 and are likely to retire
21 within the next decade.

22 (5) A nationwide physician shortage will result
23 in many people in the United States waiting longer
24 and traveling farther for health care; seeking non-
25 emergent care in emergency departments; and delay-

1 ing treatment until their health care needs become
2 more serious, complex, and costly.

3 (6) Changing demographics (such as an aging
4 population), new health care delivery models (such
5 as medical homes), and other factors (such as dis-
6 aster preparedness) are contributing to a shortage of
7 both generalist and specialist physicians.

8 (7) These shortages will have the most severe
9 impact on vulnerable and underserved populations,
10 including racial and ethnic minorities and the ap-
11 proximately 20 percent of people in the United
12 States who live in rural or inner-city locations des-
13 ignated as health professional shortage areas.

14 (8) The health care utilization equity model of
15 the Association of American Medical Colleges esti-
16 mates that if racial and ethnic minorities and indi-
17 viduals from rural areas utilized health care in a
18 similar way to their Caucasian counterparts living in
19 metropolitan areas, the physician shortage would re-
20 quire an additional 96,000 physicians.

21 (9) To address the physician shortage, medical
22 education and training need to be accessible for stu-
23 dents and physicians from all backgrounds. Inter-
24 national graduates play an important role in health
25 care in the United States, representing roughly 25

1 percent of the health care workforce. Immigration
2 pathways like student, exchange-visitor, and employ-
3 ment visas, and programs like the National Interest
4 Waiver and Conrad 30 J-1 Visa Waiver, help im-
5 prove health access across the United States.

6 (10) United States medical school enrollment
7 will grow by 30 percent from 2018 to 2019 to help
8 reduce the shortage of quality physicians in the
9 United States.

10 (11) An increase in United States medical
11 school graduates must be accompanied by an in-
12 crease of 4,000 graduate medical education training
13 positions each year.

14 (12) Graduate medical education programs and
15 teaching hospitals provide venues in which the next
16 generation of physicians learns to work collabo-
17 ratively with other physicians and health profes-
18 sionals, adopt more efficient care delivery models
19 (such as care coordination and medical homes), in-
20 corporate health information technology and elec-
21 tronic health records in every aspect of their work,
22 apply new methods of assuring quality and safety,
23 and participate in groundbreaking clinical and public
24 health research.

1 (13) The Medicare program under title XVIII
2 of the Social Security Act (42 U.S.C. 1395 et seq.)
3 (having more beneficiaries than any other health
4 care program), supports its “fair share” of the costs
5 associated with graduate medical education.

6 (14) In general, the level of support of graduate
7 medical education by the Medicare program has
8 been capped since 1997 and has not been increased
9 to support the expansion of graduate medical edu-
10 cation programs needed to avert the projected physi-
11 cian shortage or to accommodate the increase in
12 United States medical school graduates.

13 (b) SENSE OF CONGRESS.—It is the sense of Con-
14 gress that eliminating the limit of the number of residency
15 positions that receive some level of Medicare support
16 under section 1886(h) of the Social Security Act (42
17 U.S.C. 1395ww(h)), also referred to as the Medical grad-
18 uate medical education cap, is critical to—

19 (1) ensuring an appropriate supply of physi-
20 cians to meet the health care needs in the United
21 States;

22 (2) facilitating equitable access for all who seek
23 health care; and

24 (3) mitigating disparities in health and health
25 care.

1 **SEC. 313. CAREER SUPPORT FOR SKILLED, INTERNATION-**
2 **ALLY EDUCATED HEALTH PROFESSIONALS.**

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

4 (1) According to the Association of Schools and
5 Programs of Public Health, projections indicate a
6 nationwide shortage of up to 250,000 public health
7 workers needed by 2020.

8 (2) Similar trends are projected for other health
9 professions indicating shortages across disciplines,
10 including within the fields of nursing (500,000 by
11 2025), dentistry (15,000 by 2025), pharmacy
12 (38,000 by 2030), mental and behavioral health, pri-
13 mary care (46,000 by 2025), and community and al-
14 lied health.

15 (3) A nationwide health workforce shortage will
16 result in serious health threats and more severe and
17 costly health care needs, due to, in part, a delayed
18 response to food-borne outbreaks, emerging infec-
19 tious diseases, natural disasters, fewer cancer
20 screenings, and delayed treatment.

21 (4) Vulnerable and underserved populations and
22 health professional shortage areas will be most se-
23 verely impacted by the health workforce shortage.

24 (5) According to the Migration Policy Institute,
25 more than 2,000,000 college-educated immigrants in
26 the United States today are unemployed or under-

1 employed in low- or semi-skilled jobs that fail to
2 draw on their education and expertise.

3 (6) Approximately 2 out of every 5 internation-
4 ally educated immigrants are unemployed or under-
5 employed.

6 (7) According to the Drexel University Center
7 for Labor Markets and Policy, underemployment for
8 internationally educated immigrant women is 28 per-
9 cent higher than for their male counterparts.

10 (8) According to the Drexel University Center
11 for Labor Markets and Policy, the mean annual
12 earnings of underemployed immigrants were
13 \$32,000, or 43 percent less than United States born
14 college graduates employed in the college labor mar-
15 ket.

16 (9) According to Upwardly Global and the Wel-
17 come Back Initiative, with proper guidance and sup-
18 port, underemployed skilled immigrants typically in-
19 crease their income by 215 percent to 900 percent.

20 (10) According to the Brookings Institution and
21 the Partnership for a New American Economy, im-
22 migrants working in the health workforce are, on av-
23 erage, better educated than United States-born
24 workers in the health workforce.

25 (b) GRANTS TO ELIGIBLE ENTITIES.—

1 (1) AUTHORITY TO PROVIDE GRANTS.—The
2 Secretary of Health and Human Services, acting
3 through the Bureau of Health Workforce within the
4 Health Resources and Services Administration, the
5 National Institute on Minority Health and Health
6 Disparities, or the Office of Minority Health (in this
7 section referred to as the “Secretary”), may award
8 grants to eligible entities to carry out activities de-
9 scribed in subsection (c).

10 (2) ELIGIBILITY.—To be eligible to receive a
11 grant under this section, an entity shall—

12 (A) be a clinical, public health, or health
13 services organization, a community-based or
14 nonprofit entity, an academic institution, a
15 faith-based organization, a State, county, or
16 local government, an area health education cen-
17 ter, or another entity determined appropriate by
18 the Secretary; and

19 (B) submit to the Secretary an application
20 at such time, in such manner, and containing
21 such information as the Secretary may require.

22 (c) AUTHORIZED ACTIVITIES.—A grant awarded
23 under this section shall be used—

24 (1) to provide services to assist unemployed and
25 underemployed skilled immigrants, residing in the

1 United States, who have legal, permanent work au-
2 thorization and who are internationally educated
3 health professionals, enter into the health workforce
4 of the United States with employment matching
5 their health professional skills and education, and
6 advance in employment to positions that better
7 match their health professional education and exper-
8 tise;

9 (2) to provide training opportunities to reduce
10 barriers to entry and advancement in the health
11 workforce for skilled, internationally educated immi-
12 grants;

13 (3) to educate employers regarding the abilities
14 and capacities of internationally educated health
15 professionals;

16 (4) to assist in the evaluation of foreign creden-
17 tials;

18 (5) to support preceptorships for international
19 medical graduates in hospital primary care training;
20 and

21 (6) to facilitate access to contextualized and ac-
22 celerated courses on English as a second language.

1 **TITLE IV—IMPROVING HEALTH**
 2 **CARE ACCESS AND QUALITY**
 3 **Subtitle A—Expansion of Coverage**

4 **SEC. 401. 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 D the following:

9 **“Subtitle E—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 plan under title XIX of the Social Security Act
11 (or under a waiver of such plan), or are mem-
12 bers of vulnerable populations, as determined
13 by the Secretary; and

14 “(C)(i) with respect to which, not less than
15 50 percent of the entity’s patient population is
16 made up of racial and ethnic minority groups;
17 or

18 “(ii) that—

19 “(I) serves a disproportionate percent-
20 age of local patients that are from a racial
21 and ethnic minority group, or that has a
22 patient population, at least 50 percent of
23 which is composed of individuals with lim-
24 ited-English proficiency; and

1 “(II) provides an assurance that
2 amounts received under the grant will be
3 used only to support quality improvement
4 activities in the racial and ethnic minority
5 population served; and

6 “(2) prepare and submit to the Secretary an
7 application at such time, in such manner, and con-
8 taining such information as the Secretary may re-
9 quire.

10 “(c) PRIORITY.—In awarding grants under sub-
11 section (a), the Secretary shall give priority to applicants
12 under subsection (b)(2) that—

13 “(1) demonstrate an intent to operate as part
14 of a health care partnership, network, collaborative,
15 coalition, or alliance where each member entity con-
16 tributes to the design, implementation, and evalua-
17 tion of the proposed intervention; or

18 “(2) intend to use funds to carry out system-
19 wide changes with respect to health care quality im-
20 provement, including—

21 “(A) improved systems for data collection
22 and reporting;

23 “(B) innovative collaborative or similar
24 processes;

1 “(C) group programs with behavioral or
2 self-management interventions;

3 “(D) case management services;

4 “(E) physician or patient reminder sys-
5 tems;

6 “(F) educational interventions; or

7 “(G) other activities determined appro-
8 priate by the Secretary.

9 “(d) USE OF FUNDS.—An entity shall use amounts
10 received under a grant under subsection (a) to support
11 the implementation and evaluation of health care quality
12 improvement activities or minority health and health care
13 disparity reduction activities that include—

14 “(1) with respect to health care systems, activi-
15 ties relating to improving—

16 “(A) patient safety;

17 “(B) timeliness of care;

18 “(C) effectiveness of care;

19 “(D) efficiency of care;

20 “(E) patient centeredness; and

21 “(F) health information technology; and

22 “(2) with respect to patients, activities relating
23 to—

24 “(A) staying healthy;

25 “(B) getting well, mentally and physically;

1 “(C) living effectively with illness or dis-
2 ability;

3 “(D) coping with end-of-life issues; and

4 “(E) shared decisionmaking.

5 “(e) COMMON DATA SYSTEMS.—The Secretary shall
6 provide financial and other technical assistance to grant-
7 ees under this section for the development of common data
8 systems.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section
11 such sums as may be necessary for each of fiscal years
12 2019 through 2024.

13 **“SEC. 3452. CENTERS OF EXCELLENCE.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Administrator of the Health Resources and Services
16 Administration, shall designate centers of excellence at
17 public hospitals, and other health systems serving large
18 numbers of minority patients, that—

19 “(1) meet the requirements of section
20 3451(b)(1);

21 “(2) demonstrate excellence in providing care to
22 minority populations; and

23 “(3) demonstrate excellence in reducing dispari-
24 ties in health and health care.

1 “(b) REQUIREMENTS.—A hospital or health system
2 that serves as a center of excellence under subsection (a)
3 shall—

4 “(1) design, implement, and evaluate programs
5 and policies relating to the delivery of care in ra-
6 cially, ethnically, and linguistically diverse popu-
7 lations;

8 “(2) provide training and technical assistance
9 to other hospitals and health systems relating to the
10 provision of quality health care to minority popu-
11 lations; and

12 “(3) develop activities for graduate or con-
13 tinuing medical education that institutionalize a
14 focus on cultural competence training for health care
15 providers.

16 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section,
18 such sums as may be necessary for each of fiscal years
19 2019 through 2024.

20 **“SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**
21 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
22 **ING PACIFIC ISLANDERS AND THE INSULAR**
23 **AREAS.**

24 “(a) IN GENERAL.—The Secretary shall provide di-
25 rect financial assistance to designated health care pro-

1 viders and community health centers in American Samoa,
2 Guam, the Commonwealth of the Northern Mariana Is-
3 lands, the United States Virgin Islands, Puerto Rico, and
4 Hawaii for the purposes of reconstructing and improving
5 health care facilities and services in a culturally competent
6 and sustainable manner.

7 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
8 nancial assistance under subsection (a), an entity shall be
9 a public health facility or community health center located
10 in American Samoa, Guam, the Commonwealth of the
11 Northern Mariana Islands, the United States Virgin Is-
12 lands, Puerto Rico, or Hawaii that—

13 “(1) is owned or operated by—

14 “(A) the Government of American Samoa,
15 Guam, the Commonwealth of the Northern
16 Mariana Islands, the United States Virgin Is-
17 lands, Puerto Rico, or Hawaii or a unit of local
18 government; or

19 “(B) a nonprofit organization; and

20 “(2)(A) provides care or treatment for a sub-
21 stantial number of patients who are uninsured, re-
22 ceiving assistance under title XVIII of the Social Se-
23 curity Act, or a State plan under title XIX of such
24 Act (or under a waiver of such plan), or who are

1 members of a vulnerable population, as determined
2 by the Secretary; or

3 “(B) serves a disproportionate percentage of
4 local patients that are from a racial and ethnic mi-
5 nority group.

6 “(c) REPORT.—Not later than 180 days after the
7 date of enactment of this title and annually thereafter, the
8 Secretary shall submit to the Congress and the President
9 a report that includes an assessment of health resources
10 and facilities serving populations in American Samoa,
11 Guam, the Commonwealth of the Northern Mariana Is-
12 lands, the United States Virgin Islands, Puerto Rico, and
13 Hawaii. In preparing such report, the Secretary shall—

14 “(1) consult with and obtain information on all
15 health care facilities needs from the entities receiv-
16 ing direct financial assistance under subsection (a);

17 “(2) include all amounts of Federal assistance
18 received by each such entity in the preceding fiscal
19 year;

20 “(3) review the total unmet needs of health care
21 facilities serving American Samoa, Guam, the Com-
22 monwealth of the Northern Mariana Islands, the
23 United States Virgin Islands, Puerto Rico, and Ha-
24 waii, including needs for renovation and expansion
25 of existing facilities;

1 “(4) include a strategic plan for addressing the
2 needs of each such population identified in the re-
3 port; and

4 “(5) evaluate the effectiveness of the care pro-
5 vided by measuring patient outcomes and cost meas-
6 ures.

7 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated such sums as necessary
9 to carry out this section.”.

10 **SEC. 402. REMOVING CITIZENSHIP AND IMMIGRATION BAR-**
11 **RIERS TO ACCESS TO AFFORDABLE HEALTH**
12 **CARE UNDER ACA.**

13 (a) IN GENERAL.—

14 (1) PREMIUM TAX CREDITS.—Section 36B of
15 the Internal Revenue Code of 1986 is amended—

16 (A) in subsection (c)(1)(B)—

17 (i) by amending the heading to read
18 as follows: “SPECIAL RULE FOR CERTAIN
19 INDIVIDUALS INELIGIBLE FOR MEDICAID
20 DUE TO STATUS”, and

21 (ii) in clause (ii), by striking “lawfully
22 present in the United States, but” and in-
23 serting “who”, and

24 (B) by striking subsection (e).

1 (2) COST-SHARING REDUCTIONS.—Section 1402
2 of the Patient Protection and Affordable Care Act
3 (42 U.S.C. 18071) is amended by striking sub-
4 section (e).

5 (3) BASIC HEALTH PROGRAM ELIGIBILITY.—
6 Section 1331(e)(1)(B) of the Patient Protection and
7 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
8 amended by striking “lawfully present in the United
9 States”.

10 (4) RESTRICTIONS ON FEDERAL PAYMENTS.—
11 Section 1412 of the Patient Protection and Afford-
12 able Care Act (42 U.S.C. 18082) is amended by
13 striking subsection (d).

14 (5) REQUIREMENT TO MAINTAIN MINIMUM ES-
15 SENTIAL COVERAGE.—Section 5000A(d) of the In-
16 ternal Revenue Code of 1986 is amended by striking
17 paragraph (3) and by redesignating paragraph (4)
18 as paragraph (3).

19 (b) CONFORMING AMENDMENTS.—

20 (1) Section 1411(a) of the Patient Protection
21 and Affordable Care Act (42 U.S.C. 18081(a)) is
22 amended by striking paragraph (1) and redesign-
23 ating paragraphs (2), (3), and (4) as paragraphs
24 (1), (2), and (3), respectively.

1 (2) Section 1312(f) of the Patient Protection
2 and Affordable Care Act (42 U.S.C. 18032(f)) is
3 amended—

4 (A) in the heading, by striking “; ACCESS
5 LIMITED TO CITIZENS AND LAWFUL RESI-
6 DENTS”; and

7 (B) by striking paragraph (3).

8 **SEC. 403. STUDY ON THE UNINSURED.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services (in this section referred to as the “Sec-
11 retary”) shall—

12 (1) conduct a study, in accordance with the
13 standards under section 3101 of the Public Health
14 Service Act (42 U.S.C. 300kk), on the demographic
15 characteristics of the population of individuals who
16 do not have health insurance coverage or oral health
17 coverage; and

18 (2) predict, based on such study, the demo-
19 graphic characteristics of the population of individ-
20 uals who would remain without health insurance cov-
21 erage after the end of any annual open enrollment
22 or any special enrollment period or upon enactment
23 and implementation of any legislative changes to the
24 Patient Protection and Affordable Care Act (Public

1 Law 111–148) that affect the number of persons eli-
2 gible for coverage.

3 (b) REPORTING REQUIREMENTS.—

4 (1) IN GENERAL.—Not later than 12 months
5 after the date of the enactment of this Act, the Sec-
6 retary shall submit to the Congress the results of
7 the study under subsection (a)(1) and the prediction
8 made under subsection (a)(2).

9 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
10 ISTICS.—The Secretary shall—

11 (A) report the demographic characteristics
12 under paragraphs (1) and (2) of subsection (a)
13 on the basis of racial and ethnic group, and
14 shall stratify the reporting on each racial and
15 ethnic group by other demographic characteris-
16 tics that can impact access to health insurance
17 coverage, such as sexual orientation, gender
18 identity, primary language, disability status,
19 sex, socioeconomic status, age group, and citi-
20 zenship and immigration status, in a manner
21 consistent with title I of this Act, including the
22 amendments made by such title; and

23 (B) not use such report to engage in or an-
24 ticipate any deportation or immigration related

1 enforcement action by any entity, including the
2 Department of Homeland Security.

3 **SEC. 404. MEDICAID IN THE TERRITORIES.**

4 (a) ELIMINATION OF GENERAL MEDICAID FUNDING
5 LIMITATIONS (“CAP”) FOR TERRITORIES.—

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

8 (A) in subsection (f), in the matter before
9 paragraph (1), by striking “subsection (g)” and
10 inserting “subsections (g) and (h)”;

11 (B) in subsection (g)(2), in the matter be-
12 fore subparagraph (A), by inserting “and sub-
13 section (h)” after “paragraphs (3) and (5)”;
14 and

15 (C) by adding at the end the following new
16 subsection:

17 “(h) SUNSET OF MEDICAID FUNDING LIMITATIONS
18 FOR PUERTO RICO, THE VIRGIN ISLANDS OF THE
19 UNITED STATES, GUAM, THE NORTHERN MARIANA IS-
20 LANDS, AND AMERICAN SAMOA.—Subsections (f) and (g)
21 shall not apply to Puerto Rico, the Virgin Islands of the
22 United States, Guam, the Northern Mariana Islands, and
23 American Samoa beginning with fiscal year 2019.”.

24 (2) CONFORMING AMENDMENTS.—

1 (A) Section 1902(j) of the Social Security
2 Act (42 U.S.C. 1396a(j)) is amended by strik-
3 ing “, the limitation in section 1108(f),”.

4 (B) Section 1903(u) of the Social Security
5 Act (42 U.S.C. 1396b(u)) is amended by strik-
6 ing paragraph (4).

7 (C) Section 1323(c)(1) of the Patient Pro-
8 tection and Affordable Care Act (42 U.S.C.
9 18043(c)(1)) is amended by striking “2019”
10 and inserting “2018”.

11 (3) EFFECTIVE DATE.—The amendments made
12 by this section shall apply beginning with fiscal year
13 2019.

14 (b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL
15 ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR
16 TERRITORIES.—Section 1905(b) of the Social Security
17 Act (42 U.S.C. 1396d(b)) is amended, in clause (2), by
18 inserting “for fiscal years before fiscal year 2019” after
19 “American Samoa”.

20 **SEC. 405. EXTENSION OF MEDICARE SECONDARY PAYER.**

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

1 (1) in the last sentence, by inserting “, and be-
2 fore January 1, 2019” after “prior to such date”;
3 and

4 (2) by adding at the end the following new sen-
5 tence: “Effective for items and services furnished on
6 or after January 1, 2019 (with respect to periods
7 beginning on or after the date that is 42 months
8 prior to such date), clauses (i) and (ii) shall be ap-
9 plied by substituting ‘42-month’ for ‘12-month’ each
10 place it appears.”.

11 (b) **EFFECTIVE DATE.**—The amendments made by
12 this section shall take effect on the date of enactment of
13 this Act. For purposes of determining an individual’s sta-
14 tus under section 1862(b)(1)(C) of the Social Security Act
15 (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection
16 (a), an individual who is within the coordinating period
17 as of the date of enactment of this Act shall have that
18 period extended to the full 42 months described in the last
19 sentence of such section, as added by the amendment
20 made by subsection (a)(2).

21 **SEC. 406. BORDER HEALTH GRANTS.**

22 (a) **DEFINITIONS.**—In this section:

23 (1) **BORDER AREA.**—The term “border area”
24 means the United States-Mexico Border Area, as de-

1 fined in section 8 of the United States-Mexico Bor-
2 der Health Commission Act (22 U.S.C. 290n-6).

3 (2) ELIGIBLE ENTITY.—The term “eligible enti-
4 ty” means an entity that is located in the border
5 area and is any of the following:

6 (A) A State, local government, or Tribal
7 government.

8 (B) Public institution of higher education.

9 (C) Nonprofit health organization.

10 (D) Community health center.

11 (E) Community clinic that is a health cen-
12 ter receiving assistance under section 330 of the
13 Public Health Service Act (42 U.S.C. 254b).

14 (b) AUTHORIZATION.—From funds appropriated
15 under subsection (f), the Secretary of Health and Human
16 Services (in this section referred to as the “Secretary”),
17 acting through the United States members of the United
18 States-Mexico Border Health Commission, shall award
19 grants to eligible entities to address priorities and rec-
20 ommendations to improve the health of border area resi-
21 dents that are established by—

22 (1) the United States members of the United
23 States-Mexico Border Health Commission;

24 (2) the State border health offices; and

25 (3) the Secretary.

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

5 (d) USE OF FUNDS.—An eligible entity that receives
6 a grant under subsection (b) shall use the grant funds
7 for—

8 (1) programs relating to—

9 (A) maternal and child health;

10 (B) primary care and preventative health;

11 (C) public health and public health infra-
12 structure;

13 (D) musculoskeletal health and obesity;

14 (E) health education and promotion;

15 (F) oral health;

16 (G) mental and behavioral health;

17 (H) substance use disorders;

18 (I) health conditions that have a high prev-
19 alence in the border area;

20 (J) medical and health services research;

21 (K) workforce training and development;

22 (L) community health workers, patient
23 navigators, and promotoras;

1 (M) health care infrastructure problems in
2 the border area (including planning and con-
3 struction grants);

4 (N) health disparities in the border area;

5 (O) environmental health; and

6 (P) outreach and enrollment services with
7 respect to Federal programs (including pro-
8 grams authorized under titles XIX and XXI of
9 the Social Security Act (42 U.S.C. 1396 et seq.;
10 42 U.S.C. 1397aa et seq.)); and

11 (2) other programs determined appropriate by
12 the Secretary.

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

18 (f) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section,
20 \$200,000,000 for fiscal year 2019, and such sums as may
21 be necessary for each succeeding fiscal year.

22 **SEC. 407. REMOVING MEDICARE BARRIER TO HEALTH**
23 **CARE.**

24 (a) PART A.—Section 1818(a)(3) of the Social Secu-
25 rity Act (42 U.S.C. 1395i-2(a)(3)) is amended by striking

1 “an alien” and all that follows through “under this sec-
2 tion” and inserting “an individual who is lawfully present
3 in the United States”.

4 (b) PART B.—Section 1836(2) of the Social Security
5 Act (42 U.S.C. 1395o(2)) is amended by striking “an
6 alien” and all that follows through “under this part” and
7 inserting “an individual who is lawfully present in the
8 United States”.

9 **SEC. 408. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
10 **PROVIDED BY URBAN INDIAN HEALTH CEN-**
11 **TERS.**

12 (a) IN GENERAL.—The third sentence of section
13 1905(b) of the Social Security Act (42 U.S.C. 1396(b))
14 is amended by inserting “or are received through a pro-
15 gram operated by an urban Indian organization through
16 a grant or contract under title V of such Act” after “(as
17 defined in section 4 of the Indian Health Care Improve-
18 ment Act)”.

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

1 **SEC. 409. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
2 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
3 **A FEDERALLY QUALIFIED HEALTH CENTER**
4 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
5 **TEM UNDER THE MEDICAID PROGRAM.**

6 (a) IN GENERAL.—The third sentence of section
7 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),
8 as amended by section 408(a), is amended by inserting
9 before the period the following: “, and with respect to
10 medical assistance provided to a Native Hawaiian (as de-
11 fined in section 12(2) of the Native Hawaiian Health Care
12 Improvement Act) through a federally qualified health
13 center or a Native Hawaiian health care system (as de-
14 fined in section 12(6) of such Act), whether directly, by
15 referral, or under contract or other arrangement between
16 such federally qualified health center or Native Hawaiian
17 health care system and another health care provider”.

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

21 **Subtitle B—Expansion of Access**

22 **SEC. 410. PROTECTING SENSITIVE LOCATIONS.**

23 Section 287 of the Immigration and Nationality Act
24 (8 U.S.C. 1357) is amended—

1 (1) by striking “Service” each place such term
2 appears and inserting “Department of Homeland
3 Security”;

4 (2) by striking “Attorney General” each place
5 such term appears and inserting “Secretary of
6 Homeland Security”;

7 (3) in subsection (f)(1), by striking “Commis-
8 sioner” and inserting “Director of U.S. Citizenship
9 and Immigration Services”;

10 (4) in subsection (h)—

11 (A) by striking “of the Immigration and
12 Nationality Act”; and

13 (B) by striking “of such Act”; and

14 (5) by adding at the end the following:

15 “(i)(1) In this subsection:

16 “(A) The term ‘appropriate committees of Con-
17 gress’ means—

18 “(i) the Committee on Homeland Security
19 and Governmental Affairs of the Senate;

20 “(ii) the Committee on the Judiciary of the
21 Senate;

22 “(iii) the Committee on Homeland Security
23 of the House of Representatives; and

24 “(iv) the Committee on the Judiciary of
25 the House of Representatives.

1 “(B) The term ‘enforcement action’—

2 “(i) means an apprehension, arrest, inter-
3 view, request for identification, search, or sur-
4 veillance for the purposes of immigration en-
5 forcement; and

6 “(ii) includes an enforcement action at, or
7 focused on, a sensitive location that is part of
8 a joint case led by another law enforcement
9 agency.

10 “(C) The term ‘exigent circumstances’ means a
11 situation involving—

12 “(i) the imminent risk of death, violence,
13 or physical harm to any person or property, in-
14 cluding a situation implicating terrorism or the
15 national security of the United States;

16 “(ii) the immediate arrest or pursuit of a
17 dangerous felon, terrorist suspect, or other indi-
18 vidual presenting an imminent danger; or

19 “(iii) the imminent risk of destruction of
20 evidence that is material to an ongoing criminal
21 case.

22 “(D) The term ‘prior approval’ means—

23 “(i) in the case of officers and agents of
24 U.S. Immigration and Customs Enforcement,
25 prior written approval to carry out an enforce-

1 ment action involving a specific individual or in-
2 dividuals authorized by—

3 “(I) the Assistant Director of Oper-
4 ations, Homeland Security Investigations;

5 “(II) the Executive Associate Direc-
6 tor, Homeland Security Investigations;

7 “(III) the Assistant Director for Field
8 Operations, Enforcement and Removal Op-
9 erations; or

10 “(IV) the Executive Associate Direc-
11 tor for Field Operations, Enforcement and
12 Removal Operations;

13 “(ii) in the case of officers and agents of
14 U.S. Customs and Border Protection, prior
15 written approval to carry out an enforcement
16 action involving a specific individual or individ-
17 uals authorized by—

18 “(I) a Chief Patrol Agent;

19 “(II) the Director of Field Operations;

20 “(III) the Director of Air and Marine
21 Operations; or

22 “(IV) the Internal Affairs Special
23 Agent in Charge; and

24 “(iii) in the case of other Federal, State,
25 or local law enforcement officers, to carry out

1 an enforcement action involving a specific indi-
2 vidual or individuals authorized by—

3 “(I) the head of the Federal agency
4 carrying out the enforcement action; or

5 “(II) the head of the State or local
6 law enforcement agency carrying out the
7 enforcement action.

8 “(E) The term ‘sensitive location’ includes all of
9 the physical space located within 1,000 feet of—

10 “(i) any medical treatment or health care
11 facility, including any hospital, doctor’s office,
12 accredited health clinic, alcohol or drug treat-
13 ment center, or emergent or urgent care facil-
14 ity;

15 “(ii) any public or private school, including
16 any known and licensed day care facility, pre-
17 school, other early learning program facility,
18 primary school, secondary school, postsecondary
19 school (including colleges and universities), or
20 other institution of learning (including voca-
21 tional or trade schools);

22 “(iii) any scholastic or education-related
23 activity or event, including field trips and inter-
24 scholastic events;

1 “(iv) any school bus or school bus stop
2 during periods when school children are present
3 on the bus or at the stop;

4 “(v) any organization that—

5 “(I) assists children, pregnant women,
6 victims of crime or abuse, or individuals
7 with significant mental or physical disabili-
8 ties; or

9 “(II) provides disaster or emergency
10 social services and assistance;

11 “(vi) any church, synagogue, mosque, or
12 other place of worship, including buildings
13 rented for the purpose of religious services, re-
14 treats, counseling, workshops, instruction, and
15 education;

16 “(vii) any Federal, State, or local court-
17 house, including the office of an individual’s
18 legal counsel or representative, and a probation,
19 parole, or supervised release office;

20 “(viii) the site of a funeral, wedding, or
21 other religious ceremony or observance;

22 “(ix) any public demonstration, such as a
23 march, rally, or parade;

1 “(x) any domestic violence shelter, rape
2 crisis center, supervised visitation center, family
3 justice center, or victim services provider; or

4 “(xi) any other location specified by the
5 Secretary of Homeland Security for purposes of
6 this subsection.

7 “(2)(A) An enforcement action may not take place
8 at, or be focused on, a sensitive location unless—

9 “(i) the action involves exigent circumstances;
10 and

11 “(ii) prior approval for the enforcement action
12 was obtained from the appropriate official.

13 “(B) If an enforcement action is initiated pursuant
14 to subparagraph (A) and the exigent circumstances per-
15 mitting the enforcement action cease, the enforcement ac-
16 tion shall be discontinued until such exigent circumstances
17 reemerge.

18 “(C) If an enforcement action is carried out in viola-
19 tion of this subsection—

20 “(i) no information resulting from the enforce-
21 ment action may be entered into the record or re-
22 ceived into evidence in a removal proceeding result-
23 ing from the enforcement action; and

1 “(ii) the alien who is the subject of such re-
2 moval proceeding may file a motion for the imme-
3 diate termination of the removal proceeding.

4 “(3)(A) This subsection shall apply to any enforce-
5 ment action by officers or agents of the Department of
6 Homeland Security, including—

7 “(i) officers or agents of U.S. Immigration and
8 Customs Enforcement;

9 “(ii) officers or agents of U.S. Customs and
10 Border Protection; and

11 “(iii) any individual designated to perform im-
12 migration enforcement functions pursuant to sub-
13 section (g).

14 “(B) While carrying out an enforcement action at a
15 sensitive location, officers and agents referred to in sub-
16 paragraph (A) shall make every effort—

17 “(i) to limit the time spent at the sensitive loca-
18 tion;

19 “(ii) to limit the enforcement action at the sen-
20 sitive location to the person or persons for whom
21 prior approval was obtained; and

22 “(iii) to conduct themselves discreetly.

23 “(C) If, while carrying out an enforcement action
24 that is not initiated at or focused on a sensitive location,
25 officers or agents are led to a sensitive location, and no

1 exigent circumstance and prior approval with respect to
2 the sensitive location exists, such officers or agents shall—

3 “(i) cease before taking any further enforce-
4 ment action;

5 “(ii) conduct themselves in a discreet manner;

6 “(iii) maintain surveillance; and

7 “(iv) immediately consult their supervisor in
8 order to determine whether such enforcement action
9 should be discontinued.

10 “(D) The limitations under this paragraph shall not
11 apply to the transportation of an individual apprehended
12 at or near a land or sea border to a hospital or health
13 care provider for the purpose of providing medical care
14 to such individual.

15 “(4)(A) Each official specified in subparagraph (B)
16 shall ensure that the employees under his or her super-
17 vision receive annual training on compliance with—

18 “(i) the requirements under this subsection in
19 enforcement actions at or focused on sensitive loca-
20 tions and enforcement actions that lead officers or
21 agents to a sensitive location; and

22 “(ii) the requirements under section 239 of this
23 Act and section 384 of the Illegal Immigration Re-
24 form and Immigrant Responsibility Act of 1996 (8
25 U.S.C. 1367).

1 “(B) The officials specified in this subparagraph
2 are—

3 “(i) the Chief Counsel of U.S. Immigration and
4 Customs Enforcement;

5 “(ii) the Field Office Directors of U.S. Immi-
6 gration and Customs Enforcement;

7 “(iii) each Special Agent in Charge of U.S. Im-
8 migration and Customs Enforcement;

9 “(iv) each Chief Patrol Agent of U.S. Customs
10 and Border Protection;

11 “(v) the Director of Field Operations of U.S.
12 Customs and Border Protection;

13 “(vi) the Director of Air and Marine Operations
14 of U.S. Customs and Border Protection;

15 “(vii) the Internal Affairs Special Agent in
16 Charge of U.S. Customs and Border Protection; and

17 “(viii) the chief law enforcement officer of each
18 State or local law enforcement agency that enters
19 into a written agreement with the Department of
20 Homeland Security pursuant to subsection (g).

21 “(5) The Secretary of Homeland Security shall mod-
22 ify the Notice to Appear form (I-862)—

23 “(A) to provide the subjects of an enforcement
24 action with information, written in plain language,
25 summarizing the restrictions against enforcement

1 actions at sensitive locations set forth in this sub-
2 section and the remedies available to the alien if
3 such action violates such restrictions;

4 “(B) so that the information described in sub-
5 paragraph (A) is accessible to individuals with lim-
6 ited-English proficiency; and

7 “(C) so that subjects of an enforcement action
8 are not permitted to verify that the officers or
9 agents that carried out such action complied with
10 the restrictions set forth in this subsection.

11 “(6)(A) The Director of U.S. Immigration and Cus-
12 toms Enforcement and the Commissioner of U.S. Customs
13 and Border Protection shall each submit an annual report
14 to the appropriate committees of Congress that includes
15 the information set forth in subparagraph (B) with respect
16 to the respective agency.

17 “(B) Each report submitted under subparagraph (A)
18 shall include, with respect to the submitting agency during
19 the reporting period—

20 “(i) the number of enforcement actions that
21 were carried out at, or focused on, a sensitive loca-
22 tion;

23 “(ii) the number of enforcement actions in
24 which officers or agents were subsequently led to a
25 sensitive location; and

1 “(iii) for each enforcement action described in
2 clause (i) or (ii)—

3 “(I) the date on which it occurred;

4 “(II) the specific site, city, county, and
5 State in which it occurred;

6 “(III) the components of the agency in-
7 volved in the enforcement action;

8 “(IV) a description of the enforcement ac-
9 tion, including the nature of the criminal activ-
10 ity of its intended target;

11 “(V) the number of individuals, if any, ar-
12 rested or taken into custody;

13 “(VI) the number of collateral arrests, if
14 any, and the reasons for each such arrest;

15 “(VII) a certification whether the location
16 administrator was contacted before, during, or
17 after the enforcement action; and

18 “(VIII) the percentage of all of the staff
19 members and supervisors reporting to the offi-
20 cials listed in paragraph (4)(B) who completed
21 the training required under paragraph (4)(A).

22 “(7) Nothing in the subsection may be construed—

23 “(A) to affect the authority of Federal, State,
24 or local law enforcement agencies—

1 “(i) to enforce generally applicable Federal
2 or State criminal laws unrelated to immigra-
3 tion; or

4 “(ii) to protect residents from imminent
5 threats to public safety; or

6 “(B) to limit or override the protections pro-
7 vided in—

8 “(i) section 239; or

9 “(ii) section 384 of the Illegal Immigration
10 Reform and Immigrant Responsibility Act of
11 1996 (8 U.S.C. 1367).”.

12 **SEC. 411. GRANTS FOR RACIAL AND ETHNIC APPROACHES**
13 **TO COMMUNITY HEALTH.**

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

20 (b) **AUTHORITY TO AWARD GRANTS.**—The Secretary
21 of Health and Human Services, acting through the Ad-
22 ministrators of the Health Resources and Services Admin-
23 istration (referred to in this section as the “Secretary”),
24 shall award grants to eligible entities to assist in design-
25 ing, implementing, and evaluating culturally and linguis-

1 tically appropriate, science-based, and community-driven
2 sustainable strategies to eliminate racial and ethnic health
3 and health care disparities.

4 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
5 grant under this section, an entity shall—

6 (1) represent a coalition—

7 (A) whose principal purpose is to develop
8 and implement interventions to reduce or elimi-
9 nate a health or health care disparity in a tar-
10 geted racial or ethnic minority group in the
11 community served by the coalition; and

12 (B) that includes—

13 (i) members selected from among—

14 (I) public health departments;

15 (II) community-based organiza-
16 tions;

17 (III) university and research or-
18 ganizations;

19 (IV) Indian tribes or tribal orga-
20 nizations (as such terms are defined
21 in section 4 of the Indian Self-Deter-
22 mination and Education Assistance
23 Act (25 U.S.C. 5304)), the Indian
24 Health Service, or any other organiza-
25 tion that serves Alaska Natives; and

1 (V) interested public or private
2 health care providers or organizations
3 as determined appropriate by the Sec-
4 retary; and

5 (ii) at least 1 member from a commu-
6 nity-based organization that represents the
7 targeted racial or ethnic minority group;
8 and

9 (2) submit to the Secretary an application at
10 such time, in such manner, and containing such in-
11 formation as the Secretary may require, which shall
12 include—

13 (A) a description of the targeted racial or
14 ethnic populations in the community to be
15 served under the grant;

16 (B) a description of at least 1 health dis-
17 parity that exists in the racial or ethnic tar-
18 geted populations, including health issues such
19 as infant mortality, breast and cervical cancer
20 screening and management, musculoskeletal
21 diseases and obesity, prostate cancer screening
22 and management, cardiovascular disease, diabe-
23 tes, child and adult immunization levels, oral
24 disease, or other health priority areas as des-
25 ignated by the Secretary; and

1 (C) a demonstration of a proven record of
2 accomplishment of the coalition members in
3 serving and working with the targeted commu-
4 nity.

5 (d) SUSTAINABILITY.—The Secretary shall give pri-
6 ority to an eligible entity under this section if the entity
7 agrees that, with respect to the costs to be incurred by
8 the entity in carrying out the activities for which the grant
9 was awarded, the entity (and each of the participating
10 partners in the coalition represented by the entity) will
11 maintain its expenditures of non-Federal funds for such
12 activities at a level that is not less than the level of such
13 expenditures during the fiscal year immediately preceding
14 the first fiscal year for which the grant is awarded.

15 (e) NONDUPLICATION.—Any funds provided to an eli-
16 gible entity through a grant under this section shall—

17 (1) supplement, not supplant, any other Federal
18 funds made available to the entity for the purposes
19 of this section; and

20 (2) not be used to duplicate the activities of any
21 other health disparity grant program under this Act,
22 including an amendment made by this Act.

23 (f) TECHNICAL ASSISTANCE.—The Secretary may,
24 either directly or by grant or contract, provide any entity
25 that receives a grant under this section with technical and

1 other nonfinancial assistance necessary to meet the re-
2 quirements of this section.

3 (g) DISSEMINATION.—The Secretary shall encourage
4 and enable eligible entities receiving grants under this sec-
5 tion to share best practices, evaluation results, and reports
6 with communities not affiliated with such entities, by
7 using the Internet, conferences, and other pertinent infor-
8 mation regarding the projects funded by this section, in-
9 cluding through using outreach efforts of the Office of Mi-
10 nority Health and the Centers for Disease Control and
11 Prevention.

12 (h) ADMINISTRATIVE BURDENS.—The Secretary
13 shall make every effort to minimize duplicative or unneces-
14 sary administrative burdens on eligible entities receiving
15 grants under this section.

16 (i) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated such sums as may be
18 necessary to carry out this section.

19 **SEC. 412. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

20 (a) ELIMINATION OF ISOLATION TEST FOR COST-
21 BASED AMBULANCE REIMBURSEMENT.—

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

25 (A) in subparagraph (B)—

1 (i) by striking “owned and”; and

2 (ii) by inserting “(including when
3 such services are provided by the entity
4 under an arrangement with the hospital)”
5 after “hospital”; and

6 (B) by striking the comma at the end of
7 subparagraph (B) and all that follows and in-
8 serting a period.

9 (2) EFFECTIVE DATE.—The amendments made
10 by this subsection shall apply to services furnished
11 on or after January 1, 2019.

12 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
13 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
14 REQUIREMENT.—

15 (1) IN GENERAL.—Section 1820(c)(2) of the
16 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
17 amended—

18 (A) in subparagraph (B)(iii), by striking
19 “provides not more than” and inserting “sub-
20 ject to subparagraph (F), provides not more
21 than”; and

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

24 “(F) ALTERNATIVE TO 25 INPATIENT BED
25 LIMIT REQUIREMENT.—

1 “(i) IN GENERAL.—A State may elect
2 to treat a facility, with respect to the des-
3 ignation of the facility for a cost-reporting
4 period, as satisfying the requirement of
5 subparagraph (B)(iii) relating to a max-
6 imum number of acute care inpatient beds
7 if the facility elects, in accordance with a
8 method specified by the Secretary and be-
9 fore the beginning of the cost reporting pe-
10 riod, to meet the requirement under clause
11 (ii).

12 “(ii) ALTERNATE REQUIREMENT.—
13 The requirement under this clause, with
14 respect to a facility and a cost-reporting
15 period, is that the total number of inpa-
16 tient bed days described in subparagraph
17 (B)(iii) during such period will not exceed
18 7,300. For purposes of this subparagraph,
19 an individual who is an inpatient in a bed
20 in the facility for a single day shall be
21 counted as one inpatient bed day.

22 “(iii) WITHDRAWAL OF ELECTION.—
23 The option described in clause (i) shall not
24 apply to a facility for a cost-reporting pe-
25 riod if the facility (for any two consecutive

1 cost-reporting periods during the previous
 2 5 cost-reporting periods) was treated under
 3 such option and had a total number of in-
 4 patient bed days for each of such two cost-
 5 reporting periods that exceeded the num-
 6 ber specified in such clause.”.

7 (2) EFFECTIVE DATE.—The amendments made
 8 by paragraph (1) shall apply to cost-reporting peri-
 9 ods beginning on or after the date of the enactment
 10 of this Act.

11 **SEC. 413. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
 12 **PITAL (RCH) PROGRAM.**

13 (a) IN GENERAL.—Section 1861 of the Social Secu-
 14 rity Act (42 U.S.C. 1395x), as amended by section
 15 205(b)(1), is amended by adding at the end of the fol-
 16 lowing new subsection:

17 “Rural Community Hospital; Rural Community Hospital
 18 Services

19 “(kkk)(1) The term ‘rural community hospital’
 20 means a hospital (as defined in subsection (e)) that—

21 “(A) is located in a rural area (as defined in
 22 section 1886(d)(2)(D)) or treated as being so lo-
 23 cated pursuant to section 1886(d)(8)(E);

1 “(B) subject to paragraph (2), has less than 51
2 acute care inpatient beds, as reported in its most re-
3 cent cost report;

4 “(C) makes available 24-hour emergency care
5 services;

6 “(D) subject to paragraph (3), has a provider
7 agreement in effect with the Secretary and is open
8 to the public as of January 1, 2010; and

9 “(E) applies to the Secretary for such designa-
10 tion.

11 “(2) For purposes of paragraph (1)(B), beds in a
12 psychiatric or rehabilitation unit of the hospital which is
13 a distinct part of the hospital shall not be counted.

14 “(3) Paragraph (1)(D) shall not be construed to pro-
15 hibit any of the following from qualifying as a rural com-
16 munity hospital:

17 “(A) A replacement facility (as defined by the
18 Secretary in regulations in effect on January 1,
19 2012) with the same service area (as defined by the
20 Secretary in regulations in effect on such date).

21 “(B) A facility obtaining a new provider num-
22 ber pursuant to a change of ownership.

23 “(C) A facility which has a binding written
24 agreement with an outside, unrelated party for the

1 construction, reconstruction, lease, rental, or financ-
 2 ing of a building as of January 1, 2012.

3 “(4) Nothing in this subsection shall be construed as
 4 prohibiting a critical access hospital from qualifying as a
 5 rural community hospital if the critical access hospital
 6 meets the conditions otherwise applicable to hospitals
 7 under subsection (e) and section 1866.

8 “(5) Nothing in this subsection shall be construed as
 9 prohibiting a rural community hospital participating in
 10 the demonstration program under section 410A of the
 11 Medicare Prescription Drug, Improvement, and Mod-
 12 ernization Act of 2003 (Public Law 108–173; 117 Stat.
 13 2313) from qualifying as a rural community hospital if
 14 the rural community hospital meets the conditions other-
 15 wise applicable to hospitals under subsection (e) and sec-
 16 tion 1866.”.

17 (b) PAYMENT.—

18 (1) INPATIENT HOSPITAL SERVICES.—Section
 19 1814 of the Social Security Act (42 U.S.C. 1395f)
 20 is amended by adding at the end the following new
 21 subsection:

22 “Payment for Inpatient Services Furnished in Rural
 23 Community Hospitals

24 “(m) The amount of payment under this part for in-
 25 patient hospital services furnished in a rural community

1 hospital, other than such services furnished in a psy-
2 chiatric or rehabilitation unit of the hospital which is a
3 distinct part, is, at the election of the hospital in the appli-
4 cation referred to in section 1861(kkk)(1)(E)—

5 “(1) 101 percent of the reasonable costs of pro-
6 viding such services, without regard to the amount
7 of the customary or other charge, or

8 “(2) the amount of payment provided for under
9 the prospective payment system for inpatient hos-
10 pital services under section 1886(d).”.

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

14 “(w) PAYMENT FOR OUTPATIENT SERVICES FUR-
15 NISHED IN RURAL COMMUNITY HOSPITALS.—The
16 amount of payment under this part for outpatient services
17 furnished in a rural community hospital is, at the election
18 of the hospital in the application referred to in section
19 1861(kkk)(1)(E)—

20 “(1) 101 percent of the reasonable costs of pro-
21 viding such services, without regard to the amount
22 of the customary or other charge and any limitation
23 under section 1861(v)(1)(U), or

1 “(2) the amount of payment provided for under
2 the prospective payment system for covered OPD
3 services under section 1833(t).”.

4 (3) EXEMPTION FROM 30-PERCENT REDUCTION
5 IN REIMBURSEMENT FOR BAD DEBT.—Section
6 1861(v)(1)(T) of such Act (42 U.S.C.
7 1395x(v)(1)(T)) is amended by inserting “(other
8 than for a rural community hospital)” after “In de-
9 termining such reasonable costs for hospitals”.

10 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
11 SERVICES.—Section 1834(w) of such Act (as added by
12 subsection (b)(2)) is amended—

13 (1) by redesignating paragraphs (1) and (2) as
14 subparagraphs (A) and (B), respectively;

15 (2) by inserting “(1)” after “(w)”; and

16 (3) by adding at the end the following:

17 “(2) The amounts of beneficiary cost-sharing for out-
18 patient services furnished in a rural community hospital
19 under this part shall be as follows:

20 “(A) For items and services that would have
21 been paid under section 1833(t) if furnished by a
22 hospital, the amount of cost-sharing determined
23 under paragraph (8) of such section.

24 “(B) For items and services that would have
25 been paid under section 1833(h) if furnished by a

1 provider of services or supplier, no cost-sharing shall
2 apply.

3 “(C) For all other items and services, the
4 amount of cost-sharing that would apply to the item
5 or service under the methodology that would be used
6 to determine payment for such item or service if pro-
7 vided by a physician, provider of services, or sup-
8 plier, as the case may be.”.

9 (d) CONFORMING AMENDMENTS.—

10 (1) PART A PAYMENT.—Section 1814(b) of
11 such Act (42 U.S.C. 1395f(b)) is amended in the
12 matter preceding paragraph (1) by inserting “other
13 than inpatient hospital services furnished by a rural
14 community hospital,” after “critical access hospital
15 services,”.

16 (2) PART B PAYMENT.—Section 1833(a) of
17 such Act (42 U.S.C. 1395l(a)), as amended by sec-
18 tion 205(b)(3), is amended—

19 (A) in paragraph (2), in the matter before
20 subparagraph (A), by striking “and (I)” and in-
21 serting “(I), and (K)”;

22 (B) by striking “and” at the end of para-
23 graph (9);

24 (C) by striking the period at the end of
25 paragraph (10) and inserting “; and”; and

1 (D) by adding at the end the following:

2 “(11) in the case of outpatient services fur-
3 nished by a rural community hospital, the amounts
4 described in section 1834(w).”.

5 (3) TECHNICAL AMENDMENTS.—

6 (A) CONSULTATION WITH STATE AGEN-
7 CIES.—Section 1863 of such Act (42 U.S.C.
8 1395z) is amended by striking “and (dd)(2)”
9 and inserting “(dd)(2), and (kkk)(1)”.

10 (B) PROVIDER AGREEMENTS.—Section
11 1866(a)(2)(A) of such Act (42 U.S.C.
12 1395cc(a)(2)(A)) is amended by inserting “sec-
13 tion 1834(w)(2),” after “section 1833(b),”.

14 (e) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to items and services furnished on
16 or after October 1, 2019.

17 **SEC. 414. MEDICARE REMOTE MONITORING PILOT**
18 **PROJECTS.**

19 (a) PILOT PROJECTS.—

20 (1) IN GENERAL.—Not later than 9 months
21 after the date of enactment of this Act, the Sec-
22 retary of Health and Human Services (in this sec-
23 tion referred to as the “Secretary”) shall conduct
24 pilot projects under title XVIII of the Social Secu-
25 rity Act for the purpose of providing incentives to

1 home health agencies to utilize home monitoring and
2 communications technologies that—

3 (A) enhance health outcomes for Medicare
4 beneficiaries; and

5 (B) reduce expenditures under such title.

6 (2) SITE REQUIREMENTS.—

7 (A) URBAN AND RURAL.—The Secretary
8 shall conduct the pilot projects under this sec-
9 tion in both urban and rural areas.

10 (B) SITE IN A SMALL STATE.—The Sec-
11 retary shall conduct at least 3 of the pilot
12 projects in a State with a population of less
13 than 1,000,000.

14 (3) DEFINITION OF HOME HEALTH AGENCY.—

15 In this section, the term “home health agency” has
16 the meaning given that term in section 1861(o) of
17 the Social Security Act (42 U.S.C. 1395x(o)).

18 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
19 OF PROJECTS.—The Secretary shall specify the criteria
20 for identifying those Medicare beneficiaries who shall be
21 considered within the scope of the pilot projects under this
22 section for purposes of the application of subsection (c)
23 and for the assessment of the effectiveness of the home
24 health agency in achieving the objectives of this section.
25 Such criteria may provide for the inclusion in the projects

1 of Medicare beneficiaries who begin receiving home health
2 services under title XVIII of the Social Security Act after
3 the date of the implementation of the projects.

4 (c) INCENTIVES.—

5 (1) PERFORMANCE TARGETS.—The Secretary
6 shall establish for each home health agency partici-
7 pating in a pilot project under this section a per-
8 formance target using one of the following meth-
9 odologies, as determined appropriate by the Sec-
10 retary:

11 (A) ADJUSTED HISTORICAL PERFORMANCE
12 TARGET.—The Secretary shall establish for the
13 agency—

14 (i) a base expenditure amount equal
15 to the average total payments made to the
16 agency under parts A and B of title XVIII
17 of the Social Security Act for Medicare
18 beneficiaries determined to be within the
19 scope of the pilot project in a base period
20 determined by the Secretary; and

21 (ii) an annual per capita expenditure
22 target for such beneficiaries, reflecting the
23 base expenditure amount adjusted for risk
24 and adjusted growth rates.

1 (B) COMPARATIVE PERFORMANCE TAR-
2 GET.—The Secretary shall establish for the
3 agency a comparative performance target equal
4 to the average total payments under such parts
5 A and B during the pilot project for comparable
6 individuals in the same geographic area that
7 are not determined to be within the scope of the
8 pilot project.

9 (2) INCENTIVE.—Subject to paragraph (3), the
10 Secretary shall pay to each participating home care
11 agency an incentive payment for each year under the
12 pilot project equal to a portion of the Medicare sav-
13 ings realized for such year relative to the perform-
14 ance target under paragraph (1).

15 (3) LIMITATION ON EXPENDITURES.—The Sec-
16 retary shall limit incentive payments under this sec-
17 tion in order to ensure that the aggregate expendi-
18 tures under title XVIII of the Social Security Act
19 (including incentive payments under this subsection)
20 do not exceed the amount that the Secretary esti-
21 mates would have been expended if the pilot projects
22 under this section had not been implemented.

23 (d) WAIVER AUTHORITY.—The Secretary may waive
24 such provisions of titles XI and XVIII of the Social Secu-

1 rity Act as the Secretary determines to be appropriate for
2 the conduct of the pilot projects under this section.

3 (e) REPORT TO CONGRESS.—Not later than 5 years
4 after the date that the first pilot project under this section
5 is implemented, the Secretary shall submit to Congress a
6 report on the pilot projects. Such report shall contain a
7 detailed description of issues related to the expansion of
8 the projects under subsection (f) and recommendations for
9 such legislation and administrative actions as the Sec-
10 retary considers appropriate.

11 (f) EXPANSION.—If the Secretary determines that
12 any of the pilot projects under this section enhance health
13 outcomes for Medicare beneficiaries and reduce expendi-
14 tures under title XVIII of the Social Security Act, the Sec-
15 retary may initiate comparable projects in additional
16 areas.

17 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
18 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
19 tive payment under this section—

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

24 (2) shall have no effect on the amount of such
25 payments.

1 **SEC. 415. RURAL HEALTH QUALITY ADVISORY COMMISSION**
2 **AND DEMONSTRATION PROJECTS.**

3 (a) RURAL HEALTH QUALITY ADVISORY COMMISS-
4 SION.—

5 (1) ESTABLISHMENT.—Not later than 6
6 months after the date of the enactment of this sec-
7 tion, the Secretary of Health and Human Services
8 (in this section referred to as the “Secretary”) shall
9 establish a commission to be known as the Rural
10 Health Quality Advisory Commission (in this section
11 referred to as the “Commission”).

12 (2) DUTIES OF COMMISSION.—

13 (A) NATIONAL PLAN.—The Commission
14 shall develop, coordinate, and facilitate imple-
15 mentation of a national plan for rural health
16 quality improvement. The national plan shall—

17 (i) identify objectives for rural health
18 quality improvement;

19 (ii) identify strategies to eliminate
20 known gaps in rural health system capacity
21 and improve rural health quality; and

22 (iii) provide recommendations for
23 Federal programs to identify opportunities
24 for strengthening and aligning policies and
25 programs to improve rural health quality.

1 (B) DEMONSTRATION PROJECTS.—The
2 Commission shall design demonstration projects
3 to recommend to the Secretary to test alter-
4 native models for rural health quality improve-
5 ment, including with respect to both personal
6 and population health.

7 (C) MONITORING.—The Commission shall
8 monitor progress toward the objectives identi-
9 fied pursuant to paragraph (1)(A).

10 (3) MEMBERSHIP.—

11 (A) NUMBER.—The Commission shall be
12 composed of 11 members appointed by the Sec-
13 retary.

14 (B) SELECTION.—The Secretary shall se-
15 lect the members of the Commission from
16 among individuals with significant rural health
17 care and health care quality expertise, including
18 expertise in clinical health care, health care
19 quality research, population or public health, or
20 purchaser organizations.

21 (4) CONTRACTING AUTHORITY.—Subject to the
22 availability of funds, the Commission may enter into
23 contracts and make other arrangements, as may be
24 necessary to carry out the duties described in para-
25 graph (2).

1 (5) STAFF.—Upon the request of the Commis-
2 sion, the Secretary may detail, on a reimbursable
3 basis, any of the personnel of the Office of Rural
4 Health Policy of the Health Resources and Services
5 Administration, the Agency for Healthcare Quality
6 and Research, or the Centers for Medicare & Med-
7 icaid Services to the Commission to assist in car-
8 rying out this subsection.

9 (6) REPORTS TO CONGRESS.—Not later than 1
10 year after the establishment of the Commission, and
11 annually thereafter, the Commission shall submit a
12 report to the Congress on rural health quality. Each
13 such report shall include the following:

14 (A) An inventory of relevant programs and
15 recommendations for improved coordination and
16 integration of policy and programs.

17 (B) An assessment of achievement of the
18 objectives identified in the national plan devel-
19 oped under paragraph (2) and recommenda-
20 tions for realizing such objectives.

21 (C) Recommendations on Federal legisla-
22 tion, regulations, or administrative policies to
23 enhance rural health quality and outcomes.

24 (b) RURAL HEALTH QUALITY DEMONSTRATION
25 PROJECTS.—

1 (1) IN GENERAL.—Not later than 270 days
2 after the date of the enactment of this section, the
3 Secretary, in consultation with the Rural Health
4 Quality Advisory Commission, the Office of Rural
5 Health Policy of the Health Resources and Services
6 Administration, the Agency for Healthcare Research
7 and Quality, and the Centers for Medicare & Med-
8 icaid Services, shall make grants to eligible entities
9 for a total of 5 demonstration projects to implement
10 and evaluate methods for improving the quality of
11 health care in rural communities. Each such dem-
12 onstration project shall include—

13 (A) alternative community models that—

14 (i) will achieve greater integration of
15 personal and population health services;
16 and

17 (ii) address safety, effectiveness,
18 patient- or community-centeredness, timeli-
19 ness, efficiency, and equity (the 6 aims
20 identified by the Institute of Medicine of
21 the National Academy of Sciences in its re-
22 port entitled “Crossing the Quality Chasm:
23 A New Health System for the 21st Cen-
24 tury” released on March 1, 2001);

1 (B) innovative approaches to the financing
2 and delivery of health services to achieve rural
3 health quality goals; and

4 (C) development of quality improvement
5 support structures to assist rural health sys-
6 tems and professionals (such as workforce sup-
7 port structures, quality monitoring and report-
8 ing, clinical care protocols, and information
9 technology applications).

10 (2) ELIGIBLE ENTITIES.—In this subsection,
11 the term “eligible entity” means a consortium
12 that—

13 (A) shall include—

14 (i) at least one health care provider or
15 health care delivery system located in a
16 rural area; and

17 (ii) at least one organization rep-
18 resenting multiple community stakeholders;
19 and

20 (B) may include other partners such as
21 rural research centers.

22 (3) CONSULTATION.—In developing the pro-
23 gram for awarding grants under this subsection, the
24 Secretary shall consult with the Administrator of the
25 Agency for Healthcare Research and Quality, rural

1 health care providers, rural health care researchers,
2 and private and nonprofit groups (including national
3 associations) which are undertaking similar efforts.

4 (4) EXPEDITED WAIVERS.—The Secretary shall
5 expedite the processing of any waiver that—

6 (A) is authorized under title XVIII or XIX
7 of the Social Security Act (42 U.S.C. 1395 et
8 seq.); and

9 (B) is necessary to carry out a demonstra-
10 tion project under this subsection.

11 (5) DEMONSTRATION PROJECT SITES.—The
12 Secretary shall ensure that the 5 demonstration
13 projects funded under this subsection are conducted
14 at a variety of sites representing the diversity of
15 rural communities in the United States.

16 (6) DURATION.—Each demonstration project
17 under this subsection shall be for a period of 4
18 years.

19 (7) INDEPENDENT EVALUATION.—The Sec-
20 retary shall enter into an arrangement with an enti-
21 ty that has experience working directly with rural
22 health systems for the conduct of an independent
23 evaluation of the program carried out under this
24 subsection.

1 (8) REPORT.—Not later than 1 year after the
2 conclusion of all of the demonstration projects fund-
3 ed under this subsection, the Secretary shall submit
4 a report to the Congress on the results of such
5 projects. The report shall include—

6 (A) an evaluation of patient access to care,
7 patient outcomes, and an analysis of the cost
8 effectiveness of each such project; and

9 (B) recommendations on Federal legisla-
10 tion, regulations, or administrative policies to
11 enhance rural health quality and outcomes.

12 (c) APPROPRIATION.—

13 (1) IN GENERAL.—Out of funds in the Treas-
14 ury not otherwise appropriated, there are appro-
15 priated to the Secretary to carry out this section
16 \$30,000,000 for the period of fiscal years 2019
17 through 2023.

18 (2) AVAILABILITY.—

19 (A) IN GENERAL.—Funds appropriated
20 under paragraph (1) shall remain available for
21 expenditure through fiscal year 2023.

22 (B) REPORT.—For purposes of carrying
23 out subsection (b)(8), funds appropriated under
24 paragraph (1) shall remain available for ex-
25 penditure through fiscal year 2024.

1 (3) RESERVATION.—Of the amount appro-
2 priated under paragraph (1), the Secretary shall re-
3 serve—

4 (A) \$5,000,000 to carry out subsection (a);

5 and

6 (B) \$25,000,000 to carry out subsection

7 (b), of which—

8 (i) 2 percent shall be for the provision
9 of technical assistance to grant recipients;

10 and

11 (ii) 5 percent shall be for independent
12 evaluation under subsection (b)(7).

13 **SEC. 416. RURAL HEALTH CARE SERVICES.**

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

16 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
17 **RURAL HEALTH NETWORK DEVELOPMENT,**
18 **DELTA RURAL DISPARITIES AND HEALTH**
19 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
20 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
21 **MENT GRANT PROGRAMS.**

22 “(a) PURPOSE.—The purpose of this section is to
23 provide for grants—

24 “(1) under subsection (b), to promote rural
25 health care services outreach;

1 “(2) under subsection (c), to provide for the
2 planning and implementation of integrated health
3 care networks in rural areas;

4 “(3) under subsection (d), to assist rural com-
5 munities in the Delta Region to reduce health dis-
6 parities and to promote and enhance health system
7 development; and

8 “(4) under subsection (e), to provide for the
9 planning and implementation of small rural health
10 care provider quality improvement activities.

11 “(b) RURAL HEALTH CARE SERVICES OUTREACH
12 GRANTS.—

13 “(1) GRANTS.—The Director of the Office of
14 Rural Health Policy of the Health Resources and
15 Services Administration (referred to in this section
16 as the ‘Director’) may award grants to eligible enti-
17 ties to promote rural health care services outreach
18 by expanding the delivery of health care services to
19 include new and enhanced services in rural areas.
20 The Director may award the grants for periods of
21 not more than 3 years.

22 “(2) ELIGIBILITY.—To be eligible to receive a
23 grant under this subsection for a project, an enti-
24 ty—

1 “(A) shall be a rural public or rural non-
2 profit private entity, a facility that qualifies as
3 a rural health clinic under title XVIII of the
4 Social Security Act, a public or nonprofit entity
5 existing exclusively to provide services to mi-
6 grant and seasonal farm workers in rural areas,
7 or a Tribal government whose grant-funded ac-
8 tivities will be conducted within federally recog-
9 nized Tribal areas;

10 “(B) shall represent a consortium com-
11 posed of members—

12 “(i) that include 3 or more independ-
13 ently owned health care entities; and

14 “(ii) that may be nonprofit or for-
15 profit entities; and

16 “(C) shall not previously have received a
17 grant under this subsection for the same or a
18 similar project, unless the entity is proposing to
19 expand the scope of the project or the area that
20 will be served through the project.

21 “(3) APPLICATIONS.—To be eligible to receive a
22 grant under this subsection, an eligible entity shall
23 prepare and submit to the Director an application at
24 such time, in such manner, and containing such in-
25 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) a description of the manner in which
5 the project funded under the grant will meet
6 the health care needs of rural populations in
7 the local community or region to be served;

8 “(C) a plan for quantifying how health
9 care needs will be met through identification of
10 the target population and benchmarks of service
11 delivery or health status, such as—

12 “(i) quantifiable measurements of
13 health status improvement for projects fo-
14 cusing on health promotion; or

15 “(ii) benchmarks of increased access
16 to primary care, including tracking factors
17 such as the number and type of primary
18 care visits, identification of a medical
19 home, or other general measures of such
20 access;

21 “(D) a description of how the local com-
22 munity or region to be served will be involved
23 in the development and ongoing operations of
24 the project;

1 “(E) a plan for sustaining the project after
2 Federal support for the project has ended;

3 “(F) a description of how the project will
4 be evaluated;

5 “(G) the administrative capacity to submit
6 annual performance data electronically as speci-
7 fied by the Director; and

8 “(H) other such information as the Direc-
9 tor determines to be appropriate.

10 “(c) RURAL HEALTH NETWORK DEVELOPMENT
11 GRANTS.—

12 “(1) GRANTS.—

13 “(A) IN GENERAL.—The Director may
14 award rural health network development grants
15 to eligible entities to promote, through planning
16 and implementation, the development of inte-
17 grated health care networks that have combined
18 the functions of the entities participating in the
19 networks in order to—

20 “(i) achieve efficiencies and economies
21 of scale;

22 “(ii) expand access to, coordinate, and
23 improve the quality of the health care de-
24 livery system through development of orga-
25 nizational efficiencies;

1 “(iii) implement health information
2 technology to achieve efficiencies, reduce
3 medical errors, and improve quality;

4 “(iv) coordinate care and manage
5 chronic illness; and

6 “(v) strengthen the rural health care
7 system as a whole in such a manner as to
8 show a quantifiable return on investment
9 to the participants in the network.

10 “(B) GRANT PERIODS.—The Director may
11 award such a rural health network development
12 grant—

13 “(i) for a period of 3 years for imple-
14 mentation activities; or

15 “(ii) for a period of 1 year for plan-
16 ning activities to assist in the initial devel-
17 opment of an integrated health care net-
18 work, if the proposed participants in the
19 network do not have a history of collabo-
20 rative efforts and a 3-year grant would be
21 inappropriate.

22 “(2) ELIGIBILITY.—To be eligible to receive a
23 grant under this subsection, an entity—

24 “(A) shall be a rural public or rural non-
25 profit private entity, a facility that qualifies as

1 a rural health clinic under title XVIII of the
2 Social Security Act, a public or nonprofit entity
3 existing exclusively to provide services to mi-
4 grant and seasonal farm workers in rural areas,
5 or a Tribal government whose grant-funded ac-
6 tivities will be conducted within federally recog-
7 nized Tribal areas;

8 “(B) shall represent a network composed
9 of participants—

10 “(i) that include 3 or more independ-
11 ently owned health care entities; and

12 “(ii) that may be nonprofit or for-
13 profit entities; and

14 “(C) shall not previously have received a
15 grant under this subsection (other than a 1-
16 year grant for planning activities) for the same
17 or a similar project.

18 “(3) APPLICATIONS.—To be eligible to receive a
19 grant under this subsection, an eligible entity, in
20 consultation with the appropriate State office of
21 rural health or another appropriate State entity,
22 shall prepare and submit to the Director an applica-
23 tion at such time, in such manner, and containing
24 such information as the Director may require, in-
25 cluding—

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—

8 “(i) the history of collaborative activi-
9 ties carried out by the participants in the
10 network;

11 “(ii) the degree to which the partici-
12 pants are ready to integrate their func-
13 tions; and

14 “(iii) how the local community or re-
15 gion to be served will benefit from and be
16 involved in the activities carried out by the
17 network;

18 “(D) a description of how the local com-
19 munity or region to be served will experience in-
20 creased access to quality health care services
21 across the continuum of care as a result of the
22 integration activities carried out by the net-
23 work, including a description of—

24 “(i) return on investment for the com-
25 munity and the network members; and

1 “(ii) other quantifiable performance
2 measures that show the benefit of the net-
3 work activities;

4 “(E) a plan for sustaining the project after
5 Federal support for the project has ended;

6 “(F) a description of how the project will
7 be evaluated;

8 “(G) the administrative capacity to submit
9 annual performance data electronically as speci-
10 fied by the Director; and

11 “(H) other such information as the Direc-
12 tor determines to be appropriate.

13 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
14 TEMS DEVELOPMENT GRANTS.—

15 “(1) GRANTS.—The Director may award grants
16 to eligible entities to support reduction of health dis-
17 parities, improve access to health care, and enhance
18 rural health system development in the Delta Re-
19 gion.

20 “(2) ELIGIBILITY.—To be eligible to receive a
21 grant under this subsection, an entity shall be a
22 rural public or rural nonprofit private entity, a facil-
23 ity that qualifies as a rural health clinic under title
24 XVIII of the Social Security Act, a public or non-
25 profit entity existing exclusively to provide services

1 to migrant and seasonal farm workers in rural
2 areas, or a Tribal government whose grant-funded
3 activities will be conducted within federally recog-
4 nized Tribal areas.

5 “(3) APPLICATIONS.—To be eligible to receive a
6 grant under this subsection, an eligible entity shall
7 prepare and submit to the Director an application at
8 such time, in such manner, and containing such in-
9 formation as the Director may require, including—

10 “(A) a description of the project that the
11 eligible entity will carry out using the funds
12 provided under the grant;

13 “(B) an explanation of the reasons why
14 Federal assistance is required to carry out the
15 project;

16 “(C) a description of the manner in which
17 the project funded under the grant will meet
18 the health care needs of the Delta Region;

19 “(D) a description of how the local com-
20 munity or region to be served will experience in-
21 creased access to quality health care services as
22 a result of the activities carried out by the enti-
23 ty;

1 “(E) a description of how health dispari-
2 ties will be reduced or the health system will be
3 improved;

4 “(F) a plan for sustaining the project after
5 Federal support for the project has ended;

6 “(G) a description of how the project will
7 be evaluated including process and outcome
8 measures related to the quality of care provided
9 or how the health care system improves its per-
10 formance;

11 “(H) a description of how the grantee will
12 develop an advisory group made up of rep-
13 resentatives of the communities to be served to
14 provide guidance to the grantee to best meet
15 community need; and

16 “(I) other such information as the Director
17 determines to be appropriate.

18 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
19 ITY IMPROVEMENT GRANTS.—

20 “(1) GRANTS.—The Director may award grants
21 to provide for the planning and implementation of
22 small rural health care provider quality improvement
23 activities. The Director may award the grants for
24 periods of 1 to 3 years.

1 “(2) ELIGIBILITY.—To be eligible for a grant
2 under this subsection, an entity—

3 “(A) shall be—

4 “(i) a rural public or rural nonprofit
5 private health care provider or provider of
6 health care services, such as a rural health
7 clinic; or

8 “(ii) another rural provider or net-
9 work of small rural providers identified by
10 the Director as a key source of local care;
11 and

12 “(B) shall not previously have received a
13 grant under this subsection for the same or a
14 similar project.

15 “(3) PREFERENCE.—In awarding grants under
16 this subsection, the Director shall give preference to
17 facilities that qualify as rural health clinics under
18 title XVIII of the Social Security Act.

19 “(4) APPLICATIONS.—To be eligible to receive a
20 grant under this subsection, an eligible entity shall
21 prepare and submit to the Director an application at
22 such time, in such manner, and containing such in-
23 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 assure
9 continuous quality improvement in the provision
10 of services by the entity;

11 “(D) a description of how the local com-
12 munity or region to be served will experience in-
13 creased access to quality health care services as
14 a result of the activities carried out by the enti-
15 ty;

16 “(E) a plan for sustaining the project after
17 Federal support for the project has ended;

18 “(F) a description of how the project will
19 be evaluated including process and outcome
20 measures related to the quality of care pro-
21 vided; and

22 “(G) other such information as the Direc-
23 tor determines to be appropriate.

24 “(f) GENERAL REQUIREMENTS.—

1 “(1) PROHIBITED USES OF FUNDS.—An entity
2 that receives a grant under this section may not use
3 funds provided through the grant—

4 “(A) to build or acquire real property; or
5 “(B) for construction.

6 “(2) COORDINATION WITH OTHER AGENCIES.—
7 The Director shall coordinate activities carried out
8 under grant programs described in this section, to
9 the extent practicable, with Federal and State agen-
10 cies and nonprofit organizations that are operating
11 similar grant programs, to maximize the effect of
12 public dollars in funding meritorious proposals.

13 “(g) REPORT.—Not later than September 30, 2020,
14 the Secretary shall prepare and submit to the appropriate
15 committees of Congress a report on the progress and ac-
16 complishments of the grant programs described in sub-
17 sections (b), (c), (d), and (e).

18 “(h) DEFINITION OF DELTA REGION.—In this sec-
19 tion, the term ‘Delta Region’ has the meaning given to
20 the term ‘region’ in section 382A of the Consolidated
21 Farm and Rural Development Act (7 U.S.C. 2009aa).

22 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 \$40,000,000 for fiscal year 2019, and such sums as may
25 be necessary for each of fiscal years 2020 through 2023.”.

1 **SEC. 417. COMMUNITY HEALTH CENTER COLLABORATIVE**
2 **ACCESS EXPANSION.**

3 Section 330(r)(4) of the Public Health Service Act
4 (42 U.S.C. 254b(r)(4)) is amended—

5 (1) in subparagraph (A), by striking “primary
6 health care services” each place it appears and in-
7 serting “primary health care and other mental, den-
8 tal, and physical health services”; and

9 (2) in subparagraph (B)—

10 (A) in clause (i), by striking “; and” and
11 inserting “;”;

12 (B) in clause (ii), by striking the period
13 and inserting “; and”; and

14 (C) by adding at the end the following:

15 “(iii) in the case of a rural health
16 clinic described in such subparagraph—

17 “(I) that such clinic provides, to
18 the extent possible, enabling services,
19 such as transportation and language
20 assistance (including translation and
21 interpretation); and

22 “(II) that the primary health
23 care and other services described in
24 such subparagraph are subject to full
25 reimbursement according to the pro-
26 spective payment system for Federally

1 qualified health center services under
2 section 1834(o) of the Social Security
3 Act.”.

4 **SEC. 418. FACILITATING THE PROVISION OF TELEHEALTH**
5 **SERVICES ACROSS STATE LINES.**

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

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

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

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

23 (3) MEDICARE PROGRAM.—The term “Medicare
24 Program” means the program of health insurance
25 administered by the Secretary of Health and Human

1 Services under title XVIII of the Social Security Act
2 (42 U.S.C. 1395 et seq.).

3 **SEC. 419. SCORING OF PREVENTIVE HEALTH SAVINGS.**

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

7 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

8 “(1) DETERMINATION BY THE DIRECTOR.—

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

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

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

1 budgetary outyears and a description of the
2 basis for such conclusions; and

3 “(B) may prepare a budget projection that
4 includes some or all of the budgetary outyears,
5 notwithstanding the time periods for projections
6 described in subsection (e) and sections 308,
7 402, and 424.

8 “(3) DEFINITIONS.—As used in this sub-
9 section—

10 “(A) the term ‘budgetary outyears’ means
11 the 2 consecutive 10-year periods beginning
12 with the first fiscal year that is 10 years after
13 the budget year provided for in the most re-
14 cently agreed to concurrent resolution on the
15 budget; and

16 “(B) the term ‘preventive health’ means an
17 action that focuses on the health of the public,
18 individuals, and defined populations in order to
19 protect, promote, and maintain health, wellness,
20 and functional ability, and prevent disease, dis-
21 ability, and premature death that is dem-
22 onstrated by credible and publicly available epi-
23 demiological projection models, incorporating
24 clinical trials or observational studies in hu-
25 mans, to avoid future health care costs.”.

1 **SEC. 420. SENSE OF CONGRESS ON MAINTENANCE OF EF-**
2 **FORT PROVISIONS REGARDING CHILDREN'S**
3 **HEALTH.**

4 It is the sense of the Congress that—

5 (1) the maintenance of effort provisions added
6 to sections 1902 and 2105(d) of the Social Security
7 Act by sections 2001(b) and 2101(b) of the Patient
8 Protection and Affordable Care Act were intended to
9 maintain the eligibility standards for the Medicaid
10 program under title XIX of the Social Security Act
11 and Children's Health Insurance Program under
12 title XXI of such Act until the American Health
13 Benefit Exchanges in the States are fully oper-
14 ational;

15 (2) it is imperative that the maintenance of ef-
16 fort provisions are enforced to the strict standard in-
17 tended by the Congress through September 30,
18 2027;

19 (3) waiving the maintenance of effort provisions
20 should not be permitted;

21 (4) the maintenance of effort provisions ensure
22 the continued success of the Medicaid program and
23 Children's Health Insurance Program and were in-
24 tended to specifically protect vulnerable and disabled
25 adults, children, and senior citizens, many of whom
26 are also members of communities of color; and

1 (5) the maintenance of effort provisions must
2 be strictly enforced and proposals to weaken the
3 maintenance of effort provisions must not be consid-
4 ered.

5 **SEC. 421. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
6 **TION EVIDENCING CITIZENSHIP OR NATION-**
7 **ALITY UNDER THE MEDICAID PROGRAM.**

8 (a) REPEAL.—Subsections (i)(22) and (x) of section
9 1903 of the Social Security Act (42 U.S.C. 1396b) are
10 each repealed.

11 (b) CONFORMING AMENDMENTS.—

12 (1) Section 1902 of the Social Security Act (42
13 U.S.C. 1396a) is amended—

14 (A) by amending paragraph (46) of sub-
15 section (a) to read as follows:

16 “(46) provide that information is requested and
17 exchanged for purposes of income and eligibility
18 verification in accordance with a State system which
19 meets the requirements of section 1137 of this
20 Act;”;

21 (B) in subsection (e)(13)(A)(i)—

22 (i) in the matter preceding subclause
23 (I), by striking “sections 1902(a)(46)(B)
24 and 1137(d)” and inserting “section
25 1137(d)”; and

1 (ii) in subclause (IV), by striking
2 “1902(a)(46)(B) or”; and
3 (C) by striking subsection (ee).

4 (2) Section 1903 of the Social Security Act (42
5 U.S.C. 1396b) is amended—

6 (A) in subsection (i), by redesignating
7 paragraphs (23) through (26) as paragraphs
8 (22) through (25), respectively; and

9 (B) by redesignating subsections (y) and
10 (z) as subsections (x) and (y), respectively.

11 (3) Subsection (c) of section 6036 of the Deficit
12 Reduction Act of 2005 (42 U.S.C. 1396b note) is re-
13 pealed.

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

17 **SEC. 422. PROTECTION OF THE HHS OFFICES OF MINORITY**
18 **HEALTH.**

19 (a) IN GENERAL.—Pursuant to section 1707A of the
20 Public Health Service Act (42 U.S.C. 300u–6a), the Of-
21 fices of Minority Health established within the Centers for
22 Disease Control and Prevention, the Health Resources
23 and Services Administration, the Substance Abuse and
24 Mental Health Services Administration, the Agency for
25 Healthcare Research and Quality, the Food and Drug Ad-

1 ministration, and the Centers for Medicare & Medicaid
 2 Services, are offices that, regardless of change in the
 3 structure of the Department of Health and Human Serv-
 4 ices, shall report to the Secretary of Health and Human
 5 Services.

6 (b) SENSE OF CONGRESS.—It is the sense of the
 7 Congress that any effort to eliminate or consolidate such
 8 Offices of Minority Health undermines the progress
 9 achieved so far.

10 **SEC. 423. OFFICE OF MINORITY HEALTH IN VETERANS**
 11 **HEALTH ADMINISTRATION OF DEPARTMENT**
 12 **OF VETERANS AFFAIRS.**

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

16 **“§ 7310. Office of Minority Health**

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

21 “(b) HEAD.—The Director of the Office of Minority
 22 Health shall be the head of the Office. The Director of
 23 the Office of Minority Health shall be appointed by the
 24 Under Secretary for Health from among individuals quali-
 25 fied to perform the duties of the position.

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

3 “(1) To establish short-range and long-range
4 goals and objectives and coordinate all other activi-
5 ties within the Veterans Health Administration that
6 relate to disease prevention, health promotion, health
7 care services delivery, and health care research con-
8 cerning veterans who are members of a racial or eth-
9 nic minority group.

10 “(2) To support research, demonstrations, and
11 evaluations to test new and innovative models for
12 the discharge of activities described in paragraph
13 (1).

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

17 “(4) To develop mechanisms that support bet-
18 ter health care information dissemination, education,
19 prevention, and services delivery to veterans from
20 disadvantaged backgrounds, including veterans who
21 are members of a racial or ethnic minority group.

22 “(5) To enter into contracts or agreements with
23 appropriate public and nonprofit private entities to
24 develop and carry out programs to provide bilingual
25 or interpretive services to assist veterans who are

1 members of a racial or ethnic minority group and
2 who lack proficiency in speaking the English lan-
3 guage in accessing and receiving health care services
4 through the Veterans Health Administration.

5 “(6) To carry out programs to improve access
6 to health care services through the Veterans Health
7 Administration for veterans with limited proficiency
8 in speaking the English language, including the de-
9 velopment and evaluation of demonstration and pilot
10 projects for that purpose.

11 “(7) To advise the Under Secretary for Health
12 on matters relating to the development, implementa-
13 tion, and evaluation of health professions education
14 in decreasing disparities in health care outcomes be-
15 tween veterans who are members of a racial or eth-
16 nic minority group and other veterans, including cul-
17 tural competency as a method of eliminating such
18 health disparities.

19 “(8) To perform such other functions and du-
20 ties as the Secretary or the Under Secretary for
21 Health considers appropriate.

22 “(d) DEFINITIONS.—In this section:

23 “(1) The term ‘racial or ethnic minority group’
24 means any of the following:

1 “(A) American Indians (including Alaska
2 Natives, Eskimos, and Aleuts).

3 “(B) Asian Americans.

4 “(C) Native Hawaiians and other Pacific
5 Islanders.

6 “(D) Blacks.

7 “(E) Hispanics.

8 “(2) The term ‘Hispanic’ means individuals
9 whose origin is Mexican, Puerto Rican, Cuban, Cen-
10 tral or South American, or any other Spanish-speak-
11 ing country.”.

12 (b) CLERICAL AMENDMENT.—The table of sections
13 at the beginning of such chapter is amended by inserting
14 after the item relating to section 7309A the following new
15 item:

 “7310. Office of Minority Health.”.

16 **SEC. 424. INDIAN DEFINED IN TITLE I OF PPACA.**

17 (a) DEFINITION OF INDIAN.—Section 1304 of the
18 Patient Protection and Affordable Care Act (42 U.S.C.
19 18024) is amended by adding at the end the following:

20 “(f) INDIAN.—

21 “(1) IN GENERAL.—In this title, the term ‘In-
22 dian’ means any individual—

23 “(A) described in paragraph (13) or (28)
24 of section 4 of the Indian Health Care Improve-
25 ment Act (25 U.S.C. 1603);

1 “(B) who is eligible for health services pro-
2 vided by the Indian Health Service under sec-
3 tion 809 of the Indian Health Care Improve-
4 ment Act (25 U.S.C. 1679);

5 “(C) who is of Indian descent and belongs
6 to the Indian community served by the local fa-
7 cilities and program of the Indian Health Serv-
8 ice; or

9 “(D) who is described in paragraph (2).

10 “(2) INCLUSIONS.—An individual is described
11 in this paragraph if the individual is any of the fol-
12 lowing:

13 “(A) A member of a federally recognized
14 Indian Tribe.

15 “(B) A resident of an urban center who
16 meets any of the following criteria:

17 “(i) Membership in a Tribe, band, or
18 other organized group of Indians, including
19 those Tribes, bands, or groups terminated
20 since 1940 and those recognized as of the
21 date of enactment of the Health Equity
22 and Accountability Act of 2018 or later by
23 the State in which they reside, or being a
24 descendant, in the first or second degree,
25 of any such member.

1 “(ii) Is an Eskimo or Aleut or other
2 Alaska Native.

3 “(iii) Is considered by the Secretary of
4 the Interior to be an Indian for any pur-
5 pose.

6 “(iv) Is determined to be an Indian
7 under regulations promulgated by the Sec-
8 retary.

9 “(C) An individual who is considered by
10 the Secretary of the Interior to be an Indian for
11 any purpose.

12 “(D) An individual who is considered by
13 the Secretary to be an Indian for purposes of
14 eligibility for Indian health care services, includ-
15 ing as a California Indian, Eskimo, Aleut, or
16 other Alaska Native.”.

17 (b) CONFORMING AMENDMENTS.—

18 (1) AFFORDABLE CHOICES HEALTH BENEFIT
19 PLANS.—Section 1311(c)(6)(D) of the Patient Pro-
20 tection and Affordable Care Act (42 U.S.C.
21 18031(c)(6)(D)) is amended by striking “(as defined
22 in section 4 of the Indian Health Care Improvement
23 Act)”.

24 (2) REDUCED COST-SHARING FOR INDIVIDUALS
25 ENROLLING IN QUALIFIED HEALTH PLANS.—Section

1 1402(d) of the Patient Protection and Affordable
 2 Care Act (42 U.S.C. 18071(d)) is amended—

3 (A) in paragraph (1), in the matter pre-
 4 ceeding subparagraph (A), by striking “(as de-
 5 fined in section 4(d) of the Indian Self-Deter-
 6 mination and Education Assistance Act (25
 7 U.S.C. 450b(d))”; and

8 (B) in paragraph (2), in the matter pre-
 9 ceeding subparagraph (A), by striking “(as so
 10 defined)”.

11 (3) EXEMPTION FROM PENALTY FOR NOT
 12 MAINTAINING MINIMUM ESSENTIAL COVERAGE.—
 13 Section 5000A(e) of the Internal Revenue Code of
 14 1986 is amended by striking paragraph (3) and in-
 15 serting the following:

16 “(3) INDIANS.—Any applicable individual who
 17 is an Indian (as defined in section 1304(f) of the
 18 Patient Protection and Affordable Care Act).”.

19 **SEC. 425. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
 20 **ACCESS FOR LOW-INCOME PATIENTS.**

21 (a) IN GENERAL.—Not later than January 1, 2019,
 22 the Comptroller General of the United States shall con-
 23 duct a study on how amendments made by the Patient
 24 Protection and Affordable Care Act (Public Law 111–
 25 148) and the Health Care and Education Reconciliation

1 Act of 2010 (Public Law 111–152) to titles XVIII and
2 XIX of the Social Security Act (42 U.S.C. 1395 et seq.,
3 1396 et seq.) relating to disproportionate share hospital
4 adjustment payments under Medicare and Medicaid (and
5 subsequent amendments made with respect to such pay-
6 ments) affect the timely access to health care services for
7 low-income patients. Such study shall—

8 (1) evaluate and examine whether States elect-
9 ing to make medical assistance available under sec-
10 tion 1902(a)(10)(A)(i)(VIII) of the Social Security
11 Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including
12 States making such an election through a waiver of
13 the State plan) to individuals described in such sec-
14 tion mitigate the need for payments to dispropor-
15 tionate share hospitals under section 1886(d)(5)(F)
16 of the Social Security Act (42 U.S.C.
17 1395ww(d)(5)(F)) and section 1923 of such Act (42
18 U.S.C. 1396r–4), including the impact of such
19 States electing to make medical assistance available
20 to such individuals on—

21 (A) the number of individuals in the
22 United States who are without health insurance
23 and the distribution of such individuals in rela-
24 tion to areas primarily served by dispropor-
25 tionate share hospitals; and

1 (B) the low-income utilization rate of such
2 hospitals and the resulting fiscal sustainability
3 of such hospitals;

4 (2) evaluate the appropriate level and distribu-
5 tion of such payments among such disproportionate
6 share hospitals for purposes of—

7 (A) sufficiently accounting for the level of
8 uncompensated care provided by such hospitals
9 to low-income patients; and

10 (B) providing timely access to health serv-
11 ices for individuals in medically underserved
12 areas; and

13 (3) assess, with respect to such disproportionate
14 share hospitals—

15 (A) the role played by such hospitals in
16 providing critical access to emergency, inpa-
17 tient, and outpatient health services, as well as
18 the location of such hospitals in relation to
19 medically underserved areas; and

20 (B) the extent to which such hospitals sat-
21 isfy the requirements established for charitable
22 hospital organizations under section 501(r) of
23 the Internal Revenue Code of 1986 with respect
24 to community health needs assessments, finan-
25 cial assistance policy requirements, limitations

1 on charges, and billing and collection require-
2 ments.

3 (b) REPORTS.—

4 (1) REPORT TO CONGRESS.—Not later than
5 180 days after the date on which the study under
6 subsection (a) is completed, the Comptroller General
7 of the United States shall submit to the Committee
8 on Energy and Commerce of the House of Rep-
9 resentatives and the Committee on Finance of the
10 Senate a report that contains—

11 (A) the results of the study;

12 (B) recommendations to Congress for any
13 legislative changes to the payments to dis-
14 proportionate share hospitals under section
15 1886(d)(5)(F) of the Social Security Act (42
16 U.S.C. 1395ww(d)(5)(F)) and section 1923 of
17 such Act (42 U.S.C. 1396r-4) that are needed
18 to ensure access to health services for low-in-
19 come patients that—

20 (i) are based on the number of indi-
21 viduals without health insurance, the
22 amount of uncompensated care provided by
23 such hospitals, and the impact of reduced
24 payment levels on low-income communities;
25 and

1 (ii) takes into account any reports
2 submitted by the Secretary of the Treas-
3 ury, in consultation with the Secretary of
4 Health and Human Services, to Congres-
5 sional committees regarding the costs in-
6 curred by charitable hospital organizations
7 for charity care, bad debt, nonreimbursed
8 expenses for services provided to individ-
9 uals under the Medicare program under
10 title XVIII of the Social Security Act and
11 the Medicaid program under title XIX of
12 such Act, and any community benefit ac-
13 tivities provided by such organizations.

14 (2) REPORT TO THE SECRETARY OF HEALTH
15 AND HUMAN SERVICES.—Not later than 180 days
16 after the date on which the study under subsection
17 (a) is completed, the Comptroller General of the
18 United States shall submit to the Secretary of
19 Health and Human Services a report that con-
20 tains—

21 (A) the results of the study; and

22 (B) any recommendations for purposes of
23 assisting in the development of the methodology
24 for the adjustment of payments to dispropor-
25 tionate share hospitals, as required under sec-

1 tion 1886(r) of the Social Security Act (42
 2 U.S.C. 1395ww(r)) and the reduction of such
 3 payments under section 1923(f)(7) of such Act
 4 (42 U.S.C. 1396r-4(f)(7)), taking into account
 5 the reports referred to in paragraph (1)(B)(ii).

6 **SEC. 426. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
 7 **SERVICE.**

8 (a) REFERENCES.—Any reference in a law, regula-
 9 tion, document, paper, or other record of the United
 10 States to the Director of the Indian Health Service shall
 11 be deemed to be a reference to the Assistant Secretary
 12 of the Indian Health Service.

13 (b) EXECUTIVE SCHEDULE.—Section 5315 of title 5,
 14 United States Code, is amended in the matter relating to
 15 the Assistant Secretaries of Health and Human Services
 16 by striking “(6)” and inserting “(7), 1 of whom shall be
 17 the Assistant Secretary of the Indian Health Service”.

18 (c) CONFORMING AMENDMENT.—Section 5316 of
 19 title 5, United States Code, is amended by striking “Direc-
 20 tor, Indian Health Service, Department of Health and
 21 Human Services.”.

22 **SEC. 427. REAUTHORIZATION OF THE NATIVE HAWAIIAN**
 23 **HEALTH CARE IMPROVEMENT ACT.**

24 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
 25 Section 6(h)(1) of the Native Hawaiian Health Care Im-

1 provement Act (42 U.S.C. 11705(h)(1)) is amended by
2 striking “may be necessary for fiscal years 1993 through
3 2019” and inserting “are necessary”.

4 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
5 LOKAHI.—Section 7(b) of the Native Hawaiian Health
6 Care Improvement Act (42 U.S.C. 11706(b)) is amended
7 by striking “may be necessary for fiscal years 1993
8 through 2019” and inserting “are necessary”.

9 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
10 Section 10(c) of the Native Hawaiian Health Care Im-
11 provement Act (42 U.S.C. 11709(c)) is amended by strik-
12 ing “may be necessary for fiscal years 1993 through
13 2019” and inserting “are necessary”.

14 **SEC. 428. AVAILABILITY OF NON-ENGLISH LANGUAGE**
15 **SPEAKING PROVIDERS.**

16 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
17 tient Protection and Affordable Care Act (42 U.S.C.
18 18031(c)(1)(B)) is amended by inserting before the semi-
19 colon the following: “and the ability of such provider to
20 provide care in a language other than English either
21 through the provider speaking such language or by the
22 provider having a qualified interpreter for an individual
23 with limited-English proficiency (as defined in section
24 3400 of such Act) who speaks such language available
25 during office hours”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall not apply to any plan beginning on
3 or prior to the date that is 1 year after the date of the
4 enactment of this Act.

5 **SEC. 429. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.**

6 (a) ESSENTIAL COMMUNITY PROVIDERS.—Section
7 1311(c)(1)(C) of the Patient Protection and Affordable
8 Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

9 (1) by inserting “(i)” after “(C)”; and

10 (2) by adding at the end the following new
11 clauses:

12 “(ii) not later than January 1, 2020, in-
13 crease the percentage of essential community
14 providers as described in clause (i) included in
15 its network by 10 percent annually (based on
16 the level in the plan for 2016) until 90 percent
17 of all federally-qualified health centers and 75
18 percent of all other such essential community
19 providers in the contract service area are in-net-
20 work; and

21 “(iii) include at least one essential commu-
22 nity provider in each of the essential community
23 provider categories described in section
24 156.235(a)(2)(ii)(B) of title 45, Code of Fed-
25 eral Regulations (as in effect on the date of en-

1 actment of the Health Equity and Account-
 2 ability Act of 2018) in each county in the serv-
 3 ice area, where available;”.

4 (b) REPORTING REQUIREMENTS.—Section
 5 1311(e)(3) of the Patient Protection and Affordable Care
 6 Act (42 U.S.C. 18031(e)(3)) is amended by adding at the
 7 end the following new subparagraph:

8 “(E) DATA ON ESSENTIAL COMMUNITY
 9 PROVIDERS.—The Secretary shall require quali-
 10 fied health plans to submit annually to the Sec-
 11 retary data on the percentage of essential com-
 12 munity providers as described in clause (ii) of
 13 subsection (e)(1)(C), by county, that contract
 14 with each qualified health plan offered in that
 15 county and the percentage of such essential
 16 community providers, by category as described
 17 in clause (iii) of such subsection, that contract
 18 with each qualified health plan offered in that
 19 county. Such data shall be made available to
 20 the general public.”.

21 (c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS
 22 APPLIED UNDER MEDICARE AND MEDICAID.—

23 (1) MEDICARE.—Section 1852(d)(1) of the So-
 24 cial Security Act (42 U.S.C. 1395w-22(d)(1)) is
 25 amended—

1 (A) by striking “and” at the end of sub-
2 paragraph (D);

3 (B) by striking the period at the end of
4 subparagraph (E) and inserting “; and”; and

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

7 “(F) the plan meets the requirements of
8 clauses (ii) and (iii) of section 1311(c)(1)(C) of
9 the Patient Protection and Affordable Care Act
10 (relating to inclusion in networks of essential
11 community providers).”.

12 (2) MEDICAID.—Section 1932(b)(5) of the So-
13 cial Security Act (42 U.S.C. 1396u–2(b)(5)) is
14 amended—

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

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

19 (C) by adding at the end the following new
20 subparagraph:

21 “(C) meets the requirements of clauses (ii)
22 and (iii) of section 1311(c)(1)(C) of the Patient
23 Protection and Affordable Care Act (relating to
24 inclusion in networks of essential community

1 providers) with respect to services offered in the
2 service area involved.”.

3 **SEC. 430. PROVIDER NETWORK ADEQUACY IN COMMU-**
4 **NITIES OF COLOR.**

5 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
6 tient Protection and Affordable Care Act (42 U.S.C.
7 18031(c)(1)(B)), as amended by section 428(a), is further
8 amended—

9 (1) by inserting “(i)” after “(B)”; and

10 (2) by adding at the end the following the fol-
11 lowing new clauses:

12 “(ii) meet such network adequacy
13 standards as the Secretary may establish
14 with regard to—

15 “(I) appointment wait time;

16 “(II) travel time and distance to
17 health care provider facilities and pro-
18 viders by public and private transit;

19 “(III) hours of operation to ac-
20 commodate individuals who cannot
21 come to provider appointments during
22 standard business hours; and

23 “(IV) other network adequacy
24 standards to ensure that care through
25 these plans is accessible to diverse

1 communities, including individuals
2 with limited-English proficiency as de-
3 fined in section 3400 of such Act; and
4 “(iii) provide coverage for services for
5 enrollees through out-of-network providers
6 at no additional cost to the enrollees in
7 cases where in-network providers are un-
8 able to comply with the standards estab-
9 lished under subclause (III) or (IV) of
10 clause (ii) for such services and the out-of-
11 network providers can deliver such services
12 in compliance with such standards.

13 “(b) EFFECTIVE DATE.—The amendments made by
14 subsection (a) shall not apply to plans beginning on or
15 prior to the date that is 1 year after the date of the enact-
16 ment of this Act.”.

17 **SEC. 431. IMPROVING ACCESS TO DENTAL CARE.**

18 (a) REPORTS TO CONGRESS.—

19 (1) GAO REPORTS.—Not later than 1 year
20 after the date of the enactment of this Act, the
21 Comptroller General of the United States shall sub-
22 mit to Congress—

23 (A) a report on the Alaska Dental Health
24 Aide Therapists program and the Dental Ther-
25 apist and Advanced Dental Therapist programs

1 in Minnesota, to assess the effectiveness of den-
2 tal therapists in—

3 (i) improving access to timely dental
4 care among communities of color;

5 (ii) providing high quality care; and

6 (iii) providing culturally competent
7 care; and

8 (B) a report on State variations in the use
9 of dental hygienists and the effectiveness of ex-
10 panding the scope of practice for dental hygien-
11 ists in—

12 (i) improving access to timely dental
13 care among communities of color;

14 (ii) providing high quality care; and

15 (iii) providing culturally competent
16 care.

17 (2) HRSA REPORT ON DENTAL SHORTAGE
18 AREAS.—Not later than 1 year after the date of the
19 enactment of this Act, the Secretary of Health and
20 Human Services, acting through the Administrator
21 of the Health Resources and Services Administra-
22 tion, shall submit to Congress a report which details
23 geographic dental access shortages and the pre-
24 paredness of dental providers to offer culturally and

1 linguistically appropriate, affordable, accessible, and
2 timely services.

3 (b) EXPANSION OF DENTAL HEALTH AID THERA-
4 PISTS IN TRIBAL COMMUNITIES.—Section 119(d) of the
5 Indian Health Care Improvement Act (25 U.S.C.
6 1616l(d)) is amended—

7 (1) in paragraph (2), by striking “Subject to”
8 and all that follows and inserting “Subject to para-
9 graph (3), in establishing a national program under
10 paragraph (1), the Secretary shall not reduce the
11 amounts provided for the Community Health Aide
12 Program described in subsections (a) and (b).”;

13 (2) by striking paragraph (3); and

14 (3) by redesignating paragraph (4) as para-
15 graph (3).

16 (c) COVERAGE OF DENTAL SERVICES UNDER THE
17 MEDICARE PROGRAM.—

18 (1) COVERAGE.—Section 1861(s)(2) of the So-
19 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
20 ed—

21 (A) in subparagraph (FF), by striking
22 “and” at the end;

23 (B) in subparagraph (GG), by adding
24 “and” after the semicolon at the end; and

1 (C) by adding at the end the following new
2 subparagraph:

3 “(HH) oral health services (as defined in sub-
4 section (kkk));”.

5 (2) ORAL HEALTH SERVICES DEFINED.—Sec-
6 tion 1861 of the Social Security Act (42 U.S.C.
7 1395x), as amended by sections 205(b) and 413(a),
8 is amended by adding at the end the following new
9 subsection:

10 “Oral Health Services

11 “(kkk)(1) The term ‘oral health services’ means serv-
12 ices (as defined by the Secretary) that are necessary to
13 prevent disease and promote oral health, restore oral
14 structures to health and function, and treat emergency
15 conditions.

16 “(2) For purposes of paragraph (1), such term shall
17 include mobile and portable oral health services (as de-
18 fined by the Secretary) that—

19 “(A) are provided for the purpose of over-
20 coming mobility, transportation, and access barriers
21 for individuals; and

22 “(B) satisfy the standards and certification re-
23 quirements established under section 1902(a)(82)(B)
24 for the State in which the services are provided.”.

1 (3) PAYMENT AND COINSURANCE.—Section
2 1833(a)(1) of the Social Security Act (42 U.S.C.
3 1395l(a)(1)) is amended—

4 (A) by striking “and” before “(BB)”; and

5 (B) by inserting before the semicolon at
6 the end the following: “, and (CC) with respect
7 to oral health services (as defined in section
8 1861(kkk)), the amount paid shall be (i) in the
9 case of such services that are preventive, 100
10 percent of the lesser of the actual charge for
11 the services or the amount determined under
12 the payment basis determined under section
13 1848, and (ii) in the case of all other such serv-
14 ices, 80 percent of the lesser of the actual
15 charge for the services or the amount deter-
16 mined under the payment basis determined
17 under section 1848”.

18 (4) PAYMENT UNDER PHYSICIAN FEE SCHED-
19 ULE.—Section 1848(j)(3) of the Social Security Act
20 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
21 “(2)(HH),” after “risk assessment),”.

22 (5) DENTURES.—Section 1861(s)(8) of the So-
23 cial Security Act (42 U.S.C. 1395x(s)(8)) is amend-
24 ed—

1 (A) by striking “(other than dental)” and
2 inserting “(including dentures)”; and

3 (B) by striking “internal body”.

4 (6) REPEAL OF GROUND FOR EXCLUSION.—
5 Section 1862(a) of the Social Security Act (42
6 U.S.C. 1395y) is amended by striking paragraph
7 (12).

8 (7) EFFECTIVE DATE.—The amendments made
9 by this section shall apply to services furnished on
10 or after January 1, 2019.

11 (d) COVERAGE OF DENTAL SERVICES UNDER THE
12 MEDICAID PROGRAM.—

13 (1) IN GENERAL.—Section 1905 of the Social
14 Security Act (42 U.S.C. 1396d) is amended—

15 (A) in subsection (a)(10), by striking “den-
16 tal services” and inserting “oral health services
17 (as defined in subsection (ee)(1))”; and

18 (B) by adding at the end the following new
19 subsection:

20 “(ee)(1) Subject to paragraphs (2) and (3), for pur-
21 poses of this title, the term ‘oral health services’ means
22 services (as defined by the Secretary) that are necessary
23 to prevent disease and promote oral health, restore oral
24 structures to health and function, and treat emergency
25 conditions. These services shall include, in the case of

1 pregnant or postpartum women, such services as are nec-
 2 essary to address oral health conditions that exist or are
 3 exacerbated by pregnancy or childbirth or which, if left
 4 untreated, could adversely affect fetal or child develop-
 5 ment.

6 “(2) For purposes of paragraph (1), such term shall
 7 include—

8 “(A) dentures; and

9 “(B) mobile and portable oral health services
 10 (as defined by the Secretary) that—

11 “(i) are provided for the purpose of over-
 12 coming mobility, transportation, and access bar-
 13 riers for individuals; and

14 “(ii) satisfy the standards and certification
 15 requirements established under section
 16 1902(a)(84)(C) for the State in which the serv-
 17 ices are provided.

18 “(3) For purposes of paragraph (1), such term shall
 19 not include dental care or services provided to individuals
 20 under the age of 21 under subsection (r)(3).”.

21 (2) CONFORMING AMENDMENTS.—

22 (A) STATE PLAN REQUIREMENTS.—Section
 23 1902(a) of the Social Security Act (42 U.S.C.
 24 1396a(a)) is amended—

1 (i) in paragraph (10)(A), in the mat-
2 ter preceding clause (i), by inserting
3 “(10),” after “(5),”;

4 (ii) in paragraph (82), by striking
5 “and” at the end;

6 (iii) in paragraph (83), by striking the
7 period at the end and inserting “; and”;
8 and

9 (iv) by inserting after paragraph (83)
10 the following:

11 “(84) provide for—

12 “(A) informing, in writing, all individuals
13 who have been determined to be eligible for
14 medical assistance of the availability of oral
15 health services (as defined in section 1905(ee));

16 “(B) conducting targeted outreach to preg-
17 nant women who have been determined to be el-
18 igible for medical assistance about the avail-
19 ability of medical assistance for such dental
20 services and the importance of receiving dental
21 care while pregnant; and

22 “(C) establishing and maintaining stand-
23 ards for and certification of mobile and portable
24 oral health services (as described in subsections
25 (r)(3)(C) and (ee)(2)(B) of section 1905).”.

1 (B) DEFINITION OF MEDICAL ASSIST-
2 ANCE.—Section 1905(a)(12) of the Social Secu-
3 rity Act (42 U.S.C. 1396d(a)(12)) is amended
4 by striking “, dentures,”.

5 (3) MOBILE AND PORTABLE ORAL HEALTH
6 SERVICES UNDER EPSDT.—Section 1905(r)(3) of the
7 Social Security Act (42 U.S.C. 1396d(r)(3)) is
8 amended—

9 (A) in subparagraph (A)(ii), by striking “;
10 and” and inserting a semicolon;

11 (B) in subparagraph (B), by striking the
12 period at the end and inserting “; and”; and

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

15 “(C) which shall include mobile and port-
16 able oral health services (as defined by the Sec-
17 retary) that—

18 “(i) are provided for the purpose of
19 overcoming mobility, transportation, or ac-
20 cess barriers for children; and

21 “(ii) satisfy the standards and certifi-
22 cation requirements established under sec-
23 tion 1902(a)(82)(C) for the State in which
24 the services are provided.”.

1 (e) ORAL HEALTH SERVICES AS AN ESSENTIAL
2 HEALTH BENEFIT.—Section 1302(b) of the Patient Pro-
3 tection and Affordable Care Act (42 U.S.C. 18022(b)) is
4 amended—

5 (1) in paragraph (1)—

6 (A) in subparagraph (J), by striking “oral
7 and”; and

8 (B) by adding at the end the following:

9 “(K) Oral health services for children and
10 adults.”; and

11 (2) by adding at the end the following:

12 “(6) ORAL HEALTH SERVICES.—For purposes
13 of paragraph (1)(K), the term ‘oral health services’
14 means services (as defined by the Secretary), that
15 are necessary to prevent any oral disease and pro-
16 mote oral health, restore oral structures to health
17 and function, and treat emergency oral conditions.”.

18 (f) DEMONSTRATION PROGRAM ON TRAINING AND
19 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
20 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
21 VETERANS IN RURAL AND OTHER UNDERSERVED COM-
22 MUNITIES.—

23 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

24 The Secretary of Veterans Affairs may carry out a
25 demonstration program to establish programs to

1 train and employ alternative dental health care pro-
2 viders in order to increase access to dental health
3 care services for veterans who are entitled to such
4 services from the Department of Veterans Affairs
5 and reside in rural and other underserved commu-
6 nities.

7 (2) TELEHEALTH.—For purposes of alternative
8 dental health care providers and other dental care
9 providers who are licensed to provide clinical care,
10 dental services provided under the demonstration
11 program under this subsection may be administered
12 by such providers through telehealth-enabled collabo-
13 ration and supervision when appropriate and fea-
14 sible.

15 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
16 VIDERS DEFINED.—In this subsection, the term “al-
17 ternative dental health care providers” has the
18 meaning given that term in section 340G–1(a)(2) of
19 the Public Health Service Act (42 U.S.C. 256g–
20 1(a)(2)).

21 (4) AUTHORIZATION OF APPROPRIATIONS.—
22 There are authorized to be appropriated such sums
23 as are necessary to carry out the demonstration pro-
24 gram under this subsection.

1 (g) DEMONSTRATION PROGRAM ON TRAINING AND
2 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
3 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
4 MEMBERS OF THE ARMED FORCES AND DEPENDENTS
5 LACKING READY ACCESS TO SUCH SERVICES.—

6 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

7 The Secretary of Defense may carry out a dem-
8 onstration program to establish programs to train
9 and employ alternative dental health care providers
10 in order to increase access to dental health care
11 services for members of the Armed Forces and their
12 dependents who lack ready access to such services,
13 including the following:

14 (A) Members and dependents who reside in
15 rural areas or areas otherwise underserved by
16 dental health care providers.

17 (B) Members of the National Guard and
18 Reserves in active status who are potentially
19 deployable.

20 (2) TELEHEALTH.—For purposes of alternative
21 dental health care providers and other dental care
22 providers who are licensed to provide clinical care,
23 dental services provided under the demonstration
24 program under this subsection may be administered
25 by such providers through telehealth-enabled collabo-

1 ration and supervision when appropriate and fea-
2 sible.

3 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
4 VIDERS DEFINED.—In this subsection, the term “al-
5 ternative dental health care providers” has the
6 meaning given that term in section 340G–1(a)(2) of
7 the Public Health Service Act (42 U.S.C. 256g–
8 1(a)(2)).

9 (4) AUTHORIZATION OF APPROPRIATIONS.—
10 There are authorized to be appropriated such sums
11 as are necessary to carry out the demonstration pro-
12 gram under this subsection.

13 (h) DEMONSTRATION PROGRAM ON TRAINING AND
14 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
15 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
16 PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF
17 PRISONS.—

18 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
19 The Attorney General, acting through the Director
20 of the Bureau of Prisons, may carry out a dem-
21 onstration program to establish programs to train
22 and employ alternative dental health care providers
23 in order to increase access to dental health services
24 for prisoners within the custody of the Bureau of
25 Prisons.

1 (2) TELEHEALTH.—For purposes of alternative
2 dental health care providers and other dental care
3 providers who are licensed to provide clinical care,
4 dental services provided under the demonstration
5 program under this subsection may be administered
6 by such providers through telehealth-enabled collabo-
7 ration and supervision when appropriate and fea-
8 sible.

9 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
10 VIDERS DEFINED.—In this subsection and sub-
11 section (i), the term “alternative dental health care
12 providers” has the meaning given that term in sec-
13 tion 340G–1(a)(2) of the Public Health Service Act
14 (42 U.S.C. 256g–1(a)(2)).

15 (4) AUTHORIZATION OF APPROPRIATIONS.—
16 There are authorized to be appropriated such sums
17 as are necessary to carry out the demonstration pro-
18 gram under this subsection.

19 (i) DEMONSTRATION PROGRAM ON TRAINING AND
20 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
21 PROVIDERS FOR DENTAL HEALTH CARE SERVICES
22 UNDER THE INDIAN HEALTH SERVICE.—

23 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
24 The Secretary of Health and Human Services, act-
25 ing through the Indian Health Service, may carry

1 out a demonstration program to establish programs
2 to train and employ alternative dental health care
3 providers in order to help eliminate oral health dis-
4 parities and increase access to dental services
5 through health programs operated by the Indian
6 Health Service, Indian tribes, tribal organizations,
7 and urban Indian organizations (as the preceding 3
8 terms are defined in section 4 of the Indian Health
9 Care Improvement Act (25 U.S.C. 1603)).

10 (2) TELEHEALTH.—For purposes of alternative
11 dental health care providers and other dental care
12 providers who are licensed to provide clinical care,
13 dental services provided under the demonstration
14 program under this subsection may be administered
15 by such providers through telehealth-enabled collabo-
16 ration and supervision when appropriate and fea-
17 sible.

18 (3) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated such sums
20 as are necessary to carry out the demonstration pro-
21 gram under this subsection.

1 **Subtitle C—Advancing Health Eq-**
2 **uity Through Payment and De-**
3 **livery Reform**

4 **SEC. 441. SENSE OF CONGRESS.**

5 It is the Sense of Congress that—

6 (1) the sustainability of the health care system
7 in the United States hinges on restructuring how
8 health care is paid for, shifting away from paying
9 for the volume of services provided to the value the
10 services provide;

11 (2) high value care is care that provides higher
12 quality care more efficiently, achieving greater
13 health improvement and better health outcomes at
14 lower cost (per patient and overall);

15 (3) a high value health care system must deliver
16 timely, accessible, well-coordinated, high-quality, cul-
17 turally centered, and language-appropriate care to
18 everyone;

19 (4) eliminating health disparities and achieving
20 health equity must be central to efforts to achieve a
21 high value health care system;

22 (5) eliminating such disparities and achieving
23 such equity will require tailored interventions and
24 targeted investments to address inequities in health
25 and health care to make sure that health care deliv-

1 ery and payment efforts are responsive to and inclu-
 2 sive of the needs of communities of color and other
 3 communities experiencing disparities; and

4 (6) new models of value-based payment and
 5 care delivery should consider the holistic needs of
 6 the patient population, including social determinants
 7 of health and behavioral health needs.

8 **SEC. 442. CENTERS FOR MEDICARE & MEDICAID SERVICES**
 9 **QUALITY PAYMENT PROGRAM.**

10 (a) INTEGRATING ACHIEVING HEALTH EQUITY
 11 ACROSS MEASURES AND ACTIVITIES.—

12 (1) IN GENERAL.—The Centers for Medicare &
 13 Medicaid Services Quality Payment Program (in this
 14 section referred to as the “Quality Payment Pro-
 15 gram”), developed through implementation of the
 16 provisions of and amendments made by the Medicare
 17 Access and CHIP Reauthorization Act of 2015
 18 (Public Law 114–10) relating to improving quality
 19 and payment under title XVIII of the Social Secu-
 20 rity Act, shall explicitly integrate “achieving health
 21 equity” across all measures and activities under the
 22 Quality Payment Program, including under the
 23 Merit-based Incentive Payment System under sec-
 24 tion 1848(q) of such Act (42 U.S.C. 1395w–4(q)) or

1 alternative payment models in accordance with this
2 section.

3 (2) IDENTIFICATION OF LIMITED-ENGLISH PRO-
4 FICIENT INDIVIDUALS AS UNDERSERVED GROUP.—

5 The Administrator of the Centers for Medicare &
6 Medicaid Services (in this section referred to as the
7 “Administrator”) shall identify individuals with lim-
8 ited-English proficiency as a specific underserved
9 group within the Quality Payment Program and give
10 high weight under the Quality Payment Program to
11 measures and activities relating to providing lan-
12 guage services for non-English speakers. A clinician
13 or other professional may demonstrate performance
14 on measures and activities with respect to this cat-
15 egory by developing language assistance plans, pro-
16 viding oral interpretation services, and providing
17 translated documents for the population served or el-
18 igible to be served.

19 (b) STRATIFIED DATA.—

20 (1) IN GENERAL.—The Administrator shall in-
21 clude an explicit reference under the Quality Pay-
22 ment Program indicating that data stratification
23 and reporting is one way of working to achieve
24 health equity.

1 (2) STRATIFICATION OF DATA.—The Adminis-
2 trator shall require that a clinician or other profes-
3 sional, in reporting measures relating to achieving
4 health quality under this the Quality Payment Pro-
5 gram, stratify clinical quality measures by disparity
6 variables, including race, ethnicity, preferred lan-
7 guage, disability status, sexual orientation, gender
8 identity, and psychological and behavioral status. A
9 clinician or other professional may use existing de-
10 mographic data collection fields in certified elec-
11 tronic health record technology (as defined in section
12 1848(o)(4) of the Social Security Act (42 U.S.C.
13 1395w-4(o)(4))) to carry out such data stratifica-
14 tion under the preceding sentence. Such stratified
15 data may assist clinicians and other professionals in
16 the identification of disparities and distinguish ef-
17 forts to improve quality from efforts to reduce dis-
18 parities, which may not correlate without dedicated
19 work.

20 (3) REQUIREMENT OF ADOPTION OF CERT.—All
21 entities, clinicians, or other professionals partici-
22 pating in the Quality Payment Program shall be re-
23 quired to adopt 2015 certified electronic health
24 record technology (as so defined) as a condition of
25 participating in the Quality Payment Program.

1 (c) **QUALITY IMPROVEMENT ACTIVITIES.**—The Ad-
2 ministrator, upon yearly review of the Quality Payment
3 Program, shall add quality improvement activities that im-
4 plement the Culturally and Linguistically Accessible
5 Standards (CLAS) standards as Improvement Activities
6 under the Quality Payment Program.

7 **SEC. 443. DEVELOPMENT AND TESTING OF DISPARITY RE-**
8 **DUCING DELIVERY AND PAYMENT MODELS.**

9 (a) **IN GENERAL.**—The Center for Medicare and
10 Medicaid Innovation established under section 1115A of
11 the Social Security Act (42 U.S.C. 1315a) (in this section
12 referred to as the “CMI”) shall establish a dedicated fund
13 to identify, test, evaluate, and scale delivery and payment
14 models under the applicable titles (as defined in subsection
15 (a)(4)(B) of such section) that target health disparities
16 among racial and ethnic minorities, including models that
17 support high-value non-medical services that address so-
18 cially determined barriers to health, including English pro-
19 ficiency status, low health literacy, and case management,
20 transportation, and enrollment assistance needs, which
21 will help to reduce disparities and impact the overall cost
22 of care.

23 (b) **PILOT PROGRAMS.**—The CMI shall prioritize the
24 testing of models under such section 1115A that include
25 partnerships with entities, including community based or-

1 ganizations or other non-profit entities, to help address
2 socially determined barriers to health and health care.

3 (c) ALTERNATIVES.—Any model tested by the CMI
4 under such 1115A shall include measures to assess and
5 track the impact of the model on health disparities, using
6 existing measures such as the Healthcare Disparities and
7 Cultural Competency Measures endorsed by the entity
8 with a contract under section 1890(a) of the Social Secu-
9 rity Act (42 U.S.C. 1395aaa(a)), and stratified by race,
10 ethnicity, English proficiency, gender identity, sexual ori-
11 entation, and disability status.

12 **SEC. 444. SUPPORTING SAFETY NET AND COMMUNITY-**
13 **BASED PROVIDERS TO COMPETE IN VALUE-**
14 **BASED PAYMENT SYSTEMS.**

15 (a) IN GENERAL.—Any pay-for-performance or alter-
16 native payment model that is developed and tested by the
17 Center for Medicare and Medicaid Innovation established
18 under section 1115A of the Social Security Act (42 U.S.C.
19 1315a), or any other agency of the Department of Health
20 and Human Services with respect to the programs under
21 titles XVIII, XIX, or XXI of such Act, shall be assessed
22 for potential impact on safety net, community based, and
23 critical access providers, including Federally qualified
24 health centers.

1 (b) NEW MODELS.—The rollout of any such models
2 shall include training and additional up front resources for
3 community based and safety net providers to enable those
4 providers to participate in the model.

5 **Subtitle D—Health Empowerment** 6 **Zones**

7 **SEC. 451. SHORT TITLE.**

8 This subtitle may be cited as the “Health Empower-
9 ment Zone Act of 2018”.

10 **SEC. 452. FINDINGS.**

11 Congress finds the following:

12 (1) Numerous studies and reports, including
13 the 2015 National Healthcare Quality and Dispari-
14 ties Report of the Agency for Healthcare Research
15 and Quality and the 2002 report of the Institute of
16 Medicine entitled “Unequal Treatment: Confronting
17 Racial and Ethnic Disparities in Health Care”, doc-
18 ument the extensiveness to which health disparities
19 exist across the country.

20 (2) These studies have found that, on average,
21 racial and ethnic minorities are disproportionately
22 afflicted with chronic and acute conditions—such as
23 cancer, diabetes, musculoskeletal disease, obesity,
24 and hypertension—and suffer worse health out-

1 comes, worse health status, and higher mortality
2 rates than their White counterparts.

3 (3) Several recent studies also show that health
4 disparities are a function of not only access to health
5 care, but also the social determinants of health—in-
6 cluding the environment, the physical structure of
7 communities, nutrition and food options, educational
8 attainment and health literacy, employment, race,
9 ethnicity, immigration status, geography, and lan-
10 guage preference—that directly and indirectly affect
11 the health, health care, and wellness of individuals
12 and communities.

13 (4) Integrally involving and fully supporting the
14 communities most affected by health inequities in
15 the assessment, planning, launch, and evaluation of
16 health disparity elimination efforts are among the
17 leading recommendations made to adequately ad-
18 dress and ultimately reduce health disparities.

19 (5) Recommendations also include supporting
20 the efforts of community stakeholders from a broad
21 cross section—including local businesses, local de-
22 partments of commerce, education, labor, urban
23 planning, and transportation, and community-based
24 and other nonprofit organizations, including national
25 and regional intermediaries with demonstrated ca-

1 capacity to serve low-income urban communities—to
2 find areas of common ground around health dis-
3 parity elimination and collaborate to improve the
4 overall health and wellness of a community and its
5 residents.

6 **SEC. 453. DESIGNATION OF HEALTH EMPOWERMENT**
7 **ZONES.**

8 (a) **IN GENERAL.**—The Secretary may, at the request
9 of an eligible community partnership described in sub-
10 section (b)(1), designate an eligible area described in sub-
11 section (b)(2) as a health empowerment zone for the pur-
12 pose of eligibility for a grant under section 455.

13 (b) **ELIGIBILITY CRITERIA.**—

14 (1) **ELIGIBLE COMMUNITY PARTNERSHIP.**—A
15 community partnership is eligible to submit a re-
16 quest under this section if the partnership—

17 (A) demonstrates widespread public sup-
18 port from key individuals and entities in the eli-
19 gible area, including members of the target
20 community, State and local governments, non-
21 profit organizations including national and re-
22 gional intermediaries with demonstrated capac-
23 ity to serve low-income urban communities, and
24 community and industry leaders, for designa-

1 tion of the eligible area as a health empower-
2 ment zone; and

3 (B) includes representatives of—

4 (i) a broad cross section of stake-
5 holders and residents from communities in
6 the eligible area experiencing dispropor-
7 tionate disparities in health status and
8 health care; and

9 (ii) organizations, facilities, and insti-
10 tutions that have a history of working
11 within and serving such communities.

12 (2) ELIGIBLE AREA.—An area is eligible to be
13 designated as a health empowerment zone under this
14 section if one or more communities in the area expe-
15 rience disproportionate disparities in health status
16 and health care. In determining whether a commu-
17 nity experiences such disparities, the Secretary shall
18 consider data collected by the Department of Health
19 and Human Services focusing on the following areas:

20 (A) Access to affordable, high-quality
21 health services.

22 (B) The prevalence of disproportionate
23 rates of certain illnesses or diseases including
24 the following:

- 1 (i) Arthritis, osteoporosis, chronic
2 back conditions, and other musculoskeletal
3 diseases.
- 4 (ii) Cancer.
- 5 (iii) Chronic kidney disease.
- 6 (iv) Diabetes.
- 7 (v) Injury (intentional and uninten-
8 tional).
- 9 (vi) Violence (intimate and non-
10 intimate).
- 11 (vii) Maternal and paternal illnesses
12 and diseases.
- 13 (viii) Infant mortality.
- 14 (ix) Mental illness and other disabil-
15 ities.
- 16 (x) Substance use disorder treatment
17 and prevention, including underage drink-
18 ing.
- 19 (xi) Nutrition, obesity, and overweight
20 conditions.
- 21 (xii) Heart disease.
- 22 (xiii) Hypertension.
- 23 (xiv) Cerebrovascular disease or
24 stroke.
- 25 (xv) Tuberculosis.

1 (xvi) HIV/AIDS and other sexually
2 transmitted infections.

3 (xvii) Viral hepatitis.

4 (xviii) Asthma.

5 (xix) Tooth decay and other oral
6 health issues.

7 (C) Within the community, the historical
8 and persistent presence of conditions that have
9 been found to contribute to health disparities
10 including any such conditions respecting any of
11 the following:

12 (i) Poverty.

13 (ii) Educational status and the quality
14 of community schools.

15 (iii) Income.

16 (iv) Access to high-quality affordable
17 health care.

18 (v) Work and work environment.

19 (vi) Environmental conditions in the
20 community, including with respect to clean
21 water, clean air, and the presence or ab-
22 sence of pollutants.

23 (vii) Language and English pro-
24 ficiency.

1 (viii) Access to affordable healthy
2 food.

3 (ix) Access to ethnically and culturally
4 diverse health and human service providers
5 and practitioners.

6 (x) Access to culturally and linguis-
7 tically competent health and human serv-
8 ices and health and human service pro-
9 viders.

10 (xi) Health-supporting infrastructure.

11 (xii) Health insurance that is ade-
12 quate and affordable.

13 (xiii) Race, racism, and bigotry (con-
14 scious and unconscious).

15 (xiv) Sexual orientation.

16 (xv) Health literacy.

17 (xvi) Place of residence (such as
18 urban areas, rural areas, and reservations
19 of Indian tribes).

20 (xvii) Stress.

21 (c) PROCEDURE.—

22 (1) REQUEST.—A request under subsection (a)
23 shall—

1 (A) describe the bounds of the area to be
2 designated as a health empowerment zone and
3 the process used to select those bounds;

4 (B) demonstrate that the partnership sub-
5 mitting the request is an eligible community
6 partnership described in subsection (b)(1);

7 (C) demonstrate that the area is an eligible
8 area described in subsection (b)(2);

9 (D) include a comprehensive assessment of
10 disparities in health status and health care ex-
11 perience by one or more communities in the
12 area;

13 (E) set forth—

14 (i) a vision and a set of values for the
15 area; and

16 (ii) a comprehensive and holistic set of
17 goals to be achieved in the area through
18 designation as a health empowerment zone;
19 and

20 (F) include a strategic plan and an action
21 plan for achieving the goals described in sub-
22 paragraph (E)(ii).

23 (2) APPROVAL.—Not later than 60 days after
24 the receipt of a request for designation of an area
25 as a health empowerment zone under this section,

1 the Secretary shall approve or disapprove the re-
2 quest.

3 (d) MINIMUM NUMBER.—The Secretary—

4 (1) shall designate not more than 110 health
5 empowerment zones under this section; and

6 (2) shall designate at least one health empower-
7 ment zone in each of the several States, the District
8 of Columbia, and each territory or possession of the
9 United States.

10 **SEC. 454. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

11 At the request of any organization or entity seeking
12 to submit a request under section 453(a), the Secretary
13 shall provide technical assistance, and may award a grant,
14 to assist such organization or entity—

15 (1) to form an eligible community partnership
16 described in section 453(b)(1);

17 (2) to complete a health assessment, including
18 an assessment of health disparities under section
19 453(c)(1)(D); or

20 (3) to prepare and submit a request, including
21 a strategic plan, in accordance with section 453.

22 **SEC. 455. BENEFITS OF DESIGNATION.**

23 (a) PRIORITY.—In awarding a grant under sub-
24 section (b), a Federal official shall give priority to any ap-
25 plicant that—

- 1 (1) meets the eligibility criteria for the grant;
- 2 (2) proposes to use the grant for activities in a
- 3 health empowerment zone; and
- 4 (3) demonstrates that such activities will di-
- 5 rectly and significantly further the goals of the stra-
- 6 tegic plan approved for such zone under section 453.

7 (b) GRANTS FOR INITIAL IMPLEMENTATION OF

8 STRATEGIC PLAN.—

9 (1) IN GENERAL.—Upon designating an eligible

10 area as a health empowerment zone at the request

11 of an eligible community partnership, the Secretary

12 shall, subject to the availability of appropriations,

13 make a grant to the community partnership for im-

14 plementation of the strategic plan for such zone.

15 (2) GRANT PERIOD.—A grant under paragraph

16 (1) for a health empowerment zone shall be for a pe-

17 riod of 2 years and may be renewed, except that the

18 total period of grants under paragraph (1) for such

19 zone may not exceed 10 years.

20 (3) LIMITATION.—In awarding grants under

21 this subsection, the Secretary shall not give less pri-

22 ority to an applicant or reduce the amount of a

23 grant because the Secretary rendered technical as-

24 sistance or made a grant to the same applicant

25 under section 454.

1 (4) REPORTING.—The Secretary shall establish
 2 metrics for measuring the progress of grantees
 3 under this subsection and, based on such metrics,
 4 require each such grantee to report to the Secretary
 5 not less than every 6 months on the progress in im-
 6 plementing the strategic plan for the health em-
 7 powerment zone.

8 **SEC. 456. DEFINITION OF SECRETARY.**

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

17 **SEC. 457. AUTHORIZATION OF APPROPRIATIONS.**

18 To carry out this subtitle, there is authorized to be
 19 appropriated \$100,000,000 for fiscal year 2019.

20 **Subtitle E—At-Risk Community**
 21 **Coverage**

22 **SEC. 461. MEDICAID COVERAGE FOR CITIZENS OF FREELY**
 23 **ASSOCIATED STATES.**

24 (a) IN GENERAL.—Section 402(b)(2) of the Personal
 25 Responsibility and Work Opportunity Reconciliation Act

1 of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at
2 the end the following new subparagraph:

3 “(G) MEDICAID EXCEPTION FOR CITIZENS
4 OF FREELY ASSOCIATED STATES.—With respect
5 to eligibility for benefits for the designated Fed-
6 eral program described in paragraph (3)(C),
7 section 401(a) and paragraph (1) shall not
8 apply to any individual who lawfully resides in
9 1 of the 50 States or the District of Columbia
10 in accordance with the Compacts of Free Asso-
11 ciation between the Government of the United
12 States and the Governments of the Federated
13 States of Micronesia, the Republic of the Mar-
14 shall Islands, and the Republic of Palau and
15 shall not apply, at the option of the Governors
16 of Puerto Rico, the Virgin Islands, Guam, the
17 Northern Mariana Islands, or American Samoa,
18 respectively, as communicated to the Secretary
19 of Health and Human Services in writing, to
20 any individual who lawfully resides in the re-
21 spective territory in accordance with such Com-
22 pacts.”.

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

1 (1) in paragraph (1), by striking “or” at the
2 end;

3 (2) in paragraph (2), by striking the period at
4 the end and inserting “; or”; and

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

7 “(3) an individual described in section
8 402(b)(2)(G), but only with respect to the des-
9 ignated Federal program described in section
10 402(b)(3)(C).”.

11 (c) DEFINITION OF QUALIFIED ALIEN.—Section
12 431(b) of such Act (8 U.S.C. 1641(b)) is amended—

13 (1) in paragraph (6), by striking “; or” at the
14 end and inserting a comma;

15 (2) in paragraph (7), by striking the period at
16 the end and inserting “, or”; and

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

19 “(8) an individual who lawfully resides in the
20 United States in accordance with a Compact of Free
21 Association referred to in section 402(b)(2)(G), but
22 only with respect to the designated Federal program
23 described in section 402(b)(3)(C) (relating to the
24 Medicaid program).”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section take effect on October 1, 2018.

3 **SEC. 462. AT-RISK YOUTH MEDICAID PROTECTION.**

4 (a) IN GENERAL.—Section 1902 of the Social Secu-
5 rity Act (42 U.S.C. 1396a), as amended by section
6 431(d)(2), is further amended—

7 (1) in subsection (a)—

8 (A) by striking “and” at the end of para-
9 graph (83);

10 (B) by striking the period at the end of
11 paragraph (84) and inserting “; and”; and

12 (C) by inserting after paragraph (84) the
13 following new paragraph:

14 “(85) provide that—

15 “(A) the State shall not terminate eligi-
16 bility for medical assistance under a State plan
17 for an individual who is an eligible juvenile (as
18 defined in subsection (nn)(2)) because the juve-
19 nile is an inmate of a public institution (as de-
20 fined in subsection (nn)(3)), but may suspend
21 coverage during the period the juvenile is such
22 an inmate;

23 “(B) the State shall restore coverage for
24 such medical assistance to such an individual
25 upon the individual’s release from any such

1 public institution, without requiring a new ap-
 2 plication from the individual, unless (and until
 3 such date as) there is a determination that the
 4 individual no longer meets the eligibility re-
 5 quirements for such medical assistance; and

6 “(C) the State shall process any applica-
 7 tion for medical assistance submitted by, or on
 8 behalf of, a juvenile who is an inmate of a pub-
 9 lic institution notwithstanding that the juvenile
 10 is such an inmate.”; and

11 (2) by adding at the end the following new sub-
 12 section:

13 “(nn) JUVENILE; ELIGIBLE JUVENILE; PUBLIC IN-
 14 STITUTION.—For purposes of subsection (a)(84) and this
 15 subsection:

16 “(1) JUVENILE.—The term ‘juvenile’ means an
 17 individual who is—

18 “(A) under 21 years of age; or

19 “(B) is described in subsection
 20 (a)(10)(A)(i)(IX).

21 “(2) ELIGIBLE JUVENILE.—The term ‘eligible
 22 juvenile’ means a juvenile who is an inmate of a
 23 public institution and was eligible for medical assist-
 24 ance under the State plan immediately before be-
 25 coming an inmate of such a public institution or who

1 becomes eligible for such medical assistance while an
2 inmate of a public institution.

3 “(3) INMATE OF A PUBLIC INSTITUTION.—The
4 term ‘inmate of a public institution’ has the meaning
5 given such term for purposes of applying the sub-
6 division (A) following paragraph (30) of section
7 1905(a), taking into account the exception in such
8 subdivision for a patient of a medical institution.”.

9 (b) NO CHANGE IN EXCLUSION FROM MEDICAL AS-
10 SISTANCE FOR INMATES OF PUBLIC INSTITUTIONS.—
11 Nothing in this section shall be construed as changing the
12 exclusion from medical assistance under the subdivision
13 (A) following paragraph (30) of section 1905(a) of the So-
14 cial Security Act (42 U.S.C. 1396d(a)), including any ap-
15 plicable restrictions on a State submitting claims for Fed-
16 eral financial participation under title XIX of such Act
17 for such assistance.

18 (c) NO CHANGE IN CONTINUITY OF ELIGIBILITY BE-
19 FORE ADJUDICATION OR SENTENCING.—Nothing in this
20 section shall be construed to mandate, encourage, or sug-
21 gest that a State suspend or terminate coverage for indi-
22 viduals before they have been adjudicated or sentenced.

23 (d) EFFECTIVE DATE.—

24 (1) IN GENERAL.—Except as provided in para-
25 graph (2), the amendments made by subsection (a)

1 shall apply to eligibility for medical assistance under
2 a State plan under title XIX of the Social Security
3 Act of juveniles who become inmates of public insti-
4 tutions on or after the date that is 1 year after the
5 date of the enactment of this Act.

6 (2) RULE FOR CHANGES REQUIRING STATE
7 LEGISLATION.—In the case of a State plan for med-
8 ical assistance under title XIX of the Social Security
9 Act which the Secretary of Health and Human Serv-
10 ices determines requires State legislation (other than
11 legislation appropriating funds) in order for the plan
12 to meet the additional requirements imposed by the
13 amendments made by subsection (a), the State plan
14 shall not be regarded as failing to comply with the
15 requirements of such title solely on the basis of its
16 failure to meet these additional requirements before
17 the first day of the first calendar quarter beginning
18 after the close of the first regular session of the
19 State legislature that begins after the date of the en-
20 actment of this Act. For purposes of the previous
21 sentence, in the case of a State that has a 2-year
22 legislative session, each year of such session shall be
23 deemed to be a separate regular session of the State
24 legislature.

1 **TITLE V—IMPROVING HEALTH**
2 **OUTCOMES FOR WOMEN,**
3 **CHILDREN, AND FAMILIES**

4 **Subtitle A—In General**

5 **SEC. 501. GRANTS TO PROMOTE HEALTH FOR UNDER-**
6 **SERVED COMMUNITIES.**

7 Part Q of title III of the Public Health Service Act
8 (42 U.S.C. 280g et seq.) is amended by adding at the end
9 the following:

10 **“SEC. 399Z-3. GRANTS TO PROMOTE HEALTH FOR UNDER-**
11 **SERVED COMMUNITIES.**

12 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
13 laboration with the Administrator of the Health Resources
14 and Services Administration and other Federal officials
15 determined appropriate by the Secretary, is authorized to
16 award grants to eligible entities—

17 “(1) to promote health for underserved commu-
18 nities, with preference given to projects that benefit
19 racial and ethnic minority women, racial and ethnic
20 minority children, adolescents, and lesbian, gay, bi-
21 sexual, transgender, queer, or questioning commu-
22 nities; and

23 “(2) to strengthen health outreach initiatives in
24 medically underserved communities, including lin-
25 guistically isolated populations.

1 “(b) USE OF FUNDS.—Grants awarded pursuant to
2 subsection (a) may be used to support the activities of
3 community health workers, including such activities—

4 “(1) to educate and provide outreach regarding
5 enrollment in health insurance including the State
6 Children’s Health Insurance Program under title
7 XXI of the Social Security Act, Medicare under title
8 XVIII of such Act, and Medicaid under title XIX of
9 such Act;

10 “(2) to educate and provide outreach in a com-
11 munity setting regarding health problems prevalent
12 among underserved communities, and especially
13 among racial and ethnic minority women, racial and
14 ethnic minority children, adolescents, and lesbian,
15 gay, bisexual, transgender, queer, or questioning
16 communities;

17 “(3) to educate and provide experiential learn-
18 ing opportunities and target risk factors and healthy
19 behaviors that impede or contribute to achieving
20 positive health outcomes, including—

21 “(A) healthy nutrition;

22 “(B) physical activity;

23 “(C) overweight or obesity;

24 “(D) tobacco use;

25 “(E) alcohol and substance use;

1 “(F) injury and violence;

2 “(G) sexual health;

3 “(H) mental health;

4 “(I) musculoskeletal health and arthritis;

5 “(J) dental and oral health;

6 “(K) understanding informed consent; and

7 “(L) stigma;

8 “(4) to promote community wellness and aware-
9 ness; and

10 “(5) to educate and refer target populations to
11 appropriate health care agencies and community-
12 based programs and organizations in order to in-
13 crease access to quality health care services, includ-
14 ing preventive health services.

15 “(c) APPLICATION.—

16 “(1) IN GENERAL.—Each eligible entity that
17 desires to receive a grant under subsection (a) shall
18 submit an application to the Secretary, at such time,
19 in such manner, and accompanied by such additional
20 information as the Secretary may require.

21 “(2) CONTENTS.—Each application submitted
22 pursuant to paragraph (1) shall—

23 “(A) describe the activities for which as-
24 sistance under this section is sought;

1 “(B) contain an assurance that, with re-
2 spect to each community health worker pro-
3 gram receiving funds under the grant awarded,
4 such program provides in-language training and
5 supervision to community health workers to en-
6 able such workers to provide authorized pro-
7 gram activities in (at least) the most commonly
8 used languages within a particular geographic
9 region;

10 “(C) contain an assurance that the appli-
11 cant will evaluate the effectiveness of commu-
12 nity health worker programs receiving funds
13 under the grant;

14 “(D) contain an assurance that each com-
15 munity health worker program receiving funds
16 under the grant will provide culturally com-
17 petent services in the linguistic context most
18 appropriate for the individuals served by the
19 program;

20 “(E) contain a plan to document and dis-
21 seminate project descriptions and results to
22 other States and organizations as identified by
23 the Secretary; and

24 “(F) describe plans to enhance the capac-
25 ity of individuals to utilize health services and

1 health-related social services under Federal,
2 State, and local programs by—

3 “(i) assisting individuals in estab-
4 lishing eligibility under the programs and
5 in receiving the services or other benefits
6 of the programs; and

7 “(ii) providing other services, as the
8 Secretary determines to be appropriate,
9 which may include transportation and
10 translation services.

11 “(d) PRIORITY.—In awarding grants under sub-
12 section (a), the Secretary shall give priority to those appli-
13 cants—

14 “(1) who propose to target geographic areas
15 that—

16 “(A)(i) have a high percentage of residents
17 who are uninsured or underinsured (if the tar-
18 getted geographic area is located in a State that
19 has elected to make medical assistance available
20 under section 1902(a)(10)(A)(i)(VIII) of the
21 Social Security Act to individuals described in
22 such section);

23 “(ii) have a high percentage of under-
24 insured residents in a particular geographic

1 area (if the targeted geographic area is located
2 in a State that has not so elected); or

3 “(iii) have a high number of households ex-
4 periencing extreme poverty; and

5 “(B) have a high percentage of families for
6 whom English is not their primary language or
7 including smaller limited-English-proficient
8 communities within the region that are not oth-
9 erwise reached by linguistically appropriate
10 health services;

11 “(2) with experience in providing health or
12 health-related social services to individuals who are
13 underserved with respect to such services; and

14 “(3) with documented community activity and
15 experience with community health workers.

16 “(e) COLLABORATION WITH ACADEMIC INSTITU-
17 TIONS.—The Secretary shall encourage community health
18 worker programs receiving funds under this section to col-
19 laborate with academic institutions, including minority-
20 serving institutions. Nothing in this section shall be con-
21 strued to require such collaboration.

22 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
23 NESS.—The Secretary shall establish guidelines for ensur-
24 ing the quality of the training and supervision of commu-
25 nity health workers under the programs funded under this

1 section and for ensuring the cost effectiveness of such pro-
2 grams.

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 these programs on
5 the 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 “(F) by taking into consideration the
8 needs of the communities served, including the
9 prevalence rates of risk factors that impede
10 achieving positive healthy outcomes among
11 women and children, especially among racial
12 and ethnic minority women and children; and

13 “(G) by providing referral and followup
14 services.

15 “(2) COMMUNITY SETTING.—The term ‘commu-
16 nity setting’ means a home or a community organi-
17 zation that serves a population.

18 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
19 tity’ means—

20 “(A) a unit of State, territorial, local, or
21 Tribal government (including a federally recog-
22 nized Tribe or Alaska Native village); or

23 “(B) a community-based organization.

1 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
2 The term ‘medically underserved community’ means
3 a community—

4 “(A) that has a substantial number of in-
5 dividuals who are members of a medically un-
6 derserved population, as defined by section
7 330(b)(3);

8 “(B) a significant portion of which is a
9 health professional shortage area as designated
10 under section 332; and

11 “(C) that includes populations that are lin-
12 guistically isolated, such as geographic areas
13 with a shortage of health professionals able to
14 provide linguistically appropriate services.

15 “(5) SUPPORT.—The term ‘support’ means the
16 provision of training, supervision, and materials
17 needed to effectively deliver the services described in
18 subsection (b), reimbursement for services, and
19 other benefits.

20 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 \$15,000,000 for each of fiscal years 2019 through 2023.”.

1 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
2 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
3 **NANT PERSONS, AND LAWFULLY PRESENT IN-**
4 **DIVIDUALS.**

5 (a) **MEDICAID.**—Section 1903(v) of the Social Secu-
6 rity Act (42 U.S.C. 1396b(v)) is amended by striking
7 paragraph (4) and inserting the following new paragraph:
8 “(4)(A) Notwithstanding sections 401(a), 402(b),
9 403, and 421 of the Personal Responsibility and Work Op-
10 portunity Reconciliation Act of 1996 and paragraph (1),
11 payment shall be made to a State under this section for
12 medical assistance furnished to an alien under this title
13 (including an alien described in such paragraph) who
14 meets any of the following conditions:

15 “(i) The alien is otherwise eligible for such as-
16 sistance under the State plan approved under this
17 title (other than the requirement of the receipt of
18 aid or assistance under title IV, supplemental secu-
19 rity income benefits under title XVI, or a State sup-
20 plementary payment) within either or both of the
21 following eligibility categories:

22 “(I) Children under 21 years of age, in-
23 cluding any optional targeted low-income child
24 (as such term is defined in section
25 1905(u)(2)(B)).

1 “(II) Pregnant persons during pregnancy
2 and during the 60-day period beginning on the
3 last day of the pregnancy.

4 “(ii) The alien is lawfully present in the United
5 States.

6 “(B) No debt shall accrue under an affidavit of sup-
7 port against any sponsor of an alien who meets the condi-
8 tions specified in subparagraph (A) on the basis of the
9 provision of medical assistance to such alien under this
10 paragraph and the cost of such assistance shall not be con-
11 sidered as an unreimbursed cost.”.

12 (b) SCHIP.—Subparagraph (N) of section
13 2107(e)(1) of the Social Security Act (42 U.S.C.
14 1397gg(e)(1)) is amended to read as follows:

15 “(N) Paragraph (4) of section 1903(v) (re-
16 lating to coverage of categories of children,
17 pregnant persons, and other lawfully present in-
18 dividuals).”.

19 (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-
20 withstanding sections 401(a), 402(a), and 403(a) of the
21 Personal Responsibility and Work Opportunity Reconcili-
22 ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))
23 and section 6(f) of the Food and Nutrition Act of 2008
24 (7 U.S.C. 2015(f)), persons who are lawfully present in
25 the United States shall be not be ineligible for benefits

1 under the supplemental nutrition assistance program on
2 the basis of their immigration status or date of entry into
3 the United States.

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

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

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

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

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

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

2 Section 115 of the Personal Responsibility and Work
3 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
4 is amended—

5 (1) in subsection (a), by striking “for—” and
6 all that follows and inserting “for assistance under
7 any State program funded under part A of title IV
8 of the Social Security Act (42 U.S.C. 601 et seq.)”;

9 (2) in subsection (b)—

10 (A) by striking “(1) PROGRAM OF TEM-
11 PORARY ASSISTANCE FOR NEEDY FAMILIES.—”;

12 and

13 (B) by striking paragraph (2); and

14 (3) in subsection (e), by striking “it—” and all
15 that follows and inserting “the term in section
16 419(5) of the Social Security Act (42 U.S.C.
17 619(5)) when referring to assistance provided under
18 a State program funded under paragraph A of title
19 IV of the Social Security Act (42 U.S.C. 601 et
20 seq.)”.

21 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
22 **AND AWARENESS.**

23 (a) IN GENERAL.—The Secretary shall establish and
24 implement a birth defects prevention and public awareness
25 program, consisting of the activities described in sub-
26 sections (c) and (d).

1 (b) DEFINITIONS.—In this section:

2 (1) MATERNAL.—The term “maternal” refers
3 to persons who are pregnant or breastfeeding of all
4 gender identities.

5 (2) PREGNANCY AND BREASTFEEDING INFOR-
6 MATION SERVICES.—The term “pregnancy and
7 breastfeeding information services” includes only—

8 (A) information services to provide accu-
9 rate, evidence-based, clinical information re-
10 garding maternal exposures during pregnancy
11 that may be associated with birth defects or
12 other health risks, such as exposures to medica-
13 tions, chemicals, infections, foodborne patho-
14 gens, illnesses, nutrition, or lifestyle factors;

15 (B) information services to provide accu-
16 rate, evidence-based, clinical information re-
17 garding maternal exposures during breast-
18 feeding that may be associated with health risks
19 to a breast-fed infant, such as exposures to
20 medications, chemicals, infections, foodborne
21 pathogens, illnesses, nutrition, or lifestyle fac-
22 tors;

23 (C) the provision of accurate, evidence-
24 based information weighing risks of exposures

1 during breastfeeding against the benefits of
2 breastfeeding; and

3 (D) the provision of information described
4 in subparagraph (A), (B), or (C) through coun-
5 selors, Websites, fact sheets, telephonic or elec-
6 tronic communication, community outreach ef-
7 forts, or other appropriate means.

8 (3) SECRETARY.—The term “Secretary” means
9 the Secretary of Health and Human Services, acting
10 through the Director of the Centers for Disease
11 Control and Prevention.

12 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
13 subsection (a), the Secretary shall conduct or support a
14 nationwide media campaign to increase awareness among
15 health care providers and at-risk populations about preg-
16 nancy and breastfeeding information services.

17 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
18 INFORMATION SERVICES.—

19 (1) IN GENERAL.—In carrying out subsection
20 (a), the Secretary shall award grants to State or re-
21 gional agencies or organizations for any of the fol-
22 lowing:

23 (A) INFORMATION SERVICES.—The provi-
24 sion of, or campaigns to increase awareness

1 about, pregnancy and breastfeeding information
2 services.

3 (B) SURVEILLANCE AND RESEARCH.—The
4 conduct or support of—

5 (i) surveillance of or research on—

6 (I) maternal exposures and ma-
7 ternal health conditions that may in-
8 fluence the risk of birth defects, pre-
9 maturity, or other adverse pregnancy
10 outcomes; and

11 (II) maternal exposures that may
12 influence health risks to a breastfed
13 infant; or

14 (ii) networking to facilitate surveil-
15 lance or research described in this sub-
16 paragraph.

17 (2) PREFERENCE FOR CERTAIN STATES.—The
18 Secretary, in making any grant under this sub-
19 section, shall give preference to States, otherwise
20 equally qualified, that have a pregnancy and
21 breastfeeding information service in place.

22 (3) MATCHING FUNDS.—The Secretary may
23 only award a grant under this subsection to a State
24 or regional agency or organization that agrees, with
25 respect to the costs to be incurred in carrying out

1 the grant activities, to make available (directly or
2 through donations from public or private entities)
3 non-Federal funds toward such costs in an amount
4 equal to not less than 25 percent of the amount of
5 the grant.

6 (4) COORDINATION.—The Secretary shall en-
7 sure that activities funded through a grant under
8 this subsection are coordinated, to the maximum ex-
9 tent practicable, with other birth defects prevention
10 and environmental health activities of the Federal
11 Government, including with respect to pediatric envi-
12 ronmental health specialty units and children’s envi-
13 ronmental health centers.

14 (e) EVALUATION.—In furtherance of the program
15 under subsection (a), the Secretary shall provide for an
16 evaluation of pregnancy and breastfeeding information
17 services to identify efficient and effective models of—

18 (1) providing information;

19 (2) raising awareness and increasing knowledge
20 about birth defects prevention measures and tar-
21 geting education to at-risk groups;

22 (3) modifying risk behaviors; or

23 (4) other outcome measures as determined ap-
24 propriate by the Secretary.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 \$5,000,000 for fiscal year 2019, \$6,000,000 for fiscal year
4 2020, \$7,000,000 for fiscal year 2021, \$8,000,000 for fis-
5 cal year 2022, and \$9,000,000 for fiscal year 2023.

6 **SEC. 505. PREVENTING MATERNAL DEATHS.**

7 (a) PROGRAM AUTHORIZED.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services, acting through the Director of the
10 Centers for Disease Control and Prevention, shall
11 establish a grant program under which the Secretary
12 may make grants to States for the purpose of—

13 (A) carrying out the activities described in
14 subsection (b)(1);

15 (B) establishing and sustaining a State
16 maternal mortality review committee, in accord-
17 ance with subsection (b)(2);

18 (C) ensuring that the State department of
19 health carries out the activities described in
20 subsection (b)(3);

21 (D) disseminating the case abstraction
22 form developed under subsection (c); and

23 (E) providing for the public disclosure of
24 information, in accordance with subsection (d).

1 (2) CRITERIA.—The Secretary shall establish
2 criteria for determining eligibility for, and the
3 amount of a grant awarded to, a State under para-
4 graph (1). Such criteria shall provide that in the
5 case of a State that receives a grant under para-
6 graph (1) for a fiscal year and is determined by the
7 Secretary to have not used such grant in accordance
8 with this section, such State may not be eligible for
9 such a grant for any subsequent fiscal year.

10 (b) USE OF FUNDS.—

11 (1) REVIEW OF PREGNANCY-RELATED AND
12 PREGNANCY-ASSOCIATED DEATHS.—With respect to
13 a State that receives a grant under subsection
14 (a)(1), the following shall apply:

15 (A) PROCESS FOR MANDATORY REPORTING
16 OF PREGNANCY-RELATED AND PREGNANCY-AS-
17 SOCIATED DEATHS.—

18 (i) IN GENERAL.—The State, through
19 the State maternal mortality review com-
20 mittee established under subsection (a)(1),
21 shall develop a process that provides for
22 mandatory and confidential case reporting
23 to the State department of health by indi-
24 viduals and entities described in clause (ii)

1 with respect to pregnancy-related and
2 pregnancy-associated deaths.

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 professionals.

8 (II) Medical examiners.

9 (III) Medical coroners.

10 (IV) Hospitals.

11 (V) Birth centers.

12 (VI) Other health care facilities.

13 (VII) Other individuals respon-
14 sible for completing death records.

15 (VIII) Other appropriate individ-
16 uals or entities specified by the Sec-
17 retary.

18 (B) PROCESS FOR VOLUNTARY REPORTING
19 OF PREGNANCY-RELATED AND PREGNANCY-AS-
20 SOCIATED DEATHS.—The State, through the
21 State maternal mortality review committee es-
22 tablished under subsection (a)(1), shall develop
23 a process that provides for voluntary and con-
24 fidential case reporting to the State department
25 of health by family members of the deceased

1 and other individuals on possible pregnancy-re-
2 lated and pregnancy-associated deaths. Such
3 process shall include—

4 (i) making publicly available on the
5 website of the State department of health
6 a telephone number, Internet web link, and
7 email address for such reporting; and

8 (ii) publicizing to local professional or-
9 ganizations, community organizations, and
10 social services agencies the availability of
11 the telephone number, Internet web link,
12 and email address made available under
13 clause (i).

14 (C) IDENTIFICATION OF PREGNANCY-RE-
15 LATED AND PREGNANCY-ASSOCIATED DEATHS
16 BY STATE VITAL STATISTICS UNIT.—The State,
17 through the vital statistics unit of the State,
18 shall annually identify pregnancy-related and
19 pregnancy-associated deaths occurring in such
20 State in the year involved by—

21 (i) matching each death record of a
22 person in such year to a live birth certifi-
23 cate or an infant death record for the pur-
24 pose of identifying deaths of persons that

1 occurred during pregnancy and within one
2 year after the end of a pregnancy;

3 (ii) identifying each death of a person
4 reported during such year as having an un-
5 derlying or contributing cause of death re-
6 lated to pregnancy, regardless of the time
7 that has passed between the end of the
8 pregnancy and the death;

9 (iii) collecting data from medical ex-
10 aminer and coroner reports; and

11 (iv) using any other method the State
12 may devise to identify maternal deaths
13 such as reviewing a random sample of re-
14 ported deaths of persons who could have
15 been pregnant to ascertain cases of preg-
16 nancy-related and pregnancy-associated
17 deaths that are not discernable from a re-
18 view of death records alone.

19 For purposes of effectively collecting and ob-
20 taining data on pregnancy-related and preg-
21 nancy-associated deaths, the State shall adopt
22 the most recent standardized birth and death
23 records, as issued by the National Center for
24 Vital Health Statistics, including the rec-

1 ommended checkbox section for pregnancy on
2 each death record.

3 (D) CASE INVESTIGATION AND DEVELOP-
4 MENT OF CASE SUMMARIES.—

5 (i) IN GENERAL.—Following the re-
6 ceipt of reports by the State department of
7 health pursuant to subparagraph (A) or
8 (B) and the collection of cases of preg-
9 nancy-related and pregnancy-associated
10 deaths by the vital statistics unit of the
11 State under subparagraph (C), the State,
12 through the State maternal mortality re-
13 view committee established under sub-
14 section (a)(1), shall investigate each case,
15 using the case abstraction form described
16 in subsection (c), and prepare a de-identi-
17 fied case summary for each case, which
18 shall be reviewed by the committee and in-
19 cluded in applicable reports. The State de-
20 partment of health or vital statistics unit
21 of the State, as the case may be, shall pro-
22 vide the State maternal mortality review
23 committee with access to the information
24 collected pursuant to subparagraph (A) or

1 (B), or under subparagraph (C), as nec-
2 essary to carry out this subparagraph.

3 (ii) MANDATORY DATA AND INFORMA-
4 TION.—Each case investigation under this
5 subparagraph shall, subject to availability,
6 include data and information obtained
7 through—

8 (I) medical examiner and autopsy
9 reports of the person involved;

10 (II) medical records of the per-
11 son, including such records related to
12 health care prior to pregnancy, pre-
13 natal and postnatal care, labor and
14 delivery care, emergency room care,
15 hospital discharge records, and any
16 care delivered up until the time of
17 death of the person;

18 (III) oral and written interviews
19 of individuals directly involved in the
20 maternal care of the person during
21 and immediately following the preg-
22 nancy of the person, including health
23 care, mental health, and social service
24 providers, as applicable;

1 (IV) socioeconomic and other rel-
2 evant background information about
3 the person;

4 (V) any information collected
5 under subparagraph (C)(i); and

6 (VI) any other information on
7 the cause of death of the person, such
8 as social services and child welfare re-
9 ports.

10 (iii) DISCRETIONARY DATA AND IN-
11 FORMATION.—Each case investigation
12 under this subparagraph may include data
13 and information obtained through oral or
14 written interviews of the family of the per-
15 son.

16 (2) STATE MATERNAL MORTALITY REVIEW
17 COMMITTEES.—

18 (A) MANDATORY ACTIVITIES.—A State
19 maternal mortality review committee established
20 under subsection (a)(1) shall carry out the fol-
21 lowing activities:

22 (i) Develop the processes described in
23 subparagraphs (A) and (B) of paragraph
24 (1).

1 (ii) Review the data and information
2 collected by the vital statistics unit of the
3 State under paragraph (1)(C) regarding
4 pregnancy-related and pregnancy-associ-
5 ated deaths to identify trends, patterns,
6 and disparities in adverse outcomes and
7 address medical, non-medical, and system-
8 related factors that may have contributed
9 to such pregnancy-related and pregnancy-
10 associated deaths and disparities.

11 (iii) Carry out the activities described
12 in paragraph (1)(D).

13 (iv) Develop recommendations, based
14 on the case summaries prepared under
15 paragraph (1)(D) and the data and infor-
16 mation collected under paragraph (1)(C),
17 to improve maternal care, social and health
18 services, and public health policy and insti-
19 tutions, including improving access to ma-
20 ternal care and social and health services
21 and identifying disparities in maternal care
22 and outcomes.

23 (B) DISCRETIONARY ACTIVITIES.—

24 (i) IN GENERAL.—A State maternal
25 mortality review committee established

1 under subsection (a)(1) may, while subject
2 to confidentiality requirements, present
3 findings and recommendations based on
4 the case summaries prepared under para-
5 graph (1)(D) directly to a health care facil-
6 ity or its local or State professional organi-
7 zation for the purpose of—

8 (I) instituting policy changes,
9 educational activities, and improve-
10 ments in the quality of care provided
11 by the facility; and

12 (II) exploring and forming re-
13 gional collaborations.

14 (ii) INVESTIGATION OF CASES OF SE-
15 VERE MATERNAL MORBIDITY.—A State
16 maternal mortality review committee may
17 investigate cases of severe maternal mor-
18 bidity and any such investigation may in-
19 clude data and information obtained
20 through—

21 (I) identified patient registries;

22 or

23 (II) oral or written interviews of
24 the person concerned and the family
25 of such person.

1 (C) COMPOSITION OF STATE MATERNAL
2 MORTALITY REVIEW COMMITTEES.—

3 (i) IN GENERAL.—A State maternal
4 mortality review committee established
5 under subsection (a)(1) shall be multidisci-
6 plinary and diverse. Membership on the
7 State maternal mortality review committee
8 shall be reviewed annually by the State de-
9 partment of health to ensure that member-
10 ship representation requirements are being
11 fulfilled in accordance with this subpara-
12 graph.

13 (ii) REQUIRED MEMBERSHIP.—Each
14 State maternal mortality review committee
15 shall include—

16 (I) representatives from medical
17 specialties providing care to pregnant
18 and postpartum patients, including
19 obstetricians (including generalists
20 and maternal fetal medicine special-
21 ists) and family practice physicians;

22 (II) certified nurse midwives, cer-
23 tified midwives, and advanced practice
24 nurses;

- 1 (III) hospital-based registered
2 nurses;
- 3 (IV) representatives of the ma-
4 ternal and child health department of
5 the State department of health;
- 6 (V) social service providers or so-
7 cial workers, including those with ex-
8 perience working with communities di-
9 verse with respect to race, ethnicity,
10 and limited-English proficiency;
- 11 (VI) chief medical examiners or
12 designees;
- 13 (VII) facility representatives,
14 such as from hospitals or birth cen-
15 ters;
- 16 (VIII) patient advocates, commu-
17 nity maternal health organizations,
18 and minority advocacy groups that
19 represent those diverse racial and eth-
20 nic communities within the State that
21 are the most affected by pregnancy-
22 related or pregnancy-associated deaths
23 and by a lack of access to maternal
24 health care services; and

1 (IX) representatives of the de-
2 partments of health or public health
3 of major cities in the State.

4 (iii) DISCRETIONARY MEMBERSHIP.—
5 Each State maternal mortality review com-
6 mittee may also include representatives
7 from other relevant academic, health, so-
8 cial service, or policy professions or com-
9 munity organizations on an ongoing basis,
10 or as needed, as determined beneficial by
11 the committee, including—

12 (I) anesthesiologists;

13 (II) emergency physicians;

14 (III) pathologists;

15 (IV) epidemiologists;

16 (V) intensivists;

17 (VI) nutritionists;

18 (VII) mental health professionals;

19 (VIII) substance use disorder
20 treatment specialists;

21 (IX) representatives of relevant
22 patient and provider advocacy groups;

23 (X) academics;

24 (XI) paramedics; and

1 (XII) risk management special-
2 ists.

3 (iv) STAFF.—Staff of each State ma-
4 ternal mortality review committee shall in-
5 clude—

6 (I) vital health statisticians, ma-
7 ternal child health statisticians, or
8 epidemiologists;

9 (II) a coordinator of the State
10 maternal mortality review committee,
11 to be designated by the State; and

12 (III) administrative staff.

13 (D) OPTION FOR STATES TO ESTABLISH
14 REGIONAL MATERNAL MORTALITY REVIEW COM-
15 MITTEES.—States may choose to partner with
16 one or more neighboring States to carry out the
17 activities required of a State maternal mortality
18 review committee under this section. In such a
19 case, with respect to the States in such a part-
20 nership, any requirement under this section re-
21 lating to the reporting of information related to
22 such activities shall be deemed to be fulfilled by
23 each such State if a single such report is sub-
24 mitted for the partnership.

1 (E) TREATMENT AS PUBLIC HEALTH AU-
2 THORITY FOR PURPOSES OF HIPAA.—For pur-
3 poses of applying HIPAA privacy and security
4 law (as defined in section 3009(a)(2) of the
5 Public Health Service Act (42 U.S.C. 300jj–
6 19)), each State maternal mortality review com-
7 mittee and regional maternal mortality review
8 committee established under subsection (a)(1)
9 or subsection (b)(2)(D), as the case may be,
10 shall be deemed to be a public health authority
11 described in section 164.501 (and referenced in
12 section 164.512(b)(1)(i)) of title 45, Code of
13 Federal Regulations (or any successor regula-
14 tion), carrying out public health activities and
15 purposes described in such section
16 164.512(b)(1)(i) (or any such successor regula-
17 tion).

18 (3) STATE DEPARTMENT OF HEALTH ACTIVI-
19 TIES.—With respect to a State that receives a grant
20 under subsection (a)(1), the State department of
21 health shall—

22 (A) in consultation with the State maternal
23 mortality review committee and in conjunction
24 with relevant professional organizations and pa-
25 tient advocacy organizations, develop a plan for

1 ongoing health care provider education, based
2 on the findings and recommendations of the
3 committee, in order to improve the quality of
4 maternal care; and

5 (B) take steps to widely disseminate the
6 findings and recommendations of the State ma-
7 ternal mortality review committee and imple-
8 ment the recommendations of the committee.

9 (c) CASE ABSTRACTION FORM.—

10 (1) DISSEMINATION.—The Director of the Cen-
11 ters for Disease Control and Prevention shall dis-
12 seminate a uniform case abstraction form to States
13 and State maternal mortality review committees for
14 the purpose of—

15 (A) ensuring that the data and information
16 collected and reviewed by such committees can
17 be pooled for review by the Department of
18 Health and Human Services and its agencies;
19 and

20 (B) preserving the uniformity of the infor-
21 mation collected for Federal public health pur-
22 poses.

23 (2) PERMISSIBLE STATE MODIFICATION.—Each
24 State may modify the form developed under para-
25 graph (1) for implementation and use by such State

1 or by the State maternal mortality review committee
2 of such State by including on such form additional
3 information to be collected, but may not alter the
4 standard questions on such form, in order to ensure
5 that the information can be collected and reviewed
6 centrally at the Federal level.

7 (d) PUBLIC DISCLOSURE OF INFORMATION.—

8 (1) IN GENERAL.—For fiscal year 2019, or a
9 subsequent fiscal year, each State receiving a grant
10 under this section for such year shall, subject to
11 paragraph (3), provide for the public disclosure, and
12 submission to the information clearinghouse estab-
13 lished under paragraph (2), of the information in-
14 cluded in the report of the State under subsection
15 (f)(1) for such year.

16 (2) INFORMATION CLEARINGHOUSE.—The Sec-
17 retary shall establish an information clearinghouse,
18 to be administered by the Director of the Centers for
19 Disease Control and Prevention, that will maintain
20 findings and recommendations submitted pursuant
21 to paragraph (1) and provide such findings and rec-
22 ommendations for public review and research pur-
23 poses by State departments of health, State mater-
24 nal mortality review committees, health providers

1 and institutions, and national patient and provider
2 advocacy groups.

3 (3) CONFIDENTIALITY OF INFORMATION.—In
4 no case may any individually identifiable health in-
5 formation be provided to the public, or submitted to
6 the information clearinghouse, under this subsection.

7 (e) CONFIDENTIALITY OF PROCEEDINGS OF STATE
8 MATERNAL MORTALITY REVIEW COMMITTEES.—

9 (1) IN GENERAL.—All proceedings and activi-
10 ties of a State maternal mortality review committee
11 established under subsection (a)(1), opinions of
12 members of such a committee formed as a result of
13 such proceedings and activities, and records ob-
14 tained, created, or maintained pursuant to this sec-
15 tion, including records of interviews, written reports,
16 and statements procured by the Department of
17 Health and Human Services or by any other person,
18 agency, or organization acting jointly with the De-
19 partment, in connection with morbidity and mor-
20 tality reviews under this section, shall be confidential
21 and may not be subject to discovery, subpoena, or
22 introduction into evidence in any civil, criminal, leg-
23 islative, or other proceeding. Such records shall not
24 be open to public inspection.

1 (2) TESTIMONY OF MEMBERS OF COM-
2 MITTEE.—

3 (A) IN GENERAL.—Members of a State
4 maternal mortality review committee established
5 under subsection (a)(1) may not be questioned
6 in any civil, criminal, legislative, or other pro-
7 ceeding regarding information presented in, or
8 opinions formed as a result of, a meeting or
9 communication of the committee.

10 (B) CLARIFICATION.—Nothing in this sub-
11 section may be construed to prevent a member
12 of a State maternal mortality review committee
13 established under subsection (a)(1) from testi-
14 fying regarding information that was obtained
15 independent of such member's participation on
16 the committee, or public information.

17 (3) AVAILABILITY OF INFORMATION FOR RE-
18 SEARCH PURPOSES.—Nothing in this subsection may
19 prohibit a State maternal mortality review com-
20 mittee established under subsection (a)(1) or the De-
21 partment of Health and Human Services from pub-
22 lishing statistical compilations and research reports
23 that—

1 (A) are based on confidential information,
2 relating to morbidity and mortality reviews
3 under this section; and

4 (B) do not contain identifying information
5 or any other information that could be used to
6 ultimately identify the individuals concerned.

7 (f) REPORTS.—

8 (1) STATE REPORTS.—Not later than one year
9 after the end of fiscal year 2019, and each subse-
10 quent fiscal year, each State maternal mortality re-
11 view committee established under subsection (a)(1)
12 and receiving a grant under this section for such
13 year, shall submit to the Director of the Centers for
14 Disease Control and Prevention a report on the find-
15 ings and recommendations of such committee and
16 information on the implementation of such rec-
17 ommendations during such year.

18 (2) ANNUAL REPORTS TO CONGRESS.—Not
19 later than 60 days after the deadline for State re-
20 ports under paragraph (1) for fiscal year 2019, and
21 each subsequent fiscal year, the Secretary of Health
22 and Human Services shall submit to Congress a re-
23 port on—

1 (A) the findings, recommendations, and
2 implementation information submitted by any
3 State pursuant to paragraph (1); and

4 (B) the status of pregnancy-related and
5 pregnancy-associated deaths in the United
6 States, including recommendations on methods
7 to prevent such deaths in the United States.

8 (g) DEFINITIONS.—In this section:

9 (1) PREGNANCY-ASSOCIATED DEATH.—The
10 term “pregnancy-associated death” means the death
11 of a person while pregnant or during the one-year
12 period following the date of the end of pregnancy, ir-
13 respective of the cause of such death.

14 (2) PREGNANCY-RELATED DEATH.—The term
15 “pregnancy-related death” means the death of a per-
16 son while pregnant or during the one-year period fol-
17 lowing the date of the end of pregnancy, irrespective
18 of the duration of the pregnancy, from any cause re-
19 lated to, or aggravated by, the pregnancy or its
20 management, excluding any accidental or incidental
21 cause.

22 (3) SEVERE MATERNAL MORBIDITY.—The term
23 “severe maternal morbidity” means the physical and
24 psychological conditions that result from, or are ag-

1 gravated by, pregnancy and have an adverse effect
2 on the health of a person.

3 (4) STATE.—The term “State” means each of
4 the 50 States, the District of Columbia, and each of
5 the territories.

6 (5) VITAL STATISTICS UNIT.—The term “vital
7 statistics unit” means the entity that is responsible
8 for maintaining vital records for a State, including
9 official records of live births, deaths, fetal deaths,
10 marriages, divorces, and annulments.

11 (h) AUTHORIZATION OF APPROPRIATIONS.—There is
12 authorized to be appropriated to carry out this section
13 \$7,000,000 for each of fiscal years 2019 through 2023.

14 **SEC. 506. ELIMINATING DISPARITIES IN MATERNITY**
15 **HEALTH OUTCOMES.**

16 Part B of title III of the Public Health Service Act
17 is amended by inserting after section 317V (as added by
18 section 110), the following:

19 **“SEC. 317W. ELIMINATING DISPARITIES IN MATERNAL**
20 **HEALTH OUTCOMES.**

21 “(a) IN GENERAL.—The Secretary shall, in consulta-
22 tion with relevant national stakeholder organizations, such
23 as national medical specialty organizations, national ma-
24 ternal child health organizations, national patient advo-
25 cacy organizations, and national health disparity organiza-

1 tions, carry out the following activities to eliminate dis-
2 parities in maternal health outcomes:

3 “(1) Conduct research into the determinants
4 and the distribution of disparities in maternal care,
5 health risks, and health outcomes, and improve the
6 capacity of the performance measurement infrastruc-
7 ture to measure such disparities.

8 “(2) Expand access to health care services, re-
9 sources, and information that have been dem-
10 onstrated to improve the quality and outcomes of
11 maternity care for vulnerable populations.

12 “(3) Establish a demonstration project to com-
13 pare the effectiveness of interventions to reduce dis-
14 parities in maternity services and outcomes and to
15 implement and assess effective interventions.

16 “(b) SCOPE AND SELECTION OF STATES FOR DEM-
17 ONSTRATION PROJECT.—The demonstration project
18 under subsection (a)(3) shall be conducted in no more
19 than 8 States, which shall be selected by the Secretary
20 based on—

21 “(1) applications submitted by States, which
22 specify which regions and populations the State in-
23 volved will serve under the demonstration project;

24 “(2) criteria designed by the Secretary to en-
25 sure that, as a whole, the demonstration project is,

1 to the greatest extent possible, representative of the
2 demographic and geographic composition of commu-
3 nities most affected by disparities;

4 “(3) criteria designed by the Secretary to en-
5 sure that a variety of models are tested through the
6 demonstration project and that such models include
7 interventions that have an existing evidence base for
8 effectiveness; and

9 “(4) criteria designed by the Secretary to en-
10 sure that the demonstration projects and models will
11 be carried out in consultation with local and regional
12 provider organizations, such as community health
13 centers, hospital systems, and medical societies rep-
14 resenting providers of maternity services.

15 “(c) DURATION OF DEMONSTRATION PROJECT.—
16 The demonstration project under subsection (a)(3) shall
17 begin on January 1, 2019, and end on December 31,
18 2022.

19 “(d) GRANTS FOR EVALUATION AND MONITORING.—
20 The Secretary may make grants to States and health care
21 providers participating in the demonstration project under
22 subsection (a)(3) for the purpose of collecting data nec-
23 essary for the evaluation and monitoring of such project.

24 “(e) REPORTS.—

1 “(1) STATE REPORTS.—Each State that par-
 2 ticipates in the demonstration project under sub-
 3 section (a)(3) shall report to the Secretary, in a
 4 time, form, and manner specified by the Secretary,
 5 the data necessary to—

6 “(A) monitor the—

7 “(i) outcomes of the project;

8 “(ii) costs of the project; and

9 “(iii) quality of maternity care pro-
 10 vided under the project; and

11 “(B) evaluate the rationale for the selec-
 12 tion of the items and services included in any
 13 bundled payment made by the State under the
 14 project.

15 “(2) FINAL REPORT.—Not later than December
 16 31, 2022, the Secretary shall submit to Congress a
 17 report on the results of the demonstration project
 18 under subsection (a)(3).”.

19 **SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN**
 20 **UNEXPECTED INFANT DEATH AND SUDDEN**
 21 **UNEXPLAINED DEATH IN CHILDHOOD.**

22 (a) ESTABLISHMENT.—The Secretary of Health and
 23 Human Services, acting through the Administrator of the
 24 Health Resources and Services Administration and in con-
 25 sultation with the Director of the Centers for Disease Con-

1 trol and Prevention and the Director of the National Insti-
2 tutes of Health (in this section referred to as the “Sec-
3 retary”), shall establish and implement a culturally and
4 linguistically competent public health awareness and edu-
5 cation campaign to provide information that is focused on
6 decreasing the risk factors for sudden unexpected infant
7 death and sudden unexplained death in childhood, includ-
8 ing educating individuals about safe sleep environments,
9 sleep positions, and reducing exposure to smoking during
10 pregnancy and after birth.

11 (b) TARGETED POPULATIONS.—The campaign under
12 subsection (a) shall be designed to reduce health dispari-
13 ties through the targeting of populations with high rates
14 of sudden unexpected infant death and sudden unex-
15 plained death in childhood.

16 (c) CONSULTATION.—In establishing and imple-
17 menting the campaign under subsection (a), the Secretary
18 shall consult with national organizations representing
19 health care providers, including nurses and physicians,
20 parents, child care providers, children’s advocacy and safe-
21 ty organizations, maternal and child health programs, nu-
22 trition professionals focusing on women, infants, and chil-
23 dren, and other individuals and groups determined nec-
24 essary by the Secretary for such establishment and imple-
25 mentation.

1 (d) GRANTS.—

2 (1) IN GENERAL.—In carrying out the cam-
3 paign under subsection (a), the Secretary shall
4 award grants to national organizations, State and
5 local health departments, and community-based or-
6 ganizations for the conduct of education and out-
7 reach programs for nurses, parents, child care pro-
8 viders, public health agencies, and community orga-
9 nizations.

10 (2) APPLICATION.—To be eligible to receive a
11 grant under paragraph (1), an entity shall submit to
12 the Secretary an application at such time, in such
13 manner, and containing such information as the Sec-
14 retary may require.

15 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
16 authorized to be appropriated to carry out this section
17 such sums as may be necessary for each of fiscal years
18 2019 through 2023.

19 **SEC. 508. REDUCING UNINTENDED TEENAGE PREG-**
20 **NANCIES.**

21 Title III of the Public Health Service Act (42 U.S.C.
22 241 et seq.) is amended by adding at the end the fol-
23 lowing:

1 **“PART W—YOUTH ACCESS TO SEXUAL HEALTH**
2 **SERVICES**
3 **“SEC. 39900. AUTHORIZATION OF GRANTS TO SUPPORT**
4 **THE ACCESS OF MARGINALIZED YOUTH TO**
5 **SEXUAL HEALTH SERVICES.**

6 “(a) GRANTS.—The Secretary may award grants on
7 a competitive basis to eligible entities to support the access
8 of marginalized youth to sexual health services.

9 “(b) USE OF FUNDS.—An eligible entity that is
10 awarded a grant under subsection (a) may use the funds
11 to—

12 “(1) provide medically accurate and complete
13 and age-, developmentally, and culturally appro-
14 priate sexual health information to marginalized
15 youth, including information on how to access sexual
16 health services;

17 “(2) promote effective communication regarding
18 sexual health among marginalized youth;

19 “(3) promote and support better health, edu-
20 cation, and economic opportunities for school-age
21 parents; and

22 “(4) train individuals who work with
23 marginalized youth to promote—

24 “(A) the prevention of unintended preg-
25 nancy;

1 “(B) the prevention of sexually transmitted
2 infections, including the human immuno-
3 deficiency virus (HIV);

4 “(C) healthy relationships; and

5 “(D) the development of safe and sup-
6 portive environments.

7 “(c) APPLICATION.—To be awarded a grant under
8 subsection (a), an eligible entity shall submit an applica-
9 tion to the Secretary at such time, in such manner, and
10 containing such information as the Secretary may require.

11 “(d) PRIORITY.—In awarding grants under sub-
12 section (a), the Secretary shall give priority to eligible enti-
13 ties—

14 “(1) with a history of supporting the access of
15 marginalized youth to sexuality education or sexual
16 health services; and

17 “(2) that plan to serve marginalized youth that
18 are not served by Federal adolescent programs for
19 the prevention of pregnancy, HIV, and other sexu-
20 ally transmitted infections.

21 “(e) REQUIREMENTS.—The Secretary may not award
22 a grant under subsection (a) to an eligible entity unless—

23 “(1) such eligible entity has formed a partner-
24 ship with a community organization; and

25 “(2) such eligible entity agrees—

1 “(A) to employ a scientifically effective
2 strategy;

3 “(B) that all information provided to
4 marginalized youth will be—

5 “(i) age- and developmentally appro-
6 priate;

7 “(ii) medically accurate and complete;

8 “(iii) scientifically based; and

9 “(iv) provided in the language and
10 cultural context that is most appropriate
11 for the individuals served by the eligible
12 entity; and

13 “(C) that for each year the eligible entity
14 receives grant funds under subsection (a), the
15 eligible entity will submit to the Secretary an
16 annual report that includes—

17 “(i) the use of grant funds by the eli-
18 gible entity;

19 “(ii) how the use of grant funds has
20 increased the access of marginalized youth
21 to sexual health services; and

22 “(iii) such other information as the
23 Secretary may require.

24 “(f) PUBLICATION AND EVALUATIONS.—

1 “(1) EVALUATIONS.—Not less than once every
2 two years after the date of the enactment of this
3 part, the Secretary shall evaluate the effectiveness of
4 whichever of the following is greater:

5 “(A) Eight grants awarded under sub-
6 section (a).

7 “(B) Ten percent of the grants awarded
8 under subsection (a).

9 “(2) PUBLICATION.—The Secretary shall make
10 available to the public—

11 “(A) the evaluations required under para-
12 graph (1); and

13 “(B) the reports required under subsection
14 (e)(2)(C).

15 “(g) LIMITATIONS.—No funds made available to an
16 eligible entity under this section may be used by such enti-
17 ty to provide access to sexual health services that—

18 “(1) withhold sexual health-promoting or life-
19 saving information;

20 “(2) are medically inaccurate or have been sci-
21 entifically shown to be ineffective;

22 “(3) promote gender stereotypes;

23 “(4) are insensitive or unresponsive to the
24 needs of young people, including—

1 “(A) youth with varying gender identities,
2 gender expressions, and sexual orientations;

3 “(B) sexually active youth;

4 “(C) pregnant or parenting youth;

5 “(D) survivors of sexual abuse or assault;

6 and

7 “(E) youth of all physical, developmental,
8 and mental abilities; or

9 “(5) are inconsistent with the ethical impera-
10 tives of medicine and public health.

11 “(h) TRANSFER OF FUNDS.—Any unobligated bal-
12 ance of funds made available under section 510(d) of the
13 Social Security Act (42 U.S.C. 710(d)) (as in effect on
14 the day before the date of the enactment of this part) are
15 hereby transferred and made available to the Secretary to
16 carry out this section. The amounts transferred and made
17 available to carry out this section shall remain available
18 until expended.

19 “(i) DEFINITIONS.—In this section:

20 “(1) COMMUNITY ORGANIZATION.—The term
21 ‘community organization’ includes a State or local
22 health or education agency, public school, youth-fo-
23 cused organization that is faith-based and commu-
24 nity-based, juvenile justice entity, or other organiza-
25 tion that provides confidential and appropriate sexu-

1 ality education or sexual health services to
2 marginalized youth.

3 “(2) ELIGIBLE ENTITY.—The term ‘eligible en-
4 tity’ includes a State or local health or education
5 agency, public school, nonprofit organization, hos-
6 pital, or an Indian Tribe or Tribal organization (as
7 such terms are defined in section 4 of the Indian
8 Self-Determination and Education Assistance Act
9 (25 U.S.C. 5304)).

10 “(3) MARGINALIZED YOUTH.—The term
11 ‘marginalized youth’ means a person under the age
12 of 26 that is disadvantaged by underlying structural
13 barriers and social inequity.

14 “(4) MEDICALLY ACCURATE AND COMPLETE.—
15 The term ‘medically accurate and complete’, when
16 used with respect to information, means information
17 that—

18 “(A) is supported by research and recog-
19 nized as accurate, objective, and complete by
20 leading medical, psychological, psychiatric, or
21 public health organizations and agencies; and

22 “(B) does not withhold any information re-
23 lating to the effectiveness and benefits of cor-
24 rect and consistent use of condoms or other

1 contraceptives and pregnancy prevention meth-
2 ods.

3 “(5) SCIENTIFICALLY EFFECTIVE STRATEGY.—

4 The term ‘scientifically effective strategy’ means a
5 strategy that—

6 “(A) is widely recognized by leading med-
7 ical and public health agencies as effective in
8 promoting sexual health awareness and healthy
9 behavior; and

10 “(B) either—

11 “(i) has been demonstrated to be ef-
12 fective on the basis of rigorous scientific
13 research; or

14 “(ii) incorporates characteristics of ef-
15 fective programs.

16 “(6) SEXUAL HEALTH SERVICES.—The term
17 ‘sexual health services’ includes—

18 “(A) sexual health information, education,
19 and counseling;

20 “(B) contraception;

21 “(C) emergency contraception;

22 “(D) condoms and other barrier methods
23 to prevent pregnancy or sexually transmitted in-
24 fections;

1 “(E) routine gynecological care, including
2 human papillomavirus (HPV) vaccines and can-
3 cer screenings;

4 “(F) pre-exposure prophylaxis or post-ex-
5 posure prophylaxis;

6 “(G) mental health services;

7 “(H) sexual assault survivor services; and

8 “(I) other prevention, care, or treatment.”.

9 **SEC. 509. GESTATIONAL DIABETES.**

10 Part B of title III of the Public Health Service Act
11 (42 U.S.C. 243 et seq.) is amended by adding after section
12 317H the following:

13 **“SEC. 317H-1. GESTATIONAL DIABETES.**

14 “(a) UNDERSTANDING AND MONITORING GESTA-
15 TIONAL DIABETES.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Director of the Centers for Disease
18 Control and Prevention, in consultation with the Di-
19 abetes Mellitus Interagency Coordinating Committee
20 established under section 429 and representatives of
21 appropriate national health organizations, shall de-
22 velop a multisite gestational diabetes research
23 project within the diabetes program of the Centers
24 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 indi-
18 viduals 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 pregnant individuals; 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 individuals who can become preg-
25 nant with a history of gestational 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 individuals
7 who can become pregnant with a history of ges-
8 tational diabetes.

9 “(2) AUTHORIZATION OF APPROPRIATIONS.—
10 There is authorized to be appropriated to carry out
11 this subsection \$5,000,000 for each of fiscal years
12 2019 through 2023.

13 “(c) DEMONSTRATION GRANTS TO LOWER THE
14 RATE OF GESTATIONAL DIABETES.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Director of the Centers for Disease
17 Control and Prevention, shall award grants, on a
18 competitive basis, to eligible entities for demonstra-
19 tion projects that implement evidence-based inter-
20 ventions to reduce the incidence of gestational diabe-
21 tes, the recurrence of gestational diabetes in subse-
22 quent pregnancies, and the development of type 2 di-
23 abetes in individuals who can become pregnant with
24 a history of gestational diabetes.

1 “(2) PRIORITY.—In making grants under this
2 subsection, the Secretary shall give priority to
3 projects focusing on—

4 “(A) helping individuals who can become
5 pregnant who have 1 or more risk factors for
6 developing gestational diabetes;

7 “(B) working with individuals who can be-
8 come pregnant with a history of gestational dia-
9 betes during a previous pregnancy;

10 “(C) providing postpartum care for indi-
11 viduals who can become pregnant with gesta-
12 tional diabetes;

13 “(D) tracking cases where individuals who
14 can become pregnant with a history of gesta-
15 tional diabetes developed type 2 diabetes;

16 “(E) educating mothers with a history of
17 gestational diabetes about the increased risk of
18 their child developing diabetes;

19 “(F) working to prevent gestational diabe-
20 tes and prevent or delay the development of
21 type 2 diabetes in individuals who can become
22 pregnant with a history of gestational diabetes;
23 and

24 “(G) achieving outcomes designed to assess
25 the efficacy and cost-effectiveness of interven-

1 tions that can inform decisions on long-term
2 sustainability, including third-party reimburse-
3 ment.

4 “(3) APPLICATION.—An eligible entity desiring
5 to receive a grant under this subsection shall submit
6 to the Secretary—

7 “(A) an application at such time, in such
8 manner, and containing such information as the
9 Secretary may require; and

10 “(B) a plan to—

11 “(i) lower the rate of gestational dia-
12 betes during pregnancy; or

13 “(ii) develop methods of tracking indi-
14 viduals who can become pregnant with a
15 history of gestational diabetes and develop
16 effective interventions to lower the inci-
17 dence of the recurrence of gestational dia-
18 betes in subsequent pregnancies and the
19 development of type 2 diabetes.

20 “(4) USES OF FUNDS.—An eligible entity re-
21 ceiving a grant under this subsection shall use the
22 grant funds to carry out demonstration projects de-
23 scribed in paragraph (1), including—

24 “(A) expanding community-based health
25 promotion education, activities, and incentives

1 focused on the prevention of gestational diabe-
2 tes and development of type 2 diabetes in indi-
3 viduals who can become pregnant with a history
4 of gestational diabetes;

5 “(B) aiding State- and Tribal-based diabe-
6 tes prevention and control programs to collect,
7 analyze, disseminate, and report surveillance
8 data on individuals who can become pregnant
9 with, and at risk for, gestational diabetes, the
10 recurrence of gestational diabetes in subsequent
11 pregnancies, and, for individuals who can be-
12 come pregnant with a history of gestational dia-
13 betes, the development of type 2 diabetes; and

14 “(C) training and encouraging health care
15 providers—

16 “(i) to promote risk assessment, high-
17 quality care, and self-management for ges-
18 tational diabetes and the recurrence of ges-
19 tational diabetes in subsequent preg-
20 nancies; and

21 “(ii) to prevent the development of
22 type 2 diabetes in individuals who can be-
23 come pregnant with a history of gesta-
24 tional diabetes, and its complications in the

1 practice settings of the health care pro-
2 viders.

3 “(5) REPORT.—Not later than 4 years after the
4 date of the enactment of this section, the Secretary
5 shall prepare and submit to the Congress a report
6 concerning the results of the demonstration projects
7 conducted through the grants awarded under this
8 subsection.

9 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
10 this subsection, the term ‘eligible entity’ means a
11 nonprofit organization (such as a nonprofit academic
12 center or community health center) or a State, Trib-
13 al, or local health agency.

14 “(7) AUTHORIZATION OF APPROPRIATIONS.—
15 There is authorized to be appropriated to carry out
16 this subsection \$5,000,000 for each of fiscal years
17 2019 through 2023.

18 “(d) POSTPARTUM FOLLOWUP REGARDING GESTA-
19 TIONAL DIABETES.—The Secretary, acting through the
20 Director of the Centers for Disease Control and Preven-
21 tion, shall work with the State- and Tribal-based diabetes
22 prevention and control programs assisted by the Centers
23 to encourage postpartum followup after gestational diabe-
24 tes, as medically appropriate, for the purpose of reducing
25 the incidence of gestational diabetes, the recurrence of

1 gestational diabetes in subsequent pregnancies, the devel-
2 opment of type 2 diabetes in individuals with a history
3 of gestational diabetes, and related complications.”.

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

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

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

13 (2) DISSEMINATION.—The Secretary may dis-
14 seminate medically accurate and complete informa-
15 tion under paragraph (1) directly or through ar-
16 rangements with nonprofit organizations, community
17 health workers including promotoras, consumer
18 groups, institutions of higher education, clinics, the
19 media, and Federal, State, and local agencies.

20 (3) INFORMATION.—The information dissemi-
21 nated under paragraph (1) shall—

22 (A) include, at a minimum, a description
23 of emergency contraception and an explanation
24 of the use, safety, efficacy, and availability of

1 such contraception and options for no-copay ac-
2 cess through insurance; and

3 (B) be pilot tested for consumer com-
4 prehension, cultural and linguistic appropriate-
5 ness, and acceptance of the messages across
6 geographically, racially, ethnically, and linguis-
7 tically diverse populations.

8 (b) EMERGENCY CONTRACEPTION INFORMATION
9 PROGRAM FOR HEALTH CARE PROVIDERS.—

10 (1) IN GENERAL.—The Secretary, acting
11 through the Administrator of the Health Resources
12 and Services Administration and in consultation
13 with major medical and public health organizations,
14 shall develop and disseminate to health care pro-
15 viders information on emergency contraception.

16 (2) INFORMATION.—The information dissemi-
17 nated under paragraph (1) shall include, at a min-
18 imum—

19 (A) information describing the use, safety,
20 efficacy, availability of emergency contraception,
21 and options for no-copay access through insur-
22 ance;

23 (B) a recommendation regarding the use of
24 such contraception; and

1 (C) information explaining how to obtain
2 copies of the information developed under sub-
3 section (a) for distribution to the patients of
4 the providers.

5 (c) DEFINITIONS.—In this section:

6 (1) EMERGENCY CONTRACEPTION.—The term
7 “emergency contraception” means a drug or device
8 (as the terms are defined in section 201 of the Fed-
9 eral Food, Drug, and Cosmetic Act (21 U.S.C. 321))
10 or a drug regimen that—

11 (A) is used postcoitally;

12 (B) prevents pregnancy primarily by pre-
13 venting or delaying ovulation, and does not ter-
14 minate an established pregnancy; and

15 (C) is approved by the Food and Drug Ad-
16 ministration.

17 (2) HEALTH CARE PROVIDER.—The term
18 “health care provider” means an individual who is li-
19 censed or certified under State law to provide health
20 care services and who is operating within the scope
21 of such license. Such term shall include a phar-
22 macist.

23 (3) INSTITUTION OF HIGHER EDUCATION.—The
24 term “institution of higher education” has the same

1 meaning given such term in section 101(a) of the
2 Higher Education Act of 1965 (20 U.S.C. 1001(a)).

3 (4) **MEDICALLY ACCURATE AND COMPLETE.**—

4 The term “medically accurate and complete” means,
5 with respect to information, activities, or services
6 verified or supported by the weight of research con-
7 ducted in compliance with accepted scientific meth-
8 ods and—

9 (A) published in peer-reviewed journals,
10 where applicable; or

11 (B) comprising information that leading
12 professional organizations and agencies with
13 relevant expertise in the field recognize as accu-
14 rate, objective, and complete.

15 (5) **SECRETARY.**—The term “Secretary” means
16 the Secretary of Health and Human Services.

17 (d) **AUTHORIZATION OF APPROPRIATIONS.**—There
18 are authorized to be appropriated to carry out this section
19 such sums as may be necessary for each of the fiscal years
20 2019 through 2023.

21 **SEC. 511. COMPREHENSIVE SEX EDUCATION PROGRAMS.**

22 (a) **PURPOSES; FINDING; SENSE OF CONGRESS.**—

23 (1) **PURPOSES.**—The purposes of this section
24 are to provide young people with comprehensive sex
25 education programs that—

1 (A) promote and uphold the rights of
2 young people to information in order to make
3 healthy decisions about their sexual health;

4 (B) provide the information and skills all
5 young people need to make informed, respon-
6 sible, and healthy decisions in order to become
7 sexually healthy adults and have healthy rela-
8 tionships;

9 (C) provide information about the preven-
10 tion of unintended pregnancy, sexually trans-
11 mitted infections, including HIV, dating vio-
12 lence, sexual assault, bullying, and harassment;
13 and

14 (D) provide resources and information on
15 topics ranging from gender stereotyping and
16 gender roles and stigma and socio-cultural in-
17 fluences surrounding sex and sexuality.

18 (2) FINDING ON REQUIRED RESOURCES.—In
19 order to provide the comprehensive sex education de-
20 scribed in paragraph (1), Congress finds that in-
21 creased resources are required for sex education pro-
22 grams that—

23 (A) substantially incorporate elements of
24 evidence-based programs or characteristics of
25 effective programs;

1 (B) cover a broad range of topics, includ-
2 ing medically accurate and complete informa-
3 tion that is age and developmentally appro-
4 priate about all the aspects of sex, sexual
5 health, and sexuality;

6 (C) are gender and gender identity-sen-
7 sitive, emphasizing the importance of equality
8 and the social environment for achieving sexual
9 and reproductive health and overall well-being;

10 (D) promote educational achievement, crit-
11 ical thinking, decisionmaking, self-esteem, and
12 self-efficacy;

13 (E) help develop healthy attitudes and in-
14 sights necessary for understanding relationships
15 between oneself and others and society;

16 (F) foster leadership skills and community
17 engagement by—

18 (i) promoting principles of fairness,
19 human dignity, and respect; and

20 (ii) engaging young people as partners
21 in their communities; and

22 (G) are culturally and linguistically appro-
23 priate, reflecting the diverse circumstances and
24 realities of young people.

1 (3) SENSE OF CONGRESS.—It is the sense of
2 Congress that—

3 (A) federally funded sex education pro-
4 grams should aim to—

5 (i) provide information about a range
6 of human sexuality topics, including—

7 (I) human development, healthy
8 relationships, personal skills;

9 (II) sexual behavior including ab-
10 stinence;

11 (III) sexual health including pre-
12 venting unintended pregnancy;

13 (IV) sexually transmitted infec-
14 tions including HIV; and

15 (V) society and culture;

16 (ii) promote safe and healthy relation-
17 ships;

18 (iii) promote gender equity;

19 (iv) use, and be informed by, the best
20 scientific information available;

21 (v) be culturally appropriate and in-
22 clusive of youth with varying gender identi-
23 ties, gender expressions, and sexual ori-
24 entations;

1 (vi) be built on characteristics of ef-
2 fective programs;

3 (vii) expand the existing body of re-
4 search on comprehensive sex education
5 programs through program evaluation;

6 (viii) expand training programs for
7 teachers of comprehensive sex education;

8 (ix) build on programs funded under
9 section 513 of the Social Security Act (42
10 U.S.C. 713) and the Office of Adolescent
11 Health’s Teen Pregnancy Prevention Pro-
12 gram, funded under title II of the Consoli-
13 dated Appropriations Act, 2010 (Public
14 Law 111–117; 123 Stat. 3253), and on
15 programs supported through the Centers
16 for Disease Control and Prevention (CDC);
17 and

18 (x) promote and uphold the rights of
19 young people to information in order to
20 make healthy and autonomous decisions
21 about their sexual health; and

22 (B) no Federal funds should be used for
23 health education programs that—

- 1 (i) withhold health-promoting or life-
2 saving information about sexuality-related
3 topics, including HIV;
- 4 (ii) are medically inaccurate or have
5 been scientifically shown to be ineffective;
- 6 (iii) promote gender or racial stereo-
7 types;
- 8 (iv) are insensitive and unresponsive
9 to the needs of sexually active young peo-
10 ple;
- 11 (v) are insensitive and unresponsive to
12 the needs of survivors of sexual violence;
- 13 (vi) are insensitive and unresponsive
14 to the needs of youth of all physical, devel-
15 opmental, and mental abilities;
- 16 (vii) are insensitive and unresponsive
17 to the needs of youth with varying gender
18 identities, gender expressions, and sexual
19 orientations; or
- 20 (viii) are inconsistent with the ethical
21 imperatives of medicine and public health.

22 (b) GRANTS FOR COMPREHENSIVE SEX EDUCATION
23 FOR ADOLESCENTS.—

- 24 (1) PROGRAM AUTHORIZED.—The Secretary of
25 Health and Human Services, in coordination with

1 the Associate Commissioner of the Family and
2 Youth Services Bureau of the Administration on
3 Children, Youth, and Families of the Department of
4 Health and Human Services, the Director of the Of-
5 fice of Adolescent Health, the Director of the Divi-
6 sion of Adolescent and School Health within the
7 Centers for Disease Control and Prevention and the
8 Secretary of Education, shall award grants, on a
9 competitive basis, to eligible entities to enable such
10 eligible entities to carry out programs that provide
11 adolescents with comprehensive sex education, as de-
12 scribed in paragraph (6).

13 (2) DURATION.—Grants awarded under this
14 section shall be for a period of 5 years.

15 (3) ELIGIBLE ENTITY.—In this section, the
16 term “eligible entity” means a public or private enti-
17 ty that focuses on adolescent health and education
18 or has experience working with adolescents.

19 (4) APPLICATIONS.—An eligible entity desiring
20 a grant under this subsection shall submit an appli-
21 cation to the Secretary at such time, in such man-
22 ner, and containing such information as the Sec-
23 retary may require, including an assurance to par-
24 ticipate in the evaluation described in subsection (e).

1 (5) PRIORITY.—In awarding grants under this
2 section, the Secretary shall give priority to eligible
3 entities that—

4 (A) are State or local public entities;

5 (B) are entities not currently receiving
6 funds under—

7 (i) section 513 of the Social Security
8 Act (42 U.S.C. 713);

9 (ii) the Office of Adolescent Health’s
10 Teen Pregnancy Prevention Program,
11 funded under title II of the Consolidated
12 Appropriations Act, 2010 (Public Law
13 111–117; 123 Stat. 3253), or any substan-
14 tially similar successive program; or

15 (iii) the Centers for Disease Control
16 and Prevention’s Division of Adolescent
17 and School Health; and

18 (C) address health inequities among young
19 people that face systemic barriers resulting in
20 disproportionate rates of not less than one of
21 the following:

22 (i) Unintended pregnancies.

23 (ii) Sexually transmitted infections,
24 including HIV.

1 (iii) Dating violence and sexual vio-
2 lence.

3 (6) USE OF FUNDS.—

4 (A) IN GENERAL.—Each eligible entity
5 that receives a grant under this section shall
6 use the grant funds to carry out an education
7 program that provides adolescents with com-
8 prehensive sex education that—

9 (i) is age and developmentally appro-
10 priate;

11 (ii) is medically accurate and com-
12 plete;

13 (iii) substantially incorporates ele-
14 ments of evidence-based sex education in-
15 struction; or

16 (iv) creates a demonstration project
17 based on characteristics of effective pro-
18 grams.

19 (B) CONTENTS OF COMPREHENSIVE SEX
20 EDUCATION PROGRAMS.—The comprehensive
21 sex education programs funded under this sec-
22 tion shall include instruction and materials that
23 address—

24 (i) the physical, social, and emotional
25 changes of human development including,

- 1 human anatomy, reproduction, and sexual
2 development;
- 3 (ii) healthy relationships, including
4 friendships, within families, and society,
5 that are based on mutual respect, and the
6 ability to distinguish between healthy and
7 unhealthy relationships, including—
- 8 (I) effective communication, ne-
9 gotiation and refusal skills, including
10 the skills to recognize and report in-
11 appropriate or abusive sexual ad-
12 vances;
- 13 (II) bodily autonomy, setting and
14 respecting personal boundaries, prac-
15 ticing personal safety, and consent;
16 and
- 17 (III) the limitations and harm of
18 gender- role stereotypes, violence, co-
19 ercion, bullying, harassment, and in-
20 timidation in relationships;
- 21 (iii) healthy decisionmaking skills
22 about sexuality and relationships that in-
23 clude—

- 1 (I) critical thinking, problem
2 solving, self-efficacy, stress-manage-
3 ment, self-care, and decisionmaking;
- 4 (II) individual values and atti-
5 tudes;
- 6 (III) the promotion of positive
7 body images;
- 8 (IV) developing an understanding
9 that there are a range of body types
10 and encouraging positive feeling about
11 students' own body types;
- 12 (V) information on how to re-
13 spect others and ensure safety on the
14 internet and when using other forms
15 of digital communication;
- 16 (VI) information on local services
17 and resources where students can ob-
18 tain additional information related to
19 bullying, harassment, dating violence
20 and sexual assault, suicide prevention,
21 and other related care;
- 22 (VII) encouragement for youth to
23 communicate with their parents or
24 guardians, health and social service
25 professionals, and other trusted adults

1 about sexuality and intimate relation-
2 ships;

3 (VIII) information on how to cre-
4 ate a safe environment for all stu-
5 dents and others in society;

6 (IX) examples of varying types of
7 relationships, couples, and family
8 structures; and

9 (X) affirmative representation of
10 varying gender identities, gender ex-
11 pressions, and sexual orientations, in-
12 cluding individuals and relationships
13 between same sex couples and their
14 families;

15 (iv) abstinence, delaying age of first
16 sexual activity, the use of condoms, preven-
17 tive medication, vaccination, birth control,
18 and other sexually transmitted infection
19 prevention measures, and the options for
20 pregnancy, including parenting, adoption,
21 and abortion, including—

22 (I) the importance of effectively
23 using condoms, preventive medication,
24 and applicable vaccinations to protect

1 against sexually transmitted infec-
2 tions, including HIV;

3 (II) the benefits of effective con-
4 traceptive and condom use in avoiding
5 unintended pregnancy;

6 (III) the relationship between
7 substance use and sexual health and
8 behaviors; and

9 (IV) information about local
10 health services where students can ob-
11 tain additional information and serv-
12 ices related to sexual and reproductive
13 health and other related care;

14 (v) through affirmative recognition,
15 the roles that traditions, values, religion,
16 norms, gender roles, acculturation, family
17 structure, health beliefs, and political
18 power play in how students make decisions
19 that affect their sexual health, using exam-
20 ples of various types of races, ethnicities,
21 cultures, and families, including single-par-
22 ent households and young families;

23 (vi) information about gender identity,
24 gender expression, and sexual orientation
25 for all students, including—

1 (I) affirmative recognition that
2 people have different gender identi-
3 ties, gender expressions, and sexual
4 orientations; and

5 (II) community resources that
6 can provide additional support for in-
7 dividuals with varying gender identi-
8 ties, gender expressions, and sexual
9 orientations; and

10 (vii) opportunities to explore the roles
11 that race, ethnicity, immigration status,
12 disability status, economic status, home-
13 lessness, foster care status, and language
14 within different communities affect sexual
15 attitudes in society and culture and how
16 this may impact student sexual health.

17 (c) GRANTS FOR COMPREHENSIVE SEX EDUCATION
18 AT INSTITUTIONS OF HIGHER EDUCATION.—

19 (1) PROGRAM AUTHORIZED.—The Secretary, in
20 coordination with the Secretary of Education, shall
21 award grants, on a competitive basis, to institutions
22 of higher education or consortia of such institutions
23 to enable such institutions to provide young people
24 with comprehensive sex education, as described in
25 paragraph (5)(B).

1 (2) DURATION.—Grants awarded under this
2 subsection shall be for a period of 5 years.

3 (3) APPLICATIONS.—An institution of higher
4 education or consortium of such institutions desiring
5 a grant under this subsection shall submit an appli-
6 cation to the Secretary at such time, in such man-
7 ner, and containing such information as the Sec-
8 retary may require, including an assurance to par-
9 ticipate in the evaluation described in subsection (e).

10 (4) PRIORITY.—In awarding grants under this
11 subsection, the Secretary shall give priority to an in-
12 stitution of higher education that—

13 (A) has an enrollment of needy students,
14 as defined in section 318(b) of the Higher Edu-
15 cation Act of 1965 (20 U.S.C. 1059e(b));

16 (B) is a Hispanic-serving institution, as
17 defined in section 502(a) of such Act (20
18 U.S.C. 1101a(a));

19 (C) is a Tribal College or University, as
20 defined in section 316(b) of such Act (20
21 U.S.C. 1059c(b));

22 (D) is an Alaska Native-serving institution,
23 as defined in section 317(b) of such Act (20
24 U.S.C. 1059d(b));

1 (E) is a Native Hawaiian-serving institu-
2 tion, as defined in section 317(b) of such Act
3 (20 U.S.C. 1059d(b));

4 (F) is a Predominately Black Institution,
5 as defined in section 318(b) of such Act (20
6 U.S.C. 1059e(b));

7 (G) is a Native American-serving, non-
8 tribal institution, as defined in section 319(b)
9 of such Act (20 U.S.C. 1059f(b));

10 (H) is an Asian American and Native
11 American Pacific Islander-serving institution, as
12 defined in section 320(b) of such Act (20
13 U.S.C. 1059g(b)); or

14 (I) is a minority institution, as defined in
15 section 365 of such Act (20 U.S.C. 1067k),
16 with an enrollment of needy students, as de-
17 fined in section 312 of such Act (20 U.S.C.
18 1058).

19 (5) USES OF FUNDS.—

20 (A) IN GENERAL.—An institution of higher
21 education, or a consortium, receiving a grant
22 under this subsection shall use grant funds to
23 integrate issues relating to comprehensive sex
24 education into the institution of higher edu-
25 cation, or consortium, in order to reach a large

1 number of students, by carrying out 1 or more
2 of the following activities:

3 (i) Developing or adopting educational
4 content for issues relating to comprehen-
5 sive sex education that will be incorporated
6 into student orientation, general education,
7 or core courses.

8 (ii) Developing or adopting, and im-
9 plementing schoolwide educational pro-
10 gramming outside of class that delivers ele-
11 ments of comprehensive sex education pro-
12 grams to students, faculty, and staff.

13 (iii) Developing or adopting innovative
14 technology-based approaches to deliver sex
15 education to students, faculty, and staff.

16 (iv) Developing or adopting, and im-
17 plementing peer-outreach and education
18 programs to generate discussion, educate,
19 and raise awareness among students about
20 issues relating to comprehensive sex edu-
21 cation.

22 (B) CONTENTS OF SEX EDUCATION PRO-
23 GRAMS.—Each institution of higher education’s
24 program of comprehensive sex education funded
25 under this section shall include instruction and

1 materials that address the contents required
2 under subsection (b)(6).

3 (d) GRANTS FOR PRE-SERVICE AND IN-SERVICE
4 TEACHER TRAINING.—

5 (1) PROGRAM AUTHORIZED.—The Secretary, in
6 coordination with the Director of the Centers for
7 Disease Control and Prevention and the Secretary of
8 Education, shall award grants, on a competitive
9 basis, to eligible entities to enable such eligible enti-
10 ties to carry out the activities described in para-
11 graph (5).

12 (2) DURATION.—Grants awarded under this
13 section shall be for a period of 5 years.

14 (3) ELIGIBLE ENTITY.—In this section, the
15 term “eligible entity” means—

16 (A) a State educational agency, as defined
17 in section 8101 of the Elementary and Sec-
18 ondary Education of 1965 (20 U.S.C. 7801);

19 (B) a local educational agency, as defined
20 in section 8101 of the Elementary and Sec-
21 ondary Education of 1965 (20 U.S.C. 7801);

22 (C) a Tribe or Tribal organization, as de-
23 fined in section 4 of the Indian Self-Determina-
24 tion and Education Assistance Act (25 U.S.C.
25 5304);

1 (D) a State or local department of health;

2 (E) a State or local department of edu-
3 cation;

4 (F) an educational service agency, as de-
5 fined in section 8101 of the Elementary and
6 Secondary Education of 1965 (20 U.S.C.
7 7801);;

8 (G) a nonprofit institution of higher edu-
9 cation, as defined in section 101 of the Higher
10 Education Act of 1965 (20 U.S.C. 1001);

11 (H) a national or statewide nonprofit orga-
12 nization that has as its primary purpose the im-
13 provement of provision of comprehensive sex
14 education through training and effective teach-
15 ing of comprehensive sex education; or

16 (I) a consortium of nonprofit organizations
17 that has as its primary purpose the improve-
18 ment of provision of comprehensive sex edu-
19 cation through training and effective teaching
20 of comprehensive sex education.

21 (4) APPLICATION.—An eligible entity desiring a
22 grant under this subsection shall submit an applica-
23 tion to the Secretary at such time, in such manner,
24 and containing such information as the Secretary

1 may require, including an assurance to participate in
2 the evaluation described in subsection (e).

3 (5) AUTHORIZED ACTIVITIES.—

4 (A) REQUIRED ACTIVITY.—Each eligible
5 entity receiving a grant under this section shall
6 use grant funds for professional development
7 and training of relevant faculty, school adminis-
8 trators, teachers, and staff, in order to increase
9 effective teaching of comprehensive sex edu-
10 cation students.

11 (B) PERMISSIBLE ACTIVITIES.—Each eligi-
12 ble entity receiving a grant under this section
13 may use grant funds to—

14 (i) provide research-based training of
15 teachers for comprehensive sex education
16 for adolescents as a means of broadening
17 student knowledge about issues related to
18 human development, healthy relationships,
19 personal skills, and sexual behavior, includ-
20 ing abstinence, sexual health, and society
21 and culture;

22 (ii) support the dissemination of infor-
23 mation on effective practices and research
24 findings concerning the teaching of com-
25 prehensive sex education;

- 1 (iii) support research on—
- 2 (I) effective comprehensive sex
3 education teaching practices; and
- 4 (II) the development of assess-
5 ment instruments and strategies to
6 document—
- 7 (aa) student understanding
8 of comprehensive sex education;
9 and
- 10 (bb) the effects of com-
11 prehensive sex education;
- 12 (iv) convene national conferences on
13 comprehensive sex education, in order to
14 effectively train teachers in the provision of
15 comprehensive sex education; and
- 16 (v) develop and disseminate appro-
17 priate research-based materials to foster
18 comprehensive sex education.
- 19 (C) SUBGRANTS.—Each eligible entity re-
20 ceiving a grant under this subsection may
21 award subgrants to nonprofit organizations that
22 possess a demonstrated record of providing
23 training to faculty, school administrators,
24 teachers, and staff on comprehensive sex edu-
25 cation to—

- 1 (i) train teachers in comprehensive
2 sex education;
- 3 (ii) support Internet or distance learn-
4 ing related to comprehensive sex education;
- 5 (iii) promote rigorous academic stand-
6 ards and assessment techniques to guide
7 and measure student performance in com-
8 prehensive sex education;
- 9 (iv) encourage replication of best
10 practices and model programs to promote
11 comprehensive sex education;
- 12 (v) develop and disseminate effective,
13 research-based comprehensive sex edu-
14 cation learning materials;
- 15 (vi) develop academic courses on the
16 pedagogy of sex education at institutions
17 of higher education; or
- 18 (vii) convene State-based conferences
19 to train teachers in comprehensive sex edu-
20 cation and to identify strategies for im-
21 provement.

22 (e) IMPACT EVALUATION AND REPORTING.—

23 (1) MULTI-YEAR EVALUATION.—

- 24 (A) IN GENERAL.—Not later than 6
25 months after the date of the enactment of this

1 Act, the Secretary shall enter into a contract
2 with a nonprofit organization with experience in
3 conducting impact evaluations, to conduct a
4 multi-year evaluation on the impact of the
5 grants under subsections (b), (c), and (d), and
6 to report to Congress and the Secretary on the
7 findings of such evaluation.

8 (B) EVALUATION.—The evaluation con-
9 ducted under this subsection shall—

10 (i) be conducted in a manner con-
11 sistent with relevant, nationally recognized
12 professional and technical evaluation
13 standards;

14 (ii) use sound statistical methods and
15 techniques relating to the behavioral
16 sciences, including quasi-experimental de-
17 signs, inferential statistics, and other
18 methodologies and techniques that allow
19 for conclusions to be reached;

20 (iii) be carried out by an independent
21 organization that has not received a grant
22 under subsection (b), (c), or (d); and

23 (iv) be designed to provide informa-
24 tion on—

1 (I) output measures, such as the
2 number of individuals served under
3 the grant and the number of hours of
4 instruction;

5 (II) outcome measures, including
6 measures relating to—

7 (aa) the knowledge that in-
8 dividuals participating in the
9 grant program have gained in
10 each of the following age and de-
11 velopmentally appropriate
12 areas—

13 (AA) growth and devel-
14 opment;

15 (BB) relationship dy-
16 namics;

17 (CC) ways to prevent
18 unintended pregnancy and
19 sexually transmitted infec-
20 tions, including HIV; and

21 (DD) sexual health;

22 (bb) the age and develop-
23 mentally appropriate skills that
24 individuals participating in the

1 grant program have gained re-
2 garding—

3 (AA) negotiation and
4 communication;

5 (BB) decisionmaking
6 and goal-setting;

7 (CC) interpersonal
8 skills and healthy relation-
9 ships; and

10 (DD) condom use; and

11 (cc) the behaviors of adoles-
12 cents participating in the grant
13 program, including data about—

14 (AA) age of first inter-
15 course;

16 (BB) condom and con-
17 traceptive use at first inter-
18 course;

19 (CC) recent condom
20 and contraceptive use;

21 (DD) substance use;

22 (EE) dating abuse and
23 lifetime history of sexual as-
24 sult, dating violence, bul-

1 lying, harassment, stalking;
2 and
3 (F) academic per-
4 formance; and
5 (III) other measures necessary to
6 evaluate the impact of the grant pro-
7 gram.

8 (C) REPORT.—Not later than 6 years after
9 the date of enactment of this Act, the organiza-
10 tion conducting the evaluation under this sub-
11 section shall prepare and submit to the appro-
12 priate committees of Congress and the Sec-
13 retary an evaluation report. Such report shall
14 be made publicly available, including on the
15 website of the Department of Health and
16 Human Services.

17 (2) SECRETARY'S REPORT TO CONGRESS.—Not
18 later than 1 year after the date of the enactment of
19 this Act, and annually thereafter for a period of 5
20 years, the Secretary shall prepare and submit to the
21 appropriate committees of Congress a report on the
22 activities to provide adolescents and young people
23 with comprehensive sex education and pre-service
24 and in-service teacher training funded under this

1 section. The Secretary's report to Congress shall in-
2 clude—

3 (A) a statement of how grants awarded by
4 the Secretary meet the purposes described in
5 subsection (a)(1); and

6 (B) information about—

7 (i) the number of eligible entities and
8 institutions of higher education that are
9 receiving grant funds under subsections
10 (b), (c), and (d);

11 (ii) the specific activities supported by
12 grant funds awarded under subsections
13 (b), (c), and (d);

14 (iii) the number of adolescents served
15 by grant programs funded under sub-
16 section (b);

17 (iv) the number of young people
18 served by grant programs funded under
19 subsection (c);

20 (v) the number of faculty, school ad-
21 ministrators, teachers, and staff trained
22 under subsection (d); and

23 (vi) the status of the evaluation re-
24 quired under paragraph (1).

1 (f) NONDISCRIMINATION.—Programs funded under
2 this section shall not discriminate on the basis of actual
3 or perceived sex, race, color, ethnicity, national origin, dis-
4 ability, sexual orientation, gender identity, or religion.
5 Nothing in this section shall be construed to invalidate or
6 limit rights, remedies, procedures, or legal standards avail-
7 able under any other Federal law or any law of a State
8 or a political subdivision of a State, including the Civil
9 Rights Act of 1964 (42 U.S.C. 2000a et seq.), title IX
10 of the Education Amendments of 1972 (20 U.S.C. 1681
11 et seq.), section 504 of the Rehabilitation Act of 1973 (29
12 U.S.C. 794), the Americans with Disabilities Act of 1990
13 (42 U.S.C. 12101 et seq.), and section 1557 of the Patient
14 Protection and Affordable Care Act (42 U.S.C. 18116).

15 (g) LIMITATION.—No Federal funds provided under
16 this section may be used for health education programs
17 that—

18 (1) withhold health-promoting or life-saving in-
19 formation about sexuality-related topics, including
20 HIV;

21 (2) are medically inaccurate or have been sci-
22 entifically shown to be ineffective;

23 (3) promote gender or racial stereotypes;

24 (4) are insensitive and unresponsive to the
25 needs of sexually active young people;

1 (5) are insensitive and unresponsive to the
2 needs of pregnant or parenting young people;

3 (6) are insensitive and unresponsive to the
4 needs of survivors of sexual abuse or assault;

5 (7) are insensitive and unresponsive to the
6 needs of youth of all physical, developmental, or
7 mental abilities;

8 (8) are insensitive and unresponsive to individ-
9 uals with varying gender identities, gender expres-
10 sions, and sexual orientations; or

11 (9) are inconsistent with the ethical imperatives
12 of medicine and public health.

13 (h) AMENDMENTS TO OTHER LAWS.—

14 (1) AMENDMENT TO THE PUBLIC HEALTH
15 SERVICE ACT.—Section 2500 of the Public Health
16 Service Act (42 U.S.C. 300ee) is amended by strik-
17 ing subsections (b) through (d) and inserting the fol-
18 lowing:

19 “(b) CONTENTS OF PROGRAMS.—All programs of
20 education and information receiving funds under this sub-
21 chapter shall include information about the potential ef-
22 fects of intravenous substance abuse.”.

23 (2) AMENDMENTS TO THE ELEMENTARY AND
24 SECONDARY EDUCATION ACT OF 1965.—Section 8526

1 of the Elementary and Secondary Education Act of
2 (20 U.S.C. 7906) is amended—

3 (A) by striking paragraph (3);

4 (B) by redesignating paragraphs (4) and
5 (5) as paragraphs (3) and (4), respectively;

6 (C) in paragraph (4), by inserting “or”
7 after the semicolon;

8 (D) in paragraph (5), by striking “; or”
9 and inserting a period; and

10 (E) by striking paragraph (6).

11 (i) DEFINITIONS.—In this section:

12 (1) ADOLESCENTS.—The term “adolescents”
13 means individuals who are ages 10 through 19 at
14 the time of commencement of participation in a pro-
15 gram supported under this section.

16 (2) AGE AND DEVELOPMENTALLY APPRO-
17 PRIATE.—The term “age and developmentally appro-
18 priate” means topics, messages, and teaching meth-
19 ods suitable to particular age, age group of children
20 and adolescents, or developmental levels, based on
21 cognitive, emotional, social, and behavioral capacity
22 of most students at that age level.

23 (3) APPROPRIATE COMMITTEES OF CON-
24 GRESS.—The term “appropriate committees of Con-
25 gress” means the Committee on Health, Education,

1 Labor, and Pensions of the Senate, the Committee
2 on Appropriations of the Senate, the Committee on
3 Energy and Commerce of the House of Representa-
4 tives, the Committee on Education and the Work-
5 force of the House of Representatives, and the Com-
6 mittee on Appropriations of the House of Represent-
7 atives.

8 (4) CHARACTERISTICS OF EFFECTIVE PRO-
9 GRAMS.—The term “characteristics of effective pro-
10 grams” means the aspects of evidence-based pro-
11 grams, including development, content, and imple-
12 mentation of such programs, that—

13 (A) have been shown to be effective in
14 terms of increasing knowledge, clarifying values
15 and attitudes, increasing skills, and impacting
16 upon behavior; and

17 (B) are widely recognized by leading med-
18 ical and public health agencies to be effective in
19 changing sexual behaviors that lead to sexually
20 transmitted infections, including HIV, unin-
21 tended pregnancy, and dating violence and sex-
22 ual assault among young people.

23 (5) COMPREHENSIVE SEX EDUCATION.—The
24 term “comprehensive sex education” means instruc-
25 tional part of a comprehensive school health edu-

1 cation approach which addresses the physical, men-
2 tal, emotional, and social dimensions of human sexu-
3 ality; designed to motivate and assist students to
4 maintain and improve their sexual health, prevent
5 disease and reduce sexual health-related risk behav-
6 iors; and enable and empower students to develop
7 and demonstrate age and developmentally appro-
8 priate sexuality and sexual health-related knowledge,
9 attitudes, skills, and practices.

10 (6) CONSENT.—The term “consent” means af-
11 firmative, conscious, and voluntary agreement to en-
12 gage in interpersonal, physical, or sexual activity.

13 (7) CULTURALLY APPROPRIATE.—The term
14 “culturally appropriate” means materials and in-
15 struction that respond to culturally diverse individ-
16 uals, families and communities in an inclusive, re-
17 spectful and effective manner; including materials
18 and instruction that are inclusive of race, ethnicity,
19 languages, cultural background, religion, sex, gender
20 identity, sexual orientation, and different abilities.

21 (8) EVIDENCE-BASED.—The term “evidence-
22 based”, when used with respect to sex education in-
23 struction, means a sex education program that has
24 been proven through rigorous evaluation to be effec-
25 tive in changing sexual behavior or incorporates ele-

1 ments of other programs that have been proven to
2 be effective in changing sexual behavior.

3 (9) GENDER EXPRESSION.—The term “gender
4 expression”, when used with respect to a sex edu-
5 cation program, means the expression of one’s gen-
6 der, such as through behavior, clothing, haircut, or
7 voice, and which may or may not conform to socially
8 defined behaviors and characteristics typically asso-
9 ciated with being either masculine or feminine.

10 (10) GENDER IDENTITY.—Except with respect
11 to subsection (f), the term “gender identity”, when
12 used with respect to a sex education program, means
13 the gender-related identity, appearance, mannerisms,
14 or other gender-related characteristics of an indi-
15 vidual, regardless of the individual’s designated sex
16 at birth including a person’s deeply held sense or
17 knowledge of their own gender; such as male, fe-
18 male, both or neither.

19 (11) INCLUSIVE.—The term “inclusive”, when
20 used with respect to a sex education program, means
21 curriculum that ensures that students from histori-
22 cally marginalized communities are reflected in
23 classroom materials and lessons.

24 (12) INSTITUTION OF HIGHER EDUCATION.—
25 The term “institution of higher education” has the

1 meaning given the term in section 101 of the Higher
2 Education Act of 1965 (20 U.S.C. 1001).

3 (13) MEDICALLY ACCURATE AND COMPLETE.—

4 The term “medically accurate and complete”, when
5 used with respect to a sex education program, means
6 that—

7 (A) the information provided through the
8 program is verified or supported by the weight
9 of research conducted in compliance with ac-
10 cepted scientific methods and is published in
11 peer-reviewed journals, where applicable; or

12 (B)(i) the program contains information
13 that leading professional organizations and
14 agencies with relevant expertise in the field rec-
15 ognize as accurate, objective, and complete; and

16 (ii) the program does not withhold infor-
17 mation about the effectiveness and benefits of
18 correct and consistent use of condoms and
19 other contraceptives.

20 (14) SECRETARY.—The term “Secretary”
21 means the Secretary of Health and Human Services.

22 (15) SEXUAL DEVELOPMENT.—The term “sex-
23 ual development” means the lifelong process of phys-
24 ical, behavioral, cognitive, and emotional growth and
25 change as it relates to an individual’s sexuality and

1 sexual maturation, including puberty, identity devel-
2 opment, socio-cultural influences, and sexual behav-
3 iors.

4 (16) SEXUAL ORIENTATION.—Except with re-
5 spect to subsection (f), the term “sexual orienta-
6 tion”, when used with respect to a sex education
7 program, means an individual’s attraction, including
8 physical or emotional, to the same or different gen-
9 der.

10 (17) YOUNG PEOPLE.—The term “young peo-
11 ple” means individuals who are ages 10 through 24
12 at the time of commencement of participation in a
13 program supported under this section.

14 (j) FUNDING.—

15 (1) APPROPRIATION.—For the purpose of car-
16 rying out this section, there is appropriated
17 \$75,000,000 for each of fiscal years 2019 through
18 2024. Amounts appropriated under this subsection
19 shall remain available until expended.

20 (2) RESERVATIONS OF FUNDS.—

21 (A) The Secretary shall reserve 50 percent
22 of the amount appropriated under paragraph
23 (1) for the purposes of awarding grants for
24 comprehensive sex education for adolescents
25 under subsection (c).

1 (B) The Secretary shall reserve 25 percent
2 of the amount appropriated under paragraph
3 (1) for the purposes of awarding grants for
4 comprehensive sex education at institutes of
5 higher education under subsection (d).

6 (C) The Secretary shall reserve 20 percent
7 of the amount appropriated under paragraph
8 (1) for the purposes of awarding grants for pre-
9 service and in-service teacher training under
10 subsection (e).

11 (D) The Secretary shall reserve 2 percent
12 of the amount appropriated under paragraph
13 (1) for the purpose of carrying out the impact
14 evaluation and reporting required under sub-
15 section (a).

16 (3) SECRETARIAL RESPONSIBILITIES.—The
17 Secretary shall reserve 3 percent of the amount ap-
18 propriated under paragraph (1) for each fiscal year
19 for expenditures by the Secretary to provide, directly
20 or through a competitive grant process, research,
21 training, and technical assistance, including dissemi-
22 nation of research and information regarding effec-
23 tive and promising practices, providing consultation
24 and resources, and developing resources and mate-
25 rials to support the activities of recipients of grants.

1 In carrying out such functions, the Secretary shall
2 collaborate with a variety of entities that have exper-
3 tise in adolescent sexual health development, edu-
4 cation, and promotion.

5 (4) REPROGRAMMING OF ABSTINENCE ONLY
6 UNTIL MARRIAGE PROGRAM FUNDING.—The unobli-
7 gated balance of funds made available to carry out
8 section 510 of the Social Security Act (42 U.S.C.
9 710) (as in effect on the day before the date of en-
10 actment of this Act) are hereby transferred and shall
11 be used by the Secretary to carry out this section.
12 The amounts transferred and made available to
13 carry out this section shall remain available until ex-
14 pended.

15 (5) REPEAL OF ABSTINENCE ONLY UNTIL MAR-
16 RIAGE PROGRAM.—Section 510 of the Social Secu-
17 rity Act (42 U.S.C. 710 et seq.) is repealed.

18 **SEC. 512. COMPASSIONATE ASSISTANCE FOR RAPE EMER-**
19 **GENCIES.**

20 (a) MEDICARE.—

21 (1) LIMITATION ON PAYMENT.—Section
22 1866(a)(1) of the Social Security Act (42 U.S.C.
23 1395cc(a)(1)) is amended—

24 (A) by moving the indentation of subpara-
25 graph (W) 2 ems to the left;

1 (B) in subparagraph (X)—

2 (i) by moving the indentation 2 ems
3 to the left; and

4 (ii) by striking “and” at the end;

5 (C) in subparagraph (Y), by striking the
6 period at the end and inserting “; and”; and

7 (D) by inserting after subparagraph (Y)
8 the following new subparagraph:

9 “(Z) in the case of a hospital or critical access
10 hospital, to adopt and enforce a policy to ensure
11 compliance with the requirements of subsection (l)
12 and to meet the requirements of such subsection.”.

13 (2) ASSISTANCE TO VICTIMS.—Section 1866 of
14 the Social Security Act (42 U.S.C. 1395cc) is
15 amended by adding at the end the following new
16 subsection:

17 “(1) COMPASSIONATE ASSISTANCE FOR RAPE EMER-
18 GENCIES.—

19 “(1) IN GENERAL.—For purposes of section
20 1866(a)(1)(Z), a hospital meets the requirements of
21 this subsection if the hospital provides each of the
22 services described in paragraph (2) to each indi-
23 vidual, whether or not eligible for benefits under this
24 title or under any other form of health insurance,

1 who comes to the hospital on or after January 1,
2 2019, and—

3 “(A) who states to hospital personnel that
4 they are victims of sexual assault;

5 “(B) who is accompanied by an individual
6 who states to hospital personnel that the indi-
7 vidual is a victim of sexual assault; or

8 “(C) whom hospital personnel, during the
9 course of treatment and care for the individual,
10 have reason to believe is a victim of sexual as-
11 sault.

12 “(2) REQUIRED SERVICES DESCRIBED.—For
13 purposes of paragraph (1), the services described in
14 this subparagraph are the following:

15 “(A) Provision of medically and factually
16 accurate and unbiased written and oral infor-
17 mation about emergency contraception that—

18 “(i) is written in clear and concise
19 language;

20 “(ii) is readily comprehensible;

21 “(iii) includes an explanation that
22 emergency contraception—

23 “(I) has been approved by the
24 Food and Drug Administration as an
25 over-the-counter or prescription medi-

1 cation for individuals and is a safe
2 and effective way to prevent preg-
3 nancy after unprotected intercourse or
4 contraceptive failure if taken in a
5 timely manner;

6 “(II) is more effective the sooner
7 it is taken; and

8 “(III) does not cause an abortion
9 and cannot interrupt an established
10 pregnancy;

11 “(iv) meets such conditions regarding
12 the provision of such information in lan-
13 guages other than English as the Secretary
14 may establish; and

15 “(v) is provided without regard to the
16 ability of the individual or their family to
17 pay costs associated with the provision of
18 such information to the individual.

19 “(B) Immediate offer to provide emergency
20 contraception to the individual at the hospital
21 and, in the case that the individual accepts such
22 offer, immediate provision to the individual of
23 such contraception on the same day it is re-
24 quested without regard to the inability of the
25 individual or their family to pay costs associ-

1 ated with the offer and provision of such con-
2 traception.

3 “(C) Development and implementation of a
4 written policy to ensure that an individual is
5 present at the hospital, or on-call, who—

6 “(i) has authority to dispense or pre-
7 scribe emergency contraception, independ-
8 ently, or under a protocol prepared by a
9 physician for the administration of emer-
10 gency contraception at the hospital to a
11 victim of sexual assault; and

12 “(ii) is trained to comply with the re-
13 quirements of this section.

14 “(D) Provision of medically and factually
15 accurate and unbiased written and oral infor-
16 mation and counseling about post-exposure pro-
17 phylaxis (PEP) protocol for the prevention of
18 HIV.

19 “(E) Immediately offer to begin PEP to
20 the individual at the hospital except in cases
21 where the medical professional’s best judgement
22 is that further evaluation is required or that
23 such a regimen will be substantially detrimental
24 to the individual’s health. Such provision shall
25 be offered regardless of the individual’s ability

1 to pay. Hospitals shall be responsible for ensur-
2 ing adequate supply of PEP medications to pro-
3 vide to patients.

4 “(3) DEFINITIONS.—For purposes of this para-
5 graph:

6 “(A) The term ‘emergency contraception’
7 means a drug or device (as such terms are de-
8 fined in section 201 of the Federal Food, Drug,
9 and Cosmetic Act (21 U.S.C. 321)) or a drug
10 regimen that—

11 “(i) is used postcoitally;

12 “(ii) prevents pregnancy primarily by
13 preventing or delaying ovulation, and does
14 not terminate an established pregnancy;
15 and

16 “(iii) is approved by the Food and
17 Drug Administration.

18 “(B) The term ‘hospital’ includes a critical
19 access hospital, as defined in section
20 1861(mm)(1).

21 “(C) The term ‘sexual assault’ means co-
22 itus in which the individual involved does not
23 consent or lacks the legal capacity to consent.”.

24 (b) LIMITATION ON PAYMENT UNDER MEDICAID.—
25 Section 1903(i) of the Social Security Act (42 U.S.C.

1 1396b(i)) is amended by inserting after paragraph (11)
 2 the following new paragraph:

3 “(12) with respect to any amount expended for
 4 care or services furnished under the plan by a hos-
 5 pital on or after January 1, 2019, unless such hos-
 6 pital meets the requirements specified in section
 7 1866(l) for purposes of title XVIII.”.

8 **SEC. 513. ACCESS TO BIRTH CONTROL DUTIES OF PHAR-**
 9 **MACIES TO ENSURE PROVISION OF FDA-AP-**
 10 **PROVED CONTRACEPTION.**

11 Part B of title II of the Public Health Service Act
 12 (42 U.S.C. 238 et seq.) is amended by adding at the end
 13 the following:

14 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
 15 **OF FDA-APPROVED CONTRACEPTION.**

16 “(a) IN GENERAL.—Subject to subsection (c), a
 17 pharmacy that receives Food and Drug Administration-
 18 approved drugs or devices in interstate commerce shall
 19 maintain compliance with the following:

20 “(1) If a customer requests a contraceptive, in-
 21 cluding emergency contraception, that is in stock,
 22 the pharmacy shall ensure that the contraceptive is
 23 provided to the customer—

24 “(A) without delay;

1 “(B) without regard to the customer’s age,
2 gender, gender identity, or sexual orientation;

3 “(C) without a requirement that identifica-
4 tion be presented; and

5 “(D) despite any conflicts of employees to
6 filling a prescription and dispensing a par-
7 ticular prescription drug or device due to sin-
8 cerely held moral, philosophical, or religious be-
9 liefs.

10 “(2) If a customer requests a contraceptive that
11 is not in stock and the pharmacy in the normal
12 course of business stocks contraception, the phar-
13 macy shall immediately inform the customer that the
14 contraceptive is not in stock and without delay offer
15 the customer the following options:

16 “(A) If the customer prefers to obtain the
17 contraceptive through a referral or transfer, the
18 pharmacy shall—

19 “(i) locate a pharmacy of the cus-
20 tomer’s choice or the closest pharmacy
21 confirmed to have the contraceptive in
22 stock; and

23 “(ii) refer the customer or transfer
24 the prescription to that pharmacy.

1 “(B) If the customer prefers for the phar-
2 macy to order the contraceptive, the pharmacy
3 shall obtain the contraceptive under the phar-
4 macy’s standard procedure for expedited order-
5 ing of medication and notify the customer when
6 the contraceptive arrives.

7 “(3) The pharmacy shall ensure that its em-
8 ployees do not—

9 “(A) intimidate, threaten, or harass cus-
10 tomers in the delivery of services relating to a
11 request for contraception;

12 “(B) interfere with or obstruct the delivery
13 of services relating to a request for contracep-
14 tion;

15 “(C) intentionally misrepresent or deceive
16 customers about the availability of contracep-
17 tion or its mechanism of action;

18 “(D) breach medical confidentiality with
19 respect to a request for contraception or threat-
20 en to breach such confidentiality; or

21 “(E) refuse to return a valid, lawful pre-
22 scription for contraception upon customer re-
23 quest.

24 “(b) CONTRACEPTIVES NOT ORDINARILY
25 STOCKED.—Nothing in subsection (a)(2) shall be con-

1 strued to require any pharmacy to comply with such sub-
2 section if the pharmacy does not ordinarily stock contra-
3 ceptives in the normal course of business.

4 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
5 MACY PRACTICE.—This section does not prohibit a phar-
6 macy from refusing to provide a contraceptive to a cus-
7 tomer in accordance with any of the following:

8 “(1) If it is unlawful to dispense the contracep-
9 tive to the customer without a valid, lawful prescrip-
10 tion and no such prescription is presented.

11 “(2) If the customer is unable to pay for the
12 contraceptive.

13 “(3) If the employee of the pharmacy refuses to
14 provide the contraceptive on the basis of a profes-
15 sional clinical judgment.

16 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
17 tion shall be construed to invalidate or limit rights, rem-
18 edies, procedures, or legal standards under title VII of the
19 Civil Rights Act of 1964.

20 “(e) PREEMPTION.—This section does not preempt
21 any provision of State law or any professional obligation
22 made applicable by a State board or other entity respon-
23 sible for licensing or discipline of pharmacies or phar-
24 macists, to the extent that such State law or professional

1 obligation provides protections for customers that are
2 greater than the protections provided by this section.

3 “(f) ENFORCEMENT.—

4 “(1) CIVIL PENALTY.—A pharmacy that vio-
5 lates a requirement of subsection (a) is liable to the
6 United States for a civil penalty in an amount not
7 exceeding \$1,000 per day of violation, not to exceed
8 \$100,000 for all violations adjudicated in a single
9 proceeding.

10 “(2) PRIVATE CAUSE OF ACTION.—Any person
11 aggrieved as a result of a violation of a requirement
12 of subsection (a) may, in any court of competent ju-
13 risdiction, commence a civil action against the phar-
14 macy involved to obtain appropriate relief, including
15 actual and punitive damages, injunctive relief, and a
16 reasonable attorney’s fee and cost.

17 “(3) LIMITATIONS.—A civil action under para-
18 graph (1) or (2) may not be commenced against a
19 pharmacy after the expiration of the 5-year period
20 beginning on the date on which the pharmacy alleg-
21 edly engaged in the violation involved.

22 “(g) DEFINITIONS.—In this section:

23 “(1) CONTRACEPTION.—The term ‘contracep-
24 tion’ or ‘contraceptive’ means any drug or device ap-

1 proved by the Food and Drug Administration to pre-
2 vent pregnancy.

3 “(2) EMPLOYEE.—The term ‘employee’ means
4 a person hired, by contract or any other form of an
5 agreement, by a pharmacy.

6 “(3) PHARMACY.—The term ‘pharmacy’ means
7 an entity that—

8 “(A) is authorized by a State to engage in
9 the business of selling prescription drugs at re-
10 tail; and

11 “(B) employs one or more employees.

12 “(4) PRODUCT.—The term ‘product’ means a
13 Food and Drug Administration-approved drug or de-
14 vice.

15 “(5) PROFESSIONAL CLINICAL JUDGMENT.—
16 The term ‘professional clinical judgment’ means the
17 use of professional knowledge and skills to form a
18 clinical judgment, in accordance with prevailing
19 medical standards.

20 “(6) WITHOUT DELAY.—The term ‘without
21 delay’, with respect to a pharmacy providing, pro-
22 viding a referral for, or ordering contraception, or
23 transferring the prescription for contraception,
24 means within the usual and customary timeframe at
25 the pharmacy for providing, providing a referral for,

1 or ordering other products, or transferring the pre-
2 scription for other products, respectively.

3 “(h) EFFECTIVE DATE.—This section shall take ef-
4 fect on the 31st day after the date of the enactment of
5 this section, without regard to whether the Secretary has
6 issued any guidance or final rule regarding this section.”.

7 **SEC. 514. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
8 **WOMEN’S HEALTH.**

9 Section 229(b) of the Public Health Service Act (42
10 U.S.C. 237a(b)) is amended—

11 (1) in paragraph (6), at the end, by striking
12 “and”;

13 (2) in paragraph (7), at the end, by striking the
14 period and inserting a semicolon; and

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

17 “(8) facilitate policymakers, health system lead-
18 ers and providers, consumers, and other stake-
19 holders in understanding optimal maternity care and
20 support for the provision of such care, including the
21 priorities of—

22 “(A) protecting, promoting, and supporting
23 the innate capacities of childbearing individuals
24 and their newborns for childbirth, breastfeed-
25 ing, and attachment;

1 “(B) using obstetric interventions only
2 when such interventions are supported by
3 strong, high-quality evidence, and minimizing
4 overuse of maternity practices that have been
5 shown to have benefit in limited situations and
6 that can expose women, infants, or both to risk
7 of harm if used routinely and indiscriminately,
8 including continuous electronic fetal monitoring,
9 labor induction, epidural analgesia, primary ce-
10 sarean section, and routine repeat cesarean
11 birth;

12 “(C) reliably incorporating noninvasive,
13 evidence-based practices that have documented
14 correlation with considerable improvement in
15 outcomes with no detrimental side effects, such
16 as smoking cessation programs in pregnancy
17 and proven models of group prenatal care that
18 integrate health assessment, education, and
19 support into a unified program and supporting
20 evidence-based breastfeeding promotion efforts
21 with respect for a breastfeeding individual’s
22 personal decisionmaking;

23 “(D) a shared understanding of the quali-
24 fications of licensed providers of maternity care
25 and the best evidence about the safety, satisfac-

1 tion, outcomes, and costs of their care, and ap-
2 propriate deployment of such caregivers within
3 the maternity care workforce to address the
4 needs of childbearing individuals and newborns
5 and the growing shortage of maternity care-
6 givers;

7 “(E) a shared understanding of the results
8 of the best available research comparing hos-
9 pital, birth center, and planned home births, in-
10 cluding information about each setting’s safety,
11 satisfaction, outcomes, and costs; and

12 “(F) high-quality, evidence-based child-
13 birth education that promotes a natural,
14 healthy, and safe approach to pregnancy, child-
15 birth, and early parenting; is taught by certified
16 educators, peer counselors, and health profes-
17 sionals; and promotes informed decisionmaking
18 by childbearing individual;”.

19 **SEC. 515. INTERAGENCY COORDINATING COMMITTEE ON**
20 **THE PROMOTION OF OPTIMAL MATERNITY**
21 **OUTCOMES.**

22 (a) IN GENERAL.—Part A of title II of the Public
23 Health Service Act (42 U.S.C. 202 et seq.) is amended
24 by adding at the end the following:

1 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON**
2 **THE PROMOTION OF OPTIMAL MATERNITY**
3 **OUTCOMES.**

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Deputy Assistant Secretary for Women’s Health under
6 section 229 and in collaboration with the Federal officials
7 specified in subsection (b), shall establish the Interagency
8 Coordinating Committee on the Promotion of Optimal Ma-
9 ternity Outcomes (referred to in this section as the
10 ‘ICCPOM’).

11 “(b) OTHER AGENCIES.—The officials specified in
12 this subsection are the Secretary of Labor, the Secretary
13 of Defense, the Secretary of Veterans Affairs, the Surgeon
14 General, the Director of the Centers for Disease Control
15 and Prevention, the Administrator of the Health Re-
16 sources and Services Administration, the Administrator of
17 the Centers for Medicare & Medicaid Services, the Direc-
18 tor of the Indian Health Service, the Administrator of the
19 Substance Abuse and Mental Health Services Administra-
20 tion, the Director of the National Institute on Child
21 Health and Development, the Director of the Agency for
22 Healthcare Research and Quality, the Assistant Secretary
23 for Children and Families, the Deputy Assistant Secretary
24 for Minority Health, the Director of the Office of Per-
25 sonnel Management, and such other Federal officials as

1 the Secretary of Health and Human Services determines
2 to be appropriate.

3 “(c) CHAIR.—The Deputy Assistant Secretary for
4 Women’s Health shall serve as the chair of the ICCPOM.

5 “(d) DUTIES.—The ICCPOM shall guide policy and
6 program development across the Federal Government with
7 respect to promotion of optimal maternity care, provided,
8 however, that nothing in this section shall be construed
9 as transferring regulatory or program authority from an
10 agency to the ICCPOM.

11 “(e) CONSULTATIONS.—The ICCPOM shall actively
12 seek the input of, and shall consult with, all appropriate
13 and interested stakeholders, including State health depart-
14 ments, public health research and interest groups, founda-
15 tions, childbearing individuals and their advocates, and
16 maternity care professional associations and organiza-
17 tions, reflecting racially, ethnically, demographically, and
18 geographically diverse communities.

19 “(f) ANNUAL REPORT.—

20 “(1) IN GENERAL.—The Secretary, on behalf of
21 the ICCPOM, shall annually submit to Congress a
22 report that summarizes—

23 “(A) all programs and policies of Federal
24 agencies (including the Medicare Program
25 under title XVIII of the Social Security Act and

1 the Medicaid program under title XIX of such
2 Act) designed to promote optimal maternity
3 care, focusing particularly on programs and
4 policies that support the adoption of evidence
5 based maternity care, as defined by timely, sci-
6 entifically sound systematic reviews;

7 “(B) all programs and policies of Federal
8 agencies (including the Medicare Program
9 under title XVIII of the Social Security Act and
10 the Medicaid program under title XIX of such
11 Act) designed to address the problems of mater-
12 nal mortality and morbidity, infant mortality,
13 prematurity, and low birth weight, including
14 such programs and policies designed to address
15 racial and ethnic disparities with respect to
16 each of such problems;

17 “(C) the extent of progress in reducing
18 maternal mortality and infant mortality, low
19 birth weight, and prematurity at State and na-
20 tional levels; and

21 “(D) such other information regarding op-
22 timal maternity care as the Secretary deter-
23 mines to be appropriate.

24 The information specified in subparagraph (C) shall
25 be included in each such report in a manner that

1 disaggregates such information by race, ethnicity,
2 and indigenous status in order to determine the ex-
3 tent of progress in reducing racial and ethnic dis-
4 parities and disparities related to indigenous status.

5 “(2) CERTAIN INFORMATION.—Each report
6 under paragraph (1) shall include information
7 (disaggregated by race, ethnicity, and indigenous
8 status, as applicable) on the following rates and
9 costs by State:

10 “(A) The rate of primary cesarean deliv-
11 eries and repeat cesarean deliveries.

12 “(B) The rate of vaginal births after cesar-
13 ean.

14 “(C) The rate of vaginal breech births.

15 “(D) The rate of induction of labor.

16 “(E) The rate of freestanding birth center
17 births.

18 “(F) The rate of planned and unplanned
19 home birth.

20 “(G) The rate of attended births by pro-
21 vider, including by an obstetrician-gynecologist,
22 family practice physician, obstetrician-gyne-
23 cologist physician assistant, certified nurse-mid-
24 wife, certified midwife, and certified profes-
25 sional midwife.

1 “(H) The cost of maternity care
2 disaggregated by place of birth and provider of
3 care, including—

4 “(i) uncomplicated vaginal birth;

5 “(ii) complicated vaginal birth;

6 “(iii) uncomplicated cesarean birth;

7 and

8 “(iv) complicated cesarean birth.

9 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
10 is authorized to be appropriated, in addition to amounts
11 authorized to be appropriated under section 229(e), to
12 carry out this section \$1,000,000 for each of the fiscal
13 years 2019 through 2023.”.

14 (b) CONFORMING AMENDMENTS.—

15 (1) INCLUSION AS DUTY OF HHS OFFICE ON
16 WOMEN’S HEALTH.—Section 229(b) of such Act (42
17 U.S.C. 237a(b)), as amended by section 514, is fur-
18 ther amended by adding at the end the following
19 new paragraph:

20 “(9) establish the Interagency Coordinating
21 Committee on the Promotion of Optimal Maternity
22 Outcomes in accordance with section 229A; and”.

23 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
24 tion 229(d) of such Act (42 U.S.C. 237a(d)) is

1 amended by inserting “(other than under subsection
2 (b)(9))” after “under this section”.

3 **SEC. 516. CONSUMER EDUCATION CAMPAIGN.**

4 Section 229(b) of the Public Health Service Act (42
5 U.S.C. 237a(b)), as amended by sections 514 and 515,
6 is further amended by adding at the end the following:

7 “(10) not later than one year after the date of
8 the enactment of the Health Equity and Account-
9 ability Act of 2018, develop and implement a 4-year
10 culturally and linguistically appropriate multimedia
11 consumer education campaign that is designed to
12 promote understanding and acceptance of evidence-
13 based maternity practices and models of care for op-
14 timal maternity outcomes among individuals of
15 childbearing ages and families of such individuals
16 and that—

17 “(A) highlights the importance of pro-
18 tecting, promoting, and supporting the innate
19 capacities of childbearing individuals and their
20 newborns for childbirth, breastfeeding, and at-
21 tachment;

22 “(B) promotes understanding of the impor-
23 tance of using obstetric interventions when
24 medically necessary and when supported by
25 strong, high-quality evidence;

1 “(C) highlights the widespread overuse of
2 maternity practices that have been shown to
3 have benefit when used appropriately in situa-
4 tions of medical necessity, but which can expose
5 pregnant individuals, infants, or both to risk of
6 harm if used routinely and indiscriminately, in-
7 cluding continuous fetal monitoring, labor in-
8 duction, epidural anesthesia, elective primary
9 cesarean section, and repeat cesarean delivery;

10 “(D) emphasizes the noninvasive maternity
11 practices that have strong proven correlation or
12 may be associated with considerable improve-
13 ment in outcomes with no detrimental side ef-
14 fects, and are significantly underused in the
15 United States, including smoking cessation pro-
16 grams in pregnancy, group model prenatal care,
17 continuous labor support, nonsupine positions
18 for birth, and external version to turn breech
19 babies at term;

20 “(E) educates consumers about the quali-
21 fications of licensed providers of maternity care
22 and the best evidence about their safety, satis-
23 faction, outcomes, and costs;

24 “(F) informs consumers about the best
25 available research comparing birth center

1 births, planned home births, and hospital
 2 births, including information about each set-
 3 ting’s safety, satisfaction, outcomes, and costs;

4 “(G) fosters participation in high-quality,
 5 evidence-based childbirth education that pro-
 6 motes a natural, healthy, and safe approach to
 7 pregnancy, childbirth, and early parenting; is
 8 taught by certified educators, peer counselors,
 9 and health professionals; and promotes in-
 10 formed decisionmaking by childbearing individ-
 11 uals; and

12 “(H) is pilot tested for consumer com-
 13 prehension, cultural sensitivity, and acceptance
 14 of the messages across geographically, racially,
 15 ethnically, and linguistically diverse popu-
 16 lations.”.

17 **SEC. 517. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**

18 **IEWS FOR CARE OF CHILDBEARING INDI-**

19 **VIDUALS AND NEWBORNS.**

20 (a) IN GENERAL.—Not later than one year after the
 21 date of the enactment of this Act, the Secretary of Health
 22 and Human Services, through the Agency for Healthcare
 23 Research and Quality, shall—

24 (1) make publicly available an online biblio-
 25 graphic database identifying systematic reviews, in-

1 including an explanation of the level and quality of
2 evidence, for care of childbearing individuals and
3 newborns; and

4 (2) initiate regular updates that incorporate
5 newly issued and updated systematic reviews.

6 (b) SOURCES.—To aim for a comprehensive inventory
7 of systematic reviews relevant to maternal and newborn
8 care, the database shall identify reviews from diverse
9 sources, including—

10 (1) scientific peer-reviewed journals;

11 (2) databases, including Cochrane Database of
12 Systematic Reviews, Clinical Evidence, and Data-
13 base of Abstracts of Reviews of Effects; and

14 (3) Internet Websites of agencies and organiza-
15 tions throughout the world that produce such sys-
16 tematic reviews.

17 (c) FEATURES.—The database shall—

18 (1) provide bibliographic citations for each
19 record within the database, and for each such cita-
20 tion include an explanation of the level and quality
21 of evidence;

22 (2) include abstracts, as available;

23 (3) provide reference to companion documents
24 as may exist for each review, such as evidence tables

1 and guidelines or consumer educational materials de-
2 veloped from the review;

3 (4) provide links to the source of the full review
4 and to any companion documents;

5 (5) provide links to the source of a previous
6 version or update of the review;

7 (6) be searchable by intervention or other topic
8 of the review, reported outcomes, author, title, and
9 source; and

10 (7) offer to users periodic electronic notification
11 of database updates relating to users' topics of inter-
12 est.

13 (d) OUTREACH.—Not later than the first date the
14 database is made publicly available and periodically there-
15 after, the Secretary of Health and Human Services shall
16 publicize the availability, features, and uses of the data-
17 base under this section to the stakeholders described in
18 subsection (e).

19 (e) CONSULTATION.—For purposes of developing the
20 database under this section and maintaining and updating
21 such database, the Secretary of Health and Human Serv-
22 ices shall convene and consult with an advisory committee
23 composed of relevant stakeholders, including—

24 (1) Federal Medicaid administrators and State
25 agencies administering State plans under title XIX

1 of the Social Security Act pursuant to section
2 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

3 (2) providers of maternity and newborn care
4 from both academic and community-based settings,
5 including obstetrician-gynecologists, family physi-
6 cians, certified nurse midwives, certified midwives,
7 certified professional midwives, physician assistants,
8 perinatal nurses, pediatricians, and nurse practi-
9 tioners;

10 (3) maternal-fetal medicine specialists;

11 (4) neonatologists;

12 (5) childbearing individuals and advocates for
13 such individuals, including childbirth educators cer-
14 tified by a nationally accredited program, rep-
15 resenting communities that are diverse in terms of
16 race, ethnicity, indigenous status, and geographic
17 area;

18 (6) employers and purchasers;

19 (7) health facility and system leaders, including
20 both hospital and birth center facilities;

21 (8) journalists; and

22 (9) bibliographic informatics specialists.

23 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
24 authorized to be appropriated \$2,500,000 for each of the
25 fiscal years 2019 through 2021 for the purpose of devel-

1 opening the database and such sums as may be necessary
2 for each subsequent fiscal year for updating the database
3 and providing outreach and notification to users, as de-
4 scribed in this section.

5 **SEC. 518. MATERNITY CARE HEALTH PROFESSIONAL**
6 **SHORTAGE AREAS.**

7 Section 332 of the Public Health Service Act (42
8 U.S.C. 254e) is amended by adding at the end the fol-
9 lowing:

10 “(k)(1) The Secretary, acting through the Adminis-
11 trator of the Health Resources and Services Administra-
12 tion, shall designate maternity care health professional
13 shortage areas in the States, publish a descriptive list of
14 the area’s population groups, medical facilities, and other
15 public facilities so designated, and at least annually review
16 and, as necessary, revise such designations.

17 “(2) For purposes of paragraph (1), a complete de-
18 scriptive list shall be published in the Federal Register not
19 later than one year after the date of the enactment of the
20 Health Equity and Accountability Act of 2018 and annu-
21 ally thereafter.

22 “(3) The provisions of subsections (b), (c), (e), (f),
23 (g), (h), (i), and (j) (other than (j)(1)(B)) of this section
24 shall apply to the designation of a maternity care health
25 professional shortage area in a similar manner and extent

1 as such provisions apply to the designation of health pro-
2 fessional shortage areas, except in applying subsection
3 (b)(3), the reference in such subsection to ‘physicians’
4 shall be deemed to be a reference to nationally certified
5 and State licensed obstetricians, family practice physicians
6 who practice full-scope maternity care, certified nurse
7 midwives, certified midwives, certified professional mid-
8 wives, and physician’s assistants who practice full scope
9 maternity care.

10 “(4) For purposes of this subsection, the term ‘ma-
11 ternity care health professional shortage area’ means—

12 “(A) an area in an urban or rural area (which
13 need not conform to the geographic boundaries of a
14 political subdivision and which is a rational area for
15 the delivery of health services) which the Secretary
16 determines has a shortage of providers of maternity
17 care health services including those referenced in
18 paragraph (3) or an urban or rural area that the
19 Secretary determines has lost a significant number
20 of such providers during the 10-year period begin-
21 ning with 2004 or has no obstetrical providers li-
22 censed to provide operative obstetrical services;

23 “(B) an area in an urban or rural area (which
24 need not conform to the geographic boundaries of a
25 political subdivision and which is a rational area for

1 the delivery of health services) which the Secretary
2 determines has a shortage of hospital or labor and
3 delivery units, hospital birth center units, or free-
4 standing birth centers or an area that lost a signifi-
5 cant number of these units during the 10-year pe-
6 riod beginning with 2004; or

7 “(C) a population group which the Secretary
8 determines has such a shortage of providers or fa-
9 cilities.”.

10 **SEC. 519. EXPANSION OF CDC PREVENTION RESEARCH**
11 **CENTERS PROGRAM TO INCLUDE CENTERS**
12 **ON OPTIMAL MATERNITY OUTCOMES.**

13 (a) IN GENERAL.—Not later than one year after the
14 date of the enactment of this Act, the Secretary of Health
15 and Human Services, shall support the establishment of
16 additional Prevention Research Centers under the Preven-
17 tion Research Center Program administered by the Cen-
18 ters for Disease Control and Prevention. Such additional
19 centers shall each be known as a Center for Excellence
20 on Optimal Maternity Outcomes.

21 (b) RESEARCH.—Each Center for Excellence on Opti-
22 mal Maternity Outcomes shall—

23 (1) conduct at least one focused program of re-
24 search to improve maternity outcomes, including the
25 reduction of cesarean birth rates, elective inductions,

1 prematurity rates, and low birth weight rates within
2 an underserved population that has a disproportion-
3 ately large burden of suboptimal maternity out-
4 comes, including maternal mortality and morbidity,
5 infant mortality, prematurity, or low birth weight;

6 (2) work with partners on special interest
7 projects, as specified by the Centers for Disease
8 Control and Prevention and other relevant agencies
9 within the Department of Health and Human Serv-
10 ices, and on projects funded by other sources; and

11 (3) involve a minimum of two distinct birth set-
12 ting models, such as a hospital labor and delivery
13 model and freestanding birth center model; or a hos-
14 pital labor and delivery model and planned home
15 birth model.

16 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
17 for Excellence on Optimal Maternity Outcomes shall in-
18 clude the following interdisciplinary providers of maternity
19 care:

20 (1) Obstetrician-gynecologists.

21 (2) At least two of the following providers:

22 (A) Family practice physicians.

23 (B) Nurse practitioners.

24 (C) Physician assistants.

25 (D) Certified professional midwives.

1 (d) SERVICES.—Research conducted by each Center
2 for Excellence on Optimal Maternity Outcomes shall in-
3 clude at least 2 (and preferably more) of the following sup-
4 portive provider services:

- 5 (1) Mental health.
- 6 (2) Doula labor support.
- 7 (3) Nutrition education.
- 8 (4) Childbirth education.
- 9 (5) Social work.
- 10 (6) Physical therapy or occupation therapy.
- 11 (7) Substance abuse services.
- 12 (8) Home visiting.

13 (e) COORDINATION.—The programs of research at
14 each of the two Centers of Excellence on Optimal Mater-
15 nity Outcomes shall compliment and not replicate the
16 work of the other.

17 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
18 authorized to be appropriated to carry out this section
19 \$2,000,000 for each of the fiscal years 2019 through
20 2023.

1 **SEC. 520. EXPANDING MODELS ALLOWED TO BE TESTED BY**
2 **CENTER FOR MEDICARE & MEDICAID INNO-**
3 **VATION TO INCLUDE MATERNITY CARE MOD-**
4 **ELS.**

5 Section 1115A(b)(2)(B) of the Social Security Act
6 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
7 end the following new clause:

8 “(xxv) Promoting evidence-based mod-
9 els of care that have been associated with
10 reductions in maternal and infant health
11 disparities, including incorporating the use
12 of doula and promotoras support for preg-
13 nant and childbearing individuals into evi-
14 dence-based models of prenatal care, labor
15 and delivery, and postpartum care, and
16 supporting the appropriate use of out-of-
17 hospital birth models, including births at
18 home and in freestanding birth centers.”.

19 **SEC. 521. DEVELOPMENT OF INTERPROFESSIONAL MATER-**
20 **NITY CARE EDUCATIONAL MODELS AND**
21 **TOOLS.**

22 (a) IN GENERAL.—Not later than 6 months after the
23 date of the enactment of this Act, the Secretary of Health
24 and Human Services, acting in conjunction with the Ad-
25 ministrator of Health Resources and Services Administra-
26 tion, shall convene, for a 1-year period, an Interprofes-

1 sional Maternity Provider Education Commission to dis-
2 cuss and make recommendations for—

3 (1) a consensus standard physiologic maternity
4 care curriculum that takes into account the core
5 competencies for basic midwifery practice such as
6 those developed by the American College of Nurse
7 Midwives and the North American Registry of Mid-
8 wives, and the educational objectives for physicians
9 practicing in obstetrics and gynecology as deter-
10 mined by the Council on Resident Education in Ob-
11 stetrics and Gynecology;

12 (2) suggestions for multidisciplinary use of the
13 consensus physiologic curriculum;

14 (3) strategies to integrate and coordinate edu-
15 cation across maternity care disciplines, including
16 recommendations to increase medical and midwifery
17 student exposure to out-of-hospital birth; and

18 (4) pilot demonstrations of interprofessional
19 educational models.

20 (b) PARTICIPANTS.—The Commission shall include
21 maternity care educators, curriculum developers, service
22 leaders, certification leaders, and accreditation leaders
23 from the various professions that provide maternity care
24 in the United States. Such professions shall include obste-
25 trician gynecologists, certified nurse midwives or certified

1 midwives, family practice physicians, nurse practitioners,
2 physician assistants, certified professional midwives, and
3 perinatal nurses. Additionally, the Commission shall in-
4 clude representation from maternity care consumer advo-
5 cates.

6 (c) CURRICULUM.—The consensus standard physio-
7 logic maternity care curriculum described in subsection
8 (a)(1) shall—

9 (1) have a public health focus with a foundation
10 in health promotion and disease prevention;

11 (2) foster physiologic childbearing and woman
12 and family centered care;

13 (3) integrate strategies to reduce maternal and
14 infant morbidity and mortality;

15 (4) incorporate recommendations to ensure re-
16 spectful, safe, and seamless consultation, referral,
17 transport, and transfer of care when necessary; and

18 (5) include cultural sensitivity and strategies to
19 decrease disparities in maternity outcomes.

20 (d) REPORT.—Not later than 6 months after the final
21 meeting of the Commission, the Secretary of Health and
22 Human Services shall—

23 (1) submit to Congress a report containing the
24 recommendations made by the Commission under
25 this section; and

1 (2) make such report publicly available.

2 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
3 authorized to be appropriated to carry out this section
4 \$1,000,000 for each of the fiscal years 2019 and 2020,
5 and such sums as are necessary for each of the fiscal years
6 2021 through 2023.

7 **SEC. 522. INCLUDING SERVICES FURNISHED BY CERTAIN**
8 **STUDENTS, INTERNS, AND RESIDENTS SU-**
9 **PERVISED BY CERTIFIED NURSE MIDWIVES**
10 **WITHIN INPATIENT HOSPITAL SERVICES**
11 **UNDER MEDICARE.**

12 (a) IN GENERAL.—Section 1861(b) of the Social Se-
13 curity Act (42 U.S.C. 1395x(b)) is amended—

14 (1) in paragraph (6), by striking “; or” at the
15 end and inserting “, or in the case of services in a
16 hospital or osteopathic hospital by a student midwife
17 or an intern or resident-in-training under a teaching
18 program previously described in this paragraph who
19 is in the field of obstetrics and gynecology, if such
20 student midwife, intern, or resident-in-training is su-
21 pervised by a certified nurse-midwife to the extent
22 permitted under applicable State law and as may be
23 authorized by the hospital;”;

24 (2) in paragraph (7), by striking the period at
25 the end and inserting “; or”; and

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

3 “(8) a certified nurse-midwife where the hos-
4 pital has a teaching program approved as specified
5 in paragraph (6), if—

6 “(A) the hospital elects to receive any pay-
7 ment due under this title for reasonable costs of
8 such services; and

9 “(B) all certified nurse-midwives in such
10 hospital agree not to bill charges for profes-
11 sional services rendered in such hospital to indi-
12 viduals covered under the insurance program
13 established by this title.”.

14 (b) EFFECTIVE DATE.—The amendments made by
15 subsection (a) shall apply to services furnished on or after
16 the date of the enactment of this Act.

17 **SEC. 523. GRANTS TO PROFESSIONAL ORGANIZATIONS TO**
18 **INCREASE DIVERSITY IN MATERNAL, REPRO-**
19 **DUCTIVE, AND SEXUAL HEALTH PROFES-**
20 **SIONALS.**

21 (a) IN GENERAL.—The Secretary of Health and
22 Human Services, through the Administrator of the Health
23 Resources and Services Administration, shall carry out a
24 grant program under which the Secretary may make to
25 eligible health professional organizations—

1 (1) for fiscal year 2019, planning grants de-
2 scribed in subsection (b); and

3 (2) for the subsequent 4-year period, implemen-
4 tation grants described in subsection (c).

5 (b) PLANNING GRANTS.—

6 (1) IN GENERAL.—Planning grants described in
7 this subsection are grants for the following purposes:

8 (A) To collect data and identify any work-
9 force disparities, with respect to a health pro-
10 fession, at each of the following areas along the
11 health professional continuum:

12 (i) Pipeline availability with respect to
13 students at the high school and college or
14 university levels considering and working
15 toward entrance in the profession.

16 (ii) Entrance into the training pro-
17 gram for the profession.

18 (iii) Graduation from such training
19 program.

20 (iv) Entrance into practice.

21 (v) Retention in practice for more
22 than a 5-year period.

23 (B) To develop one or more strategies to
24 address the workforce disparities within the
25 health profession, as identified under (and in

1 response to the findings pursuant to) subpara-
2 graph (A).

3 (2) APPLICATION.—To be eligible to receive a
4 grant under this subsection, an eligible health pro-
5 fessional organization shall submit to the Secretary
6 of Health and Human Services an application in
7 such form and manner and containing such informa-
8 tion as specified by the Secretary.

9 (3) AMOUNT.—Each grant awarded under this
10 subsection shall be for an amount not to exceed
11 \$300,000.

12 (4) REPORT.—Each recipient of a grant under
13 this subsection shall submit to the Secretary of
14 Health and Human Services a report containing—

15 (A) information on the extent and distribu-
16 tion of workforce disparities identified through
17 the grant; and

18 (B) reasonable objectives and strategies
19 developed to address such disparities within a
20 5-, 10-, and 25-year period.

21 (c) IMPLEMENTATION GRANTS.—

22 (1) IN GENERAL.—Implementation grants de-
23 scribed in this subsection are grants to implement
24 one or more of the strategies developed pursuant to
25 a planning grant awarded under subsection (b).

1 (2) APPLICATION.—To be eligible to receive a
2 grant under this subsection, an eligible health pro-
3 fessional organization shall submit to the Secretary
4 of Health and Human Services an application in
5 such form and manner as specified by the Secretary.
6 Each such application shall contain information on
7 the capability of the organization to carry out a
8 strategy described in paragraph (1), involvement of
9 partners or coalitions, plans for developing sustain-
10 ability of the efforts after the culmination of the
11 grant cycle, and any other information specified by
12 the Secretary.

13 (3) AMOUNT.—Each grant awarded under this
14 subsection shall be for an amount not to exceed
15 \$500,000 each year during the 4-year period of the
16 grant.

17 (4) REPORTS.—For each of the first 3 years for
18 which an eligible health professional organization is
19 awarded a grant under this subsection, the organiza-
20 tion shall submit to the Secretary of Health and
21 Human Services a report on the activities carried
22 out by such organization through the grant during
23 such year and objectives for the subsequent year.
24 For the fourth year for which an eligible health pro-
25 fessional organization is awarded a grant under this

1 subsection, the organization shall submit to the Sec-
2 retary a report that includes an analysis of all the
3 activities carried out by the organization through the
4 grant and a detailed plan for continuation of out-
5 reach efforts.

6 (d) **ELIGIBLE HEALTH PROFESSIONAL ORGANIZA-**
7 **TION DEFINED.**—For purposes of this section, the term
8 “eligible health professional organization” means a profes-
9 sional organization representing obstetrician-gynecolo-
10 gists, certified nurse midwives, certified midwives, family
11 practice physicians, nurse practitioners whose scope of
12 practice includes maternity or sexual and reproductive
13 health care, physician assistants whose scope of practice
14 includes obstetrical or sexual and reproductive health care,
15 or certified professional midwives adolescent medicine spe-
16 cialists, and pediatricians who provide sexual and repro-
17 ductive health care.

18 (e) **AUTHORIZATION OF APPROPRIATIONS.**—There is
19 authorized to be appropriated to carry out this section
20 \$2,000,000 for fiscal year 2019 and \$3,000,000 for each
21 of the fiscal years 2020 through 2023.

22 **SEC. 524. INTERAGENCY UPDATE TO THE QUALITY FAMILY**
23 **PLANNING GUIDELINES.**

24 (a) **IN GENERAL.**—Not later than six months after
25 the date of enactment of this Act, the Director of the Cen-

1 ters for Disease Control and Prevention and the Office
2 of Population Affairs shall review and expand the 2014
3 Quality Family Planning Guidelines to address—

4 (1) health disparities; and

5 (2) the importance of patient-directed contra-
6 ceptive decisionmaking.

7 (b) CONSULTATION.—In carrying out subsection (a),
8 the Director of the Centers for Disease Control and Pre-
9 vention and the Office of Population Affairs shall convene
10 a meeting, and solicit the views of, stakeholders including
11 experts on health disparities, experts on reproductive coer-
12 cion, representatives of provider organizations, patient ad-
13 vocates, reproductive justice organizations, organizations
14 that represent racial and ethnic minority communities, or-
15 ganizations that represent people with disabilities, organi-
16 zations that represent LGBTQ persons, and organizations
17 that represent people with limited-English proficiency.

18 **SEC. 525. DISSEMINATION OF THE QUALITY FAMILY PLAN-**
19 **NING GUIDELINES.**

20 (a) IN GENERAL.—Not later than six months after
21 the date of enactment of this Act, the Secretary of Health
22 and Human Services and the Director of the Centers for
23 Disease Control and Prevention shall—

24 (1) develop a plan for outreach to publicly fund-
25 ed health care providers, including federally qualified

1 health centers and branches of the Indian Health
 2 Service, about the quality family planning guidelines
 3 referred to in section 524; and

4 (2) award grants to eligible entities to imple-
 5 ment these guidelines for all patients seeking family
 6 planning services.

7 (b) DEFINITION.—In this section, the term “eligible
 8 entity” means a publicly funded health care provider that
 9 serves persons of reproductive age.

10 **Subtitle B—Pregnancy Screening**

11 **SEC. 531. PREGNANCY INTENTION SCREENING INITIATIVE** 12 **DEMONSTRATION PROGRAM.**

13 Part P of title III of the Public Health Service Act
 14 (42 U.S.C. 280g et seq.) is amended by adding at the end
 15 the following:

16 **“SEC. 399V-7. PREGNANCY INTENTION SCREENING INITIA-** 17 **TIVE DEMONSTRATION PROGRAM.**

18 “(a) PROGRAM ESTABLISHMENT.—The Secretary,
 19 acting through the Director of the Centers for Disease
 20 Control and Prevention, shall establish a demonstration
 21 program to facilitate the clinical adoption of pregnancy in-
 22 tention screening initiatives by health care providers.

23 “(b) GRANTS.—The Secretary may carry out the
 24 demonstration program through awarding grants to eligi-

1 ble entities to implement pregnancy intention screening
2 initiatives, collect data, and evaluate such initiatives.

3 “(c) ELIGIBLE ENTITIES.—

4 “(1) IN GENERAL.—An eligible entity under
5 this section is an entity described in paragraph (2)
6 that provides non-directive, comprehensive, medically
7 accurate information.

8 “(2) ENTITIES DESCRIBED.—For purposes of
9 paragraph (1), an entity described in this paragraph
10 is a community-based organization, voluntary health
11 organization, public health department, community
12 health center, or other interested public or private
13 health care provider or organization.

14 “(d) PREGNANCY INTENTION SCREENING INITIA-
15 TIVE.—For purposes of this section, the term ‘pregnancy
16 intention screening initiative’ means any initiative by a
17 health care provider to routinely screen women with re-
18 spect to their pregnancy intentions and goals to either pre-
19 vent unintended pregnancies or improve the likelihood of
20 healthy pregnancies, in order to better provide health care
21 that meets the contraceptive or pre-pregnancy needs of
22 such women.

23 “(e) EVALUATION.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Director of the Centers for Disease

1 Control and Prevention, shall, by grant or contract,
2 and after consultation as described in paragraph (2),
3 conduct an evaluation of the demonstration pro-
4 gram, with respect to pregnancy intention screening
5 initiatives, conducted under this section. The evalua-
6 tion shall include:

7 “(A) Assessment of the implementation of
8 pregnancy intention screening protocols among
9 a diverse group of patients and providers, in-
10 cluding collecting data on the experiences and
11 outcomes for diverse patient populations in a
12 variety of clinical settings.

13 “(B) Analysis of outcome measures that
14 will facilitate effective and widespread adoption
15 of such protocols by health care providers for
16 inquiring about and responding to pregnancy
17 intentions of women with both contraceptive
18 and pre-pregnancy care.

19 “(C) Consideration of health disparities
20 among the population served.

21 “(D) Assessment of the equitable and vol-
22 untary application of such initiatives to minor-
23 ity and medically underserved communities.

24 “(E) Assessment of the training, capacity,
25 and ongoing technical assistance needed for

1 providers to effectively implement such preg-
2 nancy intention screening protocols.

3 “(F) Assessment of whether referral sys-
4 tems for selected protocols follow evidence-based
5 standards that ensure access to comprehensive
6 health services and appropriate follow-up care.

7 “(2) INDEPENDENT, EXPERT ADVISORY
8 PANEL.—In conducting the evaluation under para-
9 graph (1), the Director of the Centers for Disease
10 Control and Prevention shall consult with physi-
11 cians, physician assistants, and nurses who spe-
12 cialize in women’s health, and other experts in clin-
13 ical practice, program evaluation, and research.

14 “(3) REPORT.—Not later than one year after
15 the last day of the demonstration program under
16 this section, the Director of the Centers for Disease
17 Control and Prevention shall submit to Congress a
18 report on the results of the evaluation conducted
19 under paragraph (1) and shall make the report pub-
20 licly available.

21 “(f) FUNDING.—

22 “(1) AUTHORIZATION OF APPROPRIATIONS.—
23 To carry out this section, there is authorized to be
24 appropriated \$5,000,000 for each of fiscal years
25 2019 through 2021.

1 “(2) LIMITATION.—Not more than 25 percent
2 of funds appropriated to carry out this section pur-
3 suant to paragraph (1) for a fiscal year may be used
4 for purposes of the evaluation under subsection
5 (e).”.

6 **TITLE VI—MENTAL HEALTH**

7 **SEC. 601. MENTAL HEALTH FINDINGS.**

8 Congress finds the following:

9 (1) Despite the existence of effective treat-
10 ments, disparities lie in the availability, accessibility,
11 and quality of mental health services for racial and
12 ethnic minorities.

13 (2) These disparities have powerful significance
14 for minority groups and for society as a whole.

15 (3) Racial and ethnic minorities bear a greater
16 burden from unmet mental health needs and thus
17 suffer a greater loss to their overall health and pro-
18 ductivity.

19 (4) The foremost barriers include the cost of
20 care, societal stigma, and the fragmented organiza-
21 tion of services.

22 (5) African-American attitudes toward mental
23 illness are another barrier to seeking mental health
24 care.

1 (6) Mental illness retains considerable stigma,
2 and seeking treatment is not always encouraged.

3 (7) Mental illness is highly stigmatizing in
4 many Asian cultures.

5 (8) Addressing mental health stigma in commu-
6 nities will help increase utilization of mental health
7 services and reduce the burden of mental illness.

8 **SEC. 602. COVERAGE OF MARRIAGE AND FAMILY THERA-**
9 **PYST SERVICES, MENTAL HEALTH COUN-**
10 **SELOR SERVICES, AND SUBSTANCE ABUSE**
11 **COUNSELOR SERVICES UNDER PART B OF**
12 **THE MEDICARE PROGRAM.**

13 (a) COVERAGE OF SERVICES.—

14 (1) IN GENERAL.—Section 1861(s)(2) of the
15 Social Security Act (42 U.S.C. 1395x(s)(2)), as
16 amended by section 431(c), is amended—

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

19 (B) in subparagraph (HH), by inserting
20 “and” at the end; and

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

23 “(II) marriage and family therapist services (as
24 defined in subsection (lll)(1)) and mental health
25 counselor services (as defined in subsection (lll)(3))

1 and substance abuse counselor services (as defined
2 in subsection (ll)(5));”.

3 (2) DEFINITIONS.—Section 1861 of the Social
4 Security Act (42 U.S.C. 1395x), as amended by sec-
5 tions 205(b)(a), 413(a), and 431(c), is amended by
6 adding at the end the following new subsection:

7 “Marriage and Family Therapist Services; Marriage and
8 Family Therapist; Mental Health Counselor Serv-
9 ices; Mental Health Counselor; Substance Abuse
10 Counselor Services; Substance Abuse Counselor

11 “(ll)(1) The term ‘marriage and family therapist
12 services’ means services performed by a marriage and
13 family therapist (as defined in paragraph (2)) for the diag-
14 nosis and treatment of mental illnesses, which the mar-
15 riage and family therapist is legally authorized to perform
16 under State law (or the State regulatory mechanism pro-
17 vided by State law) of the State in which such services
18 are performed, as would otherwise be covered if furnished
19 by a physician or as an incident to a physician’s profes-
20 sional service, but only if no facility or other provider
21 charges or is paid any amounts with respect to the fur-
22 nishing of such services.

23 “(2) The term ‘marriage and family therapist’ means
24 an individual who—

1 “(A) possesses a master’s or doctoral degree
2 that qualifies for licensure or certification as a mar-
3 riage and family therapist pursuant to State law;

4 “(B) after obtaining such degree has performed
5 at least 2 years of clinical supervised experience in
6 marriage and family therapy; and

7 “(C) in the case of an individual performing
8 services in a State that provides for licensure or cer-
9 tification of marriage and family therapists, is li-
10 censed or certified as a marriage and family thera-
11 pist in such State.

12 “(3) The term ‘mental health counselor services’
13 means services performed by a mental health counselor (as
14 defined in paragraph (4)) for the diagnosis and treatment
15 of mental illnesses that the mental health counselor is le-
16 gally authorized to perform under State law (or the State
17 regulatory mechanism provided by the State law) of the
18 State in which such services are performed, as would oth-
19 erwise be covered if furnished by a physician or as incident
20 to a physician’s professional service, but only if no facility
21 or other provider charges or is paid any amounts with re-
22 spect to the furnishing of such services.

23 “(4) The term ‘mental health counselor’ means an
24 individual who—

1 “(A) possesses a master’s or doctor’s degree in
2 mental health counseling or a related field;

3 “(B) after obtaining such a degree has per-
4 formed at least 2 years of supervised mental health
5 counselor practice; and

6 “(C) in the case of an individual performing
7 services in a State that provides for licensure or cer-
8 tification of mental health counselors or professional
9 counselors, is licensed or certified as a mental health
10 counselor or professional counselor in such State.

11 “(5) The term ‘substance abuse counselor services’
12 means services performed by a substance abuse counselor
13 (as defined in paragraph (6)) for the diagnosis and treat-
14 ment of substance abuse and addiction that the substance
15 abuse counselor is legally authorized to perform under
16 State law (or the State regulatory mechanism provided by
17 the State law) of the State in which such services are per-
18 formed, as would otherwise be covered if furnished by a
19 physician or as incident to a physician’s professional serv-
20 ice, but only if no facility or other provider charges or is
21 paid any amounts with respect to the furnishing of such
22 services.

23 “(6) The term ‘substance abuse counselor’ means an
24 individual who—

1 “(A) has performed at least 2 years of super-
2 vised substance abuse counselor practice;

3 “(B) in the case of an individual performing
4 services in a State that provides for licensure or cer-
5 tification of substance abuse counselors or profes-
6 sional counselors, is licensed or certified as a sub-
7 stance abuse counselor or professional counselor in
8 such State; or

9 “(C) is a drug and alcohol counselor as defined
10 in section 40.281 of title 49, Code of Federal Regu-
11 lations.”.

12 (3) PROVISION FOR PAYMENT UNDER PART
13 B.—Section 1832(a)(2)(B) of the Social Security
14 Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

15 (A) by striking “and” at the end of clause
16 (iv); and

17 (B) by adding at the end the following new
18 clause:

19 “(v) marriage and family therapist
20 services, mental health counselor services,
21 and substance abuse counselor services;
22 and”.

23 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
24 of the Social Security Act (42 U.S.C. 1395l(a)(1)),
25 as amended by section 431(c)(3), is amended—

1 (A) by striking “and” before “(CC)”; and
 2 (B) by inserting before the semicolon at
 3 the end the following: “, and (DD) with respect
 4 to marriage and family therapist services, men-
 5 tal health counselor services, and substance
 6 abuse counselor services under section
 7 1861(s)(2)(II), the amounts paid shall be 80
 8 percent of the lesser of the actual charge for
 9 the services or 75 percent of the amount deter-
 10 mined for payment of a psychologist under sub-
 11 paragraph (L)”.

12 (5) EXCLUSION OF MARRIAGE AND FAMILY
 13 THERAPIST SERVICES AND MENTAL HEALTH COUN-
 14 SELOR SERVICES FROM SKILLED NURSING FACILITY
 15 PROSPECTIVE PAYMENT SYSTEM.—Section
 16 1888(e)(2)(A)(ii) of the Social Security Act (42
 17 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting
 18 “marriage and family therapist services (as defined
 19 in section 1861(III)(1)), mental health counselor
 20 services (as defined in section 1861(III)(3)),” after
 21 “qualified psychologist services,”.

22 (6) INCLUSION OF MARRIAGE AND FAMILY
 23 THERAPISTS, MENTAL HEALTH COUNSELORS, AND
 24 SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS
 25 FOR ASSIGNMENT OF CLAIMS.—Section

1 1842(b)(18)(C) of the Social Security Act (42
2 U.S.C. 1395u(b)(18)(C)) is amended by adding at
3 the end the following new clauses:

4 “(vii) A marriage and family therapist (as de-
5 fined in section 1861(lll)(2)).

6 “(viii) A mental health counselor (as defined in
7 section 1861(lll)(4)).

8 “(ix) A substance abuse counselor (as defined
9 in section 1861(lll)(6)).”.

10 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
11 ICES PROVIDED IN CERTAIN SETTINGS.—

12 (1) RURAL HEALTH CLINICS AND FEDERALLY
13 QUALIFIED HEALTH CENTERS.—Section
14 1861(aa)(1)(B) of the Social Security Act (42
15 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
16 by a clinical social worker (as defined in subsection
17 (hh)(1)),” and inserting “, by a clinical social worker
18 (as defined in subsection (hh)(1)), by a marriage
19 and family therapist (as defined in subsection
20 (lll)(2)), or by a mental health counselor (as defined
21 in subsection (lll)(4)), or by a substance abuse coun-
22 selor (as defined in section 1861 (lll)(6)).”.

23 (2) HOSPICE PROGRAMS.—Section
24 1861(dd)(2)(B)(i)(III) of the Social Security Act (42
25 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by in-

1 serting “or one marriage and family therapist (as
2 defined in subsection (ll)(2))” after “social worker”.

3 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
4 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR
5 POSTHOSPITAL SERVICES.—Section 1861(ee)(2)(G) of
6 the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is
7 amended by inserting “marriage and family therapist (as
8 defined in subsection (ll)(2)),” after “social worker,”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply with respect to services furnished
11 on or after January 1, 2019.

12 **SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION**
13 **PROGRAM.**

14 Part D of title V of the Public Health Service Act
15 (42 U.S.C. 290dd et seq.) is amended by adding at the
16 end the following:

17 **“SEC. 550. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
18 **PROVISION OF BEHAVIORAL HEALTH CARE**
19 **IN PRIMARY CARE SETTINGS.**

20 “(a) GRANTS.—The Secretary, acting through the
21 Assistant Secretary for Mental Health and Substance
22 Abuse, shall award grants to eligible entities for the pur-
23 pose of establishing interprofessional health care teams
24 that provide behavioral health care.

1 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
2 a grant under this section, an entity shall be a Federally
3 qualified health center (as defined in section 1861(aa) of
4 the Social Security Act), rural health clinic, or behavioral
5 health program, serving a high proportion of individuals
6 from racial and ethnic minority groups (as defined in sec-
7 tion 1707(g)).

8 “(c) SCIENTIFICALLY BASED.—Integrated health
9 care funded through this section shall be scientifically
10 based, taking into consideration the results of the most
11 recent peer-reviewed research available.

12 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
13 carry out this section, there is authorized to be appro-
14 priated \$20,000,000 for each of fiscal years 2019 through
15 2024.”.

16 **SEC. 604. ADDRESSING RACIAL AND ETHNIC MINORITY**
17 **MENTAL HEALTH DISPARITIES RESEARCH**
18 **GAPS.**

19 (a) IN GENERAL.—Not later than 6 months after the
20 date of the enactment of this Act, the Director of the Na-
21 tional Institute on Minority Health and Health Disparities
22 shall enter into an arrangement with the National Acad-
23 emy of Sciences to carry out the activities under sub-
24 section (b), or, if the National Academy of Sciences de-
25 clines to enter into such an arrangement, the Director of

1 the National Institute on Minority Health and Health Dis-
2 parities, in cooperation with the Agency for Healthcare
3 Research and Quality, shall carry out the activities under
4 subsection (b).

5 (b) ACTIVITIES.—The applicable entity under sub-
6 section (a) shall—

7 (1) conduct a study with respect to mental
8 health disparities in racial and ethnic minority
9 groups (as defined in section 1707(g) of the Public
10 Health Service Act (42 U.S.C. 300u–6(g))); and

11 (2) submit to Congress a report on the results
12 of such study, including—

13 (A) a compilation of information on the dy-
14 namics of mental disorders in such racial and
15 ethnic minority groups; and

16 (B) a compilation of information on the
17 impact of exposure to community violence, ad-
18 verse childhood experiences, and other psycho-
19 logical traumas on mental disorders in such ra-
20 cial and minority groups.

21 **SEC. 605. HEALTH PROFESSIONS COMPETENCIES TO AD-**
22 **DRESS RACIAL AND ETHNIC MINORITY MEN-**
23 **TAL HEALTH DISPARITIES.**

24 (a) IN GENERAL.—The Secretary of Health and
25 Human Services, acting through the Assistant Secretary

1 for Mental Health and Substance Use, shall award grants
2 to qualified national organizations for the purposes of—

3 (1) developing, and disseminating to health pro-
4 fessional educational programs curricula or core
5 competencies addressing mental health disparities
6 among racial and ethnic minority groups for use in
7 the training of students in the professions of social
8 work, psychology, psychiatry, marriage and family
9 therapy, mental health counseling, and substance
10 abuse counseling; and

11 (2) certifying community health workers and
12 peer wellness specialists with respect to such cur-
13 ricula and core competencies and integrating and ex-
14 panding the use of such workers and specialists into
15 health care to address mental health disparities
16 among racial and ethnic minority groups.

17 (b) CURRICULA; CORE COMPETENCIES.—Organiza-
18 tions receiving funds under subsection (a) may use the
19 funds to engage in the following activities related to the
20 development and dissemination of curricula or core com-
21 petencies described in subsection (a)(1):

22 (1) Formation of committees or working groups
23 comprised of experts from accredited health profes-
24 sions schools to identify core competencies relating

1 to mental health disparities among racial and ethnic
2 minority groups.

3 (2) Planning of workshops in national fora to
4 allow for public input into the educational needs as-
5 sociated with mental health disparities among racial
6 and ethnic minority groups.

7 (3) Dissemination and promotion of the use of
8 curricula or core competencies in undergraduate and
9 graduate health professions training programs na-
10 tionwide.

11 (4) Establishing external stakeholder advisory
12 boards to provide meaningful input into policy and
13 program development and best practices to reduce
14 mental health disparities among racial and ethnic
15 minority groups.

16 (c) DEFINITIONS.—In this section:

17 (1) QUALIFIED NATIONAL ORGANIZATION.—The
18 term “qualified national organization” means a na-
19 tional organization that focuses on the education of
20 students in programs of social work, psychology,
21 psychiatry, and marriage and family therapy.

22 (2) RACIAL AND ETHNIC MINORITY GROUP.—
23 The term “racial and ethnic minority group” has the
24 meaning given to such term in section 1707(g) of

1 the Public Health Service Act (42 U.S.C. 300u–
2 6(g)).

3 (d) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2019 through 2024.

7 **SEC. 606. GEOACCESS STUDY.**

8 The Assistant Secretary for Mental Health and Sub-
9 stance Use shall—

10 (1) conduct a study to—

11 (A) determine which geographic areas of
12 the United States have shortages of specialty
13 mental health providers; and

14 (B) assess the preparedness of speciality
15 mental health providers to deliver culturally and
16 linguistically appropriate, affordable, and acces-
17 sible services; and

18 (2) submit a report to Congress on the results
19 of such study.

20 **SEC. 607. ASIAN AMERICAN, NATIVE HAWAIIAN, AND PA-**
21 **CIFIC ISLANDER BEHAVIORAL AND MENTAL**
22 **HEALTH OUTREACH AND EDUCATION STRAT-**
23 **EGIES.**

24 Part D of title V of the Public Health Service Act
25 (42 U.S.C. 290dd et seq.), as amended by section 603,

1 is further amended by adding at the end the following new
2 section:

3 **“SEC. 551. BEHAVIORAL AND MENTAL HEALTH OUTREACH**
4 **AND EDUCATION STRATEGIES.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Assistant Secretary for Mental Health and Substance
7 Use, shall, in coordination with advocacy and behavioral
8 and mental health organizations serving populations of
9 Asian American, Native Hawaiian, and Pacific Islander
10 individuals or communities, develop and implement an out-
11 reach and education strategy to promote behavioral and
12 mental health and reduce stigma associated with mental
13 health conditions and substance abuse among the Asian
14 American, Native Hawaiian, and Pacific Islander popu-
15 lations. Such strategy shall—

16 “(1) be designed to—

17 “(A) meet the diverse cultural and lan-
18 guage needs of the various Asian American,
19 Native Hawaiian, and Pacific Islander popu-
20 lations; and

21 “(B) ensure such strategies are develop-
22 mentally and age appropriate;

23 “(2) increase awareness of symptoms of mental
24 illnesses common among such populations, taking
25 into account differences within subgroups, such as

1 gender, gender identity, age, sexual orientation, or
2 ethnicity, of such populations;

3 “(3) provide information on evidence-based, cul-
4 turally and linguistically appropriate and adapted
5 interventions and treatments;

6 “(4) ensure full participation of, and engage,
7 both consumers and community members in the de-
8 velopment and implementation of materials; and

9 “(5) seek to broaden the perspective among
10 both individuals in such communities and stake-
11 holders serving such communities to use a com-
12 prehensive public health approach to promoting be-
13 havioral health that addresses a holistic view of
14 health by focusing on the intersection between be-
15 havioral and physical health.

16 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
17 is authorized to be appropriated to carry out this section
18 \$300,000 for fiscal year 2019.”.

19 **SEC. 608. MENTAL HEALTH IN SCHOOLS.**

20 (a) PURPOSE.—It is the purpose of this section to—

21 (1) revise, increase funding for, and expand the
22 scope of the Project AWARE State Educational
23 Agency Grant Program carried out by the Secretary
24 of Health and Human Services, in order to provide

1 access to more comprehensive school-based mental
2 health services and supports;

3 (2) provide for comprehensive staff development
4 for school and community service personnel working
5 in the school; and

6 (3) provide for comprehensive training for chil-
7 dren with mental health disorders, for parents, sib-
8 lings, and other family members of such children,
9 and for concerned members of the community.

10 (b) TECHNICAL AMENDMENTS.—The second part G
11 (relating to services provided through religious organiza-
12 tions) of title V of the Public Health Service Act (42
13 U.S.C. 290kk et seq.) is amended—

14 (1) by redesignating such part as part J; and

15 (2) by redesignating sections 581 through 584
16 as sections 596 through 596C, respectively.

17 (c) SCHOOL-BASED MENTAL HEALTH AND CHIL-
18 DREN AND VIOLENCE.—Section 581 of the Public Health
19 Service Act (42 U.S.C. 290hh) is amended to read as fol-
20 lows:

21 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH AND CHIL-**
22 **DREN AND VIOLENCE.**

23 “(a) IN GENERAL.—The Secretary, in collaboration
24 with the Secretary of Education and in consultation with
25 the Attorney General, shall, directly or through grants,

1 contracts, or cooperative agreements awarded to eligible
2 entities described in subsection (c), assist local commu-
3 nities and schools (including schools funded by the Bureau
4 of Indian Education) in applying a public health approach
5 to mental health services both in schools and in the com-
6 munity. Such approach should provide comprehensive age
7 appropriate services and supports, be linguistically and
8 culturally appropriate, be trauma-informed, and incor-
9 porate age appropriate strategies of positive behavioral
10 interventions and supports. A comprehensive school men-
11 tal health program funded under this section shall assist
12 children in dealing with trauma and violence.

13 “(b) ACTIVITIES.—Under the program under sub-
14 section (a), the Secretary may—

15 “(1) provide financial support to enable local
16 communities to implement a comprehensive cul-
17 turally and linguistically appropriate, trauma-in-
18 formed, and age-appropriate, school-based mental
19 health program that—

20 “(A) builds awareness of trauma;

21 “(B) trains appropriate staff to identify
22 signs of trauma or mental health disorders; and

23 “(C) incorporates positive behavioral inter-
24 ventions, family engagement, student treatment,

1 and multi-generational supports to foster the
2 health and development of children;

3 “(2) provide technical assistance to local com-
4 munities with respect to the development of pro-
5 grams described in paragraph (1);

6 “(3) provide assistance to local communities in
7 the development of policies to address child and ado-
8 lescent trauma and mental health issues and violence
9 when and if it occurs;

10 “(4) facilitate community partnerships among
11 families, students, law enforcement agencies, edu-
12 cation systems, mental health and substance use dis-
13 order service systems, family-based mental health
14 service systems, child welfare agencies, health care
15 service systems (including primary care physicians),
16 faith-based programs, trauma networks, and other
17 community-based systems; and

18 “(5) establish mechanisms for children and ado-
19 lescents to report incidents of violence or plans by
20 other children, adolescents, or adults to commit vio-
21 lence.

22 “(c) REQUIREMENTS.—

23 “(1) IN GENERAL.—To be eligible for a grant,
24 contract, or cooperative agreement under subsection
25 (a), an entity shall—

1 “(A) be a partnership that—

2 “(i) shall include a State educational
3 agency and one or more local educational
4 agencies, with a local educational agency
5 serving as the lead partner; and

6 “(ii) may include, in accordance with
7 paragraph (2)(A)(i), appropriate public or
8 private entities that use interventions that
9 are evidence-based, as defined in section
10 8101 of the Elementary and Secondary
11 Education Act of 1965 (20 U.S.C. 7801);
12 and

13 “(B) submit an application, that is en-
14 dorsed by all members of the partnership, that
15 contains the assurances described in paragraph
16 (2).

17 “(2) REQUIRED ASSURANCES.—An application
18 under paragraph (1) shall contain assurances as fol-
19 lows:

20 “(A) That the eligible entity will ensure
21 that, in carrying out activities under this sec-
22 tion, the eligible entity will enter into a memo-
23 randum of understanding—

24 “(i) with at least 1 public or private
25 mental health entity, health care entity,

1 law enforcement or juvenile justice entity,
2 child welfare agency, family-based mental
3 health entity, trauma network, or other
4 community-based entity; and

5 “(ii) that clearly states—

6 “(I) the responsibilities of each
7 partner with respect to the activities
8 to be carried out, including how fam-
9 ily engagement will be incorporated in
10 the activities;

11 “(II) how school-employed and
12 school-based mental health profes-
13 sionals will be utilized for carrying out
14 such responsibilities;

15 “(III) how each such partner will
16 be accountable for carrying out such
17 responsibilities; and

18 “(IV) the amount of non-Federal
19 funding or in-kind contributions that
20 each such partner will contribute in
21 order to sustain the program.

22 “(B) That the comprehensive school-based
23 mental health program carried out under this
24 section supports the flexible use of funds to ad-
25 dress—

1 “(i) the promotion of the social, emo-
2 tional, and behavioral health of all students
3 in an environment that is conducive to
4 learning;

5 “(ii) the reduction in the likelihood of
6 at risk students developing social, emo-
7 tional, behavioral health problems, or sub-
8 stance use disorders;

9 “(iii) the early identification of social,
10 emotional, behavioral problems, or sub-
11 stance use disorders and the provision of
12 early intervention services;

13 “(iv) the treatment or referral for
14 treatment of students with existing social,
15 emotional, behavioral health problems, or
16 substance use disorders; and

17 “(v) the development and implementa-
18 tion of programs to assist children in deal-
19 ing with trauma and violence, including
20 program curricula, school supports, and
21 after-school programs.

22 “(C) That the comprehensive school-based
23 mental health program carried out under this
24 section will provide for in-service training of all

1 school personnel, including ancillary staff and
2 volunteers, in—

3 “(i) the techniques and supports need-
4 ed to identify early children with trauma
5 histories and children with, or at risk of,
6 mental illness;

7 “(ii) the use of referral mechanisms
8 that effectively link such children to appro-
9 priate treatment and intervention services
10 in the school and in the community and to
11 follow-up when services are not available;

12 “(iii) strategies that promote a school-
13 wide positive environment;

14 “(iv) strategies for promoting the so-
15 cial, emotional, mental, and behavioral
16 health of all students; and

17 “(v) strategies to increase the knowl-
18 edge and skills of school and community
19 leaders about the impact of trauma and vi-
20 olence and on the application of a public
21 health approach to comprehensive school-
22 based mental health programs.

23 “(D) That the comprehensive school-based
24 mental health program carried out under this
25 section will include comprehensive training for

1 parents, siblings, and other family members of
2 children with mental health disorders, and for
3 concerned members of the community in—

4 “(i) the techniques and supports need-
5 ed to identify early children with trauma
6 histories, and children with, or at risk of,
7 mental illness;

8 “(ii) the use of referral mechanisms
9 that effectively link such children to appro-
10 priate treatment and intervention services
11 in the school and in the community and
12 follow-up when such services are not avail-
13 able; and

14 “(iii) strategies that promote a school-
15 wide positive environment.

16 “(E) That the comprehensive school-based
17 mental health program carried out under this
18 section will demonstrate the measures to be
19 taken to sustain the program after funding
20 under this section terminates (which may in-
21 clude seeking funding for the program under a
22 State Medicaid plan under title XIX of the So-
23 cial Security Act (42 U.S.C. 1396 et seq.) or a
24 waiver of such a plan).

1 “(F) That the eligible entity is supported
2 by the State agency with primary responsibility
3 for behavioral health to ensure that the sustain-
4 ability of the programs is established after
5 funding under this section terminates.

6 “(G) That the comprehensive school-based
7 mental health program carried out under this
8 section will be based on trauma-informed and
9 evidence-based practices.

10 “(H) That the comprehensive school-based
11 mental health program carried out under this
12 section will be coordinated with early inter-
13 vening activities carried out under the Individ-
14 uals with Disabilities Education Act (20 U.S.C.
15 1400 et seq.).

16 “(I) That the comprehensive school-based
17 mental health program carried out under this
18 section will be trauma-informed and culturally
19 and linguistically appropriate.

20 “(J) That the comprehensive school-based
21 mental health program carried out under this
22 section will include a broad needs assessment of
23 youth who drop out of school due to policies of
24 ‘zero tolerance’ with respect to drugs, alcohol,

1 or weapons and an inability to obtain appro-
2 priate services.

3 “(K) That the mental health services pro-
4 vided through the comprehensive school-based
5 mental health program carried out under this
6 section will be provided by qualified mental and
7 behavioral health professionals who are certified
8 or licensed by the State involved and practicing
9 within their area of expertise.

10 “(3) COORDINATOR.—Any entity that is a
11 member of a partnership described in paragraph
12 (1)(A) may serve as the coordinator of funding and
13 activities under the grant if all members of the part-
14 nership agree.

15 “(4) COMPLIANCE WITH HIPAA.—A grantee
16 under this section shall be deemed to be a covered
17 entity for purposes of compliance with the regula-
18 tions promulgated under section 264(c) of the
19 Health Insurance Portability and Accountability Act
20 of 1996 (42 U.S.C. 1320d–2 note) with respect to
21 any patient records developed through activities
22 under the grant.

23 “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary
24 shall ensure that grants, contracts, or cooperative agree-
25 ments under subsection (a) will be distributed equitably

1 among the regions of the country and among urban and
2 rural areas.

3 “(e) DURATION OF AWARDS.—With respect to a
4 grant, contract, or cooperative agreement under sub-
5 section (a), the period during which payments under such
6 an award will be made to the recipient shall be 5 years.
7 An eligible entity described in subsection (c) may receive
8 only one award under this section, except that an eligible
9 entity that is providing services and supports on a regional
10 basis may receive additional funding after the expiration
11 of the preceding grant period.

12 “(f) EVALUATION AND MEASURES OF OUTCOMES.—

13 “(1) DEVELOPMENT OF PROCESS.—The Assist-
14 ant Secretary shall develop a fiscally appropriate
15 process for evaluating activities carried out under
16 this section. Such process shall include—

17 “(A) the development of guidelines for the
18 submission of program data by grant, contract,
19 or cooperative agreement recipients;

20 “(B) the development of measures of out-
21 comes (in accordance with paragraph (2)) to be
22 applied by such recipients in evaluating pro-
23 grams carried out under this section; and

1 “(C) the submission of annual reports by
2 such recipients concerning the effectiveness of
3 programs carried out under this section.

4 “(2) MEASURES OF OUTCOMES.—

5 “(A) IN GENERAL.—The Assistant Sec-
6 retary shall develop measures of outcomes to be
7 applied by recipients of assistance under this
8 section, and the Assistant Secretary, in evalu-
9 ating the effectiveness of programs carried out
10 under this section. Such measures shall include
11 student and family measures as provided for in
12 subparagraph (B) and local educational meas-
13 ures as provided for under subparagraph (C).

14 “(B) STUDENT AND FAMILY MEASURES OF
15 OUTCOMES.—The measures of outcomes devel-
16 oped under paragraph (1)(B) relating to stu-
17 dents and families shall, with respect to activi-
18 ties carried out under a program under this
19 section, at a minimum include provisions to
20 evaluate whether the program is effective in—

21 “(i) increasing social and emotional
22 competency;

23 “(ii) increasing academic competency
24 (as defined by the Secretary);

1 “(iii) reducing disruptive and aggres-
2 sive behaviors;

3 “(iv) improving child functioning;

4 “(v) reducing substance use disorders;

5 “(vi) reducing suspensions, truancy,
6 expulsions, and violence;

7 “(vii) increasing high school gradua-
8 tion rates, calculated using the four-year
9 adjusted cohort graduation rate or the ex-
10 tended-year adjusted cohort graduation
11 rate (as such terms are defined in section
12 8101 of the Elementary and Secondary
13 Education Act of 1965 (20 U.S.C. 7801));
14 and

15 “(viii) improving access to care for
16 mental health disorders.

17 “(C) LOCAL EDUCATIONAL OUTCOMES.—

18 The outcome measures developed under para-
19 graph (1)(B) relating to local educational sys-
20 tems shall, with respect to activities carried out
21 under a program under this section, at a min-
22 imum include provisions to evaluate—

23 “(i) the effectiveness of comprehensive
24 school mental health programs established
25 under this section;

1 “(ii) the effectiveness of formal part-
2 nership linkages among child and family
3 serving institutions, community support
4 systems, and the educational system;

5 “(iii) the progress made in sustaining
6 the program once funding under the grant
7 has expired;

8 “(iv) the effectiveness of training and
9 professional development programs for all
10 school personnel that incorporate indica-
11 tors that measure cultural and linguistic
12 competencies under the program in a man-
13 ner that incorporates appropriate cultural
14 and linguistic training;

15 “(v) the improvement in perception of
16 a safe and supportive learning environment
17 among school staff, students, and parents;

18 “(vi) the improvement in case-finding
19 of students in need of more intensive serv-
20 ices and referral of identified students to
21 early intervention and clinical services;

22 “(vii) the improvement in the imme-
23 diate availability of clinical assessment and
24 treatment services within the context of

1 the local community to students posing a
2 danger to themselves or others;

3 “(viii) the increased successful matric-
4 ulation to postsecondary school; and

5 “(ix) reduced referrals to juvenile jus-
6 tice.

7 “(3) SUBMISSION OF ANNUAL DATA.—An eligi-
8 ble entity described in subsection (c) that receives a
9 grant, contract, or cooperative agreement under this
10 section shall annually submit to the Assistant Sec-
11 retary a report that includes data to evaluate the
12 success of the program carried out by the entity
13 based on whether such program is achieving the pur-
14 poses of the program. Such reports shall utilize the
15 measures of outcomes under paragraph (2) in a rea-
16 sonable manner to demonstrate the progress of the
17 program in achieving such purposes.

18 “(4) EVALUATION BY ASSISTANT SECRETARY.—
19 Based on the data submitted under paragraph (3),
20 the Assistant Secretary shall annually submit to
21 Congress a report concerning the results and effec-
22 tiveness of the programs carried out with assistance
23 received under this section.

24 “(5) LIMITATION.—An eligible entity shall use
25 not more than 10 percent of amounts received under

1 a grant under this section to carry out evaluation
2 activities under this subsection.

3 “(g) INFORMATION AND EDUCATION.—The Sec-
4 retary shall establish comprehensive information and edu-
5 cation programs to disseminate the findings of the knowl-
6 edge development and application under this section to the
7 general public and to health care professionals.

8 “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF
9 APPROPRIATIONS.—

10 “(1) AMOUNT OF GRANTS.—A grant under this
11 section shall be in an amount that is not more than
12 \$2,000,000 for each of fiscal years 2019 through
13 2023. The Secretary shall determine the amount of
14 each such grant based on the population of children
15 up to age 21 of the area to be served under the
16 grant.

17 “(2) AUTHORIZATION OF APPROPRIATIONS.—
18 There is authorized to be appropriated to carry out
19 this section, \$200,000,000 for each of fiscal years
20 2019 through 2023.”.

21 (d) CONFORMING AMENDMENT.—Part G of title V
22 of the Public Health Service Act (42 U.S.C. 290hh et
23 seq.), as amended by this section, is further amended by
24 striking the part heading and inserting the following:

1 **“PART G—SCHOOL-BASED MENTAL HEALTH”.**
2 **TITLE VII—ADDRESSING HIGH**
3 **IMPACT MINORITY DISEASES**
4 **Subtitle A—Cancer**

5 **SEC. 701. LUNG CANCER MORTALITY REDUCTION.**

6 (a) **SHORT TITLE.**—This section may be cited as the
7 “Lung Cancer Mortality Reduction Act of 2018”.

8 (b) **FINDINGS.**—Congress makes the following find-
9 ings:

10 (1) Lung cancer is the leading cause of cancer
11 death for both men and women, accounting for 25
12 percent of all cancer deaths.

13 (2) Lung cancer kills more people annually
14 than breast cancer, prostate cancer, colon cancer,
15 liver cancer, melanoma, and kidney cancer combined.

16 (3) Since the National Cancer Act of 1971
17 (Public Law 92–218; 85 Stat. 778), coordinated and
18 comprehensive research has raised the 5-year sur-
19 vival rates for breast cancer to 90 percent, for pros-
20 tate cancer to 99 percent, and for colon cancer to
21 64 percent.

22 (4) The 5-year survival rate for lung cancer is
23 still only 18 percent, and a similar coordinated and
24 comprehensive research effort is required to achieve
25 increases in lung cancer survivability rates.

1 (5) Sixty percent of lung cancer cases are now
2 diagnosed in nonsmokers or former smokers.

3 (6) Two-thirds of nonsmokers diagnosed with
4 lung cancer are women.

5 (7) Certain minority populations, such as Afri-
6 can-American males, have disproportionately high
7 rates of lung cancer incidence and mortality, despite
8 their smoking rate being similar to other racial
9 groups.

10 (8) Members of the Baby Boomer Generation
11 are entering their 60s, the most common age at
12 which people develop lung cancer.

13 (9) Tobacco addiction and exposure to other
14 lung cancer carcinogens such as Agent Orange and
15 other herbicides and battlefield emissions are serious
16 problems among military personnel and war vet-
17 erans.

18 (10) Significant and rapid improvements in
19 lung cancer mortality can be expected through great-
20 er use and access to lung cancer screening tests for
21 at-risk individuals.

22 (11) Recent research has shown that screening
23 with low-dose computed tomography scan reduced
24 lung cancer death mortality by 20 percent for those
25 with a high risk of lung cancer through early detec-

1 tion. The Centers for Medicare & Medicaid Services
2 supports annual lung cancer screening for high-risk
3 patients with low-dose computed tomography.

4 (12) Additional strategies are necessary to fur-
5 ther enhance the existing tests and therapies avail-
6 able to diagnose and treat lung cancer in the future.

7 (13) The August 2001 Report of the Lung
8 Cancer Progress Review Group of the National Can-
9 cer Institute stated that funding for lung cancer re-
10 search was “far below the levels characterized for
11 other common malignancies and far out of propor-
12 tion to its massive health impact”.

13 (14) The Report of the Lung Cancer Progress
14 Review Group identified as its “highest priority” the
15 creation of integrated, multidisciplinary, multi-insti-
16 tutional research consortia organized around the
17 problem of lung cancer rather than around specific
18 research disciplines.

19 (15) The United States must enhance its re-
20 sponse to the issues raised in the Report of the
21 Lung Cancer Progress Review Group, and this can
22 be accomplished through the establishment of a co-
23 ordinated effort designed to reduce the lung cancer
24 mortality rate by 50 percent by 2020 and targeted
25 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 the Health Equity and Ac-
20 countability Act of 2018, the Secretary, in consultation
21 with the Secretary of Defense, the Secretary of Veterans
22 Affairs, the Director of the National Institutes of Health,
23 the Director of the Centers for Disease Control and Pre-
24 vention, the Commissioner of Food and Drugs, the Admin-
25 istrator of the Centers for Medicare & Medicaid Services,

1 the Director of the National Institute on Minority Health
2 and Health Disparities, and other members of the Lung
3 Cancer Advisory Board established under section 701 of
4 the Health Equity and Accountability Act of 2018, shall
5 implement a comprehensive program, to be known as the
6 Lung Cancer Mortality Reduction Program, to achieve a
7 reduction of at least 25 percent in the mortality rate of
8 lung cancer by 2020.

9 “(b) REQUIREMENTS.—The Program shall include at
10 least the following:

11 “(1) With respect to the National Institutes of
12 Health—

13 “(A) a strategic review and prioritization
14 by the National Cancer Institute of research
15 grants to achieve the goal of the Lung Cancer
16 Mortality Reduction Program in reducing lung
17 cancer mortality;

18 “(B) the provision of funds to enable the
19 Airway Biology and Disease Branch of the Na-
20 tional Heart, Lung, and Blood Institute to ex-
21 pand its research programs to include pre-
22 dispositions to lung cancer, the interrelationship
23 between lung cancer and other pulmonary and
24 cardiac disease, and the diagnosis and treat-
25 ment of those 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 529B 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 promotion (including education) of
7 lung cancer screening within minority and rural pop-
8 ulations and the study of the effectiveness of efforts
9 to increase such screening.

10 “(6) The cooperation and coordination of all
11 minority and health disparity programs within the
12 Department of Health and Human Services to en-
13 sure that all aspects of the Lung Cancer Mortality
14 Reduction Program under this section adequately
15 address the burden of lung cancer on minority and
16 rural populations.

17 “(7) The cooperation and coordination of all to-
18 bacco control and cessation programs within agen-
19 cies of the Department of Health and Human Serv-
20 ices to achieve the goals of the Lung Cancer Mor-
21 tality Reduction Program under this section with
22 particular emphasis on the coordination of drug and
23 other cessation treatments with early detection pro-
24 tocols.”.

1 (2) FEDERAL FOOD, DRUG, AND COSMETIC
2 ACT.—Subchapter B of chapter V of the Federal
3 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
4 seq.) is amended by adding at the end the following:

5 **“SEC. 529B. DRUGS RELATING TO LUNG CANCER.**

6 “(a) IN GENERAL.—The provisions of this sub-
7 chapter shall apply to a drug described in subsection (b)
8 to the same extent and in the same manner as such provi-
9 sions apply to a drug for a rare disease or condition.

10 “(b) QUALIFIED DRUGS.—A drug described in this
11 subsection is—

12 “(1) a chemoprevention drug for precancerous
13 conditions of the lung;

14 “(2) a drug for targeted therapeutic treat-
15 ments, including any vaccine, for lung cancer; or

16 “(3) a drug to curtail or prevent nicotine addic-
17 tion.

18 “(c) BOARD.—The Board established under section
19 701 of the Health Equity and Accountability Act of 2018
20 shall monitor the program implemented under this sec-
21 tion.”.

22 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
23 tion 561(e) of the Federal Food, Drug, and Cos-
24 metic Act (21 U.S.C. 360bbb(e)) is amended by in-
25 serting before the period the following: “and shall

1 include expanding access to drugs under section
2 529B, with substantial consideration being given to
3 whether the totality of information available to the
4 Secretary regarding the safety and effectiveness of
5 an investigational drug, as compared to the risk of
6 morbidity and death from the disease, indicates that
7 a patient may obtain more benefit than risk if treat-
8 ed with the drug”.

9 (4) CDC.—Title XV of the Public Health Serv-
10 ice Act (42 U.S.C. 300k et seq.) is amended by add-
11 ing at the end the following:

12 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
13 **PROGRAM.**

14 “The Secretary shall establish and implement an
15 early disease research and management program targeted
16 at the high incidence and mortality rates of lung cancer
17 among minority and low-income populations.”.

18 (e) DEPARTMENT OF DEFENSE AND THE DEPART-
19 MENT OF VETERANS AFFAIRS.—The Secretary of Defense
20 and the Secretary of Veterans Affairs, each in coordina-
21 tion with the Secretary of Health and Human Services,
22 shall engage—

23 (1) in the implementation within the Depart-
24 ment of Defense and the Department of Veterans
25 Affairs of an early detection and disease manage-

1 ment research program for military personnel and
2 veterans whose smoking history and exposure to car-
3 cinogens during active duty service has increased
4 their risk for lung cancer; and

5 (2) in the implementation of coordinated care
6 programs for military personnel and veterans diag-
7 nosed with lung cancer.

8 (f) LUNG CANCER ADVISORY BOARD.—

9 (1) IN GENERAL.—The Secretary of Health and
10 Human Services shall convene a Lung Cancer Advi-
11 sory Board (referred to in this section as the
12 “Board”)—

13 (A) to monitor the programs established
14 under this section (and the amendments made
15 by this section); and

16 (B) to provide annual reports to the Con-
17 gress concerning benchmarks, expenditures,
18 lung cancer statistics, and the public health im-
19 pact of such programs.

20 (2) COMPOSITION.—The Board shall be com-
21 prised of—

22 (A) the Secretary of Health and Human
23 Services;

24 (B) the Secretary of Defense;

25 (C) the Secretary of Veterans Affairs; and

1 (D) 2 representatives each from the fields
2 of clinical medicine focused on lung cancer,
3 lung cancer research, imaging, drug develop-
4 ment, and lung cancer advocacy, to be ap-
5 pointed by the Secretary of Health and Human
6 Services.

7 (g) AUTHORIZATION OF APPROPRIATIONS.—

8 (1) IN GENERAL.—To carry out this section
9 (and the amendments made by this section), there
10 are authorized to be appropriated \$75,000,0000 for
11 fiscal year 2019 and such sums as may be necessary
12 for each of fiscal years 2020 through 2023.

13 (2) LUNG CANCER MORTALITY REDUCTION PRO-
14 GRAM.—The amounts appropriated under paragraph
15 (1) shall be allocated as follows:

16 (A) \$25,000,000 for fiscal year 2019, and
17 such sums as may be necessary for each of fis-
18 cal years 2020 through 2023, for the activities
19 described in section 417H(b)(1)(B) of the Pub-
20 lic Health Service Act, as added by subsection
21 (d);

22 (B) \$25,000,000 for fiscal year 2019, and
23 such sums as may be necessary for each of fis-
24 cal years 2020 through 2023, for the activities

1 described in section 417H(b)(1)(C) of the Pub-
2 lic Health Service Act;

3 (C) \$10,000,000 for fiscal year 2019, and
4 such sums as may be necessary for each of fis-
5 cal years 2020 through 2023, for the activities
6 described in section 417H(b)(1)(D) of the Pub-
7 lic Health Service Act; and

8 (D) \$15,000,000 for fiscal year 2019, and
9 such sums as may be necessary for each of fis-
10 cal years 2020 through 2023, for the activities
11 described in section 417H(b)(3) of the Public
12 Health Service Act.

13 **SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUT-**
14 **REACH, SCREENING, TESTING, ACCESS, AND**
15 **TREATMENT EFFECTIVENESS.**

16 (a) **SHORT TITLE.**—This section may be cited as the
17 “Prostate Research, Outreach, Screening, Testing, Access,
18 and Treatment Effectiveness Act of 2018” or the “PROS-
19 TATE Act”.

20 (b) **FINDINGS.**—Congress makes the following find-
21 ings:

22 (1) Prostate cancer is the second leading cause
23 of cancer death among men.

1 (2) In 2018, an estimated 164,690 men will be
2 diagnosed with prostate cancer and more than
3 29,000 will die from this disease.

4 (3) Roughly 2,000,000 to 3,000,000 people in
5 the United States are living with a diagnosis of pros-
6 tate cancer and its consequences.

7 (4) While prostate cancer generally affects older
8 individuals, younger men are also at risk for the dis-
9 ease, and when prostate cancer appears in early
10 middle age, it frequently takes on a more aggressive
11 form.

12 (5) There are significant racial and ethnic dis-
13 parities that demand attention; African Americans
14 have prostate cancer mortality rates that are more
15 than double those in the White population.

16 (6) Underserved rural populations have higher
17 rates of mortality compared to their urban counter-
18 parts, and innovative and cost-efficient methods to
19 improve rural access to high-quality care should take
20 advantage of advances in telehealth to diagnose and
21 treat prostate cancer when appropriate.

22 (7) Certain veterans populations may have
23 nearly twice the incidence of prostate cancer as the
24 general population of the United States.

1 (8) Urologists may constitute the specialists
2 who diagnose and treat the vast majority of prostate
3 cancer patients.

4 (9) Although much basic and translational re-
5 search has been completed and much is currently
6 known, there are still many unanswered questions,
7 such as the extent to which known disparities are at-
8 tributable to disease etiology, access to care, or edu-
9 cation and awareness in the community.

10 (10) Causes of prostate cancer are not known.
11 There is not good information regarding how to dif-
12 ferentiate accurately, early on, between aggressive
13 and indolent forms of the disease. As a result, there
14 is significant overtreatment in prostate cancer.
15 There are no treatments that can durably arrest
16 growth or cure prostate cancer once it has metasta-
17 sized.

18 (11) A significant proportion (about 23 to 54
19 percent) of cases may be clinically indolent and
20 “overdiagnosed”, resulting in significant overtreat-
21 ment. More accurate tests will allow men and their
22 families to face less physical, psychological, financial,
23 and emotional trauma, and billions of dollars could
24 be saved in private and public health care systems
25 in an area that has been identified by the Medicare

1 program under title XVIII of the Social Security Act
2 (42 U.S.C. 1395 et seq.) as one of 8 high-volume,
3 high-cost areas in the Resource Utilization Report
4 Program established under the Medicare Improve-
5 ments for Patients and Providers Act of 2008 (Pub-
6 lic Law 110–275).

7 (12) Prostate cancer research and health care
8 programs across Federal agencies should be coordi-
9 nated to improve accountability and actively encour-
10 age the translation of research into practice, to iden-
11 tify and implement best practices, in order to foster
12 an integrated and consistent focus on effective pre-
13 vention, diagnosis, and treatment of this disease.

14 (c) PROSTATE CANCER COORDINATION AND EDU-
15 CATION.—

16 (1) INTERAGENCY PROSTATE CANCER COORDI-
17 NATION AND EDUCATION TASK FORCE.—Not later
18 than 180 days after the date of the enactment of
19 this section, the Secretary of Veterans Affairs, in co-
20 operation with the Secretary of Defense and the Sec-
21 retary of Health and Human Services, shall estab-
22 lish an Interagency Prostate Cancer Coordination
23 and Education Task Force (in this section referred
24 to as the “Prostate Cancer Task Force”).

1 (2) DUTIES.—The Prostate Cancer Task Force
2 shall—

3 (A) develop a summary of advances in
4 prostate cancer research supported or con-
5 ducted by Federal agencies relevant to the diag-
6 nosis, prevention, and treatment of prostate
7 cancer, including psychosocial impairments re-
8 lated to prostate cancer treatment, and compile
9 a list of best practices that warrant broader
10 adoption in health care programs;

11 (B) consider establishing, and advocating
12 for, a guidance to enable physicians to allow
13 screening of men who are over age 74, on a
14 case-by-case basis, taking into account quality
15 of life and family history of prostate cancer;

16 (C) share and coordinate information on
17 Federal research and health care program ac-
18 tivities, including activities related to—

19 (i) determining how to improve re-
20 search and health care programs, including
21 psychosocial impairments related to pros-
22 tate cancer treatment;

23 (ii) identifying any gaps in the overall
24 research inventory and in health care pro-
25 grams;

1 (iii) identifying opportunities to pro-
2 mote translation of research into practice;
3 and

4 (iv) maximizing the effects of Federal
5 efforts by identifying opportunities for col-
6 laboration and leveraging of resources in
7 research and health care programs that
8 serve individuals who are susceptible to or
9 diagnosed with prostate cancer;

10 (D) develop a comprehensive interagency
11 strategy and advise relevant Federal agencies in
12 the solicitation of proposals for collaborative,
13 multidisciplinary research and health care pro-
14 grams, including proposals to evaluate factors
15 that may be related to the etiology of prostate
16 cancer, that would—

17 (i) result in innovative approaches to
18 study emerging scientific opportunities or
19 eliminate knowledge gaps in research to
20 improve the prostate cancer research port-
21 folio of the Federal Government;

22 (ii) outline key research questions,
23 methodologies, and knowledge gaps; and

1 (iii) ensure consistent action, as out-
2 lined by section 402(b) of the Public
3 Health Service Act;

4 (E) develop a coordinated message related
5 to screening and treatment for prostate cancer
6 to be reflected in educational and beneficiary
7 materials for Federal health programs as such
8 documents are updated; and

9 (F) not later than 2 years after the date
10 of the establishment of the Prostate Cancer
11 Task Force, submit to the Expert Advisory
12 Panel to be reviewed and returned within 30
13 days, and then within 90 days submitted to
14 Congress recommendations—

15 (i) regarding any appropriate changes
16 to research and health care programs, in-
17 cluding recommendations to improve the
18 research portfolio of the Department of
19 Veterans Affairs, the Department of De-
20 fense, National Institutes of Health, and
21 other Federal agencies to ensure that sci-
22 entifically based strategic planning is im-
23 plemented in support of research and
24 health care program priorities;

1 (ii) designed to ensure that the re-
2 search and health care programs and ac-
3 tivities of the Department of Veterans Af-
4 fairs, the Department of Defense, the De-
5 partment of Health and Human Services,
6 and other Federal agencies are free of un-
7 necessary duplication;

8 (iii) regarding public participation in
9 decisions relating to prostate cancer re-
10 search and health care programs to in-
11 crease the involvement of patient advo-
12 cates, community organizations, and med-
13 ical associations representing a broad geo-
14 graphical area;

15 (iv) on how to best disseminate infor-
16 mation on prostate cancer research and
17 progress achieved by health care programs;

18 (v) about how to expand partnerships
19 between public entities, including Federal
20 agencies, and private entities to encourage
21 collaborative, cross-cutting research and
22 health care delivery;

23 (vi) assessing any cost savings and ef-
24 ficiencies realized through the efforts iden-
25 tified and supported in this section and

1 recommending expansion of those efforts
2 that have proved most promising while also
3 ensuring against any conflicts in directives
4 from other congressional or statutory man-
5 dates or enabling statutes;

6 (vii) identifying key priority action
7 items from among the recommendations;
8 and

9 (viii) with respect to the level of fund-
10 ing needed by each agency to implement
11 the recommendations contained in the re-
12 port.

13 (3) MEMBERS OF THE PROSTATE CANCER TASK
14 FORCE.—The Prostate Cancer Task Force described
15 in this subsection shall be comprised of representa-
16 tives from such Federal agencies, as each head of
17 such applicable agencies determines necessary, to co-
18 ordinate a uniform message relating to prostate can-
19 cer screening and treatment where appropriate, in-
20 cluding representatives of the following:

21 (A) The Department of Veterans Affairs,
22 including representatives of each relevant pro-
23 gram area of the Department of Veterans Af-
24 fairs.

1 (B) The Prostate Cancer Research Pro-
2 gram of the Congressionally Directed Medical
3 Research program of the Department of De-
4 fense.

5 (C) The Department of Health and
6 Human Services, including at a minimum rep-
7 resentatives of each of the following:

8 (i) The National Institutes of Health.

9 (ii) National research institutes and
10 centers, including the National Cancer In-
11 stitute, the National Institute of Allergy
12 and Infectious Diseases, and the Office of
13 Minority Health.

14 (iii) The Centers for Medicare & Med-
15 icaid Services.

16 (iv) The Food and Drug Administra-
17 tion.

18 (v) The Centers for Disease Control
19 and Prevention.

20 (vi) The Agency for Healthcare Re-
21 search and Quality.

22 (vii) The Health Resources and Serv-
23 ices Administration.

24 (4) APPOINTING EXPERT ADVISORY PANELS.—

25 The Prostate Cancer Task Force shall appoint ex-

1 pert advisory panels, as such task force determines
2 appropriate, to provide input and concurrence from
3 individuals and organizations from the medical,
4 prostate cancer patient and advocate, research, and
5 delivery communities with expertise in prostate can-
6 cer diagnosis, treatment, and research, including
7 practicing urologists, primary care providers, and
8 others and individuals with expertise in education
9 and outreach to underserved populations affected by
10 prostate cancer.

11 (5) MEETINGS.—The Prostate Cancer Task
12 Force shall convene not less than twice a year, or
13 more frequently as the Secretary of Veterans Affairs
14 determines to be appropriate.

15 (6) FEDERAL ADVISORY COMMITTEE ACT.—

16 (A) IN GENERAL.—Except as provided in
17 subparagraph (B), the Federal Advisory Com-
18 mittee Act (5 U.S.C. App.) shall apply to the
19 Prostate Cancer Task Force.

20 (B) EXCEPTION.—Section 14(a)(2)(B) of
21 such Act (relating to the termination of advi-
22 sory committees) shall not apply to the Prostate
23 Cancer Task Force.

24 (7) SUNSET DATE.—The Prostate Cancer Task
25 Force shall terminate on September 30, 2021.

1 (d) PROSTATE CANCER RESEARCH.—

2 (1) RESEARCH COORDINATION.—The Secretary
3 of Veterans Affairs, in coordination with the Sec-
4 retary of Defense and the Secretary of Health and
5 Human Services, shall establish and carry out a pro-
6 gram to coordinate and intensify prostate cancer re-
7 search. Such research program shall—

8 (A) develop advances in diagnostic and
9 prognostic methods and tests, including bio-
10 markers and an improved prostate cancer
11 screening blood test, including improvements or
12 alternatives to the prostate specific antigen test
13 and additional tests to distinguish indolent from
14 aggressive disease;

15 (B) develop better understanding of the
16 etiology of the disease (including an analysis of
17 lifestyle factors proven to be involved in higher
18 rates of prostate cancer, such as obesity and
19 diet, and in different ethnic, racial, and socio-
20 economic groups, such as the African-American,
21 Latino or Hispanic, and American Indian popu-
22 lations and men with a family history of pros-
23 tate cancer) to improve prevention efforts;

1 (C) expand basic research into prostate
2 cancer, including studies of fundamental molec-
3 ular and cellular mechanisms;

4 (D) identify and provide clinical testing of
5 novel agents for the prevention and treatment
6 of prostate cancer;

7 (E) establish clinical registries for prostate
8 cancer;

9 (F) use the National Institute of Bio-
10 medical Imaging and Bioengineering and the
11 National Cancer Institute for assessment of ap-
12 propriate imaging modalities; and

13 (G) address such other matters relating to
14 prostate cancer research as may be identified by
15 the Federal agencies participating in the pro-
16 gram under this subsection.

17 (2) PROSTATE CANCER ADVISORY BOARD.—

18 There is established in the Office of the Chief Sci-
19 entist of the Food and Drug Administration a Pros-
20 tate Cancer Scientific Advisory Board. Such board
21 shall be responsible for accelerating real-time shar-
22 ing of the latest research data and accelerating
23 movement of new medicines to patients.

1 (3) UNDERSERVED MINORITY GRANT PRO-
2 GRAM.—In carrying out such program, the Secretary
3 shall—

4 (A) award grants to eligible entities to
5 carry out components of the research outlined
6 in paragraph (1);

7 (B) integrate and build upon existing
8 knowledge gained from comparative effective-
9 ness research; and

10 (C) recognize and address—

11 (i) the racial and ethnic disparities in
12 the incidence and mortality rates of pros-
13 tate cancer and men with a family history
14 of prostate cancer;

15 (ii) any barriers in access to care and
16 participation in clinical trials that are spe-
17 cific to racial, ethnic, and other under-
18 served minorities and men with a family
19 history of prostate cancer;

20 (iii) outreach and educational efforts
21 to raise awareness among the populations
22 described in clause (ii); and

23 (iv) appropriate access and utilization
24 of imaging modalities.

1 (e) TELEHEALTH AND RURAL ACCESS PILOT
2 PROJECTS.—

3 (1) IN GENERAL.—The Secretary of Veterans
4 Affairs, in cooperation with the Secretary of Defense
5 and the Secretary of Health and Human Services
6 (referred to in this section collectively as the “Secre-
7 taries”) shall establish 4-year telehealth pilot
8 projects for the purpose of analyzing the clinical out-
9 comes and cost-effectiveness associated with tele-
10 health services in a variety of geographic areas that
11 contain high proportions of medically underserved
12 populations, including African Americans, Latinos or
13 Hispanics, American Indians or Alaska Natives, and
14 those in rural areas. Such projects shall promote ef-
15 ficient use of specialist care through better coordina-
16 tion of primary care and physician extender teams
17 in underserved areas and more effectively employ
18 tumor boards to better counsel patients.

19 (2) ELIGIBLE ENTITIES.—

20 (A) IN GENERAL.—The Secretaries shall
21 select eligible entities to participate in the pilot
22 projects under this section.

23 (B) PRIORITY.—In selecting eligible enti-
24 ties to participate in the pilot projects under
25 this section, the Secretaries shall give priority

1 to such entities located in medically under-
2 served areas, particularly those that include Af-
3 rican Americans, Latinos and Hispanics, and
4 facilities of the Indian Health Service, including
5 Indian Health Service-operated facilities, trib-
6 ally operated facilities, and Urban Indian Clin-
7 ics, and those in rural areas.

8 (3) EVALUATION.—The Secretaries shall,
9 through the pilot projects, evaluate—

10 (A) the effective and economic delivery of
11 care in diagnosing and treating prostate cancer
12 with the use of telehealth services in medically
13 underserved and Tribal areas including collabo-
14 rative uses of health professionals and integra-
15 tion of the range of telehealth and other tech-
16 nologies;

17 (B) the effectiveness of improving the ca-
18 pacity of nonmedical providers and nonspecial-
19 ized medical providers to provide health services
20 for prostate cancer in medically underserved
21 and Tribal areas, including the exploration of
22 innovative medical home models with collabora-
23 tion between urologists, other relevant medical
24 specialists, including oncologists, radiologists,
25 and primary care teams and coordination of

1 care through the efficient use of primary care
2 teams and physician extenders; and

3 (C) the effectiveness of using telehealth
4 services to provide prostate cancer treatment in
5 medically underserved areas, including the use
6 of tumor boards to facilitate better patient
7 counseling.

8 (4) REPORT.—Not later than 1 year after the
9 completion of the pilot projects under this sub-
10 section, the Secretaries shall submit to Congress a
11 report describing the outcomes of such pilot projects,
12 including any cost savings and efficiencies realized,
13 and providing recommendations, if any, for expand-
14 ing the use of telehealth services.

15 (f) EDUCATION AND AWARENESS.—

16 (1) IN GENERAL.—The Secretary of Veterans
17 Affairs (referred to in this subsection as the “Sec-
18 retary”) shall develop a national education campaign
19 for prostate cancer. Such campaign shall involve the
20 use of written educational materials and public serv-
21 ice announcements consistent with the findings of
22 the Prostate Cancer Task Force under subsection
23 (c), that are intended to encourage men to seek
24 prostate cancer screening when appropriate.

1 (2) RACIAL DISPARITIES AND THE POPULATION
2 OF MEN WITH A FAMILY HISTORY OF PROSTATE
3 CANCER.—In developing the national campaign
4 under paragraph (1), the Secretary shall ensure that
5 such educational materials and public service an-
6 nouncements are more readily available in commu-
7 nities experiencing racial disparities in the incidence
8 and mortality rates of prostate cancer and by men
9 of any race classification with a family history of
10 prostate cancer.

11 (3) GRANTS.—In carrying out the national
12 campaign under this section, the Secretary shall
13 award grants to nonprofit private entities to enable
14 such entities to test alternative outreach and edu-
15 cation strategies.

16 (g) AUTHORIZATION OF APPROPRIATIONS.—

17 (1) IN GENERAL.—There is authorized to be
18 appropriated to carry out this section for the period
19 of fiscal years 2019 through 2023 an amount equal
20 to the savings described in paragraph (2).

21 (2) CORRESPONDING REDUCTION.—The savings
22 described in this paragraph is the amount author-
23 ized to be appropriated by provisions of law other
24 than this section for the period of fiscal years 2019
25 through 2023 for Federal research and health care

1 program activities related to prostate cancer, re-
2 duced by the amount of Federal savings projected to
3 be achieved over such period by implementation of
4 this section.

5 **SEC. 703. IMPROVED MEDICAID COVERAGE FOR CERTAIN**
6 **BREAST AND CERVICAL CANCER PATIENTS**
7 **IN THE TERRITORIES.**

8 (a) **ELIMINATION OF FUNDING LIMITATIONS.**—

9 (1) **IN GENERAL.**—Section 1108(g)(4) of the
10 Social Security Act (42 U.S.C. 1308(g)(4)) is
11 amended by adding at the end the following: “With
12 respect to fiscal years beginning with fiscal year
13 2019, payment for medical assistance for individuals
14 who are eligible for such assistance only on the basis
15 of section 1902(a)(10)(A)(ii)(XVIII) shall not be
16 taken into account in applying subsection (f) (as in-
17 creased in accordance with paragraphs (1), (2), (3),
18 and (5) of this subsection) to Puerto Rico, the Vir-
19 gin Islands, Guam, the Northern Mariana Islands,
20 or American Samoa for such fiscal year.”.

21 (2) **TECHNICAL AMENDMENT.**—Such section is
22 further amended by striking “(3), and (4)” and in-
23 serting “(3), and (5)”.

24 (b) **APPLICATION OF ENHANCED FMAP FOR HIGH-**
25 **EST STATE.**—Section 1905(b) of such Act (42 U.S.C.

1 1396d(b)) is amended by adding at the end the following:
2 “Notwithstanding the first sentence of this subsection,
3 with respect to medical assistance described in clause (4)
4 of such sentence that is furnished in Puerto Rico, the Vir-
5 gin Islands, Guam, the Northern Mariana Islands, or
6 American Samoa in a fiscal year, the Federal medical as-
7 sistance percentage is equal to the highest such percentage
8 applied under such clause for such fiscal year for any of
9 the 50 States or the District of Columbia that provides
10 such medical assistance for any portion of such fiscal
11 year.”

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to payment for medical assistance
14 for items and services furnished on or after October 1,
15 2018.

16 **SEC. 704. CANCER PREVENTION AND TREATMENT DEM-**
17 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
18 **NORITIES.**

19 (a) DEMONSTRATION.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services (referred to in this section as the
22 “Secretary”) shall conduct demonstration projects
23 for the purpose of developing models and evaluating
24 methods that—

1 (A) improve the quality of items and serv-
2 ices provided to target individuals in order to
3 facilitate reduced disparities in early detection
4 and treatment of cancer;

5 (B) improve clinical outcomes, satisfaction,
6 quality of life, appropriate use of items and
7 services covered under the Medicare program
8 under title XVIII of the Social Security Act (42
9 U.S.C. 1395 et seq.), and referral patterns with
10 respect to target individuals with cancer;

11 (C) eliminate disparities in the rate of pre-
12 ventive cancer screening measures, such as Pap
13 smears, prostate cancer screenings, colon cancer
14 screenings, breast cancer screenings, and com-
15 puted tomography scans, for lung cancer among
16 target individuals;

17 (D) promote collaboration with community-
18 based organizations to ensure cultural com-
19 petency of health care professionals and lin-
20 guistic access for target individuals who are
21 persons with limited-English proficiency; and

22 (E) encourage the incorporation of commu-
23 nity health workers to increase the efficiency
24 and appropriateness of cancer screening pro-
25 grams.

1 (2) COMMUNITY HEALTH WORKER DEFINED.—

2 In this section, the term “community health worker”
3 includes a community health advocate, a lay health
4 worker, a community health representative, a peer
5 health promoter, a community health outreach work-
6 er, and a promotore de salud, who promotes health
7 or nutrition within the community in which the indi-
8 vidual resides.

9 (3) TARGET INDIVIDUAL DEFINED.—In this
10 section, the term “target individual” means an indi-
11 vidual of a racial and ethnic minority group, as de-
12 fined in section 1707(g)(1) of the Public Health
13 Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-
14 tled to benefits under part A, and enrolled under
15 part B, of title XVIII of the Social Security Act.

16 (b) PROGRAM DESIGN.—

17 (1) INITIAL DESIGN.—Not later than 1 year
18 after the date of the enactment of this Act, the Sec-
19 retary shall evaluate best practices in the private
20 sector, community programs, and academic research
21 of methods that reduce disparities among individuals
22 of racial and ethnic minority groups in the preven-
23 tion and treatment of cancer and shall design the
24 demonstration projects based on such evaluation.

1 (2) NUMBER AND PROJECT AREAS.—Not later
2 than 2 years after the date of the enactment of this
3 Act, the Secretary shall implement at least 9 dem-
4 onstration projects, including the following:

5 (A) Two projects, each of which shall tar-
6 get different ethnic subpopulations, for each of
7 the 4 following major racial and ethnic minority
8 groups:

9 (i) American Indians and Alaska Na-
10 tives, Eskimos, and Aleuts.

11 (ii) Asian Americans.

12 (iii) Blacks and African Americans.

13 (iv) Latinos and Hispanics.

14 (v) Native Hawaiians and other Pa-
15 cific Islanders.

16 (B) One project within the Pacific Islands
17 or United States insular areas.

18 (C) At least one project in a rural area.

19 (D) At least one project in an inner-city
20 area.

21 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
22 TION OF DEMONSTRATION PROJECT RESULTS.—The
23 Secretary shall continue the existing demonstration
24 projects and may expand the number of demonstra-
25 tion projects if the initial report under subsection (c)

1 contains an evaluation that demonstration
2 projects—

3 (A) reduce expenditures under the Medi-
4 care program under title XVIII of the Social
5 Security Act (42 U.S.C. 1395 et seq.); or

6 (B) do not increase expenditures under
7 such Medicare program and reduce racial and
8 ethnic health disparities in the quality of health
9 care services provided to target individuals and
10 increase satisfaction of Medicare beneficiaries
11 and health care providers.

12 (c) REPORT TO CONGRESS.—

13 (1) IN GENERAL.—Not later than 2 years after
14 the date the Secretary implements the initial dem-
15 onstration projects, and biannually thereafter, the
16 Secretary shall submit to Congress a report regard-
17 ing the demonstration projects.

18 (2) CONTENT OF REPORT.—Each report under
19 paragraph (1) shall include the following:

20 (A) A description of the demonstration
21 projects.

22 (B) An evaluation of—

23 (i) the cost-effectiveness of the dem-
24 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 (42 U.S.C. 1395 et seq.) to such extent
13 and for such period as the Secretary determines is nec-
14 essary to conduct demonstration 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 an entity that specializes in de-
23 veloping quality measures for cancer care under
24 which the entity shall develop a uniform set of meas-

1 ures to evaluate disparities in the quality of cancer
2 care and annually update such set of measures.

3 (2) MEASURES TO BE INCLUDED.—Such set of
4 measures shall include, with respect to the treatment
5 of cancer, measures of patient outcomes, the process
6 for delivering medical care related to such treat-
7 ment, patient counseling and engagement in deci-
8 sionmaking, patient experience of care, resource use,
9 and practice capabilities, such as care coordination.

10 (b) ESTABLISHMENT OF REPORTING PROCESS.—

11 (1) IN GENERAL.—The Secretary shall establish
12 a reporting process that requires and provides for a
13 method for health care providers specified under
14 paragraph (2) to submit to the Secretary and make
15 public data on the performance of such providers
16 during each reporting period through use of the
17 measures developed pursuant to subsection (a). Such
18 data shall be submitted in a form and manner and
19 at a time specified by the Secretary.

20 (2) SPECIFICATION OF PROVIDERS TO REPORT
21 ON MEASURES.—The Secretary shall specify the
22 classes of Medicare providers of services and sup-
23 pliers, including hospitals, cancer centers, physi-
24 cians, primary care providers, and specialty pro-
25 viders, that will be required under such process to

1 publicly report on the measures specified under sub-
2 section (a).

3 (3) ASSESSMENT OF CHANGES.—Under such
4 reporting process, the Secretary shall establish a for-
5 mat that assesses changes in both the absolute and
6 relative disparities in cancer care over time. These
7 measures shall be presented in an easily comprehen-
8 sible format, such as those presented in the final
9 publications relating to Healthy People 2010 or the
10 National Healthcare Disparities Report.

11 (4) INITIAL IMPLEMENTATION.—The Secretary
12 shall implement the reporting process under this
13 subsection for reporting periods beginning not later
14 than 6 months after the date that measures are first
15 established under subsection (a).

16 **Subtitle B—Viral Hepatitis and**
17 **Liver Cancer Control and Pre-**
18 **vention**

19 **SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL**
20 **AND PREVENTION.**

21 (a) SHORT TITLE.—This subtitle may be cited as the
22 “Viral Hepatitis and Liver Cancer Control and Prevention
23 Act of 2018”.

24 (b) FINDINGS.—Congress finds the following:

1 (1) In the United States, approximately
2 4,400,000 persons are living with the hepatitis B
3 virus (referred to in this section as “HBV”) or the
4 hepatitis C virus (referred to in this section as
5 “HCV”).

6 (2) In the United States, chronic HBV and
7 HCV are the most common causes of liver cancer,
8 one of the most lethal and fastest growing cancers
9 in this country. Such viruses are the most common
10 cause of chronic liver disease, liver cirrhosis, and the
11 most common indications for liver transplantation.
12 At least 18,000 deaths per year in the United States
13 can be attributed to chronic HBV and HCV. Chron-
14 ic HCV is also a leading cause of death in Ameri-
15 cans living with HIV/AIDS; many of those living
16 with HIV/AIDS are coinfecting with chronic HBV,
17 chronic HCV, or both.

18 (3) According to the Centers for Disease Con-
19 trol and Prevention (referred to in this section as
20 the “CDC”), approximately 2 percent of the popu-
21 lation of the United States is living with chronic
22 HBV, chronic HCV, or both. The CDC has recog-
23 nized HCV as the Nation’s most common chronic
24 bloodborne virus infection and HBV as the deadliest
25 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 contact with infectious
4 blood, semen, or other body fluids. HCV is trans-
5 mitted by contact with infectious blood, particularly
6 through percutaneous exposures (such as puncture
7 through the skin).

8 (5) The CDC estimates that in 2016, more
9 than 41,000 people in the United States were newly
10 infected with HCV and nearly 21,000 people in the
11 United States were newly infected with HBV. These
12 estimates could be much higher due to many rea-
13 sons, including lack of screening education and
14 awareness, and perceived marginalization of the pop-
15 ulations at risk.

16 (6) In 2012, CDC released new guidelines rec-
17 ommending every person born between 1945 and
18 1965 receive a one-time test. Among the estimated
19 102,000,000 (1,600,000 chronically HCV-infected)
20 eligible for screening, birth-cohort screening leads to
21 84,000 fewer cases of decompensated cirrhosis,
22 46,000 fewer cases of hepatocellular carcinoma,
23 10,000 fewer liver transplants, and 78,000 fewer
24 HCV-related deaths gained versus risk-based screen-
25 ing.

1 (7) In 2013, the United States Preventive Serv-
2 ices Task Force (referred to in this section as the
3 “USPSTF”) issued a Grade B rating for screening
4 for HCV infection in persons at high risk for infec-
5 tion and adults born between 1945 and 1965. In
6 2014, the USPSTF issued a Grade B for screening
7 for HBV in persons at high-risk of hepatitis B infec-
8 tion. In 2009, the USPSTF issued a Grade A for
9 screening pregnant women for HBV during their
10 first prenatal visit.

11 (8) There were 59 outbreaks (24 of HBV and
12 36 of HCV, including one of both HBV and HCV)
13 reported to CDC for investigation from 2008
14 through 2016 related to health care-associated infec-
15 tion of HBV and HCV, 56 of which occurred in non-
16 hospital settings. There were more than 115,983 pa-
17 tients potentially exposed to one of the viruses.

18 (9) Chronic HBV and chronic HCV usually do
19 not cause symptoms early in the course of the dis-
20 ease, but after many years of a clinically “silent”
21 phase, CDC estimates show more than 33 percent of
22 infected individuals will develop cirrhosis, end-stage
23 liver disease, or liver cancer. Since most individuals
24 with chronic HBV, HCV, or both are unaware of
25 their infection, they do not know to take precautions

1 to prevent the spread of their infection and can un-
2 knowingly exacerbate their own disease progression.

3 (10) HBV and HCV disproportionately affect
4 certain populations in the United States. Although
5 representing only about 6 percent of the population,
6 Asian Americans and Pacific Islanders account for
7 half of all chronic HBV cases in the United States.
8 Baby Boomers (those born between 1945 and 1965)
9 account for approximately 75 percent of domestic
10 chronic HCV cases. In addition, African Americans,
11 Latinos, and American Indian and Native Alaskans
12 are among the groups which have disproportionately
13 high rates of HBV or HCV infections in the United
14 States.

15 (11) 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 (12) Advancements have led to the development
23 of improved diagnostic tests for viral hepatitis.
24 These tests, including rapid, point of care testing
25 and others in development, can facilitate testing, no-

1 tification of results and post-test counseling, and re-
2 ferral to care at the time of the testing visit. In par-
3 ticular, these tests are also advantageous because
4 they can be used simultaneously with HIV rapid
5 testing for persons at risk for both HCV and HIV
6 infections.

7 (13) For those chronically infected with HBV
8 or HCV, regular monitoring can lead to the early de-
9 tection of liver cancer at a stage where a cure is still
10 possible. Liver cancer is the second deadliest cancer
11 in the United States; however, liver cancer has re-
12 ceived little funding for research, prevention, or
13 treatment.

14 (14) Treatment for chronic HCV can eradicate
15 the disease in approximately 90 percent of those cur-
16 rently treated. The treatment of chronic HBV can
17 effectively suppress viral replication in the over-
18 whelming majority (over 80 percent) of those treat-
19 ed, thereby reducing the risk of transmission and
20 progression to liver scarring or liver cancer, even
21 though a complete cure is much less common than
22 for HCV.

23 (15) To combat the viral hepatitis epidemic in
24 the United States, in February 2017, the Depart-
25 ment of Health and Human Services released its

1 “National Viral Hepatitis Action Plan 2017–2020”
2 (referred to in this section as the “HHS Action
3 Plan”). In March 2017, the National Academies of
4 Sciences, Engineering, and Medicine released a re-
5 port entitled, “A National Strategy for the Elimini-
6 nation of Hepatitis B and C: Phase Two Report”
7 (referred to in this section as the “NAS report”),
8 recommending specific actions to eliminate viral hep-
9 atitis as public health problems in the United States
10 by 2030.

11 (16) The annual health care costs attributable
12 to HBV and HCV in the United States are signifi-
13 cant. For HBV, it is estimated to be approximately
14 \$2,500,000,000 (\$2,000 per infected person). In
15 2000, the lifetime cost of HBV—before the avail-
16 ability of most current therapies—was approximately
17 \$80,000 per chronically infected person, totaling
18 more than \$100,000,000,000. For HCV, medical
19 costs for patients are expected to increase from
20 \$30,000,000,000 in 2009 to over \$85,000,000,000
21 in 2024. Avoiding these costs by screening and diag-
22 nosing individuals earlier—and connecting them to
23 appropriate treatment and care, will save lives and
24 critical health care dollars. Currently, without a
25 comprehensive screening, testing, and diagnosis pro-

1 gram, most patients are diagnosed too late when
2 they need a liver transplant costing at least
3 \$314,000 for uncomplicated cases or when they have
4 liver cancer or end-stage liver disease which costs
5 \$30,980 to \$110,576 per hospital admission. As
6 health care costs continue to grow, it is critical that
7 the Federal Government invests in effective mecha-
8 nisms to avoid documented cost drivers.

9 (17) According to the NAS report in 2010,
10 chronic HBV and HCV infections cause substantial
11 morbidity and mortality despite being preventable
12 and treatable. Deficiencies in the implementation of
13 established guidelines for the prevention, diagnosis,
14 and medical management of chronic HBV and HCV
15 infections perpetuate personal and economic bur-
16 dens. Existing grants are not sufficient for the scale
17 of the health burden presented by HBV and HCV.

18 (18) Screening and testing for HBV and HCV
19 is aligned with the goal of Healthy People 2020 to
20 increase immunization rates and reduce preventable
21 infectious diseases. Awareness of disease and access
22 to prevention and treatment remain essential compo-
23 nents for reducing infectious disease transmission.

24 (19) Federal support is necessary to increase
25 knowledge and awareness of HBV and HCV and to

1 assist State and local prevention and control efforts
2 in reducing the morbidity and mortality of these
3 epidemics.

4 (20) The Secretary of Health and Human Serv-
5 ices has the discretion to carry out this subtitle (in-
6 cluding the amendments made by this subtitle) di-
7 rectly and through whichever of the agencies of the
8 Public Health Service the Secretary determines to be
9 appropriate, which may (in the Secretary's discre-
10 tion) include the Centers for Disease Control and
11 Prevention, the Health Resources and Services Ad-
12 ministration, the Substance Abuse and Mental
13 Health Services Administration, the National Insti-
14 tutes of Health (including the National Institute on
15 Minority Health and Health Disparities), and other
16 agencies of such Service.

17 (21) The Centers for Disease Control and Pre-
18 vention reported a 233 percent increase in hepatitis
19 C cases from 2010 to 2016, stemming from the
20 opioid, heroin, and overdose epidemics affecting com-
21 munities nationwide. From 2014 to 2015, the num-
22 ber of reported cases of acute hepatitis B infection
23 in the United States rose for the first time since
24 2006, increasing by 20.7 percent, which is also
25 largely attributable to the opioid epidemic.

1 (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B
2 AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,
3 AND MEDICAL MANAGEMENT PLAN.—Title III of the
4 Public Health Service Act (42 U.S.C. 241 et seq.), as
5 amended by title V, is further amended—

6 (1) by striking section 317N (42 U.S.C. 247b–
7 15); and

8 (2) by adding after part W, as added by section
9 508, the following:

10 **“PART X—BIENNIAL ASSESSMENT OF HHS HEPA-**
11 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
12 **CATION, RESEARCH, AND MEDICAL MANAGE-**
13 **MENT PLAN**

14 **“SEC. 399PP. BIENNIAL UPDATE OF THE PLAN.**

15 “(a) IN GENERAL.—The Secretary shall conduct a bi-
16 ennial assessment of the Secretary’s plan for the preven-
17 tion, control, and medical management of, and education
18 and research relating to, hepatitis B and hepatitis C, for
19 the purposes of—

20 “(1) incorporating into such plan new knowl-
21 edge or observations relating to hepatitis B and hep-
22 atitis C (such as knowledge and observations that
23 may be derived from clinical, laboratory, and epide-
24 miological research and disease detection, preven-
25 tion, and surveillance outcomes);

1 “(2) addressing gaps in the coverage or effec-
2 tiveness of the plan; and

3 “(3) evaluating and, if appropriate, updating
4 recommendations, guidelines, or educational mate-
5 rials of the Centers for Disease Control and Preven-
6 tion or the National Institutes of Health for health
7 care providers or the public on viral hepatitis in
8 order to be consistent with the plan.

9 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
10 Not later than October 1 of the first even-numbered year
11 beginning after the date of the enactment of this part,
12 and October 1 of each even-numbered year thereafter, the
13 Secretary shall publish in the Federal Register a notice
14 of the results of the assessments conducted under para-
15 graph (1). Such notice shall include—

16 “(1) a description of any revisions to the plan
17 referred to in subsection (a) as a result of the as-
18 sessment;

19 “(2) an explanation of the basis for any such
20 revisions, including the ways in which such revisions
21 can reasonably be expected to further promote the
22 original goals and objectives of the plan; and

23 “(3) in the case of a determination by the Sec-
24 retary that the plan does not need revision, an expla-
25 nation of the basis for such determination.

1 **“SEC. 399PP-1. ELEMENTS OF PROGRAM.**

2 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
3 Secretary, acting through the Director of the Centers for
4 Disease Control and Prevention, the Administrator of the
5 Health Resources and Services Administration, and the
6 Administrator of the Substance Abuse and Mental Health
7 Services Administration, and in accordance with the plan
8 referred to in section 399PP(a), shall implement programs
9 to increase awareness and enhance knowledge and under-
10 standing of hepatitis B and hepatitis C. Such programs
11 shall include—

12 “(1) the conduct of culturally and language ap-
13 propriate health education in primary and secondary
14 schools, college campuses, public awareness cam-
15 paigns, and community outreach activities (especially
16 to the ethnic communities with high rates of chronic
17 hepatitis B and chronic hepatitis C and other high-
18 risk groups) to promote public awareness and knowl-
19 edge about the value of hepatitis A and hepatitis B
20 immunization, risk factors, the transmission and
21 prevention of hepatitis B and hepatitis C, the value
22 of screening for the early detection of hepatitis B
23 and hepatitis C, and options available for the treat-
24 ment of chronic hepatitis B and chronic hepatitis C;

25 “(2) the promotion of immunization programs
26 that increase awareness and access to hepatitis A

1 and hepatitis B vaccines for susceptible adults and
2 children;

3 “(3) the training of health care professionals
4 regarding the importance of vaccinating individuals
5 infected with hepatitis C and individuals who are at
6 risk for hepatitis C infection against hepatitis A and
7 hepatitis B;

8 “(4) the training of health care professionals
9 regarding the importance of vaccinating individuals
10 chronically infected with hepatitis B and individuals
11 who are at risk for chronic hepatitis B infection
12 against the hepatitis A virus;

13 “(5) the training of health care professionals
14 and health educators to make them aware of the
15 high rates of chronic hepatitis B and chronic hep-
16 atitis C in certain adult ethnic populations, and the
17 importance of prevention, detection, and medical
18 management of hepatitis B and hepatitis C and of
19 liver cancer screening;

20 “(6) the development and distribution of health
21 education curricula (including information relating
22 to the special needs of individuals infected with hep-
23 atitis B and hepatitis C, such as the importance of
24 prevention and early intervention, regular moni-
25 toring, the recognition of psychosocial needs, appro-

1 appropriate treatment, and liver cancer screening) for in-
2 dividuals providing hepatitis B and hepatitis C coun-
3 seling; and

4 “(7) support for the implementation curricula
5 described in paragraph (6) by State and local public
6 health agencies.

7 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
8 PROGRAMS.—

9 “(1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall support the integra-
12 tion of activities described in paragraph (3) into ex-
13 isting clinical and public health programs at State,
14 local, territorial, and Tribal levels (including commu-
15 nity health clinics, programs for the prevention and
16 treatment of HIV/AIDS, sexually transmitted infec-
17 tions, and substance abuse, and programs for indi-
18 viduals in correctional settings).

19 “(2) COORDINATION OF DEVELOPMENT OF
20 FEDERAL SCREENING GUIDELINES.—

21 “(A) REFERENCES.—For purposes of this
22 subsection, the term ‘CDC Director’ means the
23 Director of the Centers for Disease Control and
24 Prevention, and the term ‘AHRQ Director’

1 means the Director of the Agency for
2 Healthcare Research and Quality.

3 “(B) AGENCY FOR HEALTHCARE RE-
4 SEARCH AND QUALITY.—Due to the rapidly
5 evolving standard of care associated with diag-
6 nosing and treating viral hepatitis infection, the
7 AHRQ Director shall convene the Preventive
8 Services Task Force under section 915(a) to re-
9 view its recommendation for screening for HBV
10 and HCV infection every 3 years.

11 “(3) ACTIVITIES.—

12 “(A) VOLUNTARY TESTING PROGRAMS.—

13 “(i) IN GENERAL.—The Secretary
14 shall establish a mechanism by which to
15 support and promote the development of
16 State, local, territorial, and tribal vol-
17 untary hepatitis B and hepatitis C testing
18 programs to screen the high-prevalence
19 populations to aid in the early identifica-
20 tion of chronically infected individuals.

21 “(ii) CONFIDENTIALITY OF THE TEST
22 RESULTS.—The Secretary shall prohibit
23 the use of the results of a hepatitis B or
24 hepatitis C test conducted by a testing pro-

1 gram developed or supported under this
2 subparagraph for any of the following:

3 “(I) Issues relating to health in-
4 surance.

5 “(II) To screen or determine
6 suitability for employment.

7 “(III) To discharge a person
8 from employment.

9 “(B) COUNSELING REGARDING VIRAL HEP-
10 ATITIS.—The Secretary shall support State,
11 local, territorial, and tribal programs in a wide
12 variety of settings, including those providing
13 primary and specialty health care services in
14 nonprofit private and public sectors, to—

15 “(i) provide individuals with ongoing
16 risk factors for hepatitis B and hepatitis C
17 infection with client-centered education
18 and counseling which concentrates on—

19 “(I) promoting testing of individ-
20 uals that have been exposed to their
21 blood, family members, and their sex-
22 ual partners; and

23 “(II) changing behaviors that
24 place individuals at risk for infection;

1 “(ii) provide individuals chronically in-
2 fected with hepatitis B or hepatitis C with
3 education, health information, and coun-
4 seling to reduce their risk of—

5 “(I) dying from end-stage liver
6 disease and liver cancer; and

7 “(II) transmitting viral hepatitis
8 to others; and

9 “(iii) provide women chronically in-
10 fected with hepatitis B or hepatitis C who
11 are pregnant or of childbearing age with
12 culturally and linguistically appropriate
13 health information, such as how to prevent
14 hepatitis B perinatal infection, and to al-
15 leviate fears associated with pregnancy or
16 raising a family.

17 “(C) IMMUNIZATION.—The Secretary shall
18 support State, local, territorial, and tribal ef-
19 forts to expand the current vaccination pro-
20 grams to protect every child in the Nation and
21 all susceptible adults, particularly those infected
22 with hepatitis C and high-prevalence ethnic
23 populations and other high-risk groups, from
24 the risks of acute and chronic hepatitis B infec-
25 tion by—

1 “(i) ensuring continued funding for
2 hepatitis B vaccination for all children 19
3 years of age or younger through the Vac-
4 cines for Children program;

5 “(ii) ensuring that the recommenda-
6 tions of the Advisory Committee on Immu-
7 nization Practices of the Centers for Dis-
8 ease Control and Prevention are followed
9 regarding the birth dose of hepatitis B vac-
10 cinations for newborns;

11 “(iii) requiring proof of hepatitis B
12 vaccination for entry into public or private
13 daycare, preschool, elementary school, sec-
14 ondary school, and institutions of higher
15 education;

16 “(iv) expanding the availability of
17 hepatitis B vaccination for all susceptible
18 adults to protect them from becoming
19 acutely or chronically infected, including
20 ethnic and other populations with high
21 prevalence rates of chronic hepatitis B in-
22 fection;

23 “(v) expanding the availability of hep-
24 atitis B vaccination for all susceptible
25 adults, particularly those of reproductive

1 age (women and men less than 45 years of
2 age), to protect them from the risk of hep-
3 atitis B infection;

4 “(vi) ensuring the vaccination of indi-
5 viduals infected, or at risk for infection,
6 with hepatitis C against hepatitis A, hepa-
7 titis B, and other infectious diseases, as
8 appropriate, for which such individuals
9 may be at increased risk; and

10 “(vii) ensuring the vaccination of indi-
11 viduals infected, or at risk for infection,
12 with hepatitis B against hepatitis A virus
13 and other infectious diseases, as appro-
14 priate, for which such individuals may be
15 at increased risk.

16 “(D) MEDICAL REFERRAL.—The Secretary
17 shall support State, local, territorial, and tribal
18 programs that support—

19 “(i) referral of persons chronically in-
20 fected with hepatitis B or hepatitis C—

21 “(I) for medical evaluation to de-
22 termine the appropriateness for
23 antiviral treatment to reduce the risk
24 of progression to cirrhosis and liver
25 cancer; and

1 “(II) for ongoing medical man-
2 agement including regular monitoring
3 of liver function and screening for
4 liver cancer; and

5 “(ii) referral of persons infected with
6 acute or chronic hepatitis B infection or
7 acute or chronic hepatitis C infection for
8 drug and alcohol abuse treatment where
9 appropriate.

10 “(4) INCREASED SUPPORT FOR ADULT VIRAL
11 HEPATITIS PREVENTION COORDINATORS.—The Sec-
12 retary, acting through the CDC Director, shall pro-
13 vide increased support to adult viral hepatitis pre-
14 vention coordinators in State, local, territorial, and
15 tribal health departments in order to enhance the
16 additional management, networking, and technical
17 expertise needed to ensure successful integration of
18 hepatitis B and hepatitis C prevention and control
19 activities into existing public health programs.

20 “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

21 “(1) IN GENERAL.—The Secretary, acting
22 through the Director of the Centers for Disease
23 Control and Prevention, shall support the establish-
24 ment and maintenance of a national chronic and

1 acute hepatitis B and hepatitis C surveillance pro-
2 gram, in order to identify—

3 “(A) trends in the incidence of acute and
4 chronic hepatitis B and acute and chronic hepa-
5 titis C;

6 “(B) trends in the prevalence of acute and
7 chronic hepatitis B and acute and chronic hepa-
8 titis C infection among groups that may be dis-
9 proportionately affected; and

10 “(C) trends in liver cancer and end-stage
11 liver disease incidence and deaths, caused by
12 chronic hepatitis B and chronic hepatitis C in
13 the high-risk ethnic populations.

14 “(2) SEROPREVALENCE AND LIVER CANCER
15 STUDIES.—The Secretary, acting through the Direc-
16 tor of the Centers for Disease Control and Preven-
17 tion, shall prepare a report outlining the population-
18 based seroprevalence studies currently underway, fu-
19 ture planned studies, the criteria involved in deter-
20 mining which seroprevalence studies to conduct,
21 defer, or suspend, and the scope of those studies, the
22 economic and clinical impact of hepatitis B and hep-
23 atitis C, and the impact of chronic hepatitis B and
24 chronic hepatitis C infections on the quality of life.
25 Not later than one year after the date of the enact-

1 ment of this part, the Secretary shall submit the re-
2 port to the Committee on Health, Education, Labor,
3 and Pensions of the Senate and the Committee on
4 Energy and Commerce of the House of Representa-
5 tives.

6 “(3) CONFIDENTIALITY.—The Secretary shall
7 not disclose any individually identifiable information
8 identified under paragraph (1) or derived through
9 studies under paragraph (2).

10 “(d) RESEARCH.—The Secretary, acting through the
11 Director of the Centers for Disease Control and Preven-
12 tion, the Director of the National Cancer Institute, and
13 the Director of the National Institutes of Health, shall—

14 “(1) conduct epidemiologic and community-
15 based research to develop, implement, and evaluate
16 best practices for hepatitis B and hepatitis C pre-
17 vention especially in the ethnic populations with high
18 rates of chronic hepatitis B and chronic hepatitis C
19 and other high-risk groups;

20 “(2) conduct research on hepatitis B and hepa-
21 titis C natural history, pathophysiology, improved
22 treatments and prevention (such as the hepatitis C
23 vaccine), and noninvasive tests that help to predict
24 the risk of progression to liver cirrhosis and liver
25 cancer;

1 “(3) conduct research that will lead to better
2 noninvasive or blood tests to screen for liver cancer,
3 and more effective treatments of liver cancer caused
4 by chronic hepatitis B and chronic hepatitis C; and

5 “(4) conduct research comparing the effective-
6 ness of screening, diagnostic, management, and
7 treatment approaches for chronic hepatitis B, chron-
8 ic hepatitis C, and liver cancer in the affected com-
9 munities.

10 “(e) **UNDERSERVED AND DISPROPORTIONATELY AF-**
11 **FECTED POPULATIONS.**—In carrying out this section, the
12 Secretary shall provide expanded support for individuals
13 with limited access to health education, testing, and health
14 care services and groups that may be disproportionately
15 affected by hepatitis B and hepatitis C.

16 “(f) **EVALUATION OF PROGRAM.**—The Secretary
17 shall develop benchmarks for evaluating the effectiveness
18 of the programs and activities conducted under this sec-
19 tion and make determinations as to whether such bench-
20 marks have been achieved.

21 **“SEC. 399PP-2. GRANTS.**

22 “(a) **IN GENERAL.**—The Secretary may award grants
23 to, or enter into contracts or cooperative agreements with,
24 States, political subdivisions of States, territories, Indian
25 tribes, or nonprofit entities that have special expertise re-

1 lating to hepatitis B, hepatitis C, or both, to carry out
2 activities under this part.

3 “(b) APPLICATION.—To be eligible for a grant, con-
4 tract, or cooperative agreement under subsection (a), an
5 entity shall prepare and submit to the Secretary an appli-
6 cation at such time, in such manner, and containing such
7 information as the Secretary may require.

8 **“SEC. 399PP-3. AUTHORIZATION OF APPROPRIATIONS.**

9 “There are authorized to be appropriated to carry out
10 this part \$90,000,000 for fiscal year 2019, \$90,000,000
11 for fiscal year 2020, \$110,000,000 for fiscal year 2021,
12 \$130,000,000 for fiscal year 2022, and \$150,000,000 for
13 fiscal year 2023.”.

14 **Subtitle C—Acquired Bone Marrow**
15 **Failure Diseases**

16 **SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

17 (a) SHORT TITLE.—This subtitle may be cited as the
18 “Bone Marrow Failure Disease Research and Treatment
19 Act of 2018”.

20 (b) FINDINGS.—The Congress finds the following:

21 (1) Between 20,000 and 30,000 people in the
22 United States are diagnosed each year with
23 myelodysplastic syndromes, aplastic anemia, parox-
24 ysmal nocturnal hemoglobinuria, and other acquired
25 bone marrow failure diseases.

1 (2) Acquired bone marrow failure diseases have
2 a debilitating and often fatal impact on those diag-
3 nosed with these diseases.

4 (3) While some treatments for acquired bone
5 marrow failure diseases can prolong and improve the
6 quality of patients' lives, there is no single cure for
7 these diseases.

8 (4) The prevalence of acquired bone marrow
9 failure diseases in the United States will continue to
10 grow as the general public ages.

11 (5) Evidence exists suggesting that acquired
12 bone marrow failure diseases occur more often in
13 minority populations, particularly in Asian-American
14 and Latino or Hispanic populations.

15 (6) The National Heart, Lung, and Blood Insti-
16 tute and the National Cancer Institute have con-
17 ducted important research into the causes of and
18 treatments for acquired bone marrow failure dis-
19 eases.

20 (7) The National Marrow Donor Program Reg-
21 istry has made significant contributions to the fight
22 against bone marrow failure diseases by connecting
23 millions of potential marrow donors with individuals
24 and families suffering from these conditions.

1 (8) Despite these advances, a more comprehensive Federal strategic effort among numerous Federal agencies is needed to discover a cure for acquired bone marrow failure disorders.

5 (9) Greater Federal surveillance of acquired bone marrow failure diseases is needed to gain a better understanding of the causes of acquired bone marrow failure diseases.

9 (10) The Federal Government should increase its research support for and engage with public and private organizations in developing a comprehensive approach to combat and cure acquired bone marrow failure diseases.

14 (c) NATIONAL ACQUIRED BONE MARROW FAILURE DISEASE REGISTRY.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by inserting after section 317W, as added by section 506, the following:

19 **“SEC. 317X. NATIONAL ACQUIRED BONE MARROW FAILURE**
20 **DISEASE REGISTRY.**

21 “(a) ESTABLISHMENT OF REGISTRY.—

22 “(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

1 “(A) develop a system to collect data on
2 acquired bone marrow failure diseases; and

3 “(B) establish and maintain a national and
4 publicly available registry, to be known as the
5 National Acquired Bone Marrow Failure Dis-
6 ease Registry, in accordance with paragraph
7 (3).

8 “(2) RECOMMENDATIONS OF ADVISORY COM-
9 MITTEE.—In carrying out this subsection, the Sec-
10 retary shall take into consideration the recommenda-
11 tions of the Advisory Committee on Acquired Bone
12 Marrow Failure Diseases established under sub-
13 section (b).

14 “(3) PURPOSES OF REGISTRY.—The National
15 Acquired Bone Marrow Failure Disease Registry
16 shall—

17 “(A) identify the incidence and prevalence
18 of acquired bone marrow failure diseases in the
19 United States;

20 “(B) be used to collect and store data on
21 acquired bone marrow failure diseases, includ-
22 ing data concerning—

23 “(i) the age, race or ethnicity, general
24 geographic location, sex, and family history
25 of individuals who are diagnosed with ac-

1 required bone marrow failure diseases, and
2 any other characteristics of such individ-
3 uals determined appropriate by the Sec-
4 retary;

5 “(ii) the genetic and environmental
6 factors that may be associated with devel-
7 oping acquired bone marrow failure dis-
8 eases;

9 “(iii) treatment approaches for deal-
10 ing with acquired bone marrow failure dis-
11 eases;

12 “(iv) outcomes for individuals treated
13 for acquired bone marrow failure diseases,
14 including outcomes for recipients of stem
15 cell therapeutic products as contained in
16 the database established pursuant to sec-
17 tion 379A; and

18 “(v) any other factors pertaining to
19 acquired bone marrow failure diseases de-
20 termined appropriate by the Secretary; and
21 “(C) be made available—

22 “(i) to the general public; and

23 “(ii) to researchers to facilitate fur-
24 ther research into the causes of, and treat-
25 ments for, acquired bone marrow failure

1 diseases in accordance with standard prac-
2 tices of the Centers for Disease Control
3 and Preventions.

4 “(b) ADVISORY COMMITTEE.—

5 “(1) ESTABLISHMENT.—Not later than 6
6 months after the date of the enactment of this sec-
7 tion, the Secretary, acting through the Director of
8 the Centers for Disease Control and Prevention,
9 shall establish an advisory committee, to be known
10 as the Advisory Committee on Acquired Bone Mar-
11 row Failure Diseases.

12 “(2) MEMBERS.—The members of the Advisory
13 Committee on Acquired Bone Marrow Failure Dis-
14 eases shall be appointed by the Secretary, acting
15 through the Director of the Centers for Disease
16 Control and Prevention, and shall include at least
17 one representative from each of the following:

18 “(A) A national patient advocacy organiza-
19 tion with experience advocating on behalf of pa-
20 tients suffering from acquired bone marrow
21 failure diseases.

22 “(B) The National Institutes of Health, in-
23 cluding at least one representative from each
24 of—

25 “(i) the National Cancer Institute;

1 “(ii) the National Heart, Lung, and
2 Blood Institute; and

3 “(iii) the Office of Rare Diseases.

4 “(C) The Centers for Disease Control and
5 Prevention.

6 “(D) Clinicians with experience in—

7 “(i) diagnosing or treating acquired
8 bone marrow failure diseases; or

9 “(ii) medical data registries.

10 “(E) Epidemiologists who have experience
11 with data registries.

12 “(F) Publicly or privately funded research-
13 ers who have experience researching acquired
14 bone marrow failure diseases.

15 “(G) The entity operating the C.W. Bill
16 Young Cell Transplantation Program estab-
17 lished pursuant to section 379 and the entity
18 operating the C.W. Bill Young Cell Transplan-
19 tation Program Outcomes Database.

20 “(3) RESPONSIBILITIES.—The Advisory Com-
21 mittee on Acquired Bone Marrow Failure Diseases
22 shall provide recommendations to the Secretary on
23 the establishment and maintenance of the National
24 Acquired Bone Marrow Failure Disease Registry, in-

1 including recommendations on the collection, mainte-
2 nance, and dissemination of data.

3 “(4) PUBLIC AVAILABILITY.—The Secretary
4 shall make the recommendations of the Advisory
5 Committee on Acquired Bone Marrow Failure Dis-
6 ease publicly available.

7 “(c) GRANTS.—The Secretary, acting through the
8 Director of the Centers for Disease Control and Preven-
9 tion, may award grants to, and enter into contracts and
10 cooperative agreements with, public or private nonprofit
11 entities for the management of, as well as the collection,
12 analysis, and reporting of data to be included in, the Na-
13 tional Acquired Bone Marrow Failure Disease Registry.

14 “(d) DEFINITION.—In this section, the term ‘ac-
15 quired bone marrow failure disease’ means—

16 “(1) myelodysplastic syndromes;

17 “(2) aplastic anemia;

18 “(3) paroxysmal nocturnal hemoglobinuria;

19 “(4) pure red cell aplasia;

20 “(5) acute myeloid leukemia that has pro-
21 gressed from myelodysplastic syndromes; or

22 “(6) large granular lymphocytic leukemia.

23 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section
25 \$3,000,000 for each of fiscal years 2019 through 2023.”.

1 (d) PILOT STUDIES THROUGH THE AGENCY FOR
2 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

3 (1) PILOT STUDIES.—The Secretary of Health
4 and Human Services, acting through the Director of
5 the Agency for Toxic Substances and Disease Reg-
6 istry, shall conduct pilot studies to determine which
7 environmental factors, including exposure to toxins,
8 may cause acquired bone marrow failure diseases.

9 (2) COLLABORATION WITH THE RADIATION IN-
10 JURY TREATMENT NETWORK.—In carrying out the
11 directives of this section, the Secretary may collabo-
12 rate with the Radiation Injury Treatment Network
13 of the C.W. Bill Young Cell Transplantation Pro-
14 gram established pursuant to section 379 of the
15 Public Health Service Act (42 U.S.C. 274k) to—

16 (A) augment data for the pilot studies au-
17 thorized by this section;

18 (B) access technical assistance that may be
19 provided by the Radiation Injury Treatment
20 Network; or

21 (C) perform joint research projects.

22 (3) AUTHORIZATION OF APPROPRIATIONS.—
23 There is authorized to be appropriated to carry out
24 this section \$1,000,000 for each of fiscal years 2019
25 through 2023.

1 (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
2 BONE MARROW FAILURE DISEASES.—Title XVII of the
3 Public Health Service Act (42 U.S.C. 300u et seq.) is
4 amended by inserting after section 1707A the following:

5 **“SEC. 1707B. MINORITY-FOCUSED PROGRAMS ON AC-**
6 **QUIRED BONE MARROW FAILURE DISEASE.**

7 “(a) INFORMATION AND REFERRAL SERVICES.—

8 “(1) IN GENERAL.—Not later than 6 months
9 after the date of the enactment of this section, the
10 Secretary, acting through the Deputy Assistant Sec-
11 retary for Minority Health, shall establish and co-
12 ordinate outreach and informational programs tar-
13 geted to minority populations affected by acquired
14 bone marrow failure diseases.

15 “(2) PROGRAM REQUIREMENTS.—Minority-fo-
16 cused outreach and informational programs author-
17 ized by this section at the National Minority Health
18 Resource Center supported under section 1707(b)(8)
19 (including by means of the Center’s website, through
20 appropriate locations such as the Center’s knowledge
21 center, and through appropriate programs such as
22 the Center’s resource persons network) and through
23 minority health consultants located at each Depart-
24 ment of Health and Human Services regional of-
25 fice—

1 “(A) shall make information about treat-
2 ment options and clinical trials for acquired
3 bone marrow failure diseases publicly available;
4 and

5 “(B) shall provide referral services for
6 treatment options and clinical trials.

7 “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
8 ISLANDER OUTREACH.—

9 “(1) IN GENERAL.—The Secretary, acting
10 through the Deputy Assistant Secretary for Minority
11 Health, shall undertake a coordinated outreach ef-
12 fort to connect Hispanic, Asian-American, and Pa-
13 cific Islander communities with comprehensive serv-
14 ices focused on treatment of, and information about,
15 acquired bone marrow failure diseases.

16 “(2) COLLABORATION.—In carrying out this
17 subsection, the Secretary may collaborate with public
18 health agencies, nonprofit organizations, community
19 groups, and online entities to disseminate informa-
20 tion about treatment options and clinical trials for
21 acquired bone marrow failure diseases.

22 “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

23 “(1) IN GENERAL.—Not later than 6 months
24 after the date of the enactment of this section, the
25 Secretary, acting through the Deputy Assistant Sec-

1 retary for Minority Health, shall award grants to, or
2 enter into cooperative agreements with, entities to
3 perform research on acquired bone marrow failure
4 diseases.

5 “(2) REQUIREMENT.—Grants and cooperative
6 agreements authorized by this subsection shall be
7 awarded or entered into on a competitive, peer-re-
8 viewed basis.

9 “(3) SCOPE OF RESEARCH.—Research funded
10 under this section shall examine factors affecting the
11 incidence of acquired bone marrow failure diseases
12 in minority populations.

13 “(d) DEFINITION.—In this section, the term ‘ac-
14 quired bone marrow failure disease’ has the meaning given
15 to such term in section 317X(d).

16 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
17 is authorized to be appropriated to carry out this section
18 \$2,000,000 for each of fiscal years 2019 through 2023.”.

19 (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-
20 QUIRED BONE MARROW FAILURE DISEASES.—

21 (1) GRANTS.—The Secretary of Health and
22 Human Services, acting through the Director of the
23 Agency for Healthcare Research and Quality, shall
24 award grants to entities to improve diagnostic prac-

1 tices and quality of care with respect to patients
2 with acquired bone marrow failure diseases.

3 (2) AUTHORIZATION OF APPROPRIATIONS.—

4 There is authorized to be appropriated to carry out
5 this section \$2,000,000 for each of fiscal years 2019
6 through 2023.

7 (g) DEFINITION.—In this section, the term “acquired
8 bone marrow failure disease” has the meaning given such
9 term in section 317X(d) of the Public Health Service Act,
10 as added by subsection (c).

11 **Subtitle D—Cardiovascular Dis-**
12 **ease, Chronic Disease, and**
13 **Other Disease Issues**

14 **SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MI-**
15 **NORITY PATIENTS.**

16 (a) IN GENERAL.—The Secretary, acting through the
17 Director of the Agency for Healthcare Research and Qual-
18 ity, shall convene a series of meetings to develop guidelines
19 for disease screening for minority patient populations that
20 have a higher than average risk for many chronic diseases
21 and cancers.

22 (b) PARTICIPANTS.—In convening meetings under
23 subsection (a), the Secretary shall ensure that meeting
24 participants include representatives of—

25 (1) professional societies and associations;

1 (2) minority health organizations;

2 (3) health care researchers and providers, in-
3 cluding those with expertise in minority health;

4 (4) Federal health agencies, including the Of-
5 fice of Minority Health, the National Institute on
6 Minority Health and Health Disparities, and the
7 National Institutes of Health; and

8 (5) other experts as the Secretary determines
9 appropriate.

10 (c) DISEASES.—Screening guidelines for minority
11 populations shall be developed as appropriate under sub-
12 section (a) for—

13 (1) hypertension;

14 (2) hypercholesterolemia;

15 (3) diabetes;

16 (4) cardiovascular disease;

17 (5) cancers, including breast, prostate, colon,
18 cervical, and lung cancer;

19 (6) other pulmonary problems including sleep
20 apnea;

21 (7) asthma;

22 (8) diabetes;

23 (9) kidney diseases;

24 (10) eye diseases and disorders, including glau-
25 coma;

- 1 (11) HIV/AIDS and sexually transmitted infec-
2 tions;
- 3 (12) uterine fibroids;
- 4 (13) autoimmune disease;
- 5 (14) mental health conditions;
- 6 (15) dental health conditions and oral diseases,
7 including oral cancer;
- 8 (16) environmental and related health illnesses
9 and conditions;
- 10 (17) sickle cell disease and sickle cell trait;
- 11 (18) violence and injury prevention and control;
- 12 (19) genetic and related conditions;
- 13 (20) heart disease and stroke;
- 14 (21) tuberculosis;
- 15 (22) chronic obstructive pulmonary disease;
- 16 (23) musculoskeletal diseases, arthritis, and
17 obesity; and
- 18 (24) other diseases determined appropriate by
19 the Secretary.
- 20 (d) DISSEMINATION.—Not later than 2 years after
21 the date of enactment of this Act, the Secretary shall pub-
22 lish and disseminate to health care provider organizations
23 the guidelines developed under subsection (a).
- 24 (e) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of fiscal years
2 2019 through 2023.

3 **SEC. 732. CDC WISEWOMAN SCREENING PROGRAM.**

4 Section 1509 of the Public Health Service Act (42
5 U.S.C. 300n-4a) is amended—

6 (1) in subsection (a)—

7 (A) by striking the heading and inserting
8 “IN GENERAL.—”; and

9 (B) in the matter preceding paragraph (1),
10 by striking “may make grants” and all that fol-
11 lows through “purpose” and inserting the fol-
12 lowing: “may make grants to such States for
13 the purpose”; and

14 (2) in subsection (d)(1), by striking “there are
15 authorized” and all that follows through the period
16 and inserting “there are authorized to be appro-
17 priated \$23,000,000 for fiscal year 2019,
18 \$25,300,000 for fiscal year 2020, \$27,800,000 for
19 fiscal year 2021, \$30,800,000 for fiscal year 2022,
20 and \$34,000,000 for fiscal year 2023.”.

21 **SEC. 733. REPORT ON CARDIOVASCULAR CARE FOR WOMEN**
22 **AND MINORITIES.**

23 Part P of title III of the Public Health Service Act
24 (42 U.S.C. 280g et seq.), as amended by section 531, is
25 further amended by adding at the end the following:

1 **“SEC. 399V-8. REPORT ON CARDIOVASCULAR CARE FOR**
2 **WOMEN AND MINORITIES.**

3 “Not later than September 30, 2019, and annually
4 thereafter, the Secretary shall prepare and submit to Con-
5 gress a report on the quality of and access to care for
6 women and minorities with heart disease, stroke, and
7 other cardiovascular diseases. The report shall contain rec-
8 ommendations for eliminating disparities in, and improv-
9 ing the treatment of, heart disease, stroke, and other car-
10 diovascular diseases in women, racial and ethnic minori-
11 ties, those for whom English is not their primary lan-
12 guage, and individuals with disabilities.”.

13 **SEC. 734. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
14 **SATION SERVICES IN MEDICAID AND PRI-**
15 **VATE HEALTH INSURANCE.**

16 (a) **REQUIRING MEDICAID COVERAGE OF COUN-**
17 **SELING AND PHARMACOTHERAPY FOR CESSATION OF TO-**
18 **BACCO USE.**—Section 1905 of the Social Security Act (42
19 U.S.C. 1396d) is amended—

20 (1) in subsection (a)(4)(D), by striking “by
21 pregnant women”; and

22 (2) in subsection (bb)—

23 (A) by striking “by pregnant women” each
24 place it appears;

1 (B) in paragraph (1), in the matter before
2 subparagraph (A), by inserting “by individuals”
3 before “who use tobacco”; and

4 (C) in paragraph (2)(A), by striking “with
5 respect to pregnant women”.

6 (b) EXCEPTION FROM OPTIONAL RESTRICTION
7 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
8 Section 1927(d)(2)(F) of the Social Security Act (42
9 U.S.C. 1396r–8(d)(2)(F)) is amended—

10 (1) by striking “in the case of pregnant
11 women”; and

12 (2) by striking “under the over-the-counter
13 monograph process”.

14 (c) STATE MONITORING AND PROMOTING OF COM-
15 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
16 MEDICAID.—Section 1902(a) of the Social Security Act
17 (42 U.S.C. 1396a(a)), as amended by section 462(a), is
18 amended—

19 (1) by striking “and” at the end of paragraph
20 (84);

21 (2) by striking the period at the end of para-
22 graph (85) and inserting “; and”; and

23 (3) by inserting after paragraph (85) the fol-
24 lowing new paragraph:

1 “(86) provide for the State to monitor and pro-
2 mote the use of comprehensive tobacco cessation
3 services under the State plan, including conducting
4 an outreach campaign to increase awareness of, and
5 the benefits of using, such services among—

6 “(A) individuals entitled to medical assist-
7 ance under the State plan who use tobacco
8 products; and

9 “(B) clinicians and others who provide
10 services to individuals entitled to medical assist-
11 ance under the State plan.”.

12 (d) FEDERAL REIMBURSEMENT FOR MEDICAID OUT-
13 REACH CAMPAIGN TO INCREASE AWARENESS.—Section
14 1903(a) of the Social Security Act (42 U.S.C. 1396b(a))
15 is amended—

16 (1) by striking the period at the end of para-
17 graph (7) and inserting “; plus”; and

18 (2) by inserting after paragraph (7) the fol-
19 lowing new paragraph:

20 “(8) an amount equal to 90 percent of the
21 sums expended during each quarter which are attrib-
22 utable to the development, implementation, and eval-
23 uation of an outreach campaign to—

1 “(A) increase awareness of comprehensive
2 tobacco cessation services covered in the State
3 plan among—

4 “(i) individuals who are likely to be el-
5 igible for medical assistance under the
6 State plan; and

7 “(ii) clinicians and others who provide
8 services to individuals who are likely to be
9 eligible for medical assistance under the
10 State plan; and

11 “(B) increase awareness of the benefits of
12 using comprehensive tobacco cessation services
13 covered in the State plan among—

14 “(i) individuals who are likely to be el-
15 igible for medical assistance under the
16 State plan; and

17 “(ii) clinicians and others who provide
18 services to individuals who are likely to be
19 eligible for medical assistance under the
20 State plan about the benefits of using com-
21 prehensive tobacco cessation services.”.

22 (e) REMOVAL OF COST SHARING FOR COUNSELING
23 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
24 USE UNDER MEDICAID.—

1 (1) GENERAL COST SHARING LIMITATIONS.—
2 Section 1916 of the Social Security Act (42 U.S.C.
3 1396o) is amended—

4 (A) in subsections (a)(2)(B) and (b)(2)(B),
5 by striking “and counseling and pharmacother-
6 apy for cessation of tobacco use by pregnant
7 women (as defined in section 1905(bb) of this
8 title) and covered outpatient drugs (as defined
9 in subsection (k)(2) of section 1927 and includ-
10 ing nonprescription drugs described in sub-
11 section (d)(2) of such section) that are pre-
12 scribed for purposes of promoting, and when
13 used to promote, tobacco cessation by pregnant
14 women in accordance with the Guideline re-
15 ferred to in section 1905(bb)(2)(A)” each place
16 it appears; and

17 (B) in each of subsections (a)(2)(B) and
18 (b)(2)(B) by inserting “and counseling and
19 pharmacotherapy for cessation of tobacco use
20 (as defined in section 1905d(bb) of this title)
21 and covered outpatient drugs (as defined in
22 subsection (k)(2) of section 1927 and including
23 nonprescription drugs described in subsection
24 (d)(2) of such section) that are prescribed for
25 purposes of promoting, and when used to pro-

1 mote, tobacco cessation in accordance with the
2 Guideline referred to in section
3 1905(bb)(2)(A)” after “(or at the option of the
4 State, any services furnished to pregnant
5 women”.

6 (2) APPLICATION TO ALTERNATIVE COST SHAR-
7 ING.—Section 1916A(b)(3)(B) of such Act (42
8 U.S.C. 1396o–1(b)(3)(B)) is amended—

9 (A) in clause (iii), by striking “, and coun-
10 seling and pharmacotherapy for cessation of to-
11 bacco use by pregnant women (as defined in
12 section 1905(bb))”; and

13 (B) by adding at the end the following:

14 “(xi) Counseling and pharmacothe-
15 rapy for cessation of tobacco use (as defined
16 in section 1905(bb)) and covered out-
17 patient drugs (as defined in subsection
18 (k)(2) of section 1927 and including non-
19 prescription drugs described in subsection
20 (d)(2) of such section) that are prescribed
21 for purposes of promoting, and when used
22 to promote, tobacco cessation in accord-
23 ance with the Guideline referred to in sec-
24 tion 1396d (bb)(2)(A) of this title.”.

1 (f) NO PRIOR AUTHORIZATION FOR TOBACCO CES-
2 SATION DRUGS UNDER MEDICAID.—Section 1927(d) of
3 the Social Security Act (42 U.S.C. 1396r–8) is amended—

4 (1) by striking in paragraph (1)(A) “A State”
5 and inserting “Except as otherwise provided in para-
6 graph (6), a State”;

7 (2) by redesignating paragraphs (6) and (7) as
8 paragraphs (7) and (8), respectively; and

9 (3) by inserting after paragraph (5) the fol-
10 lowing:

11 “(6) NO PRIOR AUTHORIZATION PROGRAMS FOR
12 TOBACCO CESSATION DRUGS.—A State plan under
13 this title shall not require, as a condition of coverage
14 or payment for a covered outpatient drug for which
15 Federal financial participation is available in accord-
16 ance with this section, the approval of an agent
17 when used to promote smoking cessation, including
18 agents approved by the Food and Drug Administra-
19 tion for the purposes of promoting, and when used
20 to promote, tobacco cessation.”.

21 (g) COMPREHENSIVE COVERAGE OF TOBACCO CES-
22 SATION COVERAGE IN PRIVATE HEALTH INSURANCE.—
23 Section 2713 of the Public Health Service Act (42 U.S.C.
24 300gg–3) is amended by adding at the end the following:

1 “(d) NO PRIOR AUTHORIZATION.—A group health
2 plan and a health insurance issuer offering group or indi-
3 vidual health insurance coverage shall not impose any
4 prior authorization requirement for tobacco cessation
5 counseling and pharmacotherapy that has in effect a rat-
6 ing of ‘A’ or ‘B’ in the current recommendations of the
7 United States Preventive Services Task Force.”.

8 (h) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to items and services furnished on
10 or after January 1, 2019.

11 **SEC. 735. CLINICAL RESEARCH FUNDING FOR ORAL**
12 **HEALTH.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services shall expand and intensify the conduct
15 and support of the research activities of the National In-
16 stitutes of Health and the National Institute of Dental
17 and Craniofacial Research to improve the oral health of
18 the population through the prevention and management
19 of oral diseases and conditions.

20 (b) INCLUDED RESEARCH ACTIVITIES.—Research
21 activities under subsection (a) shall include—

22 (1) comparative effectiveness research and clin-
23 ical disease management research addressing early
24 childhood caries and oral cancer; and

1 (2) awarding of grants and contracts to support
 2 the training and development of health services re-
 3 searchers, comparative effectiveness researchers, and
 4 clinical researchers whose research improves the oral
 5 health of the population.

6 **SEC. 736. PARTICIPATION BY MEDICAID BENEFICIARIES IN**
 7 **APPROVED CLINICAL TRIALS.**

8 (a) IN GENERAL.—Title XIX of the Social Security
 9 Act (42 U.S.C. 1396 et seq.) is amended by inserting after
 10 section 1943 the following new section:

11 **“SEC. 1944. PARTICIPATION IN AN APPROVED CLINICAL**
 12 **TRIAL.**

13 “(a) COVERAGE OF ROUTINE PATIENT COSTS ASSO-
 14 CIATED WITH APPROVED CLINICAL TRIALS.—

15 “(1) INCLUSION.—Subject to paragraph (2),
 16 routine patient costs shall include all items and serv-
 17 ices consistent with the medical assistance provided
 18 under the State plan that would otherwise be pro-
 19 vided to the individual under such State plan if such
 20 individual was not enrolled in an approved clinical
 21 trial, including any items or services related to the
 22 prevention, detection, and treatment of any medical
 23 complications that arise as a result of participation
 24 in the approved clinical trial.

1 “(2) EXCLUSION.—For purposes of paragraph
2 (1), routine patient costs does not include—

3 “(A) the investigational item, device, or
4 service itself;

5 “(B) items and services that are provided
6 solely to satisfy data collection and analysis
7 needs and that are not used in the direct clin-
8 ical management of the patient; or

9 “(C) a service that is clearly inconsistent
10 with widely accepted and established standards
11 of care for a particular diagnosis.

12 “(3) INFORMATION CONCERNING CLINICAL
13 TRIALS.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B), the Secretary, in consultation with
16 relevant stakeholders, shall develop a single
17 standardized electronic form for use by the indi-
18 vidual or the referring health care provider to
19 submit to the State agency administering the
20 State plan in order to verify that the clinical
21 trial meets the conditions established for an ap-
22 proved clinical trial (as defined in subsection
23 (c)).

24 “(B) EXCLUDED INFORMATION.—For pur-
25 poses of subparagraph (A) or any such request

1 by the State agency for information regarding
2 a clinical trial, an individual or referring health
3 care provider shall not be required to submit—

4 “(i) the clinical protocol document for
5 the clinical trial; or

6 “(ii) subject to subparagraph (C), any
7 additional information other than such in-
8 formation as is required pursuant to the
9 form described in subparagraph (A).

10 “(C) OPTIONAL INFORMATION.—For pur-
11 poses of subparagraphs (A) and (B)(ii), the
12 form may include a requirement that the refer-
13 ring health care provider attest that the indi-
14 vidual is eligible to participate in the clinical
15 trial pursuant to the trial protocol and that in-
16 dividual participation in such trial would be ap-
17 propriate.

18 “(D) REVIEW OF INFORMATION.—

19 “(i) IN GENERAL.—A State plan
20 under this title shall establish a process for
21 timely review by the State agency of the
22 form and information submitted pursuant
23 to subparagraph (A) and, not later than
24 48 hours after receipt of such form, con-
25 firmation that the information provided in

1 such form satisfies the requirements estab-
2 lished under such subparagraph, with such
3 process to include establishment and oper-
4 ation of a 24-hour, toll-free telephone num-
5 ber and email address to provide for expe-
6 dited communication.

7 “(ii) FAILURE TO RESPOND.—If an
8 individual or the referring health care pro-
9 vider does not receive a response or re-
10 quest for additional information from the
11 State agency following the 48-hour period
12 described in clause (i), the information
13 provided in the form may be presumed to
14 satisfy the requirements established under
15 this paragraph.

16 “(b) ENCOURAGEMENT OF PARTICIPATION IN AP-
17 PROVED CLINICAL TRIALS.—

18 “(1) REASONABLY ACCESSIBLE PROVIDER.—
19 For purposes of participation in an approved clinical
20 trial by an individual eligible for medical assistance
21 under this title, the State agency administering the
22 State plan shall make reasonable efforts to ensure
23 that the individual is provided with access to a pro-
24 vider who is—

1 “(A) participating in the approved clinical
2 trial;

3 “(B) located not more than 25 miles from
4 the residence of the individual (or, if no such
5 provider is available, as close as possible to the
6 residence of the individual); and

7 “(C) a participating provider under the
8 State plan or has been deemed to be a partici-
9 pating provider under the State plan for pur-
10 poses of providing medical assistance to the in-
11 dividual during their participation in the ap-
12 proved clinical trial.

13 “(2) INFORMATIONAL MATERIALS.—The State
14 agency administering the plan approved under this
15 title shall develop informational materials and pro-
16 grams to encourage participating providers to make
17 appropriate referrals to physicians and other appro-
18 priate health care professionals who can provide in-
19 dividuals with access to approved clinical trials.

20 “(c) DEFINITION OF APPROVED CLINICAL TRIAL.—
21 The term ‘approved clinical trial’ has the same meaning
22 as provided under subsection (d) of the section 2709 of
23 the Public Health Service Act that relates to coverage for
24 individuals participating in approved clinical trials.”.

1 (b) CONFORMING AMENDMENT.—Section 1902(a) of
2 the Social Security Act (42 U.S.C. 1396a(a)), as amended
3 by section 734(c), is amended—

4 (1) by striking “and” at the end of paragraph
5 (85);

6 (2) by striking the period at the end of para-
7 graph (86) and inserting “; and”; and

8 (3) by inserting after paragraph (86) the fol-
9 lowing new paragraph:

10 “(87) provide that participation in an approved
11 clinical trial and coverage of routine patient costs
12 associated with such trial for an individual eligible
13 for medical assistance under this title is conducted
14 in accordance with the requirements under section
15 1944.”.

16 (c) EFFECTIVE DATE.—

17 (1) IN GENERAL.—Except as provided in para-
18 graph (2), the amendments made by this section
19 shall apply to calendar quarters beginning on or
20 after October 1, 2018.

21 (2) DELAY PERMITTED FOR STATE PLAN
22 AMENDMENT.—In the case of a State plan for med-
23 ical assistance under title XIX of the Social Security
24 Act which the Secretary of Health and Human Serv-
25 ices determines requires State legislation (other than

1 legislation appropriating funds) in order for the plan
2 to meet the additional requirements imposed by the
3 amendments made by this section, the State plan
4 shall not be regarded as failing to comply with the
5 requirements of such title solely on the basis of its
6 failure to meet these additional requirements before
7 the first day of the first calendar quarter beginning
8 after the close of the first regular session of the
9 State legislature that begins after the date of enact-
10 ment of this Act. For purposes of the previous sen-
11 tence, in the case of a State that has a 2-year legis-
12 lative session, each year of such session shall be
13 deemed to be a separate regular session of the State
14 legislature.

15 **Subtitle E—HIV/AIDS**

16 **SEC. 741. STATEMENT OF POLICY.**

17 It is the policy of the United States to achieve an
18 AIDS-free generation, and to—

19 (1) expand access to lifesaving antiretroviral
20 therapy for people living with HIV/AIDS and imme-
21 diately link people to continuous and coordinated
22 high-quality care when they learn they are infected
23 with HIV;

24 (2) expand targeted efforts to prevent HIV in-
25 fection using a combination of effective, evidence-

1 based approaches, including routine HIV screening,
2 and universal access to HIV prevention tools in the
3 communities where HIV/AIDS is most heavily con-
4 centrated, particularly communities of color;

5 (3) ensure laws, policies, and regulations do not
6 impede access to prevention, treatment, and care for
7 people living with HIV/AIDS or at risk for acquiring
8 HIV;

9 (4) accelerate research for more efficacious HIV
10 prevention and treatments tools, a cure, and a vac-
11 cine; and

12 (5) respect the human rights and dignity of
13 persons living with HIV/AIDS.

14 **SEC. 742. FINDINGS.**

15 The Congress finds the following:

16 (1) Over 1,000,000 people are estimated to be
17 living with HIV in the United States according to
18 the Centers for Disease Control and Prevention, 15
19 percent of whom are unaware of their HIV-positive
20 status.

21 (2) Annually there are about 37,600 new HIV
22 infections and 20,000 deaths in people with an HIV
23 diagnoses in 50 States and 6 dependent areas of the
24 United States.

1 (3) The Centers for Disease Control and Pre-
2 vention estimates that, in 2015, there were approxi-
3 mately 37,600 people newly diagnosed with HIV.
4 The estimated number of annual new HIV infections
5 declined 10 percent from 2010 to 2014. However,
6 the number of new infections is increasing among
7 certain populations, such as Latino gay and bisexual
8 men, where annual infections increase 14 percent.
9 New infections among Black gay or bisexual men
10 are remaining stable.

11 (4) HIV disproportionately affects certain popu-
12 lations in the United States. Though African Ameri-
13 cans represent approximately 12 percent of the pop-
14 ulation, African Americans account for almost half
15 (45 percent) of all people living with HIV in the
16 United States. Men who have sex with men account
17 for 67 percent of all new HIV infections and are the
18 only risk group in which HIV infections continue to
19 increase.

20 (5) Disparities exist among Latinos and His-
21 panics; in 2015, Latinos and Hispanics made up 18
22 percent of the United States population and 24 per-
23 cent of new infections.

24 (6) Though the rate of new infections among
25 American Indians and Alaska Natives (referred to in

1 this section as “AI/AN”) is proportional to their
2 population size, from 2005 to 2014, the annual
3 number of HIV diagnoses increased 19 percent
4 among AI/AN overall and 63 percent among AI/AN
5 gay and bisexual men.

6 (7) Asian Americans account for about 2 per-
7 cent of new HIV infections, but in 2013, 22 percent
8 were undiagnosed, the highest rate of undiagnosed
9 HIV among any race or ethnicity.

10 (8) The latest data from the Centers for Dis-
11 ease Control and Prevention in 2015 indicate that
12 new infections among women declined 20 percent.

13 (9) The history of HIV shows that culturally
14 relevant and gender-responsive supportive services,
15 including psychosocial support, treatment literacy,
16 case management, and transportation are necessary
17 strategies to reach and engage women and girls in
18 medical care.

19 (10) The limited data available on transgender
20 individuals point to a disproportionate burden of
21 HIV infection.

22 (11) Stigma and discrimination contribute to
23 such disparities.

24 (12) The Centers for Disease Control and Pre-
25 vention has determined that increasing the propor-

1 tion of people who know their HIV status is an es-
2 sential component of comprehensive HIV/AIDS
3 treatment and prevention efforts and that early di-
4 agnosis is critical in order for people with HIV/
5 AIDS to receive life-extending therapy. Additionally,
6 the Centers for Disease Control and Prevention rec-
7 ommend routine HIV screening in health care set-
8 tings for all patients aged 13 to 64, regardless of
9 risk.

10 (13) In 1998, Congress created the National
11 Minority AIDS Initiative to provide technical assist-
12 ance, build capacity, and strengthen outreach efforts
13 among local institutions and community-based orga-
14 nizations that serve racial and ethnic minorities liv-
15 ing with or vulnerable to HIV/AIDS.

16 (14) To combat the HIV epidemic in the United
17 States, the National HIV/AIDS Strategy (referred
18 to in this section as “NHAS”) provides a framework
19 of increasing access to care, reducing new infections,
20 and eliminating HIV-related health disparities. The
21 vision of NHAS is “The United States will become
22 a place where new HIV infections are rare and when
23 they do occur, every person, regardless of age, gen-
24 der, race/ethnicity, gender identity, or socioeconomic
25 circumstance, will have unfettered access to high

1 quality, life-extending care, free from stigma and
2 discrimination.”.

3 (15) At present, many States and United
4 States territories have criminal statutes based on
5 “exposure” to HIV. Most of these laws were adopted
6 before the availability of effective antiretroviral
7 treatment for HIV/AIDS.

8 (16) Research shows that stable housing leads
9 to better health outcomes for those living with HIV.
10 Inadequate or unstable housing is not only a barrier
11 to effective treatment, but also increases the likeli-
12 hood of engaging in risky behaviors leading to HIV
13 infection. Insecure housing puts people with HIV/
14 AIDS at risk of premature death from exposure to
15 other diseases, poor nutrition, and lack of medical
16 care.

17 (17) Due to advances in treatment, many peo-
18 ple living with HIV/AIDS (referred to in this section
19 as “PLWHA”) today are living healthy lives and
20 have the ability and desire to fully participate in all
21 aspects of community life, including employment.
22 Research associates being employed with tremendous
23 economic, social, and health benefits for many people
24 living with HIV/AIDS.

1 (18) The common benefits associated with em-
2 ployment include income, autonomy, productivity,
3 and status within society, daily structure, making a
4 contribution to one's community, and increased skills
5 and self-esteem. Research also indicates that many
6 people with disabilities, including PLWHA, report
7 perceiving themselves as being less disabled or not
8 disabled at all, when working. Furthermore, some
9 studies link working with better physical and mental
10 health outcomes for PLWHA when compared to
11 those who are not working. Preliminary data also
12 suggest that transitioning to employment is associ-
13 ated with reduced HIV-related health risk behavior
14 for many people.

15 (19) On July 16, 2012, the Food and Drug Ad-
16 ministration approved the first drug to reduce the
17 risk of HIV infection in uninfected individuals who
18 are at high risk of HIV infection and who may en-
19 gage in sexual activity with HIV-infected partners.

20 (20) Syringe service programs have been associ-
21 ated with lowered HIV infections, lower hepatitis C
22 infections, and increased linkage to substance use
23 treatment.

24 (21) There is now conclusive scientific evidence
25 that a person living with HIV who is on

1 antiretroviral therapy and is durably virally sup-
2 pressed (defined as having a consistent viral load of
3 less than <200 copies/ml) does not sexually trans-
4 mit HIV. The conclusive evidence about the highly
5 effective preventative benefits of antiretroviral ther-
6 apy provides an unprecedented opportunity to im-
7 prove the lives of people living with HIV, improve
8 treatment uptake and adherence, and advocate for
9 expanded access to treatment and care.

10 **SEC. 743. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
11 **ANCE PROGRAM TREATMENTS.**

12 Section 2623 of the Public Health Service Act (42
13 U.S.C. 300ff–31b) is amended by adding at the end the
14 following:

15 “(c) **ADDITIONAL FUNDING FOR AIDS DRUG AS-**
16 **SISTANCE PROGRAM TREATMENTS.**—In addition to
17 amounts otherwise authorized to be appropriated for car-
18 rying out this subpart, there are authorized to be appro-
19 priated such sums as may be necessary to carry out sec-
20 tions 2612(b)(3)(B) and 2616 for each of fiscal years
21 2019 through 2022.”.

22 **SEC. 744. ENHANCING THE NATIONAL HIV SURVEILLANCE**
23 **SYSTEM.**

24 (a) **GRANTS.**—The Secretary of Health and Human
25 Services, acting through the Director of the Centers for

1 Disease Control and Prevention, shall make grants to
2 States to support integration of public health surveillance
3 systems into all electronic health records in order to allow
4 rapid communications between the clinical setting and
5 health departments, by means that include—

6 (1) providing technical assistance and policy
7 guidance to State and local health departments, clin-
8 ical providers, and other agencies serving individuals
9 with HIV to improve the interoperability of data sys-
10 tems relevant to monitoring HIV care and sup-
11 portive services;

12 (2) capturing longitudinal data pertaining to
13 the initiation and ongoing prescription or dispensing
14 of antiretroviral therapy for individuals diagnosed
15 with HIV (such as through pharmacy-based report-
16 ing);

17 (3) obtaining information—

18 (A) on a voluntary basis, on sexual orienta-
19 tion and gender identity; and

20 (B) on sources of coverage (or the lack of
21 coverage) for medical treatment (including cov-
22 erage through the Medicaid program, the Medi-
23 care program, the program under title XXVI of
24 the Public Health Service Act (42 U.S.C.
25 300ff–11 et seq.); commonly referred to as the

1 “Ryan White HIV/AIDS Program”), other pub-
2 lic funding, private insurance, and health main-
3 tenance organizations); and

4 (4) obtaining and using current geographic
5 markers of residence (such as current address, zip
6 code, partial zip code, and census block).

7 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
8 rying out this section, the Secretary of Health and Human
9 Services shall ensure that appropriate privacy and security
10 safeguards are met to prevent unauthorized disclosure of
11 protected health information and compliance with the
12 HIPAA privacy and security law (as defined in section
13 3009 of the Public Health Service Act (42 U.S.C. 300jj–
14 19)) and other relevant laws and regulations.

15 (c) PROHIBITION AGAINST IMPROPER USE OF
16 DATA.—No grant under this section may be used to allow
17 or facilitate the collection or use of surveillance or clinical
18 data or records—

19 (1) for punitive measures of any kind, civil or
20 criminal, against the subject of such data or records;
21 or

22 (2) for imposing any requirement or restriction
23 with respect to an individual without the individual’s
24 written consent.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 such sums as may be necessary for each of fiscal years
4 2019 through 2023.

5 **SEC. 745. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
6 **LINKAGE TO AND RETENTION IN APPRO-**
7 **PRIATE CARE.**

8 (a) STRATEGIES.—The Secretary of Health and
9 Human Services, in collaboration with the Director of the
10 Centers for Disease Control and Prevention, the Assistant
11 Secretary for Mental Health and Substance Use, the Di-
12 rector of the Office of AIDS Research, the Administrator
13 of the Health Resources and Services Administration, and
14 the Administrator of the Centers for Medicare & Medicaid
15 Services, shall—

16 (1) identify evidence-based strategies most ef-
17 fective at addressing the multifaceted issues that im-
18 pede disease status awareness and linkage to and re-
19 tention in appropriate care, taking into consideration
20 health care systems issues, clinic and provider
21 issues, and individual psychosocial, environmental,
22 and other contextual factors;

23 (2) support the wide-scale implementation of
24 the evidence-based strategies identified pursuant to
25 paragraph (1), including through incorporating such

1 strategies into health care coverage supported by the
2 Medicaid program under title XIX of the Social Se-
3 curity Act (42 U.S.C. 1396 et seq.), the program
4 under title XXVI of the Public Health Service Act
5 (42 U.S.C. 300ff–11 et seq.; commonly referred to
6 as the “Ryan White HIV/AIDS Program”), and
7 health plans purchased through an American Health
8 Benefit Exchange established pursuant to section
9 1311 of the Patient Protection and Affordable Care
10 Act (42 U.S.C. 18031); and

11 (3) not later than 1 year after the date of the
12 enactment of this Act, submit a report to the Con-
13 gress on the status of activities under paragraphs
14 (1) and (2).

15 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
16 out this section, there are authorized to be appropriated
17 such sums as may be necessary for fiscal years 2019
18 through 2023.

19 **SEC. 746. IMPROVING ENTRY INTO AND RETENTION IN**
20 **CARE AND ANTIRETROVIRAL ADHERENCE**
21 **FOR PERSONS WITH HIV.**

22 (a) SENSE OF CONGRESS.—It is the sense of Con-
23 gress that AIDS research has led to scientific advance-
24 ments that have—

1 (1) saved the lives of millions of people with
2 HIV/AIDS;

3 (2) prevented millions of people from being in-
4 fected; and

5 (3) had broad benefits that extend far beyond
6 helping people at risk for or living with HIV.

7 (b) IN GENERAL.—The Secretary of Health and
8 Human Services, acting through the Director of the Na-
9 tional Institutes of Health, shall expand, intensify, and co-
10 ordinate operational and translational research and other
11 activities of the National Institutes of Health regarding
12 methods—

13 (1) to increase adoption of evidence-based ad-
14 herence strategies within HIV care and treatment
15 programs;

16 (2) to increase HIV testing and case detection
17 rates;

18 (3) to reduce HIV-related health disparities;

19 (4) to ensure that research to improve adher-
20 ence to HIV care and treatment programs address
21 the unique concerns of women;

22 (5) to integrate HIV/AIDS prevention and care
23 services with mental health and substance use pre-
24 vention and treatment delivery systems;

1 (6) to increase knowledge on the implementa-
2 tion of preexposure prophylaxis (referred to in this
3 section as “PrEP”), including with respect to—

4 (A) who can benefit most from PrEP;

5 (B) how to provide PrEP safely and effi-
6 ciently;

7 (C) how to integrate PrEP with other es-
8 sential prevention methods such as condoms;
9 and

10 (D) how to ensure high levels of adherence;

11 and

12 (7) to increase knowledge of undetectable and
13 untransmittable a person living with HIV who is on
14 antiretroviral therapy and is durably virally sup-
15 pressed (defined as having a consistent viral load of
16 less than <200 copies/ml) cannot sexually transmit
17 HIV.

18 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 such sums as may be necessary for fiscal years 2019
21 through 2023.

22 **SEC. 747. 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 of Health and Human Services, acting through the
2 Deputy Assistant Secretary for Minority Health, may
3 make grants to public health agencies and faith-based or-
4 ganizations to conduct—

5 (1) outreach activities related to HIV/AIDS
6 prevention and testing activities;

7 (2) HIV/AIDS prevention activities; and

8 (3) HIV/AIDS testing activities.

9 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
10 out this section, there are authorized to be appropriated
11 such sums as may be necessary for fiscal years 2019
12 through 2023.

13 **SEC. 748. MINORITY AIDS INITIATIVE.**

14 (a) EXPANDED FUNDING.—The Secretary of Health
15 and Human Services, in collaboration with the Deputy As-
16 sistant Secretary for Minority Health, the Director of the
17 Centers for Disease Control and Prevention, the Adminis-
18 trator of the Health Resources and Services Administra-
19 tion, and the Assistant Secretary for Mental Health and
20 Substance Use, shall provide funds and carry out activities
21 to expand the Minority HIV/AIDS Initiative.

22 (b) USE OF FUNDS.—The additional funds made
23 available under this section may be used, through the Mi-
24 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) men who have sex with men;

15 (2) youth;

16 (3) persons who engage in intravenous drug
17 abuse;

18 (4) women;

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 2019 and such sums

1 as may be necessary for each of fiscal years 2020 through
2 2023.

3 **SEC. 749. HEALTH CARE PROFESSIONALS TREATING INDI-**
4 **VIDUALS WITH HIV/AIDS.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services, acting through the Administrator of the
7 Health Resources and Services Administration, shall ex-
8 pand, intensify, and coordinate workforce initiatives of the
9 Health Resources and Services Administration to increase
10 the capacity of the health workforce focusing primarily on
11 HIV/AIDS to meet the demand for culturally competent
12 care, and may award grants for any of the following:

13 (1) Development of curricula for training pri-
14 mary care providers in HIV/AIDS prevention and
15 care, including routine HIV testing.

16 (2) Support to expand access to culturally and
17 linguistically accessible benefits counselors, trained
18 peer navigators, and mental and behavioral health
19 professionals with expertise in HIV/AIDS.

20 (3) Training health care professionals to pro-
21 vide care to individuals with HIV/AIDS.

22 (4) Development by grant recipients under title
23 XXVI of the Public Health Service Act (42 U.S.C.
24 300ff–11 et seq.; commonly referred to as the “Ryan
25 White HIV/AIDS Program”) and other persons, of

1 policies for providing culturally relevant and sen-
2 sitive treatment to individuals with HIV/AIDS, with
3 particular emphasis on treatment to racial and eth-
4 nic minorities, men who have sex with men, and
5 women, young people, and children with HIV/AIDS.

6 (5) Development and implementation of pro-
7 grams to increase the use of telehealth to respond to
8 HIV/AIDS-specific health care needs in rural and
9 minority communities, with particular emphasis
10 given to medically underserved communities and in-
11 sular areas.

12 (6) Evaluating interdisciplinary medical pro-
13 vider care team models that promote high-quality
14 care, with particular emphasis on care to racial and
15 ethnic minorities.

16 (7) Training health care professionals to make
17 them aware of the high rates of chronic hepatitis B
18 and chronic hepatitis C in adult racial and ethnic
19 populations, and the importance of prevention, de-
20 tection, and medical management of hepatitis B and
21 hepatitis C and of liver cancer screening.

22 (8) Development of curricula for training pri-
23 mary care providers that HIV/AIDS and tuber-
24 culosis are significant mutual comorbidities, and
25 that a patient who tests positive for one disease

1 should be offered and encouraged to receive testing
2 for the other.

3 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there are authorized to be appropriated
5 such sums as may be necessary for fiscal years 2019
6 through 2023.

7 **SEC. 750. HIV/AIDS PROVIDER LOAN REPAYMENT PRO-**
8 **GRAM.**

9 (a) IN GENERAL.—The Secretary may enter into an
10 agreement with any physician, nurse practitioner, or phy-
11 sician assistant under which—

12 (1) the physician, nurse practitioner, or physi-
13 cian assistant agrees to serve as a medical provider
14 for a period of not less than 2 years—

15 (A) at a Ryan White-funded or title X-
16 funded facility with a critical shortage of doc-
17 tors (as determined by the Secretary); or

18 (B) in an area with a high incidence of
19 HIV/AIDS; and

20 (2) the Secretary agrees to make payments in
21 accordance with subsection (b) on the professional
22 education loans of the physician, nurse practitioner,
23 or physician assistant.

1 (b) MANNER OF PAYMENTS.—The payments de-
2 scribed in subsection (a) shall be made by the Secretary
3 as follows:

4 (1) Upon completion by the physician, nurse
5 practitioner, or physician assistant for whom the
6 payments are to be made of the first year of the
7 service specified in the agreement entered into with
8 the Secretary under subsection (a), the Secretary
9 shall pay 30 percent of the principal of and the in-
10 terest on the individual's professional education
11 loans.

12 (2) Upon completion by the physician, nurse
13 practitioner, or physician assistant of the second
14 year of such service, the Secretary shall pay another
15 30 percent of the principal of and the interest on
16 such loans.

17 (3) Upon completion by that individual of a
18 third year of such service, the Secretary shall pay
19 another 25 percent of the principal of and the inter-
20 est on such loans.

21 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
22 part III of part D of title III of the Public Health Service
23 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent
24 with this section, apply to the program carried out under
25 this section in the same manner and to the same extent

1 as such provisions apply to the National Health Service
2 Corps loan repayment program.

3 (d) REPORTS.—Not later than 18 months after the
4 date of the enactment of this Act, and annually thereafter,
5 the Secretary shall prepare and submit to Congress a re-
6 port describing the program carried out under this section,
7 including statements regarding the following:

8 (1) The number of physicians, nurse practi-
9 tioners, and physician assistants enrolled in the pro-
10 gram.

11 (2) The number and amount of loan repay-
12 ments.

13 (3) The placement location of loan repayment
14 recipients at facilities described in subsection (a)(1).

15 (4) The default rate and actions required.

16 (5) The amount of outstanding default funds.

17 (6) To the extent that it can be determined, the
18 reason for the default.

19 (7) The demographics of individuals partici-
20 pating in the program.

21 (8) An evaluation of the overall costs and bene-
22 fits of the program.

23 (e) DEFINITIONS.—In this section:

1 (1) HIV/AIDS.—The term “HIV/AIDS” means
2 human immunodeficiency virus and acquired im-
3 mune deficiency syndrome.

4 (2) NURSE PRACTITIONER.—The term “nurse
5 practitioner” means a registered nurse who has com-
6 pleted an accredited graduate degree program in ad-
7 vanced nurse practice and has successfully passed a
8 national certification exam.

9 (3) PHYSICIAN.—The term “physician” means
10 a graduate of a school of medicine who has com-
11 pleted postgraduate training in general or pediatric
12 medicine.

13 (4) PHYSICIAN ASSISTANT.—The term “physi-
14 cian assistant” means a medical provider who com-
15 pleted an accredited physician assistant training pro-
16 gram and successfully passed the Physician Assist-
17 ant National Certifying Examination.

18 (5) PROFESSIONAL EDUCATION LOAN.—The
19 term “professional education loan”—

20 (A) means a loan that is incurred for the
21 cost of attendance (including tuition, other rea-
22 sonable educational expenses, and reasonable
23 living costs) at a school of medicine, nursing, or
24 physician assistant training program; and

1 (B) includes only the portion of the loan
2 that is outstanding on the date the physician,
3 nurse practitioner, or physician assistant in-
4 volved begins the service specified in the agree-
5 ment under subsection (a).

6 (6) RYAN WHITE-FUNDED.—The term “Ryan
7 White-funded” means, with respect to a facility, re-
8 ceiving funds under title XXVI of the Public Health
9 Service Act (42 U.S.C. 300ff–11 et seq.).

10 (7) SECRETARY.—The term “Secretary” means
11 the Secretary of Health and Human Services.

12 (8) SCHOOL OF MEDICINE.—The term “school
13 of medicine” has the meaning given to that term in
14 section 799B of the Public Health Service Act (42
15 U.S.C. 295p).

16 (9) TITLE X-FUNDED.—The term “title X-fund-
17 ed” means, with respect to a facility, receiving funds
18 under title X of the Public Health Service Act (42
19 U.S.C. 300 et seq.).

20 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
21 out this section, there are authorized to be appropriated
22 such sums as may be necessary for fiscal years 2019
23 through 2023.

1 **SEC. 751. DENTAL EDUCATION LOAN REPAYMENT PRO-**
2 **GRAM.**

3 (a) **IN GENERAL.**—The Secretary may enter into an
4 agreement with any dentist under which—

5 (1) the dentist agrees to serve as a dentist for
6 a period of not less than 2 years at a facility with
7 a critical shortage of dentists (as determined by the
8 Secretary) in an area with a high incidence of HIV/
9 AIDS; and

10 (2) the Secretary agrees to make payments in
11 accordance with subsection (b) on the dental edu-
12 cation loans of the dentist.

13 (b) **MANNER OF PAYMENTS.**—The payments de-
14 scribed in subsection (a) shall be made by the Secretary
15 as follows:

16 (1) Upon completion by the dentist for whom
17 the payments are to be made of the first year of the
18 service specified in the agreement entered into with
19 the Secretary under subsection (a), the Secretary
20 shall pay 30 percent of the principal of and the in-
21 terest on the dental education loans of the dentist.

22 (2) Upon completion by the dentist of the sec-
23 ond year of such service, the Secretary shall pay an-
24 other 30 percent of the principal of and the interest
25 on such loans.

1 (3) Upon completion by that individual of a
2 third year of such service, the Secretary shall pay
3 another 25 percent of the principal of and the inter-
4 est on such loans.

5 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
6 part III of part D of title III of the Public Health Service
7 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent
8 with this section, apply to the program carried out under
9 this section in the same manner and to the same extent
10 as such provisions apply to the National Health Service
11 Corps Loan Repayment Program.

12 (d) REPORTS.—Not later than 18 months after the
13 date of the enactment of this Act, and annually thereafter,
14 the Secretary shall prepare and submit to the Congress
15 a report describing the program carried out under this sec-
16 tion, including statements regarding the following:

17 (1) The number of dentists enrolled in the pro-
18 gram.

19 (2) The number and amount of loan repay-
20 ments.

21 (3) The placement location of loan repayment
22 recipients at facilities described in subsection (a)(1).

23 (4) The default rate and actions required.

24 (5) The amount of outstanding default funds.

1 (6) To the extent that it can be determined, the
2 reason for the default.

3 (7) The demographics of individuals partici-
4 pating in the program.

5 (8) An evaluation of the overall costs and bene-
6 fits of the program.

7 (e) DEFINITIONS.—In this section:

8 (1) DENTAL EDUCATION LOAN.—The term
9 “dental education loan”—

10 (A) means a loan that is incurred for the
11 cost of attendance (including tuition, other rea-
12 sonable educational expenses, and reasonable
13 living costs) at a school of dentistry; and

14 (B) includes only the portion of the loan
15 that is outstanding on the date the dentist in-
16 volved begins the service specified in the agree-
17 ment under subsection (a).

18 (2) DENTIST.—The term “dentist” means a
19 graduate of a school of dentistry who has completed
20 postgraduate training in general or pediatric den-
21 tistry.

22 (3) HIV/AIDS.—The term “HIV/AIDS” means
23 human immunodeficiency virus and acquired im-
24 mune deficiency syndrome.

1 (4) SCHOOL OF DENTISTRY.—The term “school
2 of dentistry” has the meaning given to that term in
3 section 799B of the Public Health Service Act (42
4 U.S.C. 295p).

5 (5) SECRETARY.—The term “Secretary” means
6 the Secretary of Health and Human Services.

7 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
8 out this section, there are authorized to be appropriated
9 such sums as may be necessary for each of fiscal years
10 2019 through 2023.

11 **SEC. 752. REDUCING NEW HIV INFECTIONS AMONG INJECT-**
12 **ING DRUG USERS.**

13 (a) SENSE OF CONGRESS.—It is the sense of Con-
14 gress that providing sterile syringes and sterilized equip-
15 ment to injecting drug users substantially reduces risk of
16 HIV infection, increases the probability that they will ini-
17 tiate drug treatment, and does not increase drug use.

18 (b) IN GENERAL.—The Secretary of Health and
19 Human Services may provide grants and technical assist-
20 ance for the purpose of reducing the rate of HIV infections
21 among injecting drug users through a comprehensive
22 package of services for such users, including the provision
23 of sterile syringes, education and outreach, access to infec-
24 tious disease testing, overdose prevention, and treatment
25 for drug dependence.

1 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 such sums as may be necessary for fiscal years 2019
4 through 2023.

5 **SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE**
6 **POPULATIONS.**

7 (a) IN GENERAL.—The Secretary shall submit to
8 Congress and the President an annual report on the im-
9 pact of HIV/AIDS for racial and ethnic minority commu-
10 nities, women, and youth aged 24 and younger.

11 (b) CONTENTS.—The report under subsection (a)
12 shall include information on the—

13 (1) progress that has been made in reducing
14 the impact of HIV/AIDS in such communities;

15 (2) opportunities that exist to make additional
16 progress in reducing the impact of HIV/AIDS in
17 such communities;

18 (3) challenges that may impede such additional
19 progress; and

20 (4) Federal funding necessary to achieve sub-
21 stantial reductions in HIV/AIDS in racial and ethnic
22 minority communities.

23 **SEC. 754. NATIONAL HIV/AIDS OBSERVANCE DAYS.**

24 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
25 of Congress that national observance days highlighting the

1 impact of HIV/AIDS on communities of color include the
2 following:

3 (1) National Black HIV/AIDS Awareness Day.

4 (2) National Latino AIDS Awareness Day.

5 (3) National Asian and Pacific Islander HIV/
6 AIDS Awareness Day.

7 (4) National Native American HIV/AIDS
8 Awareness Day.

9 (5) National Youth HIV/AIDS Awareness Day.

10 (b) CALL TO ACTION.—It is the sense of Congress
11 that the President should call on members of communities
12 of color—

13 (1) to become involved at the local community
14 level in HIV/AIDS testing, policy, and advocacy;

15 (2) to become aware, engaged, and empowered
16 on the HIV/AIDS epidemic within their commu-
17 nities; and

18 (3) to urge members of their communities to re-
19 duce risk factors, practice safe sex and other preven-
20 tive measures, be tested for HIV/AIDS, and seek
21 care when appropriate.

1 **SEC. 755. REVIEW OF ALL FEDERAL AND STATE LAWS,**
2 **POLICIES, AND REGULATIONS REGARDING**
3 **THE CRIMINAL PROSECUTION OF INDIVID-**
4 **UALS FOR HIV-RELATED OFFENSES.**

5 (a) DEFINITIONS.—

6 (1) HIV AND HIV/AIDS.—The terms “HIV” and
7 “HIV/AIDS” have the meanings given to such terms
8 in section 2689 of the Public Health Service Act (42
9 U.S.C. 300ff–88).

10 (2) STATE.—The term “State” includes the
11 District of Columbia, American Samoa, the Com-
12 monwealth of the Northern Mariana Islands, Guam,
13 Puerto Rico, and the United States Virgin Islands.

14 (b) SENSE OF CONGRESS REGARDING LAWS OR REG-
15 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV/
16 AIDS.—It is the sense of Congress that Federal and State
17 laws, policies, and regulations regarding people living with
18 HIV/AIDS—

19 (1) should not place unique or additional bur-
20 dens on such individuals solely as a result of their
21 HIV status; and

22 (2) should instead demonstrate a public health-
23 oriented, evidence-based, medically accurate, and
24 contemporary understanding of—

25 (A) the multiple factors that lead to HIV
26 transmission;

1 (B) the relative risk of HIV transmission
2 routes;

3 (C) the current health implications of liv-
4 ing with HIV;

5 (D) the associated benefits of treatment
6 and support services for people living with HIV;
7 and

8 (E) the impact of punitive HIV-specific
9 laws and policies on public health, on people liv-
10 ing with or affected by HIV, and on their fami-
11 lies and communities.

12 (c) REVIEW OF ALL FEDERAL AND STATE LAWS,
13 POLICIES, AND REGULATIONS REGARDING THE CRIMINAL
14 PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OF-
15 FENSES.—

16 (1) REVIEW OF FEDERAL AND STATE LAWS.—

17 (A) IN GENERAL.—Not later than 90 days
18 after the date of the enactment of this Act, the
19 Attorney General, the Secretary of Health and
20 Human Services, and the Secretary of Defense
21 acting jointly (in this paragraph and paragraph
22 (2) referred to as the “designated officials”) shall
23 initiate a national review of Federal and
24 State laws, policies, regulations, and judicial
25 precedents and decisions regarding criminal and

1 related civil commitment cases involving people
2 living with HIV/AIDS, including in regards to
3 the Uniform Code of Military Justice.

4 (B) CONSULTATION.—In carrying out the
5 review under subparagraph (A), the designated
6 officials shall ensure diverse participation and
7 consultation from each State, including with—

8 (i) State attorneys general (or their
9 representatives);

10 (ii) State public health officials (or
11 their representatives);

12 (iii) State judicial and court system
13 officers, including judges, district attor-
14 neys, prosecutors, defense attorneys, law
15 enforcement, and correctional officers;

16 (iv) members of the United States
17 Armed Forces, including members of other
18 Federal services subject to the Uniform
19 Code of Military Justice;

20 (v) people living with HIV/AIDS, par-
21 ticularly those who have been subject to
22 HIV-related prosecution or who are from
23 communities whose members have been
24 disproportionately subject to HIV-specific
25 arrests and prosecutions;

1 (vi) legal advocacy and HIV/AIDS
2 service organizations that work with people
3 living with HIV/AIDS;

4 (vii) nongovernmental health organi-
5 zations that work on behalf of people living
6 with HIV/AIDS; and

7 (viii) trade organizations or associa-
8 tions representing persons or entities de-
9 scribed in clauses (i) through (vii).

10 (C) RELATION TO OTHER REVIEWS.—In
11 carrying out the review under subparagraph
12 (A), the designated officials may utilize other
13 existing reviews of criminal and related civil
14 commitment cases involving people living with
15 HIV/AIDS, including any such review con-
16 ducted by any Federal or State agency or any
17 public health, legal advocacy, or trade organiza-
18 tion or association if the designated officials de-
19 termine that such reviews were conducted in ac-
20 cordance with the principles set forth in sub-
21 section (b).

22 (2) REPORT.—No later than 180 days after ini-
23 tiating the review required by paragraph (1), the At-
24 torney General shall transmit to Congress and make

1 publicly available a report containing the results of
2 the review, which includes the following:

3 (A) For each State and for the Uniform
4 Code of Military Justice, a summary of the rel-
5 evant laws, policies, regulations, and judicial
6 precedents and decisions regarding criminal
7 cases involving people living with HIV/AIDS,
8 including, if applicable, the following:

9 (i) A determination of whether such
10 laws, policies, regulations, and judicial
11 precedents and decisions place any unique
12 or additional burdens upon people living
13 with HIV/AIDS.

14 (ii) A determination of whether such
15 laws, policies, regulations, and judicial
16 precedents and decisions demonstrate a
17 public health-oriented, evidence-based,
18 medically accurate, and contemporary un-
19 derstanding of—

20 (I) the multiple factors that lead
21 to HIV transmission;

22 (II) the relative risk of HIV
23 transmission routes;

24 (III) the current health implica-
25 tions of living with HIV;

1 (IV) the associated benefits of
2 treatment and support services for
3 people living with HIV; and

4 (V) the impact of punitive HIV-
5 specific laws and policies on public
6 health, on people living with or af-
7 fected by HIV, and on their families
8 and communities.

9 (iii) An analysis of the public health
10 and legal implications of such laws, poli-
11 cies, regulations, and judicial precedents,
12 including an analysis of the consequences
13 of having a similar penal scheme applied to
14 comparable situations involving other com-
15 municable diseases.

16 (iv) An analysis of the proportionality
17 of punishments imposed under HIV-spe-
18 cific laws, policies, regulations, and judicial
19 precedents, taking into consideration pen-
20 alties attached to violation of State laws
21 against similar degrees of endangerment or
22 harm, such as driving while intoxicated or
23 transmission of other communicable dis-
24 eases, or more serious harms, such as ve-
25 hicular manslaughter offenses.

1 (B) An analysis of common elements
2 shared among State laws, policies, regulations,
3 and judicial precedents.

4 (C) A set of best practice recommendations
5 directed to State governments, including State
6 attorneys general, public health officials, and
7 judicial officers, in order to ensure that laws,
8 policies, regulations, and judicial precedents re-
9 garding people living with HIV/AIDS are in ac-
10 cordance with the principles set forth in sub-
11 section (b).

12 (D) Recommendations for adjustments to
13 the Uniform Code of Military Justice, as may
14 be necessary, in order to ensure that laws, poli-
15 cies, regulations, and judicial precedents re-
16 garding people living with HIV/AIDS are in ac-
17 cordance with the principles set forth in sub-
18 section (b).

19 (3) GUIDANCE.—Within 90 days of the release
20 of the report required by paragraph (2), the Attor-
21 ney General and the Secretary of Health and
22 Human Services, acting jointly, shall develop and
23 publicly release updated guidance for States based
24 on the set of best practice recommendations required
25 by paragraph (2)(C) in order to assist States dealing

1 with criminal and related civil commitment cases re-
2 garding people living with HIV/AIDS.

3 (4) MONITORING AND EVALUATION SYSTEM.—

4 Within 60 days of the release of the guidance re-
5 quired by paragraph (3), the Attorney General and
6 the Secretary of Health and Human Services, acting
7 jointly, shall establish an integrated monitoring and
8 evaluation system which includes, where appropriate,
9 objective and quantifiable performance goals and in-
10 dicators to measure progress toward statewide im-
11 plementation in each State of the best practice rec-
12 ommendations required in paragraph (2)(C), includ-
13 ing to monitor, track, and evaluate the effectiveness
14 of assistance provided pursuant to subsection (d).

15 (5) ADJUSTMENTS TO FEDERAL LAWS, POLI-
16 CIES, OR REGULATIONS.—

17 Within 90 days of the re-
18 lease of the report required by paragraph (2), the
19 Attorney General, the Secretary of Health and
20 Human Services, and the Secretary of Defense, act-
21 ing jointly, shall develop and transmit to the Presi-
22 dent and the Congress, and make publicly available,
23 such proposals as may be necessary to implement
24 adjustments to Federal laws, policies, or regulations,
25 including to the Uniform Code of Military Justice,
based on the recommendations required by para-

1 graph (2)(D), either through Executive order or
2 through changes to statutory law.

3 (6) AUTHORIZATION OF APPROPRIATIONS.—

4 (A) IN GENERAL.—There are authorized to
5 be appropriated such sums as may be necessary
6 for the purpose of carrying out this subsection.
7 Amounts authorized to be appropriated by the
8 preceding sentence are in addition to amounts
9 otherwise authorized to be appropriated for
10 such purpose.

11 (B) AVAILABILITY OF FUNDS.—Amounts
12 appropriated pursuant to the authorization of
13 appropriations in subparagraph (A) are author-
14 ized to remain available until expended.

15 (d) AUTHORIZATION TO PROVIDE GRANTS.—

16 (1) GRANTS BY ATTORNEY GENERAL.—

17 (A) IN GENERAL.—The Attorney General
18 may provide assistance to eligible State and
19 local entities and eligible nongovernmental orga-
20 nizations for the purpose of incorporating the
21 best practice recommendations developed under
22 subsection (c)(2)(C) within relevant State laws,
23 policies, regulations, and judicial decisions re-
24 garding people living with HIV/AIDS.

1 (B) AUTHORIZED ACTIVITIES.—The assist-
2 ance authorized by subparagraph (A) may in-
3 clude—

4 (i) direct technical assistance to eligi-
5 ble State and local entities in order to de-
6 velop, disseminate, or implement State
7 laws, policies, regulations, or judicial deci-
8 sions that conform with the best practice
9 recommendations developed under sub-
10 section (c)(2)(C);

11 (ii) direct technical assistance to eligi-
12 ble nongovernmental organizations in order
13 to provide education and training, includ-
14 ing through classes, conferences, meetings,
15 and other educational activities, to eligible
16 State and local entities; and

17 (iii) subcontracting authority to allow
18 eligible State and local entities and eligible
19 nongovernmental organizations to seek
20 technical assistance from legal and public
21 health experts with a demonstrated under-
22 standing of the principles underlying the
23 best practice recommendations developed
24 under subsection (c)(2)(C).

1 (2) GRANTS BY SECRETARY OF HEALTH AND
2 HUMAN SERVICES.—

3 (A) IN GENERAL.—The Secretary of
4 Health and Human Services, acting through the
5 Director of the Centers for Disease Control and
6 Prevention, may provide assistance to State and
7 local public health departments and eligible
8 nongovernmental organizations for the purpose
9 of supporting eligible State and local entities to
10 incorporate the best practice recommendations
11 developed under subsection (c)(2)(C) within rel-
12 evant State laws, policies, regulations, and judi-
13 cial decisions regarding people living with HIV/
14 AIDS.

15 (B) AUTHORIZED ACTIVITIES.—The assist-
16 ance authorized by subparagraph (A) may in-
17 clude—

18 (i) direct technical assistance to State
19 and local public health departments in
20 order to support the development, dissemi-
21 nation, or implementation of State laws,
22 policies, regulations, or judicial decisions
23 that conform with the set of best practice
24 recommendations developed under sub-
25 section (c)(2)(C);

1 (ii) direct technical assistance to eligi-
2 ble nongovernmental organizations in order
3 to provide education and training, includ-
4 ing through classes, conferences, meetings,
5 and other educational activities, to State
6 and local public health departments; and

7 (iii) subcontracting authority to allow
8 State and local public health departments
9 and eligible nongovernmental organizations
10 to seek technical assistance from legal and
11 public health experts with a demonstrated
12 understanding of the principles underlying
13 the best practice recommendations devel-
14 oped under subsection (c)(2)(C).

15 (3) LIMITATION.—As a condition of receiving
16 assistance through this subsection, eligible State and
17 local entities, State and local public health depart-
18 ments, and eligible nongovernmental organizations
19 shall agree—

20 (A) not to place any unique or additional
21 burdens on people living with HIV/AIDS solely
22 as a result of their HIV status; and

23 (B) that if the entity, department, or orga-
24 nization promulgates any laws, policies, regula-
25 tions, or judicial decisions regarding people liv-

1 ing with HIV/AIDS, such actions shall dem-
2 onstrate a public health-oriented, evidence-
3 based, medically accurate, and contemporary
4 understanding of—

5 (i) the multiple factors that lead to
6 HIV transmission;

7 (ii) the relative risk of HIV trans-
8 mission routes;

9 (iii) the current health implications of
10 living with HIV;

11 (iv) the associated benefits of treat-
12 ment and support services for people living
13 with HIV; and

14 (v) the impact of punitive HIV-spe-
15 cific laws and policies on public health, on
16 people living with or affected by HIV, and
17 on their families and communities.

18 (4) REPORT.—No later than 1 year after the
19 date of the enactment of this Act, and annually
20 thereafter, the Attorney General and the Secretary
21 of Health and Human Services, acting jointly, shall
22 transmit to Congress and make publicly available a
23 report describing, for each State, the impact and ef-
24 fectiveness of the assistance provided through this
25 Act. Each such report shall include—

1 (A) a detailed description of the progress
2 each State has made, if any, in implementing
3 the best practice recommendations developed
4 under subsection (c)(2)(C) as a result of the as-
5 sistance provided under this subsection, and
6 based on the performance goals and indicators
7 established as part of the monitoring and eval-
8 uation system in subsection (c)(4);

9 (B) a brief summary of any outreach ef-
10 forts undertaken during the prior year by the
11 Attorney General and the Secretary of Health
12 and Human Services to encourage States to
13 seek assistance under this subsection in order
14 to implement the best practice recommenda-
15 tions developed under subsection (c)(2)(C);

16 (C) a summary of how assistance provided
17 through this subsection is being utilized by eli-
18 gible State and local entities, State and local
19 public health departments, and eligible non-
20 governmental organizations and, if applicable,
21 any contractors, including with respect to non-
22 governmental organizations, the type of tech-
23 nical assistance provided, and an evaluation of
24 the impact of such assistance on eligible State
25 and local entities; and

1 (D) a summary and description of eligible
2 State and local entities, State and local public
3 health departments, and eligible nongovern-
4 mental organizations receiving assistance
5 through this subsection, including if applicable,
6 a summary and description of any contractors
7 selected to assist in implementing such assist-
8 ance.

9 (5) DEFINITIONS.—For the purposes of this
10 subsection:

11 (A) ELIGIBLE STATE AND LOCAL ENTI-
12 TIES.—The term “eligible State and local enti-
13 ties” means the relevant individuals, offices, or
14 organizations that directly participate in the de-
15 velopment, dissemination, or implementation of
16 State laws, policies, regulations, or judicial deci-
17 sions, including—

18 (i) State governments, including State
19 attorneys general, State departments of
20 justice, and State National Guards, or
21 their equivalents;

22 (ii) State judicial and court systems,
23 including trial courts, appellate courts,
24 State supreme courts and courts of appeal,

1 and State correctional facilities, or their
2 equivalents; and

3 (iii) local governments, including city
4 and county governments, district attorneys,
5 and local law enforcement departments, or
6 their equivalents.

7 (B) STATE AND LOCAL PUBLIC HEALTH
8 DEPARTMENTS.—The term “State and local
9 public health departments” means the fol-
10 lowing:

11 (i) State public health departments, or
12 their equivalents, including the chief officer
13 of such departments and infectious disease
14 and communicable disease specialists with-
15 in such departments.

16 (ii) Local public health departments,
17 or their equivalents, including city and
18 county public health departments, the chief
19 officer of such departments, and infectious
20 disease and communicable disease special-
21 ists within such departments.

22 (iii) Public health departments or offi-
23 cials, or their equivalents, within State or
24 local correctional facilities.

1 (iv) Public health departments or offi-
2 cials, or their equivalents, within State Na-
3 tional Guards.

4 (v) Any other recognized State or
5 local public health organization or entity
6 charged with carrying out official State or
7 local public health duties.

8 (C) ELIGIBLE NONGOVERNMENTAL ORGA-
9 NIZATIONS.—The term “eligible nongovern-
10 mental organizations” means the following:

11 (i) Nongovernmental organizations,
12 including trade organizations or associa-
13 tions that represent—

14 (I) State attorneys general, or
15 their equivalents;

16 (II) State public health officials,
17 or their equivalents;

18 (III) State judicial and court offi-
19 cers, including judges, district attor-
20 neys, prosecutors, defense attorneys,
21 law enforcement, and correctional offi-
22 cers;

23 (IV) State National Guards;

24 (V) people living with HIV/AIDS;

1 (VI) legal advocacy and HIV/
2 AIDS service organizations that work
3 with people living with HIV/AIDS;
4 and

5 (VII) nongovernmental health or-
6 ganizations that work on behalf of
7 people living with HIV/AIDS.

8 (ii) Nongovernmental organizations,
9 including trade organizations or associa-
10 tions that demonstrate a public-health ori-
11 ented, evidence-based, medically accurate,
12 and contemporary understanding of—

13 (I) the multiple factors that lead
14 to HIV transmission;

15 (II) the relative risk of HIV
16 transmission routes;

17 (III) the current health implica-
18 tions of living with HIV;

19 (IV) the associated benefits of
20 treatment and support services for
21 people living with HIV; and

22 (V) the impact of punitive HIV-
23 specific laws and policies on public
24 health, on people living with or af-

1 fected by HIV, and on their families
2 and communities.

3 (6) AUTHORIZATION OF APPROPRIATIONS.—

4 (A) IN GENERAL.—In addition to amounts
5 otherwise made available, there are authorized
6 to be appropriated to the Attorney General and
7 the Secretary of Health and Human Services
8 such sums as may be necessary to carry out
9 this subsection for each of the fiscal years 2019
10 through 2023.

11 (B) AVAILABILITY OF FUNDS.—Amounts
12 appropriated pursuant to the authorizations of
13 appropriations in subparagraph (A) are author-
14 ized to remain available until expended.

15 **SEC. 756. EXPANDING SUPPORT FOR CONDOMS IN PRIS-**
16 **ONS.**

17 (a) DEFINITIONS.—For the purposes of this section:

18 (1) COMMUNITY ORGANIZATION.—The term
19 “community organization” means a public health
20 care facility or a nonprofit organization which pro-
21 vides health- or STI-related services according to es-
22 tablished public health standards.

23 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
24 The term “comprehensive sexuality education”
25 means sexuality education—

1 (A) that includes information about absti-
2 nence and about the proper use and disposal of
3 sexual barrier protection devices; and

4 (B) which is—

5 (i) evidence-based;

6 (ii) medically accurate;

7 (iii) age and developmentally appro-
8 priate;

9 (iv) gender and identity sensitive;

10 (v) culturally and linguistically appro-
11 priate; and

12 (vi) structured to promote critical
13 thinking, self-esteem, respect for others,
14 and the development of healthy attitudes
15 and relationships.

16 (3) CORRECTIONAL FACILITY.—The term “cor-
17 rectional facility” means any prison, penitentiary,
18 adult detention facility, juvenile detention facility,
19 jail, or other facility to which persons may be sent
20 after conviction of a crime or act of juvenile delin-
21 quency within the United States.

22 (4) INCARCERATED PERSON.—The term “incar-
23 cerated person” means any person who is serving a
24 sentence in a correctional facility after conviction of
25 a crime.

1 (5) SEXUALLY TRANSMITTED INFECTION.—The
2 term “sexually transmitted infection” or “STI”
3 means any disease or infection that is commonly
4 transmitted through sexual activity, including HIV/
5 AIDS, gonorrhea, chlamydia, syphilis, genital her-
6 pes, viral hepatitis, and human papillomavirus.

7 (6) SEXUAL BARRIER PROTECTION DEVICE.—
8 The term “sexual barrier protection device” means
9 any FDA-approved physical device which has not
10 been tampered with and which reduces the prob-
11 ability of STI transmission or infection between sex-
12 ual partners, including female condoms, male
13 condoms, and dental dams.

14 (7) STATE.—The term “State” includes the
15 District of Columbia, American Samoa, the Com-
16 monwealth of the Northern Mariana Islands, Guam,
17 Puerto Rico, and the United States Virgin Islands.

18 (b) AUTHORITY TO ALLOW COMMUNITY ORGANIZA-
19 TIONS TO PROVIDE STI COUNSELING, STI PREVENTION
20 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-
21 VICES IN FEDERAL CORRECTIONAL FACILITIES.—

22 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not
23 later than 30 days after the date of enactment of
24 this Act, the Attorney General shall direct the Direc-
25 tor of the Bureau of Prisons to allow community or-

1 organizations to, in accordance with all relevant Fed-
2 eral laws and regulations which govern visitation in
3 correctional facilities—

4 (A) distribute sexual barrier protection de-
5 vices in Federal correctional facilities; and

6 (B) engage in STI counseling and STI pre-
7 vention education in Federal correctional facili-
8 ties.

9 (2) INFORMATION REQUIREMENT.—Any com-
10 munity organization permitted to distribute sexual
11 barrier protection devices under paragraph (1) shall
12 ensure that the persons to whom the devices are dis-
13 tributed are informed about the proper use and dis-
14 posal of sexual barrier protection devices in accord-
15 ance with established public health practices. Any
16 community organization conducting STI counseling
17 or STI prevention education under paragraph (1)
18 shall offer comprehensive sexuality education.

19 (3) POSSESSION OF DEVICE PROTECTED.—A
20 Federal correctional facility may not, because of the
21 possession or use of a sexual barrier protection de-
22 vice—

23 (A) take adverse action against an incar-
24 cerated person; or

1 (B) consider possession or use as evidence
2 of prohibited activity for the purpose of any
3 Federal correctional facility administrative pro-
4 ceeding.

5 (4) IMPLEMENTATION.—The Attorney General
6 and Bureau of Prisons shall implement this section
7 according to established public health practices in a
8 manner that protects the health, safety, and privacy
9 of incarcerated persons and of correctional facility
10 staff.

11 (c) SENSE OF CONGRESS REGARDING DISTRIBUTION
12 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
13 PRISON SYSTEMS.—It is the sense of the Congress that
14 States should allow for the legal distribution of sexual bar-
15 rier protection devices in State correctional facilities to re-
16 duce the prevalence and spread of STIs in those facilities.

17 (d) SURVEY OF AND REPORT ON CORRECTIONAL FA-
18 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
19 STIs.—

20 (1) SURVEY.—Not later than 180 days after
21 the date of enactment of this Act, and annually
22 thereafter for 5 years, the Attorney General, after
23 consulting with the Secretary of Health and Human
24 Services, State officials, and community organiza-
25 tions, shall, to the maximum extent practicable, con-

1 duct a survey of all Federal and State correctional
2 facilities, to determine the following:

3 (A) COUNSELING, TREATMENT, AND SUP-
4 PORTIVE SERVICES.—Whether the correctional
5 facility—

6 (i) requires incarcerated persons to
7 participate in counseling, treatment, and
8 supportive services related to STIs or

9 (ii) offers such programs to incarcer-
10 ated persons.

11 (B) ACCESS TO SEXUAL BARRIER PROTEC-
12 TION DEVICES.—Whether incarcerated persons
13 can—

14 (i) possess sexual barrier protection
15 devices;

16 (ii) purchase sexual barrier protection
17 devices;

18 (iii) purchase sexual barrier protection
19 devices at a reduced cost; or

20 (iv) obtain sexual barrier protection
21 devices without cost.

22 (C) INCIDENCE OF SEXUAL VIOLENCE.—
23 The incidence of sexual violence and assault
24 committed by incarcerated persons and by cor-
25 rectional facility staff.

1 (D) PREVENTION EDUCATION OFFERED.—

2 The type of prevention education, information,
3 or training offered to incarcerated persons and
4 correctional facility staff regarding sexual vio-
5 lence and the spread of STIs, including whether
6 such education, information, or training—

7 (i) constitutes comprehensive sexuality
8 education;

9 (ii) is compulsory for new incarcerated
10 persons and for new staff; and

11 (iii) is offered on an ongoing basis.

12 (E) STI TESTING.—Whether the correc-
13 tional facility tests incarcerated persons for
14 STIs or gives them the option to undergo such
15 testing—

16 (i) at intake;

17 (ii) on a regular basis; and

18 (iii) prior to release.

19 (F) STI TEST RESULTS.—The number of
20 incarcerated persons who are tested for STIs
21 and the outcome of such tests at each correc-
22 tional facility, disaggregated to include results
23 for—

24 (i) the type of sexually transmitted in-
25 fection tested for;

1 (ii) the race and ethnicity of individ-
2 uals tested;

3 (iii) the age of individuals tested; and

4 (iv) the gender of individuals tested.

5 (G) PRERELEASE 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) PRERELEASE 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 subparagraph (G) 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 HIV, that
5 have been reinstated;

6 (ii) a list of obstacles to reinstating
7 enrollment or to making determinations of
8 eligibility for reinstatement, if any; and

9 (iii) the number of individuals denied
10 enrollment.

11 (J) OTHER ACTIONS TAKEN.—Whether the
12 correctional facility has taken any other action,
13 in conjunction with community organizations or
14 otherwise, to reduce the prevalence and spread
15 of STIs in that facility.

16 (2) PRIVACY.—In conducting the survey under
17 paragraph (1), the Attorney General shall not re-
18 quest or retain the identity of any person who has
19 sought or been offered counseling, treatment, test-
20 ing, or prevention education information regarding
21 an STI (including information about sexual barrier
22 protection devices), or who has tested positive for an
23 STI.

24 (3) REPORT.—

1 (A) IN GENERAL.—The Attorney General
2 shall transmit to Congress and make publicly
3 available the results of the survey required
4 under paragraph (1), both for the United
5 States as a whole and disaggregated as to each
6 State and each correctional facility.

7 (B) DEADLINES.—To the maximum extent
8 possible, the Attorney General shall—

9 (i) issue the first report under sub-
10 paragraph (A) not later than 1 year after
11 the date of enactment of this Act; and

12 (ii) issue reports under subparagraph
13 (A) annually thereafter for 5 years.

14 (e) STRATEGY.—

15 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
16 Attorney General, in consultation with the Secretary
17 of Health and Human Services, State officials, and
18 community organizations, shall develop and imple-
19 ment a 5-year strategy to reduce the prevalence and
20 spread of STIs in Federal and State correctional fa-
21 cilities. To the maximum extent possible, the strat-
22 egy shall be developed, transmitted to Congress, and
23 made publicly available no later than 180 days after
24 the transmission of the first report required under
25 subsection (d)(3).

1 (2) CONTENTS OF STRATEGY.—The strategy
2 developed under paragraph (1) shall include the fol-
3 lowing:

4 (A) PREVENTION EDUCATION.—A plan for
5 improving prevention education, information,
6 and training offered to incarcerated persons
7 and correctional facility staff, including infor-
8 mation and training on sexual violence and the
9 spread of STIs, and comprehensive sexuality
10 education.

11 (B) SEXUAL BARRIER PROTECTION DEVICE
12 ACCESS.—A plan for expanding access to sexual
13 barrier protection devices in correctional facili-
14 ties.

15 (C) SEXUAL VIOLENCE REDUCTION.—A
16 plan for reducing the incidence of sexual vio-
17 lence among incarcerated persons and correc-
18 tional facility staff, developed in consultation
19 with the National Prison Rape Elimination
20 Commission.

21 (D) COUNSELING AND SUPPORTIVE SERV-
22 ICES.—A plan for expanding access to coun-
23 seling and supportive services related to STIs in
24 correctional facilities.

1 (E) TESTING.—A plan for testing incarcerated
2 ated persons for STIs during intake, during
3 regular health exams, and prior to release, and
4 that—

5 (i) is conducted in accordance with
6 guidelines established by the Centers for
7 Disease Control and Prevention;

8 (ii) includes pretest counseling;

9 (iii) requires that incarcerated persons
10 are notified of their option to decline test-
11 ing at any time;

12 (iv) requires that incarcerated persons
13 are confidentially notified of their test re-
14 sults in a timely manner; and

15 (v) ensures that incarcerated persons
16 testing positive for STIs receive post-test
17 counseling, care, treatment, and supportive
18 services.

19 (F) TREATMENT.—A plan for ensuring
20 that correctional facilities have the necessary
21 medicine and equipment to treat and monitor
22 STIs and for ensuring that incarcerated per-
23 sons living with or testing positive for STIs re-
24 ceive and have access to care and treatment
25 services.

1 (G) STRATEGIES FOR DEMOGRAPHIC
2 GROUPS.—A plan for developing and imple-
3 menting culturally appropriate, sensitive, and
4 specific strategies to reduce the spread of STIs
5 among demographic groups heavily impacted by
6 STIs.

7 (H) LINKAGES WITH COMMUNITIES AND
8 FACILITIES.—A plan for establishing and
9 strengthening linkages to local communities and
10 health facilities that—

11 (i) provide counseling, testing, care,
12 and treatment services;

13 (ii) may receive persons recently re-
14 leased from incarceration who are living
15 with STIs; and

16 (iii) accept payment through the State
17 Medicaid program.

18 (I) ENROLLMENT IN STATE MEDICAID
19 PROGRAMS.—Plans to ensure that—

20 (i) incarcerated persons who were en-
21 rolled in their State Medicaid program
22 prior to incarceration in a correctional fa-
23 cility are automatically reenrolled in such
24 program upon their release; and

1 (ii) incarcerated persons who were not
2 enrolled in their State Medicaid program
3 prior to incarceration, and who are diag-
4 nosed with HIV while incarcerated in a
5 correctional facility, are automatically en-
6 rolled in such program upon their release.

7 (J) OTHER PLANS.—Any other plans de-
8 veloped by the Attorney General for reducing
9 the spread of STIs or improving the quality of
10 health care in correctional facilities.

11 (K) MONITORING SYSTEM.—A monitoring
12 system that establishes performance goals re-
13 lated to reducing the prevalence and spread of
14 STIs in correctional facilities and which, where
15 feasible, expresses such goals in quantifiable
16 form.

17 (L) MONITORING SYSTEM PERFORMANCE
18 INDICATORS.—Performance indicators that
19 measure or assess the achievement of the per-
20 formance goals described in subparagraph (K).

21 (M) COST ESTIMATE.—A detailed estimate
22 of the funding necessary to implement the
23 strategy at the Federal and State levels for all
24 5 years, including the amount of funds required

1 by community organizations to implement the
2 parts of the strategy in which they take part.

3 (3) REPORT.—The Attorney General shall
4 transmit to Congress and make publicly available an
5 annual progress report regarding the implementation
6 and effectiveness of the strategy described in para-
7 graph (1). The progress report shall include an eval-
8 uation of the implementation of the strategy using
9 the monitoring system and performance indicators
10 provided for in subparagraphs (K) and (L) of para-
11 graph (2).

12 (f) AUTHORIZATION OF APPROPRIATIONS.—

13 (1) IN GENERAL.—There are authorized to be
14 appropriated such sums as may be necessary to
15 carry out this section for each of fiscal years 2019
16 through 2023.

17 (2) AVAILABILITY OF FUNDS.—Amounts made
18 available under paragraph (1) are authorized to re-
19 main available until expended.

1 **SEC. 757. AUTOMATIC REINSTATEMENT OR ENROLLMENT**
2 **IN MEDICAID FOR PEOPLE WHO TEST POSI-**
3 **TIVE FOR HIV BEFORE REENTERING COMMU-**
4 **NITIES.**

5 (a) IN GENERAL.—Section 1902(e) of the Social Se-
6 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
7 the end the following:

8 “(16) ENROLLMENT OF EX-OFFENDERS.—

9 “(A) AUTOMATIC ENROLLMENT OR REIN-
10 STATEMENT.—

11 “(i) IN GENERAL.—The State plan
12 shall provide for the automatic enrollment
13 or reinstatement of enrollment of an eligi-
14 ble individual—

15 “(I) if such individual is sched-
16 uled to be released from a public insti-
17 tution due to the completion of sen-
18 tence, not less than 30 days prior to
19 the scheduled date of the release; and

20 “(II) if such individual is to be
21 released from a public institution on
22 parole or on probation, as soon as
23 possible after the date on which the
24 determination to release such indi-
25 vidual was made, and before the date
26 such individual is released.

1 “(ii) EXCEPTION.—If a State makes a
2 determination that an individual is not eli-
3 gible to be enrolled under the State plan—

4 “(I) on or before the date by
5 which the individual would be enrolled
6 under clause (i), such clause shall not
7 apply to such individual; or

8 “(II) after such date, the State
9 may terminate the enrollment of such
10 individual.

11 “(B) RELATIONSHIP OF ENROLLMENT TO
12 PAYMENT FOR SERVICES.—

13 “(i) IN GENERAL.—Subject to sub-
14 paragraph (A)(ii), an eligible individual
15 who is enrolled, or whose enrollment is re-
16 instated, under subparagraph (A) shall be
17 eligible for all services for which medical
18 assistance is provided under the State plan
19 after the date that the eligible individual is
20 released from the public institution.

21 “(ii) RELATIONSHIP TO PAYMENT
22 PROHIBITION FOR INMATES.—No provision
23 of this paragraph may be construed to per-
24 mit payment for care or services for which
25 payment is excluded under subdivision (A)

1 following paragraph (29) of section
2 1905(a).

3 “(C) TREATMENT OF CONTINUOUS ELIGI-
4 BILITY.—

5 “(i) SUSPENSION FOR INMATES.—Any
6 period of continuous eligibility under this
7 title shall be suspended on the date an in-
8 dividual enrolled under this title becomes
9 an inmate of a public institution (except as
10 a patient of a medical institution).

11 “(ii) DETERMINATION OF REMAINING
12 PERIOD.—Notwithstanding any changes to
13 State law related to continuous eligibility
14 during the time that an individual is an in-
15 mate of a public institution (except as a
16 patient of a medical institution), subject to
17 clause (iii), with respect to an eligible indi-
18 vidual who was subject to a suspension
19 under clause (i), on the date that such in-
20 dividual is released from a public institu-
21 tion the suspension of continuous eligibility
22 under such clause shall be lifted for a pe-
23 riod that is equal to the time remaining in
24 the period of continuous eligibility for such

1 individual on the date that such period was
2 suspended under such clause.

3 “(iii) EXCEPTION.—If a State makes
4 a determination that an individual is not
5 eligible to be enrolled under the State
6 plan—

7 “(I) on or before the date that
8 the suspension of continuous eligibility
9 is lifted under clause (ii), such clause
10 shall not apply to such individual; or

11 “(II) after such date, the State
12 may terminate the enrollment of such
13 individual.

14 “(D) AUTOMATIC ENROLLMENT OR REIN-
15 STATEMENT OF ENROLLMENT DEFINED.—For
16 purposes of this paragraph, the term ‘automatic
17 enrollment or reinstatement of enrollment’
18 means that the State determines eligibility for
19 medical assistance under the State plan without
20 a program application from, or on behalf of, the
21 eligible individual, but an individual can only be
22 automatically enrolled in the State Medicaid
23 plan if the individual affirmatively consents to
24 being enrolled through affirmation in writing,
25 by telephone, orally, through electronic signa-

1 ture, or through any other means specified by
2 the Secretary.

3 “(E) ELIGIBLE INDIVIDUAL DEFINED.—
4 For purposes of this paragraph, the term ‘eligi-
5 ble individual’ means an individual who is an
6 inmate of a public institution (except as a pa-
7 tient in a medical institution)—

8 “(i) who was enrolled under the State
9 plan for medical assistance immediately be-
10 fore becoming an inmate of such an insti-
11 tution; or

12 “(ii) who is diagnosed with human im-
13 munodeficiency virus.”.

14 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
15 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
16 ICAID BENEFITS.—

17 (1) IN GENERAL.—Subject to paragraphs (3),
18 with respect to a State, for each of the first 4 cal-
19 endar quarters in which the State plan meets the re-
20 quirements of paragraph (16) of section 1902(e) of
21 the Social Security Act (42 U.S.C. 1396a(e)) (as
22 added by subsection (a)), the Federal matching pay-
23 ments (including payments based on the Federal
24 medical assistance percentage) made to such State
25 under section 1903 of the Social Security Act (42

1 U.S.C. 1396b) for the State expenditures described
2 in paragraph (2) shall be increased by 5 percentage
3 points.

4 (2) EXPENDITURES.—The expenditures de-
5 scribed in this paragraph are the following:

6 (A) Expenditures for which payment is
7 available under section 1903 of the Social Secu-
8 rity Act (42 U.S.C. 1396b) and which are at-
9 tributable to strengthening the State’s enroll-
10 ment and administrative resources for the pur-
11 pose of improving processes for enrolling (or re-
12 instating the enrollment of) eligible individuals
13 (as such term is defined in subparagraph (E) of
14 paragraph (16) of section 1902(e) of the Social
15 Security Act (42 U.S.C. 1396a(e)) (as amended
16 by subsection (a)).

17 (B) Expenditures for medical assistance
18 (as such term is defined in section 1905(a) of
19 the Social Security Act (42 U.S.C. 1396d(a)))
20 provided to such eligible individuals.

21 (3) REQUIREMENTS; LIMITATION.—

22 (A) REPORT.—A State is not eligible for
23 an increase in its Federal matching payments
24 under paragraph (1) unless the State agrees to
25 submit to the Secretary of Health and Human

1 Services, and make publicly available, a report
2 that contains the information required under
3 paragraph (4) by the end of the 1-year period
4 during which the State receives increased Fed-
5 eral matching payments in accordance with that
6 paragraph.

7 (B) MAINTENANCE OF ELIGIBILITY.—

8 (i) IN GENERAL.—Subject to clause
9 (ii), a State is not eligible for an increase
10 in its Federal matching payments under
11 paragraph (1) if eligibility standards,
12 methodologies, or procedures under its
13 State plan under title XIX of the Social
14 Security Act (42 U.S.C. 1396 et seq.), or
15 waiver of such a plan, are more restrictive
16 than the eligibility standards, methodolo-
17 gies, or procedures, respectively, under
18 such plan or waiver as in effect on the date
19 of enactment of this Act.

20 (ii) STATE REINSTATEMENT OF ELIGI-
21 BILITY PERMITTED.—A State that has re-
22 stricted eligibility standards, methodolo-
23 gies, or procedures under its State plan
24 under title XIX of the Social Security Act
25 (42 U.S.C. 1396 et seq.), or a waiver of

1 such plan, after the date of enactment of
2 this Act, is no longer ineligible under
3 clause (i) beginning with the first calendar
4 quarter in which the State has reinstated
5 eligibility standards, methodologies, or pro-
6 cedures that are no more restrictive than
7 the eligibility standards, methodologies, or
8 procedures, respectively, under such plan
9 (or waiver) as in effect on such date.

10 (C) LIMITATION OF MATCHING PAYMENTS
11 TO 100 PERCENT.—In no case shall an increase
12 in Federal matching payments under paragraph
13 (1) result in Federal matching payments that
14 exceed 100 percent of State expenditures.

15 (4) REQUIRED REPORT INFORMATION.—The in-
16 formation that is required in the report under para-
17 graph (3)(A) shall include—

18 (A) the results of an evaluation of the im-
19 pact of the implementation of the requirements
20 of paragraph (16) of section 1902(e) of the So-
21 cial Security Act (42 U.S.C. 1396a(e)) on im-
22 proving the State’s processes for enrolling indi-
23 viduals who are released from public institu-
24 tions under the State Medicaid plan;

1 (B) the number of individuals who were
2 automatically enrolled (or whose enrollment was
3 reinstated) under such paragraph during the 1-
4 year period during which the State received in-
5 creased payments under this subsection; and

6 (C) any other information that is required
7 by the Secretary of Health and Human Serv-
8 ices.

9 (c) EFFECTIVE DATE.—

10 (1) IN GENERAL.—Except as provided in para-
11 graph (2), the amendments made by subsection (a)
12 shall take effect 180 days after the date of the en-
13 actment of this Act.

14 (2) RULE FOR CHANGES REQUIRING STATE
15 LEGISLATION.—In the case of a State plan for med-
16 ical assistance under title XIX of the Social Security
17 Act (42 U.S.C. 1396 et seq.) which the Secretary of
18 Health and Human Services determines requires
19 State legislation (other than legislation appro-
20 priating funds) in order for the plan to meet the ad-
21 ditional requirement imposed by the amendments
22 made by subsection (a), the State plan shall not be
23 regarded as failing to comply with the requirements
24 of such title solely on the basis of its failure to meet
25 this additional requirement before the first day of

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

8 **SEC. 758. STOP AIDS IN PRISON.**

9 (a) **SHORT TITLE.**—This section may be cited as the
10 “Stop AIDS in Prison Act”.

11 (b) **IN GENERAL.**—The Director of the Bureau of
12 Prisons (referred to in this section as the “Director”) shall
13 develop a comprehensive policy to provide HIV testing,
14 treatment, and prevention for inmates within the correc-
15 tional setting and upon reentry.

16 (c) **PURPOSE.**—The purposes of the policy required
17 to be developed under subsection (b) shall be as follows:

18 (1) To stop the spread of HIV/AIDS among in-
19 mates.

20 (2) To protect prison guards and other per-
21 sonnel from HIV/AIDS infection.

22 (3) To provide comprehensive medical treat-
23 ment to inmates who are living with HIV/AIDS.

24 (4) To promote HIV/AIDS awareness and pre-
25 vention among inmates.

1 (5) To encourage inmates to take personal re-
2 sponsibility for their health.

3 (6) To reduce the risk that inmates will trans-
4 mit HIV/AIDS to other persons in the community
5 following their release from prison.

6 (d) CONSULTATION.—The Director shall consult with
7 appropriate officials of the Department of Health and
8 Human Services, the Office of National Drug Control Pol-
9 icy, the Office of National AIDS Policy, and the Centers
10 for Disease Control and Prevention regarding the develop-
11 ment of the policy required under subsection (b).

12 (e) TIME LIMIT.—Not later than 1 year after the
13 date of enactment of this Act, the Director shall draft ap-
14 propriate regulations to implement the policy required to
15 be developed under subsection (b).

16 (f) REQUIREMENTS FOR POLICY.—The policy re-
17 quired to be developed under subsection (b) shall provide
18 for the following:

19 (1) TESTING AND COUNSELING UPON IN-
20 TAKE.—

21 (A) Health care personnel shall provide
22 routine HIV testing to all inmates as a part of
23 a comprehensive medical examination imme-
24 diately following admission to a facility. Health
25 care personnel need not provide routine HIV

1 testing to an inmate who is transferred to a fa-
2 cility from another facility if the inmate's med-
3 ical records are transferred with the inmate and
4 indicate that the inmate has been tested pre-
5 viously.

6 (B) To all inmates admitted to a facility
7 prior to the effective date of this policy, health
8 care personnel shall provide routine HIV testing
9 within no more than 6 months. HIV testing for
10 these inmates may be performed in conjunction
11 with other health services provided to these in-
12 mates by health care personnel.

13 (C) All HIV tests under this paragraph
14 shall comply with the opt-out provision.

15 (2) PRE-TEST AND POST-TEST COUNSELING.—

16 Health care personnel shall provide confidential pre-
17 test and post-test counseling to all inmates who are
18 tested for HIV. Counseling may be included with
19 other general health counseling provided to inmates
20 by health care personnel.

21 (3) HIV/AIDS PREVENTION EDUCATION.—

22 (A) Health care personnel shall improve
23 HIV/AIDS awareness through frequent edu-
24 cational programs for all inmates. HIV/AIDS
25 educational programs may be provided by com-

1 community-based organizations, local health depart-
2 ments, and inmate peer educators.

3 (B) HIV/AIDS educational materials shall
4 be made available to all inmates at orientation,
5 at health care clinics, at regular educational
6 programs, and prior to release. Both written
7 and audiovisual materials shall be made avail-
8 able to all inmates.

9 (C)(i) The HIV/AIDS educational pro-
10 grams and materials under this paragraph shall
11 include information on—

12 (I) modes of transmission, including
13 transmission through tattooing, sexual con-
14 tact, and intravenous drug use;

15 (II) prevention methods;

16 (III) treatment; and

17 (IV) disease progression.

18 (ii) The programs and materials shall be
19 culturally sensitive, written or designed for low-
20 literacy levels, available in a variety of lan-
21 guages, and present scientifically accurate in-
22 formation in a clear and understandable man-
23 ner.

24 (4) HIV TESTING UPON REQUEST.—

1 (A) Health care personnel shall allow in-
2 mates to obtain HIV tests upon request once
3 per year or whenever an inmate has a reason to
4 believe the inmate may have been exposed to
5 HIV. Health care personnel shall, both orally
6 and in writing, inform inmates, during orienta-
7 tion and periodically throughout incarceration,
8 of their right to obtain HIV tests.

9 (B) Health care personnel shall encourage
10 inmates to request HIV tests if the inmate is
11 sexually active, has been raped, uses intra-
12 venous drugs, receives a tattoo, or if the inmate
13 is concerned that the inmate may have been ex-
14 posed to HIV/AIDS.

15 (C) An inmate's request for an HIV test
16 shall not be considered an indication that the
17 inmate has put him/herself at risk of infection
18 and/or committed a violation of prison rules.

19 (5) HIV TESTING OF PREGNANT WOMAN.—

20 (A) Health care personnel shall provide
21 routine HIV testing to all inmates who become
22 pregnant.

23 (B) All HIV tests under this paragraph
24 shall comply with the opt-out provision.

25 (6) COMPREHENSIVE TREATMENT.—

1 (A) Health care personnel shall provide all
2 inmates who test positive for HIV—

3 (i) timely, comprehensive medical
4 treatment;

5 (ii) confidential counseling on man-
6 aging their medical condition and pre-
7 venting its transmission to other persons;
8 and

9 (iii) voluntary partner notification
10 services.

11 (B) Health care provided under this para-
12 graph shall be consistent with current Depart-
13 ment of Health and Human Services guidelines
14 and standard medical practice. Health care per-
15 sonnel shall discuss treatment options, the im-
16 portance of adherence to antiretroviral therapy,
17 and the side effects of medications with inmates
18 receiving treatment.

19 (C) Health care personnel and pharmacy
20 personnel shall ensure that the facility for-
21 mulary contains all Food and Drug Administra-
22 tion-approved medications necessary to provide
23 comprehensive treatment for inmates living with
24 HIV/AIDS, and that the facility maintains ade-
25 quate supplies of such medications to meet in-

1 mates' medical needs. Health care personnel
2 and pharmacy personnel shall also develop and
3 implement automatic renewal systems for these
4 medications to prevent interruptions in care.

5 (D) Correctional staff, health care per-
6 sonnel, and pharmacy personnel shall develop
7 and implement distribution procedures to en-
8 sure timely and confidential access to medica-
9 tions.

10 (7) PROTECTION OF CONFIDENTIALITY.—

11 (A) Health care personnel shall develop
12 and implement procedures to ensure the con-
13 fidentiality of inmate tests, diagnoses, and
14 treatment. Health care personnel and correc-
15 tional staff shall receive regular training on the
16 implementation of these procedures. Penalties
17 for violations of inmate confidentiality by health
18 care personnel or correctional staff shall be
19 specified and strictly enforced.

20 (B) HIV testing, counseling, and treat-
21 ment shall be provided in a confidential setting
22 where other routine health services are provided
23 and in a manner that allows the inmate to re-
24 quest and obtain these services as routine med-
25 ical services.

1 (8) TESTING, COUNSELING, AND REFERRAL
2 PRIOR TO REENTRY.—

3 (A) Health care personnel shall provide
4 routine HIV testing to all inmates not earlier
5 than 3 months prior to their release and re-
6 entry into the community. Inmates who are al-
7 ready known to be infected need not be tested
8 again. This requirement may be waived if an in-
9 mate's release occurs without sufficient notice
10 to the Bureau to allow health care personnel to
11 perform a routine HIV test and notify the in-
12 mate of the results.

13 (B) All HIV tests under this paragraph
14 shall comply with the opt-out provision.

15 (C) To all inmates who test positive for
16 HIV and all inmates who already are known to
17 have HIV/AIDS, health care personnel shall
18 provide—

19 (i) confidential prerelease counseling
20 on managing their medical condition in the
21 community, accessing appropriate treat-
22 ment and services in the community, and
23 preventing the transmission of their condi-
24 tion to family members and other persons
25 in the community;

1 (ii) referrals to appropriate health
2 care providers and social service agencies
3 in the community that meet the inmate's
4 individual needs, including voluntary part-
5 ner notification services and prevention
6 counseling services for people living with
7 HIV/AIDS; and

8 (iii) a 30-day supply of any medically
9 necessary medications the inmate is cur-
10 rently receiving.

11 (9) OPT-OUT PROVISION.—Inmates shall have
12 the right to refuse routine HIV testing. Inmates
13 shall be informed both orally and in writing of this
14 right. Oral and written disclosure of this right may
15 be included with other general health information
16 and counseling provided to inmates by health care
17 personnel. If an inmate refuses a routine test for
18 HIV, health care personnel shall make a note of the
19 inmate's refusal in the inmate's confidential medical
20 records. However, the inmate's refusal shall not be
21 considered a violation of prison rules or result in dis-
22 ciplinary action. Any reference in this section to the
23 "opt-out provision" shall be deemed a reference to
24 the requirement of this paragraph.

1 (10) EXCLUSION OF TESTS PERFORMED UNDER
2 SECTION 4014(b) FROM THE DEFINITION OF ROU-
3 TINE HIV TESTING.—HIV testing of an inmate
4 under section 4014(b) of title 18, United States
5 Code, is not routine HIV testing for the purposes of
6 the opt-out provision. Health care personnel shall
7 document the reason for testing under section
8 4014(b) of title 18, United States Code, in the in-
9 mate’s confidential medical records.

10 (11) TIMELY NOTIFICATION OF TEST RE-
11 SULTS.—Health care personnel shall provide timely
12 notification to inmates of the results of HIV tests.

13 (g) CHANGES IN EXISTING LAW.—

14 (1) SCREENING IN GENERAL.—Section 4014(a)
15 of title 18, United States Code, is amended—

16 (A) by striking “for a period of 6 months
17 or more”;

18 (B) by striking “, as appropriate,”; and

19 (C) by striking “if such individual is deter-
20 mined to be at risk for infection with such virus
21 in accordance with the guidelines issued by the
22 Bureau of Prisons relating to infectious disease
23 management” and inserting “unless the indi-
24 vidual declines. The Attorney General shall also

1 cause such individual to be so tested before re-
2 lease unless the individual declines.”.

3 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
4 CIVIL AND CRIMINAL PROCEEDINGS.—Section
5 4014(d) of title 18, United States Code, is amended
6 by inserting “or under the Stop AIDS in Prison
7 Act” after “under this section”.

8 (3) SCREENING AS PART OF ROUTINE SCREEN-
9 ING.—Section 4014(e) of title 18, United States
10 Code, is amended by adding at the end the fol-
11 lowing: “Such rules shall also provide that the initial
12 test under this section be performed as part of the
13 routine health screening conducted at intake.”.

14 (h) REPORTING REQUIREMENTS.—

15 (1) REPORT ON HEPATITIS, LIVER, AND OTHER
16 DISEASES.—Not later than 1 year after the date of
17 enactment of this Act, the Director shall provide a
18 report to the Congress on the policies and proce-
19 dures of the Bureau of Prisons to provide testing,
20 treatment, and prevention education programs for
21 hepatitis, liver failure, and other liver-related dis-
22 eases transmitted through sexual activity, intra-
23 venous drug use, or other means. The Director shall
24 consult with appropriate officials of the Department
25 of Health and Human Services, the Office of Na-

1 tional Drug Control Policy, the Office of National
2 AIDS Policy, and the Centers for Disease Control
3 and Prevention regarding the development of this re-
4 port.

5 (2) ANNUAL REPORTS.—

6 (A) GENERALLY.—Not later than 2 years
7 after the date of enactment of this Act, and
8 then annually thereafter, the Director shall re-
9 port to Congress on the incidence among in-
10 mates of diseases transmitted through sexual
11 activity and intravenous drug use.

12 (B) MATTERS PERTAINING TO VARIOUS
13 DISEASES.—Each report under paragraph (1)
14 shall discuss—

15 (i) the incidence among inmates of
16 HIV/AIDS, hepatitis, and other diseases
17 transmitted through sexual activity and in-
18 travenous drug use; and

19 (ii) updates on the testing, treatment,
20 and prevention education programs for
21 these diseases conducted by the Bureau of
22 Prisons.

23 (C) MATTERS PERTAINING TO HIV/AIDS
24 ONLY.—Each report under paragraph (1) 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 Director 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 each report under paragraph (1).

22 **SEC. 759. SUPPORT DATA SYSTEM REVIEW AND INDICA-**
23 **TORS FOR MONITORING HIV CARE.**

24 The Secretary of Health and Human Services, in col-
25 laboration with the Assistant Secretary for Health, the Di-

1 rector of the Office of HIV/AIDS and Infectious Disease
2 Policy, the Director of the Centers for Disease Control and
3 Prevention, the Assistant Secretary for Mental Health and
4 Substance Use, the Director of the Department of Hous-
5 ing and Urban Development, the Director of the Office
6 of AIDS Research, the Administrator of the Health Re-
7 sources and Services Administration, and the Adminis-
8 trator of the Centers for Medicare & Medicaid Services,
9 shall expand and coordinate efforts to align metrics across
10 agencies and modify Federal data systems, to—

11 (1) adopt the National Academy of Medicine’s
12 clinical HIV care indicators as the core metrics for
13 monitoring the quality of HIV care, mental health,
14 substance abuse, and supportive services;

15 (2) better enable assessment of the impact of
16 the National HIV/AIDS Strategy and the Patient
17 Protection and Affordable Care Act (Public Law
18 111–148) on improving HIV/AIDS care and access
19 to supportive services for individuals with HIV;

20 (3) expand the demographic data elements to be
21 captured by Federal data systems relevant to HIV
22 care to permit calculation of the indicators for sub-
23 groups of the population of people with diagnosed
24 HIV infection, including—

25 (A) age;

- 1 (B) race;
- 2 (C) ethnicity;
- 3 (D) sex (assigned at birth);
- 4 (E) gender identity;
- 5 (F) sexual orientation;
- 6 (G) current geographic marker of resi-
- 7 dence;
- 8 (H) income or poverty level; and
- 9 (I) primary means of reimbursement for
- 10 medical services (including a State Medicaid
- 11 program, the Medicare program, the Ryan
- 12 White HIV/AIDS Program, private insurance,
- 13 health maintenance organizations, and no cov-
- 14 erage); and
- 15 (4) streamline data collection and systematically
- 16 review all existing reporting requirements for feder-
- 17 ally funded HIV/AIDS programs to ensure that only
- 18 essential data are collected.

19 **SEC. 760. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**

20 **NATIONAL HIV/AIDS STRATEGY.**

21 Title II of the Public Health Service Act (42 U.S.C.

22 202 et seq.) is amended by inserting after section 241 the

23 following:

1 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
2 **OF NATIONAL HIV/AIDS STRATEGY.**

3 “(a) **TRANSFER AUTHORIZATION.**—Of the discre-
4 tionary appropriations made available to the Department
5 of Health and Human Services for any fiscal year for pro-
6 grams and activities that, as determined by the Secretary,
7 pertain to HIV/AIDS, the Secretary, in coordination with
8 the Director of the Office of National HIV/AIDS Policy,
9 may transfer up to 1 percent of such appropriations to
10 the Office of the Assistant Secretary for Health for imple-
11 mentation of the National HIV/AIDS Strategy.

12 “(b) **CONGRESSIONAL NOTIFICATION.**—Not less than
13 30 days before making any transfer under this section,
14 the Secretary shall give notice of the transfer to the Con-
15 gress.

16 “(c) **DEFINITIONS.**—In this section:

17 “(1) **HIV/AIDS.**—The term ‘HIV/AIDS’ has
18 the meaning given to such term in section 2689.

19 “(2) **NATIONAL HIV/AIDS STRATEGY.**—The
20 term ‘National HIV/AIDS Strategy’ means the Na-
21 tional HIV/AIDS Strategy for the United States
22 issued by the President in July 2010 and includes
23 any subsequent revisions to such Strategy.”.

1 **SEC. 761. REPORT ON THE IMPLEMENTATION OF GOAL 4**
2 **(IMPROVED COORDINATION) OF THE NA-**
3 **TIONAL HIV/AIDS STRATEGY.**

4 (a) **REPORT REQUIRED.**—The President, in consulta-
5 tion with the heads of all relevant Federal departments
6 and agencies including the Department of Education, the
7 Department of Health and Human Services, the Depart-
8 ment of Housing and Urban Development, the Depart-
9 ment of Justice, the Department of Labor, the Depart-
10 ment of Veteran Affairs, and the Social Security Adminis-
11 tration, shall transmit to Congress and make publicly
12 available a report on the status of implementation of Goal
13 4 of the National HIV/AIDS Strategy.

14 (b) **CONTENTS.**—The report required by subsection
15 (a) shall include a description, an analysis, and an evalua-
16 tion of—

17 (1) the extent to which the National HIV/AIDS
18 Strategy has improved coordination of efforts, en-
19 hanced capacity, and strengthened infrastructure in
20 order to maximize the effective delivery of HIV/
21 AIDS prevention, care, and treatment services at the
22 community level, including coordination—

23 (A) within and among Federal agencies
24 and departments;

1 (B) between the Federal Government and
2 State and local governments and health depart-
3 ments;

4 (C) between the Federal Government and
5 nonprofit foundations and civil society organiza-
6 tions, including community- and faith-based or-
7 ganizations focused on addressing the issue of
8 HIV/AIDS; and

9 (D) between the Federal Government and
10 private businesses; and

11 (2) efforts by the Federal Government to edu-
12 cate, involve, and establish and strengthen partner-
13 ships with civil society organizations, including
14 community- and faith-based organizations, in order
15 to implement the National HIV/AIDS Strategy and
16 achieve its goals.

17 (c) DEFINITION.—In this section, the term “National
18 HIV/AIDS Strategy” means the National HIV/AIDS
19 Strategy for the United States issued by the President in
20 July 2010, the revision to such Strategy issued in July
21 2015, and any subsequent revisions to such Strategy.

Subtitle F—Diabetes

SEC. 771. RESEARCH, TREATMENT, AND EDUCATION.

Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) is amended by adding at the end the following new section:

“SEC. 434B. DIABETES IN MINORITY POPULATIONS.

“(a) IN GENERAL.—The Director of NIH shall expand, intensify, and support ongoing research and other activities with respect to prediabetes and diabetes, particularly type 2, in minority populations.

“(b) RESEARCH.—

“(1) DESCRIPTION.—Research under subsection (a) shall include investigation into—

“(A) the causes of diabetes, including socioeconomic, geographic, clinical, environmental, genetic, and other factors that may contribute to increased rates of diabetes in minority populations; and

“(B) the causes of increased incidence of diabetes complications in minority populations, and possible interventions to decrease such incidence.

“(2) INCLUSION OF MINORITY PARTICIPANTS.—

In conducting and supporting research described in subsection (a), the Director of NIH shall seek to in-

1 include minority participants as study subjects in clin-
2 ical trials.

3 “(c) REPORT; COMPREHENSIVE PLAN.—

4 “(1) IN GENERAL.—The Diabetes Mellitus
5 Interagency Coordinating Committee shall—

6 “(A) prepare and submit to the Congress,
7 not later than 6 months after the date of enact-
8 ment of this section, a report on Federal re-
9 search and public health activities with respect
10 to prediabetes and diabetes in minority popu-
11 lations; and

12 “(B) develop and submit to Congress, not
13 later than 1 year after the date of enactment of
14 this section, an effective and comprehensive
15 Federal plan (including all appropriate Federal
16 health programs) to address prediabetes and di-
17 abetes in minority populations.

18 “(2) CONTENTS.—The report under paragraph
19 (1)(A) shall at minimum address each of the fol-
20 lowing:

21 “(A) Research on diabetes and prediabetes
22 in minority populations, including such research
23 on—

24 “(i) genetic, behavioral, and environ-
25 mental factors; and

1 “(ii) prevention and complications
2 among individuals within these populations
3 who have already developed diabetes.

4 “(B) Surveillance and data collection on
5 diabetes and prediabetes in minority popu-
6 lations, including with respect to—

7 “(i) efforts to better determine the
8 prevalence of diabetes among Asian-Amer-
9 ican and Pacific Islander subgroups; and

10 “(ii) efforts to coordinate data collec-
11 tion on the American Indian population.

12 “(C) Community-based interventions to ad-
13 dress diabetes and prediabetes targeting minor-
14 ity populations, including—

15 “(i) the evidence base for such inter-
16 ventions;

17 “(ii) the cultural appropriateness of
18 such interventions; and

19 “(iii) efforts to educate the public on
20 the causes and consequences of diabetes.

21 “(D) Education and training programs for
22 health professionals (including community
23 health workers) on the prevention and manage-
24 ment of diabetes and its related complications
25 that is supported by the Health Resources and

1 Services Administration, including such pro-
2 grams supported by—

3 “(i) the National Health Service
4 Corps; or

5 “(ii) the community health centers
6 program under section 330.

7 “(d) EDUCATION.—The Director of NIH shall—

8 “(1) through the National Institute on Minority
9 Health and Health Disparities and the National Di-
10 abetes Education Program—

11 “(A) make grants to programs funded
12 under section 464z-4 for the purpose of estab-
13 lishing a mentoring program for health care
14 professionals to be more involved in weight
15 counseling, obesity research, and nutrition; and

16 “(B) provide for the participation of mi-
17 nority health professionals in diabetes-focused
18 research programs; and

19 “(2) make grants for programs to establish a
20 pipeline from high school to professional school that
21 will increase minority representation in diabetes-fo-
22 cused health fields by expanding Minority Access to
23 Research Careers program internships and men-
24 toring opportunities for recruitment.

25 “(e) DEFINITIONS.—For purposes of this section:

1 “(1) DIABETES MELLITUS INTERAGENCY CO-
2 ORDINATING COMMITTEE.—The ‘Diabetes Mellitus
3 Interagency Coordinating Committee’ means the Di-
4 abetes Mellitus Interagency Coordinating Committee
5 established under section 429.

6 “(2) MINORITY POPULATION.—The term ‘mi-
7 nority population’ means a racial and ethnic minor-
8 ity group, as defined in section 1707.”.

9 **SEC. 772. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

10 Part B of title III of the Public Health Service Act
11 (42 U.S.C. 243 et seq.), as amended by section 721, is
12 further amended by inserting after section 317X the fol-
13 lowing section:

14 **“SEC. 317Y. DIABETES IN MINORITY POPULATIONS.**

15 “(a) RESEARCH AND OTHER ACTIVITIES.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Director of the Centers for Disease
18 Control and Prevention, shall conduct and support
19 research and public health activities with respect to
20 diabetes in minority populations.

21 “(2) CERTAIN ACTIVITIES.—Activities under
22 paragraph (1) regarding diabetes in minority popu-
23 lations shall include the following:

24 “(A) Further enhancing the National
25 Health and Nutrition Examination Survey by

1 oversampling Asian American, Native Hawai-
2 ian, and Pacific Islanders in appropriate geo-
3 graphic areas to better determine the preva-
4 lence of diabetes in such populations as well as
5 to improve the data collection of diabetes pene-
6 tration disaggregated into major ethnic groups
7 within such populations. The Secretary shall en-
8 sure that any such oversampling does not re-
9 duce the oversampling of other minority popu-
10 lations including African-American and Latino
11 populations.

12 “(B) Through the Division of Diabetes
13 Translation—

14 “(i) providing for prevention research
15 to better understand how to influence
16 health care systems changes to improve
17 quality of care being delivered to such pop-
18 ulations;

19 “(ii) carrying out model demonstra-
20 tion projects to design, implement, and
21 evaluate effective diabetes prevention and
22 control interventions for minority popu-
23 lations, including culturally appropriate
24 community-based interventions;

1 “(iii) developing and implementing a
2 strategic plan to reduce diabetes in minor-
3 ity populations through applied research to
4 reduce disparities and culturally and lin-
5 guistically appropriate community-based
6 interventions;

7 “(iv) supporting, through the national
8 diabetes prevention program under section
9 399V–3, diabetes prevention program sites
10 in underserved regions highly impacted by
11 diabetes; and

12 “(v) implementing, through the na-
13 tional diabetes prevention program under
14 section 399V–3, a demonstration program
15 developing new metrics measuring health
16 outcomes related to diabetes that can be
17 stratified by specific minority populations.

18 “(b) EDUCATION.—The Secretary, acting through
19 the Director of the Centers for Disease Control and Pre-
20 vention, shall direct the Division of Diabetes Translation
21 to conduct and support both programs to educate the pub-
22 lic on diabetes in minority populations and programs to
23 educate minority populations about the causes and effects
24 of diabetes.

1 “(c) **DIABETES; HEALTH PROMOTION, PREVENTION**
2 **ACTIVITIES, AND ACCESS.**—The Secretary, acting through
3 the Director of the Centers for Disease Control and Pre-
4 vention and the National Diabetes Education Program,
5 shall conduct and support programs to educate specific
6 minority populations through culturally appropriate and
7 linguistically appropriate information campaigns about
8 prevention of, and managing, diabetes.

9 “(d) **DEFINITION.**—For purposes of this section, the
10 term ‘minority population’ means a racial and ethnic mi-
11 nority group, as defined in section 1707.”.

12 **SEC. 773. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

13 Part P of title III of the Public Health Service Act
14 (42 U.S.C. 280g et seq.), as amended by section 733, is
15 further amended by adding at the end the following new
16 section:

17 **“SEC. 399V-9. PROGRAMS TO EDUCATE HEALTH PRO-**
18 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
19 **ABETES IN MINORITY POPULATIONS.**

20 “(a) **IN GENERAL.**—The Secretary, acting through
21 the Director of the Health Resources and Services Admin-
22 istration, shall conduct and support programs described
23 in subsection (b) to educate health professionals on the
24 causes and effects of diabetes in minority populations.

1 “(b) PROGRAMS.—Programs described in this sub-
2 section, with respect to education on diabetes in minority
3 populations, shall include the following:

4 “(1) Giving priority, under the primary care
5 training and enhancement program under section
6 747—

7 “(A) to awarding grants to focus on or ad-
8 dress diabetes; and

9 “(B) to adding minority populations to the
10 list of vulnerable populations that should be
11 served by such grants.

12 “(2) Providing additional funds for the Health
13 Careers Opportunity Program, the Centers for Ex-
14 cellence, and the Minority Faculty Fellowship Pro-
15 gram to partner with the Office of Minority Health
16 under section 1707 and the National Institutes of
17 Health to strengthen programs for career opportuni-
18 ties focused on diabetes treatment and care within
19 underserved regions highly impacted by diabetes.

20 “(3) Developing a diabetes focus within, and
21 providing additional funds for, the National Health
22 Service Corps scholarship program—

23 “(A) to place individuals in areas that are
24 disproportionately affected by diabetes and to

1 provide diabetes treatment and care in such
2 areas; and

3 “(B) to provide such individuals continuing
4 medical education specific to diabetes care.”.

5 **SEC. 774. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

6 Part P of title III of the Public Health Service Act
7 (42 U.S.C. 280g et seq.), as amended by section 773, is
8 further amended by adding at the end the following sec-
9 tion:

10 **“SEC. 399V-10. RESEARCH, EDUCATION, AND OTHER ACTIVI-**

11 **TIES REGARDING DIABETES IN AMERICAN IN-**

12 **DIAN POPULATIONS.**

13 “In addition to activities under sections 399V-6 and
14 434B, the Secretary, acting through the Indian Health
15 Service and in collaboration with other appropriate Fed-
16 eral agencies, shall—

17 “(1) conduct and support research and other
18 activities with respect to diabetes; and

19 “(2) coordinate the collection of data on clini-
20 cally and culturally appropriate diabetes treatment,
21 care, prevention, and services by health care profes-
22 sionals to the American Indian population.”.

1 **SEC. 775. UPDATED REPORT ON HEALTH DISPARITIES.**

2 The Secretary of Health and Human Services shall
3 seek to enter into an arrangement with the National Acad-
4 emy of Medicine under which the National Academy will—

5 (1) not later than 1 year after the date of en-
6 actment of this Act, submit to Congress an updated
7 version of the 2002 report entitled “Unequal Treat-
8 ment: Confronting Racial and Ethnic Disparities in
9 Health Care”; and

10 (2) in such updated version, address how racial
11 and ethnic health disparities have changed since the
12 publication of the original report.

13 **Subtitle G—Lung Disease**

14 **SEC. 776. EXPANSION OF THE NATIONAL ASTHMA EDU-
15 CATION AND PREVENTION PROGRAM.**

16 (a) FINDINGS.—Congress finds as follows:

17 (1) The prevalence of asthma has increased
18 since 1980 and affects more than 26,000,000 people
19 in the United States.

20 (2) Significant disparities in asthma morbidity
21 and mortality exist for both adults and children par-
22 ticularly for low-income and minority populations,
23 particularly African Americans and Puerto Ricans.

24 (3) African-American children are twice as like-
25 ly to have asthma as White children.

1 (4) In 2016, almost 4,500,000 non-Hispanic
2 African Americans reported having asthma. African
3 Americans with asthma are 3 times as likely to visit
4 the emergency department and twice as likely to get
5 hospitalized as White patients with asthma.

6 (5) Puerto Ricans are 3.4 times as likely to die
7 from asthma compared with all other Hispanic or
8 Latino groups. Overall Hispanic Americans are 30
9 percent more likely to be hospitalized for asthma
10 than non-Hispanic Whites.

11 (6) The majority of adults with asthma are
12 women.

13 (b) IN GENERAL.—Not later than 2 years after the
14 date of the enactment of this Act, the Secretary of Health
15 and Human Services shall convene a working group com-
16 prised of patient groups, nonprofit organizations, medical
17 societies, and other relevant governmental and nongovern-
18 mental entities, including those that participate in the Na-
19 tional Asthma Education and Prevention Program, to de-
20 velop a report to Congress that—

21 (1) catalogs, with respect to asthma prevention,
22 management, and surveillance—

23 (A) the activities of the Federal Govern-
24 ment, including identifying all Federal pro-
25 grams that carry out asthma-related activities,

1 as well as assessment of the progress of the
2 Federal Government and States, with respect to
3 achieving the goals of Healthy People 2020;
4 and

5 (B) the activities of other entities that par-
6 ticipate in the program, including nonprofit or-
7 ganizations, patient advocacy groups, and med-
8 ical societies; and

9 (2) makes recommendations for the future di-
10 rection of asthma activities, in consultation with re-
11 searchers from the National Institutes of Health and
12 other member bodies of the National Asthma Edu-
13 cation and Prevention Program who are qualified to
14 review and analyze data and evaluate interventions,
15 including—

16 (A) a description of how the Federal Gov-
17 ernment may better coordinate and improve its
18 response to asthma including identifying any
19 barriers that may exist;

20 (B) a description of how the Federal Gov-
21 ernment may continue, expand, and improve its
22 private-public partnerships with respect to asth-
23 ma including identifying any barriers that may
24 exist;

1 (C) identification of steps that may be
2 taken to reduce the—

3 (i) morbidity, mortality, and overall
4 prevalence of asthma;

5 (ii) financial burden of asthma on so-
6 ciety;

7 (iii) burden of asthma on dispropor-
8 tionately affected areas, particularly those
9 in medically underserved populations (as
10 defined in section 330(b)(3) of the Public
11 Health Service Act (42 U.S.C.
12 254b(b)(3))); and

13 (iv) burden of asthma as a chronic
14 disease;

15 (D) identification of programs and policies
16 that have achieved the steps described in sub-
17 paragraph (C), and steps that may be taken to
18 expand such programs and policies to benefit
19 larger populations; and

20 (E) recommendations for future research
21 and interventions.

22 (c) REPORT TO CONGRESS.—At the end of the 5-year
23 period following the submission of the report under this
24 section, the National Asthma Education and Prevention
25 Program shall evaluate the analyses and recommendations

1 under such report and determine whether a new report
2 to the Congress is necessary, and make appropriate rec-
3 ommendations to the Congress.

4 **SEC. 777. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
5 **FOR DISEASE CONTROL AND PREVENTION.**

6 Section 317I of the Public Health Service Act (42
7 U.S.C. 247b–10) is amended to read as follows:

8 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
9 **FOR DISEASE CONTROL AND PREVENTION.**

10 “(a) PROGRAM FOR PROVIDING INFORMATION AND
11 EDUCATION TO THE PUBLIC.—The Secretary, acting
12 through the Director of the Centers for Disease Control
13 and Prevention, shall collaborate with State and local
14 health departments to conduct activities, including the
15 provision of information and education to the public re-
16 garding asthma including—

17 “(1) deterring the harmful consequences of un-
18 controlled asthma; and

19 “(2) disseminating health education and infor-
20 mation regarding prevention of asthma episodes and
21 strategies for managing asthma.

22 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—
23 The Secretary, acting through the Director of the Centers
24 for Disease Control and Prevention, shall collaborate with
25 State and local health departments to develop State plans

1 incorporating public health responses to reduce the burden
2 of asthma, particularly regarding disproportionately af-
3 fected populations.

4 “(c) COMPILATION OF DATA.—The Secretary, acting
5 through the Director of the Centers for Disease Control
6 and Prevention, shall, in cooperation with State and local
7 public health officials—

8 “(1) conduct asthma surveillance activities to
9 collect data on the prevalence and severity of asth-
10 ma, the effectiveness of public health asthma inter-
11 ventions, and the quality of asthma management, in-
12 cluding—

13 “(A) collection of household data on the
14 local burden of asthma;

15 “(B) surveillance of health care facilities;
16 and

17 “(C) collection of data not containing indi-
18 vidually identifiable information from electronic
19 health records or other electronic communica-
20 tions;

21 “(2) compile and annually publish data regard-
22 ing the prevalence and incidence of childhood asth-
23 ma, the child mortality rate, and the number of hos-
24 pital admissions and emergency department visits by
25 children associated with asthma nationally and in

1 each State and at the county level by age, sex, race,
2 and ethnicity, as well as lifetime and current preva-
3 lence; and

4 “(3) compile and annually publish data regard-
5 ing the prevalence and incidence of adult asthma,
6 the adult mortality rate, and the number of hospital
7 admissions and emergency department visits by
8 adults associated with asthma nationally and in each
9 State and at the county level by age, sex, race, eth-
10 nicity, industry, and occupation, as well as lifetime
11 and current prevalence.

12 “(d) COORDINATION OF DATA COLLECTION.—The
13 Director of the Centers for Disease Control and Preven-
14 tion, in conjunction with State and local health depart-
15 ments, shall coordinate data collection activities under
16 subsection (c)(2) so as to maximize comparability of re-
17 sults.

18 “(e) COLLABORATION.—The Centers for Disease
19 Control and Prevention are encouraged to collaborate with
20 national, State, and local nonprofit organizations to pro-
21 vide information and education about asthma, and to
22 strengthen such collaborations when possible.

23 “(f) ADDITIONAL FUNDING.—In addition to any
24 other authorization of appropriations that is available to
25 the Centers for Disease Control and Prevention for the

1 purpose of carrying out this section, there are authorized
2 to be appropriated to such Centers such sums as may be
3 necessary for each of fiscal years 2019 through 2023 for
4 the purpose of carrying out this section.”.

5 **SEC. 778. INFLUENZA AND PNEUMONIA VACCINATION CAM-**
6 **PAIGN.**

7 (a) IN GENERAL.—The Secretary of Health and
8 Human Services shall—

9 (1) enhance the annual campaign by the De-
10 partment of Health and Human Services to increase
11 the number of people vaccinated each year for influ-
12 enza and pneumonia; and

13 (2) include in such campaign the use of written
14 educational materials, public service announcements,
15 physician education, and any other means which the
16 Secretary deems effective.

17 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
18 out the annual campaign described in subsection (a), the
19 Secretary of Health and Human Services shall ensure
20 that—

21 (1) educational materials and public service an-
22 nouncements are readily and widely available in
23 communities experiencing disparities in the incidence
24 and mortality rates of influenza and pneumonia; and

1 (4) It is estimated that over 13,500,000 adults
2 in the United States have COPD.

3 (5) COPD is the third-leading cause of death in
4 the United States, claiming over 134,000 lives in
5 2010.

6 (6) Since 2000, deaths for women with COPD
7 have exceeded deaths in men.

8 (7) Although African Americans have a lower
9 prevalence of COPD in the United States, research-
10 ers have shown that African Americans may be
11 underdiagnosed. Furthermore, research has shown
12 that African Americans develop COPD with less cu-
13 mulative smoke exposure and at a younger age.

14 (b) IN GENERAL.—The Director of the Centers for
15 Disease Control and Prevention shall conduct, support,
16 and expand public health strategies, prevention, diagnosis,
17 surveillance, and public and professional awareness activi-
18 ties regarding chronic obstructive pulmonary disease.

19 (c) NATIONAL ACTION PLAN.—

20 (1) DEVELOPMENT.—Not later than 2 years
21 after the date of the enactment of this Act, the Di-
22 rector of the National Heart, Lung, and Blood Insti-
23 tute, in consultation with the Director of the Centers
24 for Disease Control and Prevention, shall develop a
25 national action plan to address chronic obstructive

1 pulmonary disease in the United States with partici-
2 pation from patients, caregivers, health profes-
3 sionals, patient advocacy organizations, researchers,
4 providers, public health professionals, and other
5 stakeholders.

6 (2) CONTENTS.—At a minimum, such plan
7 shall include recommendations for—

8 (A) public health interventions for the pur-
9 pose of implementation of the national plan;

10 (B) biomedical, health services, and public
11 health research on chronic obstructive pul-
12 monary disease; and

13 (C) inclusion of chronic obstructive pul-
14 monary disease in the health data collections of
15 all Federal agencies.

16 (3) CONSIDERATION.—In developing such plan,
17 the Director of the National Heart, Lung, and Blood
18 Institute shall consider the recommendations and
19 findings of the National Academy of Medicine in the
20 report entitled “A Nationwide Framework for Sur-
21 veillance of Cardiovascular and Chronic Lung Dis-
22 eases” (July 22, 2011).

23 (d) CHRONIC DISEASE PREVENTION PROGRAMS.—
24 The Director of the National Heart, Lung, and Blood In-
25 stitute shall carry out the following:

1 (1) Conduct public education and awareness ac-
2 tivities with patient and professional organizations
3 to stimulate earlier diagnosis and improve patient
4 outcomes from treatment of chronic obstructive pul-
5 monary disease. To the extent known and relevant,
6 such public education and awareness activities shall
7 reflect differences in chronic obstructive pulmonary
8 disease by cause (tobacco, environmental, occupa-
9 tional, biological, and genetic) and include a focus
10 on outreach to undiagnosed and, as appropriate, mi-
11 nority populations.

12 (2) Supplement and expand upon the activities
13 of the National Heart, Lung, and Blood Institute by
14 making grants to nonprofit organizations, State and
15 local jurisdictions, and Indian tribes for the purpose
16 of reducing the burden of chronic obstructive pul-
17 monary disease, especially in disproportionately im-
18 pacted communities, through public health interven-
19 tions and related activities.

20 (3) Coordinate with the Centers for Disease
21 Control and Prevention, the Indian Health Service,
22 the Health Resources and Services Administration,
23 and the Department of Veterans Affairs to develop
24 pilot programs to demonstrate best practices for the

1 diagnosis and management of chronic obstructive
2 pulmonary disease.

3 (4) Develop improved techniques and identify
4 best practices, in coordination with the Secretary of
5 Veterans Affairs, for assisting chronic obstructive
6 pulmonary disease patients to successfully stop
7 smoking, including identification of subpopulations
8 with different needs. Initiatives under this para-
9 graph may include research to determine whether
10 successful smoking cessation strategies are different
11 for chronic obstructive pulmonary disease patients
12 compared to such strategies for patients with other
13 chronic diseases.

14 (e) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
15 PROGRAMS.—The Director of the Centers for Disease
16 Control and Prevention shall—

17 (1) support research into the environmental and
18 occupational causes and biological mechanisms that
19 contribute to chronic obstructive pulmonary disease;
20 and

21 (2) develop and disseminate public health inter-
22 ventions that will lessen the impact of environmental
23 and occupational causes of chronic obstructive pul-
24 monary disease.

1 (f) DATA COLLECTION.—Not later than 180 days
2 after the enactment of this Act, the Director of the Na-
3 tional Heart, Lung, and Blood Institute and the Director
4 of the Centers for Disease Control and Prevention, acting
5 jointly, shall assess the depth and quality of information
6 on chronic obstructive pulmonary disease that is collected
7 in surveys and population studies conducted by the Cen-
8 ters for Disease Control and Prevention, including wheth-
9 er there are additional opportunities for information to be
10 collected in the National Health and Nutrition Examina-
11 tion Survey, the National Health Interview Survey, and
12 the Behavioral Risk Factors Surveillance System surveys.
13 The Director of the National Heart, Lung, and Blood In-
14 stitute shall include the results of such assessment in the
15 national action plan under subsection (c).

16 (g) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2019 through 2023.

20 **Subtitle H—Tuberculosis**

21 **SEC. 781. ELIMINATION OF ALL FORMS OF TUBERCULOSIS.**

22 (a) SHORT TITLE.—This subtitle may be cited as the
23 “End Tuberculosis Act”.

24 (b) FINDINGS.—Congress makes the following find-
25 ings:

1 (1) In the United States, 9,272 people were di-
2 agnosed with tuberculosis (referred to in this section
3 as “TB”) in 2016.

4 (2) Disparities in TB exist and significantly im-
5 pact minority communities in the United States. The
6 Centers for Disease Control and Prevention (re-
7 ferred to in this section as “CDC”) finds that 87
8 percent of people diagnosed with TB in 2016 self-
9 identified as racial and ethnic minorities.

10 (3) African Americans comprised 21 percent of
11 people diagnosed with TB during 2016. The popu-
12 lation-adjusted rate of TB among African Americans
13 is 1.7 times higher than the national total, and 8.2
14 times higher than among Whites.

15 (4) Asian Americans, Native Hawaiians, and
16 other Pacific Islanders comprised 35 percent of peo-
17 ple diagnosed with TB during 2016. The population-
18 adjusted rate of TB among Asian Americans is 6.2
19 times higher than the national total, and 30 times
20 higher than among Whites. The population-adjusted
21 rate of TB among Native Hawaiians and other Pa-
22 cific Islanders is 4.8 times higher than the national
23 total, and 23.2 times higher than among Whites.

24 (5) Hispanics and Latinos comprised 28 per-
25 cent of people diagnosed with TB during 2016. The

1 population-adjusted rate of TB among Hispanics
2 and Latinos is 1.6 times higher than the national
3 total, and 7.5 times higher than among Whites.

4 (6) TB is both preventable and curable, but the
5 current rate of decline of TB in the United States
6 remains too slow to achieve TB elimination in this
7 century.

8 (7) TB is transmitted through the air when a
9 person who has TB disease in their lungs coughs or
10 sneezes. People who are in close proximity to the
11 person with TB can breathe in the TB bacteria, and
12 the bacteria will initially settle in their lungs. With-
13 out proper and timely diagnosis and access to treat-
14 ment, the TB bacteria may grow and spread to
15 other parts of their body.

16 (8) As many as 13,000,000 people in the
17 United States may have latent TB Infection (re-
18 ferred to in this section as “LTBI”). People with
19 LTBI have TB bacteria in their bodies, but their
20 immune system is containing the bacteria, and they
21 are not sick, nor do they have any current risk of
22 spreading TB to others. LTBI can activate into in-
23 fectious, life-threatening TB if not treated. Modeling
24 has shown that eliminating TB is not possible with-
25 out addressing LTBI.

1 (9) Comorbidities associated with TB include
2 cancer, diabetes mellitus, and HIV. People with
3 these medical conditions and compromised immune
4 systems are more likely to develop active TB disease
5 and to have worse outcomes from TB.

6 (10) Forms of active TB that do not show drug
7 resistance are classified as drug-susceptible TB (re-
8 ferred to in this section as “DS-TB”). Drug-resist-
9 ant TB (referred to in this section as “DR-TB”) is
10 a rising threat to the public health of the United
11 States. DR-TB that exhibits resistance to two or
12 more first-line drugs is referred to as multi-drug re-
13 sistant TB (referred to in this section as “MDR-
14 TB”). MDR-TB that also is resistant to at least
15 one injectable second-line medication and at least
16 one fluoroquinolone is classified as extensively drug-
17 resistant TB (referred to in this section as “XDR-
18 TB”).

19 (11) Approximately 78 people in the United
20 States were diagnosed with MDR-TB in 2016. One
21 person was diagnosed with XDR-TB in the same
22 year.

23 (12) In the United States, direct treatment
24 costs average \$17,000 to treat a patient with DS-
25 TB, \$150,000 to treat a patient with MDR-TB, and

1 \$482,000 to treat a patient with XDR-TB. When
2 factoring in productivity losses during treatment,
3 DS-TB averages \$46,000, MDR-TB averages
4 \$294,000 and XDR-TB averages \$694,000. Treat-
5 ment is often difficult, with daily complex multi-pill
6 regimens and injections, with side-effects ranging
7 from hearing and vision loss to mental health issues.

8 (13) Recognizing the public health, economic
9 and societal costs to the threat of MDR-TB, the
10 National Action Plan to Combat MDR-TB was de-
11 veloped by the White House to provide the United
12 States with a comprehensive three-pronged strategy
13 to address MDR-TB by strengthening domestic ca-
14 pacity to combat MDR-TB; improve international
15 capacity and cooperation to combat MDR-TB; accel-
16 erate basic and applied research and development
17 for new therapies, diagnostics and prevention strate-
18 gies to combat MDR-TB.

19 (14) Additional Federal support is necessary to
20 expand TB control efforts in case finding and treat-
21 ment to address LTBI in a national prevention ini-
22 tiative. Key policy and research breakthroughs in-
23 crease the success of a TB prevention initiative: the
24 U.S. Preventative Services Task Force recommenda-
25 tion's "B" rating, screening for LTBI among high-

1 risk adults as a covered service increases the likeli-
 2 hood that impacted racial and ethnic minority
 3 groups can get tested for TB; a new, shorter course
 4 treatment regimen reduces the length of treatment
 5 for LTBI from every day for 6 to 9 months to one
 6 dose per week for 12 weeks, increasing likelihood of
 7 treatment completion; and the use of blood-based di-
 8 agnostic tests, Interferon-gamma release assays or
 9 IGRAs, increases ability to detect LTBI among pa-
 10 tients in affected communities.

11 **SEC. 782. ADDITIONAL FUNDING FOR STATES IN COM-**
 12 **BATING AND ELIMINATING TUBERCULOSIS.**

13 Section 317E(h) of the Public Health Act (42 U.S.C.
 14 247b–6(h)) is amended by adding at the end the following:

15 “(3) ADDITIONAL FUNDING FOR STATES IN
 16 COMBATING AND ELIMINATING TUBERCULOSIS.—In
 17 addition to amounts otherwise authorized to be ap-
 18 propriated to carry out this section, there are au-
 19 thorized to be appropriated such sums as may be
 20 necessary to carry out section 317 for each of fiscal
 21 years 2019 through 2021.”.

22 **SEC. 783. STRENGTHENING CLINICAL RESEARCH FUNDING**
 23 **FOR TUBERCULOSIS.**

24 (a) IN GENERAL.—The Secretary of Health and
 25 Human Services shall expand and intensify support for

1 current and prospective research activities of the National
2 Institutes of Health, the Biomedical Advanced Research
3 and Development Authority, and the Centers for Disease
4 Control and Prevention Division of Tuberculosis Elimination
5 to develop new therapeutics, diagnostics, vaccines,
6 and other prevention modalities in addressing all forms
7 of tuberculosis (referred to in this section as “TB”).

8 (b) INCLUDED RESEARCH ACTIVITIES.—Research
9 activities under subsection (a) shall include—

10 (1) research to develop novel, safe drugs and
11 drug regimens for the treatment of TB, including in
12 adolescent and pediatric populations and in pregnant
13 and lactating women;

14 (2) research to develop rapid diagnostic tests
15 for all forms of TB, including diagnostics that can
16 be used for pediatric populations and people living
17 with HIV, diagnostics that can detect extra pul-
18 monary TB and drug resistance, and diagnostics
19 that can be used at the point of care;

20 (3) research to advance basic knowledge of the
21 pathogenesis of TB and its major comorbidities, in-
22 cluding HIV and diabetes mellitus;

23 (4) research to improve knowledge and under-
24 standings of the role of latency in TB and the fac-

1 tors that increase the risk of latent TB infection
2 progressing to active, symptomatic TB disease;

3 (5) awarding grants and contracts to specifi-
4 cally develop new and needed vaccines to address
5 TB;

6 (6) awarding grants and contracts to support
7 the training and development of clinical researchers
8 whose research improves the landscape of tools to
9 combat TB; and

10 (7) awarding grants and contracts to support
11 capacity-building and develop clinical trial site infra-
12 structure in the United States and in TB endemic
13 countries to support the aforementioned research ac-
14 tivities.

15 **Subtitle I—Osteoarthritis and** 16 **Musculoskeletal Diseases**

17 **SEC. 785. FINDINGS.**

18 Congress finds as follows:

19 (1) Eighty percent of African-American women
20 and nearly 74 percent of Hispanic men are either
21 overweight or obese, speeding the onset and progres-
22 sion of arthritis.

23 (2) Arthritis affects 46,000,000 people in the
24 United States, and that number will rise to
25 67,000,000 by the year 2030.

1 (3) Twenty-seven million people in the United
2 States suffer from osteoarthritis, the most common
3 form of arthritis, making it the leading cause of dis-
4 ability in the United States. Osteoarthritis is some-
5 times referred to as degenerative joint disease.

6 (4) Obesity accelerates the onset of arthritis: 70
7 percent of obese adults with mild osteoarthritis of
8 the knee at age 60 will develop advanced end-stage
9 disease by age 80. In contrast, just 43 percent of
10 non-obese adults will have end-stage disease over the
11 same time period.

12 (5) Arthritis affects 1 in 5 people in the United
13 States and is the single greatest cause of chronic
14 pain and disability in the United States.

15 (6) Women, African Americans, and Hispanics
16 have more severe arthritis and functional limitations.
17 These same individuals are more likely to be obese,
18 diabetic, and have higher incidence of heart dis-
19 ease—medical conditions that can be improved with
20 physical activity. Instead of moving; however, these
21 groups have an inactivity rate of 40 to 50 percent,
22 which continues to increase.

23 (7) Arthritis costs \$128,000,000,000 a year, in-
24 cluding \$81,000,000,000 in direct costs (medical)
25 and \$47,000,000,000 in indirect costs (lost earn-

1 ings). Each year, \$309,000,000,000 in direct and in-
2 direct costs is lost due to disparities in osteoarthritis
3 and musculoskeletal diseases.

4 (8) Obesity and other chronic health conditions
5 exacerbate the debilitating impact of arthritis, lead-
6 ing to inactivity, loss of independence, and a per-
7 petual cycle of comorbid chronic conditions.

8 (9) Sixty-one percent of arthritis sufferers are
9 women, and women represent 64 percent of an esti-
10 mated 43,000,000 annual visits to physicians' offices
11 and outpatient clinics where arthritis was the pri-
12 mary diagnosis. Women also represented 60 percent
13 of approximately 1,000,000 hospitalizations that oc-
14 curred in 2003 for which arthritis was the primary
15 diagnosis.

16 (10) Women ages 65 and older have up to 2½
17 times more disabilities than men of the same age.
18 Higher rates of obesity and arthritis among this
19 group explained up to 48 percent of the gender gap
20 in disability, above all other common chronic health
21 conditions.

22 (11) The primary indication for total knee
23 arthroplasty (referred to in this section as "TKA"),
24 also known as knee replacement, is relief of signifi-
25 cant, disabling pain caused by severe arthritis.

1 (12) Knee replacement is surgery for people
2 with severe knee damage. Knee replacement can re-
3 lieve pain and allow you to be more active. When
4 you have a total knee replacement, the surgeon re-
5 moves damaged cartilage and bone from the surface
6 of your knee joint and replaces them with a man-
7 made surface of metal and plastic. In a partial knee
8 replacement, the surgeon only replaces one part of
9 your knee joint.

10 (13) Total hip replacement, also called total hip
11 arthroplasty (referred to in this section as “THA”),
12 is used if your hip pain interferes with daily activi-
13 ties and more conservative treatments have not
14 helped. Arthritis damage is the most common reason
15 to need hip replacement.

16 (14) The odds of a family practice physician
17 recommending TKA to a male patient with moderate
18 arthritis are twice that of a female patient, while the
19 odds of an orthopaedic surgeon recommending TKA
20 to a male patient with moderate arthritis are 22
21 times that of a female patient.

22 (15) African Americans with doctor-diagnosed
23 arthritis have a higher prevalence of severe pain at-
24 tributable to arthritis, compared with Whites (34.0
25 percent versus 22.6 percent). African Americans,

1 compared to Whites, report a higher proportion of
2 work limitations (39.5 percent versus 28.0 percent)
3 and a higher prevalence of arthritis-attributable
4 work limitation (6.6 percent versus 4.6 percent).

5 (16) Hispanics are 50 percent more likely than
6 non-Hispanic Whites to report needing assistance
7 with at least one instrumental activity of daily living
8 and to have difficulty walking.

9 (17) African Americans and Hispanics were 1.3
10 times more likely to have activity limitation, 1.6
11 times more likely to have work limitations, and 1.9
12 times more likely to have severe joint pain than
13 Whites.

14 (18) In 2003, the National Academy of Medi-
15 cine reported that the rates of TKA and THA
16 among African-American and Hispanic patients are
17 significantly lower than for Whites—even for those
18 with equitable health care coverage such as through
19 Medicare or the Department of Veterans Affairs.

20 (19) According to the Centers for Disease Con-
21 trol and Prevention, in 2000, African-American
22 Medicare enrollees were 37 percent less likely than
23 White Medicare enrollees to undergo total knee re-
24 placements. In 2006, the disparity increased to 39
25 percent.

1 (20) Even after adjusting for insurance and
2 health access, Hispanics and African Americans are
3 almost 50 percent less likely to undergo total knee
4 replacement than Whites.

5 **SEC. 786. OSTEOARTHRITIS AND OTHER MUSCULO-**
6 **SKELETAL HEALTH-RELATED ACTIVITIES OF**
7 **THE CENTERS FOR DISEASE CONTROL AND**
8 **PREVENTION.**

9 (a) EDUCATION AND AWARENESS ACTIVITIES.—The
10 Secretary of Health and Human Services, acting through
11 the Director of the Centers for Disease Control and Pre-
12 vention, shall direct the National Center for Chronic Dis-
13 ease Prevention and Health Promotion to conduct and ex-
14 pand the Health Community Program and Arthritis Pro-
15 gram to educate the public on—

16 (1) the causes of, preventive health actions for,
17 and effects of arthritis and other musculoskeletal
18 conditions in minority patient populations; and

19 (2) the effects of such conditions on other
20 comorbidities including obesity, hypertension, and
21 cardiovascular disease.

22 (b) PROGRAMS ON ARTHRITIS AND MUSCULO-
23 SKELETAL CONDITIONS.—Education and awareness pro-
24 grams of the Centers for Disease Control and Prevention

1 on arthritis and other musculoskeletal conditions in minor-
2 ity communities shall—

3 (1) be culturally and linguistically appropriate
4 to minority patients, targeting musculoskeletal
5 health promotion and prevention programs of each
6 major ethnic group, including—

7 (A) Native Americans and Alaska Natives;

8 (B) Asian Americans;

9 (C) African Americans and Blacks;

10 (D) Hispanic and Latino Americans; and

11 (E) Native Hawaiians and Pacific Island-
12 ers; and

13 (2) include public awareness campaigns directed
14 toward these patient populations that emphasize the
15 importance of musculoskeletal health, physical activ-
16 ity, diet and healthy lifestyle, and weight reduction
17 for overweight and obese patients.

18 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 such sums as are necessary for fiscal year 2019 and each
21 subsequent fiscal year.

1 **SEC. 787. GRANTS FOR COMPREHENSIVE OSTEOARTHRITIS**
2 **AND MUSCULOSKELETAL DISEASE HEALTH**
3 **EDUCATION WITHIN HEALTH PROFESSIONS**
4 **SCHOOLS.**

5 (a) PROGRAM AUTHORIZED.—The Secretary of
6 Health and Human Services (in this section referred to
7 as the “Secretary”), in coordination with the Secretary of
8 Education, shall award grants, on a competitive basis, to
9 academic health science centers, health professions
10 schools, and other institutions of higher education to en-
11 able such institutions to provide people with comprehen-
12 sive education on arthritis and musculoskeletal health,
13 particularly—

- 14 (1) obesity-related musculoskeletal diseases;
15 (2) arthritis and osteoarthritis;
16 (3) arthritis and musculoskeletal health dispari-
17 ties; and
18 (4) the relationship between arthritis and mus-
19 culoskeletal diseases and metabolic activity, psycho-
20 logical health, and comorbidities such as diabetes,
21 cardiovascular disease, and hypertension.

22 (b) DURATION.—Grants awarded under this section
23 shall be for a period of 5 years.

24 (c) APPLICATIONS.—An academic health science cen-
25 ter, health professions school, or other institution of high-
26 er education seeking a grant under this section shall sub-

1 mit an application to the Secretary at such time, in such
2 manner, and containing such information as the Secretary
3 may require.

4 (d) PRIORITY.—In awarding grants under this sec-
5 tion, the Secretary shall give priority to an institution of
6 higher education that—

7 (1) has an enrollment of needy students, as de-
8 fined in section 318(b) of the Higher Education Act
9 of 1965 (20 U.S.C. 1059e(b));

10 (2) is a Hispanic-serving institution, as defined
11 in section 502(a) of such Act (20 U.S.C. 1101a(a));

12 (3) is a Tribal College or University, as defined
13 in section 316(b) of such Act (20 U.S.C. 1059c(b));

14 (4) is an Alaska Native-serving institution, as
15 defined in section 317(b) of such Act (20 U.S.C.
16 1059d(b));

17 (5) is a Native Hawaiian-serving institution, as
18 defined in section 317(b) of such Act (20 U.S.C.
19 1059d(b));

20 (6) is a Predominately Black Institution, as de-
21 fined in section 318(b) of such Act (20 U.S.C.
22 1059e(b));

23 (7) is a Native American-serving, non-Tribal in-
24 stitution, as defined in section 319(b) of such Act
25 (20 U.S.C. 1059f(b));

1 (8) is an Asian-American and Native American
2 Pacific Islander-serving institution, as defined in
3 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

4 (9) is a minority institution, as defined in sec-
5 tion 365 of such Act (20 U.S.C. 1067k), with an en-
6 rollment of needy students, as defined in section 312
7 of such Act (20 U.S.C. 1058).

8 (e) USES OF FUNDS.—An institution of higher edu-
9 cation receiving a grant under this section may use grant
10 funds to integrate issues relating to comprehensive arthri-
11 tis and musculoskeletal health into the academic or sup-
12 port sectors of the institution in order to reach a large
13 number of students, by carrying out 1 or more of the fol-
14 lowing activities:

15 (1) Developing educational content for issues
16 relating to comprehensive arthritis and musculo-
17 skeletal health education that will be incorporated
18 into first-year orientation or core courses.

19 (2) Creating innovative technology-based ap-
20 proaches to deliver arthritis and musculoskeletal
21 health education to students, faculty, and staff.

22 (3) Developing and employing peer-outreach
23 and education programs to generate discussion, edu-
24 cate, and raise awareness among students about
25 issues relating to arthritis and musculoskeletal

1 health disorders, and their relationship to diabetes,
2 hypertension, cardiovascular disease, psychological
3 health, and other comorbid conditions.

4 (f) REPORT TO CONGRESS.—

5 (1) IN GENERAL.—Not later than 1 year after
6 the date of the enactment of this Act, and annually
7 thereafter for a period of 5 years, the Secretary shall
8 prepare and submit to the appropriate committees of
9 Congress a report on the activities to provide health
10 professions students with comprehensive arthritis
11 and musculoskeletal health education funded under
12 this section.

13 (2) REPORT ELEMENTS.—The report described
14 in paragraph (1) shall include information about—

15 (A) the number of entities that are receiv-
16 ing grant funds;

17 (B) the specific activities supported by
18 grant funds;

19 (C) the number of students served by
20 grant programs; and

21 (D) the status of program evaluations.

1 **Subtitle J—Sleep and Circadian** 2 **Rhythm Disorders**

3 **SEC. 791. SHORT TITLE; FINDINGS.**

4 (a) **SHORT TITLE.**—This subtitle may be cited as the
5 “Sleep and Circadian Rhythm Disorders Health Dispari-
6 ties Act”.

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

8 (1) Decrements in sleep health such as sleep
9 apnea, insufficient sleep time, and insomnia, affect
10 50,000,000 to 70,000,000 adults in the United
11 States. Twelve to eighteen million United States
12 adults have sleep apnea, a chronic disorder charac-
13 terized by one or more pauses in breathing which
14 can last from a few seconds to minutes. They may
15 occur 30 times or more an hour, disrupting sleep
16 and resulting in excessive daytime sleepiness and
17 loss in productivity.

18 (2) Seventy percent of high school students are
19 not getting enough sleep on school nights, while 33
20 percent of people in the United States get fewer
21 than 7 hours of sleep per night, and roughly 6,000
22 fatal motor vehicle crashes are caused by drowsy
23 drivers.

24 (3) Insufficient sleep and insomnia are more
25 prevalent in women. Women who are pregnant and

1 have sleep apnea are at an increased risk of cardio-
2 vascular complications during pregnancy. The im-
3 pact of disparities in sleep health is associated with
4 a growing number of health problems, including the
5 following:

6 (A) Hypertension.

7 (B) Cancer.

8 (C) Stroke.

9 (D) Cardiac arrhythmia.

10 (E) Chronic heart failure and heart dis-
11 ease.

12 (F) Diabetes.

13 (G) Cognitive functioning and behavior.

14 (H) Depression and bipolar disorder.

15 (I) Substance abuse.

16 (4) A sleep disparity exists in that poor sleep
17 quality is strongly associated with poverty and race.
18 Factors such as employment, education, and health
19 status, amongst others, significantly mediated this
20 effect only in poor subjects, suggesting a differential
21 vulnerability to these factors in poor relative to
22 nonpoor individuals in the context of sleep quality.

23 (5) African Americans sleep worse than Cauca-
24 sian Americans. African Americans take longer to
25 fall asleep, report poorer sleep quality, have more

1 light and less deep sleep, and nap more often and
2 longer.

3 (6) African Americans and individuals in lower
4 socioeconomic status groups may be at an increased
5 risk for sleep disturbances and associated health
6 consequences.

7 (7) Among young African Americans, the likeli-
8 hood of having sleep disordered breathing and exhib-
9 iting risk factors for poor sleep is twice that in
10 young Caucasians. Frequent snoring is more com-
11 mon among African-American and Hispanic women
12 and Hispanic men compared to non-Hispanic Cauca-
13 sians, independent of other factors including obesity.

14 (8) African Americans with sleep-disordered
15 breathing develop symptoms at a younger age than
16 Caucasians but appear less likely to be diagnosed
17 and treated in a timely manner. This delay may at
18 least in part be due to reduced access to care.

19 (9) Sleep loss contributes to increased risk for
20 chronic conditions such as obesity, diabetes, and hy-
21 pertension, all of which have increased prevalence in
22 underserved, underrepresented minorities. Racial
23 and ethnic disparities related to obesity may also
24 contribute to disparities in health outcomes related
25 to sleep-disordered breathing.

1 (10) Non-Caucasian adults report an insomnia
2 rate of 12.9 percent compared to only 6.6 percent
3 for Caucasians.

4 (11) African-American women have a higher in-
5 cidence of insomnia than African-American men,
6 perhaps related in part to higher risk for chronic
7 persisting symptoms.

8 **SEC. 792. SLEEP AND CIRCADIAN RHYTHM DISORDERS RE-**
9 **SEARCH ACTIVITIES OF THE NATIONAL IN-**
10 **STITUTES OF HEALTH.**

11 (a) IN GENERAL.—The Director of the National In-
12 stitutes of Health, acting through the Director of the Na-
13 tional Heart, Lung, and Blood Institute, shall—

14 (1) continue to expand research activities ad-
15 dressing sleep health disparities; and

16 (2) continue implementation of the NIH Sleep
17 Disorders Research Plan across all institutes and
18 centers of the National Institutes of Health to im-
19 prove treatment and prevention of sleep health dis-
20 parities.

21 (b) REQUIRED RESEARCH ACTIVITIES.—In con-
22 ducting or supporting research relating to sleep and circa-
23 dian rhythm, the Director of the National Heart, Lung,
24 and Blood Institute shall—

1 (1) advance epidemiology and clinical research
2 to achieve a more complete understanding of dispari-
3 ties in domains of sleep health and across population
4 subgroups for which cardiovascular and metabolic
5 health disparities exist, including—

6 (A) prevalence and severity of sleep apnea;

7 (B) habitual sleep duration;

8 (C) sleep timing and regularity; and

9 (D) insomnia;

10 (2) develop study designs and analytical ap-
11 proaches to explain and predict multilevel and life-
12 course determinants of sleep health and to elucidate
13 the sleep-related causes of cardiovascular and meta-
14 bolic health disparities across the age spectrum, in-
15 cluding such determinants and causes that are—

16 (A) environmental;

17 (B) biological or genetic;

18 (C) psychosocial;

19 (D) societal;

20 (E) political; or

21 (F) economic;

22 (3) determine the contribution of sleep impair-
23 ments such as sleep apnea, insufficient sleep dura-
24 tion, irregular sleep schedules, and insomnia to un-

1 explained disparities in cardiovascular and metabolic
2 risk and disease outcomes;

3 (4) develop study designs, data sampling and
4 collection tools, and analytical approaches to opti-
5 mize understanding of mediating and moderating
6 factors, and feedback mechanisms coupling sleep to
7 cardiovascular and metabolic health disparities;

8 (5) advance research to understand cultural
9 and linguistic barriers (on the person, provider, or
10 system level) to access to care, medical diagnosis,
11 and treatment of sleep disorders in diverse popu-
12 lation groups;

13 (6) develop and test multilevel interventions (in-
14 cluding sleep health education in diverse commu-
15 nities) to reduce disparities in sleep health that will
16 impact ability to improve disparities in cardio-
17 vascular and metabolic risk or disease;

18 (7) create opportunities to integrate sleep and
19 health disparity science by strategically utilizing re-
20 sources (existing or anticipated cohorts), exchanging
21 scientific data and ideas (cross-over into scientific
22 meetings), and develop multidisciplinary investi-
23 gator-initiated grant applications; and

1 (8) enhance the diversity and foster career de-
2 velopment of young investigators involved in sleep
3 and health disparities science.

4 (c) **AUTHORIZATION OF APPROPRIATIONS.**—To carry
5 out this section, there are authorized to be appropriated
6 such sums as may be necessary for fiscal year 2019 and
7 each subsequent fiscal year.

8 **SEC. 793. SLEEP AND CIRCADIAN RHYTHM HEALTH DIS-**
9 **PARITIES-RELATED ACTIVITIES OF THE CEN-**
10 **TERS FOR DISEASE CONTROL AND PREVEN-**
11 **TION.**

12 (a) **IN GENERAL.**—The Director of the Centers for
13 Disease Control and Prevention shall conduct, support,
14 and expand public health strategies and prevention, diag-
15 nosis, surveillance, and public and professional awareness
16 activities regarding sleep and circadian rhythm disorders.

17 (b) **FINDINGS.**—Congress finds as follows:

18 (1) Sleep disorders and sleep deficiency unre-
19 lated to a primary sleep disorder are underdiagnosed
20 and are increasingly detrimental to health status.

21 (2) The consequences to society include addi-
22 tional diseases, motor vehicle accidents, decreased
23 longevity, elevated direct medical costs, and indirect
24 costs related to work absenteeism and property dam-
25 age.

1 (c) REQUIRED SURVEILLANCE AND EDUCATION
2 AWARENESS ACTIVITIES.—In conducting or supporting
3 research relating to sleep and circadian rhythm disorders
4 surveillance and education awareness activities, the Direc-
5 tor of the Centers for Disease Control and Prevention
6 shall—

7 (1) ensure that such activities are culturally
8 and linguistically appropriate to minority patients,
9 targeting sleep and circadian rhythm health pro-
10 motion and prevention programs of each major eth-
11 nic group, including—

12 (A) Native Americans and Alaska Natives;

13 (B) Asian Americans;

14 (C) African Americans and Blacks;

15 (D) Hispanic and Latino-Americans; and

16 (E) Native Hawaiians and Pacific Island-
17 ers;

18 (2) collect and compile national and State sur-
19 veillance data on sleep disorders health disparities;

20 (3) continue to develop and implement new
21 sleep questions in public health surveillance systems
22 to increase public awareness of sleep health and
23 sleep disorders and their impact on health;

24 (4) publish monthly reports highlighting geo-
25 graphic, racial, and ethnic disparities in sleep health,

1 as well as relationships between insufficient sleep
2 and chronic disease, health risk behaviors, and other
3 outcomes as determined necessary by the Director;
4 and

5 (5) include public awareness campaigns that in-
6 form patient populations from major ethnic groups
7 about the prevalence of sleep and circadian rhythm
8 disorders and emphasize the importance of sleep
9 health.

10 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
11 out this section, there are authorized to be appropriated
12 such sums as may be necessary for fiscal year 2019 and
13 each subsequent fiscal year.

14 **SEC. 794. GRANTS FOR COMPREHENSIVE SLEEP AND CIR-**
15 **CADIAN HEALTH EDUCATION WITHIN**
16 **HEALTH PROFESSIONS SCHOOLS.**

17 (a) PROGRAM AUTHORIZED.—The Secretary of
18 Health and Human Services (referred to in this section
19 as the “Secretary”), in coordination with the Secretary of
20 Education, shall award grants, on a competitive basis, to
21 academic health science centers, health professions
22 schools, and other institutions of higher education to en-
23 able such institutions to provide people with comprehen-
24 sive education on sleep and circadian health, particu-
25 larly—

- 1 (1) poor sleep health;
- 2 (2) sleep disorders;
- 3 (3) sleep health disparities; and
- 4 (4) the relationship between sleep and circadian
- 5 health on metabolic activity, neurological activity,
- 6 comorbidities, and other diseases.

7 (b) DURATION.—Grants awarded under this section
8 shall be for a period of 5 years.

9 (c) APPLICATIONS.—Any academic health science
10 center, health professions school, or other institutions of
11 higher education seeking a grant under this section shall
12 submit an application to the Secretary at such time, in
13 such manner, and containing such information as the Sec-
14 retary may require.

15 (d) PRIORITY.—In awarding grants under this sec-
16 tion, the Secretary shall give priority to an institution
17 that—

18 (1) has an enrollment of needy students, as de-
19 fined in section 318(b) of the Higher Education Act
20 of 1965 (20 U.S.C. 1059e(b));

21 (2) is a Hispanic-serving institution, as defined
22 in section 502(a) of such Act (20 U.S.C. 1101a(a));

23 (3) is a Tribal College or University, as defined
24 in section 316(b) of such Act (20 U.S.C. 1059c(b));

1 (4) is an Alaska Native-serving institution, as
2 defined in section 317(b) of such Act (20 U.S.C.
3 1059d(b));

4 (5) is a Native Hawaiian-serving institution, as
5 defined in section 317(b) of such Act (20 U.S.C.
6 1059d(b));

7 (6) is a Predominately Black Institution, as de-
8 fined in section 318(b) of such Act (20 U.S.C.
9 1059e(b));

10 (7) is a Native American-serving, nontribal in-
11 stitution, as defined in section 319(b) of such Act
12 (20 U.S.C. 1059f(b));

13 (8) is an Asian-American and Native American
14 Pacific Islander-serving institution, as defined in
15 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

16 (9) is a minority institution, as defined in sec-
17 tion 365 of such Act (20 U.S.C. 1067k), with an en-
18 rollment of needy students, as defined in section 312
19 of such Act (20 U.S.C. 1058).

20 (e) USES OF FUNDS.—An institution of higher edu-
21 cation receiving a grant under this section may use grant
22 funds to integrate issues relating to comprehensive sleep
23 and circadian health into the academic or support sectors
24 of the institution in order to reach a large number of stu-
25 dents, by carrying out 1 or more of the following activities:

1 (1) Developing educational content for issues
2 relating to comprehensive sleep and circadian health
3 education that will be incorporated into first-year
4 orientation or core courses.

5 (2) Creating innovative technology-based ap-
6 proaches to deliver sleep health education to stu-
7 dents, faculty, and staff.

8 (3) Developing and employing peer-outreach
9 and education programs to generate discussion, edu-
10 cate, and raise awareness among students about
11 issues relating to poor quality sleep, sleep and circa-
12 dian disorders, and the role sleep health plays in
13 other diseases and comorbidities.

14 (f) REPORT TO CONGRESS.—

15 (1) IN GENERAL.—Not later than 1 year after
16 the date of the enactment of this Act, and annually
17 thereafter for a period of 5 years, the Secretary shall
18 prepare and submit to the appropriate committees of
19 Congress a report on the activities to provide health
20 professions students with comprehensive sleep and
21 circadian health education funded under this section.

22 (2) REPORT ELEMENTS.—The report described
23 in paragraph (1) shall include information about—

1 (A) the number of eligible entities and in-
2 stitutions of higher education that are receiving
3 grant funds;

4 (B) the specific activities supported by
5 grant funds;

6 (C) the number of students served by
7 grant programs; and

8 (D) the status of program evaluations.

9 **SEC. 795. REPORT ON IMPACT OF SLEEP AND CIRCADIAN**
10 **HEALTH DISORDERS IN VULNERABLE AND**
11 **RACIAL/ETHNIC POPULATIONS.**

12 (a) IN GENERAL.—Not later than 1 year after the
13 date of enactment of this Act, the Secretary of Health and
14 Human Services shall submit to Congress and the Presi-
15 dent a report on the impact of sleep and circadian health
16 disorders for racial and ethnic minority communities and
17 other vulnerable populations.

18 (b) CONTENTS.—The report under subsection (a)
19 shall include information on the—

20 (1) progress that has been made in reducing
21 the impact of sleep and circadian health disorders in
22 such communities and populations;

23 (2) opportunities that exist to make additional
24 progress in reducing the impact of sleep and circa-

1 dian health disorders in such communities and popu-
2 lations;

3 (3) challenges that may impede such additional
4 progress; and

5 (4) Federal funding necessary to achieve sub-
6 stantial reductions in sleep and circadian health dis-
7 orders in racial and ethnic minority communities.

8 **Subtitle K—Sickle Cell Disease Re-**
9 **search, Surveillance, Preven-**
10 **tion, and Treatment**

11 **SEC. 796. SHORT TITLE.**

12 This subtitle may be cited as the “Sickle Cell Disease
13 Research, Surveillance, Prevention, and Treatment Act of
14 2018”.

15 **SEC. 796A. SICKLE CELL DISEASE RESEARCH.**

16 Part P of title III of the Public Health Service Act
17 (42 U.S.C. 280g et seq.), as amended by section 774, is
18 further amended by adding at the end the following:

19 **“SEC. 399V-11. NATIONAL SICKLE CELL DISEASE RE-**
20 **SEARCH, SURVEILLANCE, PREVENTION, AND**
21 **TREATMENT PROGRAM.**

22 “(a) RESEARCH.—The Secretary may conduct or
23 support research to expand the understanding of the cause
24 of, and to find a cure for, sickle cell disease.”.

1 **SEC. 796B. SICKLE CELL DISEASE SURVEILLANCE.**

2 Section 399V–11 of the Public Health Service Act,
3 as added by section 796A, is amended by adding at the
4 end the following:

5 “(b) SURVEILLANCE.—

6 “(1) GRANTS.—The Secretary may, for each
7 fiscal year for which appropriations are available to
8 carry out this subsection, make grants—

9 “(A) to conduct surveillance and maintain
10 data on the prevalence and distribution of sickle
11 cell disease and its associated health outcomes,
12 complications, and treatments;

13 “(B) to conduct public health initiatives
14 with respect to sickle cell disease, including—

15 “(i) increasing efforts to improve ac-
16 cess to, and receipt of, high-quality sickle
17 cell disease-related health care, including
18 the use of treatments approved under sec-
19 tion 505 of the Federal Food, Drug, and
20 Cosmetic Act or licensed under section 351
21 of this Act;

22 “(ii) working with partners to improve
23 health outcomes of people with sickle cell
24 disease over their lifespan by promoting
25 guidelines for sickle cell disease screening,
26 prevention, and treatment, including man-

1 agement of sickle cell disease complica-
2 tions;

3 “(iii) providing support to community-
4 based organizations and State and local
5 health departments in conducting sickle
6 cell disease education and training activi-
7 ties for patients, communities, and health
8 care providers; and

9 “(iv) supporting and training State
10 health departments and regional labora-
11 tories in comprehensive testing to identify
12 specific forms of sickle cell disease in peo-
13 ple of all ages; and

14 “(C) to identify and evaluate promising
15 strategies for prevention and treatment of sickle
16 cell disease complications, including through—

17 “(i) improving estimates of the na-
18 tional incidence and prevalence of sickle
19 cell disease, including estimates about the
20 specific types of sickle cell disease;

21 “(ii) identifying health disparities re-
22 lated to sickle cell disease;

23 “(iii) assessing the utilization of
24 therapies and strategies to prevent com-
25 plications related to sickle cell disease; and

1 “(iv) evaluating the impact of genetic,
2 environmental, behavioral, and other risk
3 factors that may affect sickle cell disease
4 health outcomes.

5 “(2) POPULATION INCLUDED.—The Secretary
6 shall, to the extent practicable, award grants under
7 this subsection to States, academic institutions, or
8 nonprofit organizations across the United States so
9 as to include data on the majority of the United
10 States population with sickle cell disease.

11 “(3) APPLICATION.—To seek a grant under this
12 subsection, a State, academic institution, or non-
13 profit organization shall submit an application to the
14 Secretary at such time, in such manner, and con-
15 taining such information as the Secretary may re-
16 quire.”.

17 **SEC. 796C. SICKLE CELL DISEASE PREVENTION AND**
18 **TREATMENT.**

19 (a) REAUTHORIZATION.—Section 712(c) of the
20 American Jobs Creation Act of 2004 (Public Law 108–
21 357; 42 U.S.C. 300b–1 note) is amended—

22 (1) in paragraph (1)(A), by striking “grants to
23 up to 40 eligible entities for each fiscal year in which
24 the program is conducted under this section for the
25 purpose of developing and establishing systemic

1 mechanisms to improve the prevention and treat-
2 ment of Sickle Cell Disease” and inserting “grants
3 to up to 25 eligible entities for each fiscal year in
4 which the program is conducted under this section
5 for the purpose of developing and establishing sys-
6 temic mechanisms to improve the prevention and
7 treatment of sickle cell disease in populations with
8 a high density of sickle cell disease patients”;

9 (2) by striking “Sickle Cell Disease” each place
10 such term appears and inserting “sickle cell dis-
11 ease”;

12 (3) in paragraph (1)(B)—

13 (A) by striking clause (ii) (relating to pri-
14 ority); and

15 (B) by striking “GRANT AWARD REQUIRE-
16 MENTS” and all that follows through “the ad-
17 ministrator shall” and inserting “GEOGRAPHIC
18 DIVERSITY.—The Administrator shall”;

19 (4) in paragraph (2), by adding the following
20 new subparagraph at the end:

21 “(E) To expand, coordinate, and imple-
22 ment transition services for adolescents with
23 sickle cell disease making the transition to adult
24 health care.”; and

1 (5) in paragraph (6), by striking “\$10,000,000
2 for each of fiscal years 2005 through 2009” and in-
3 serting “\$4,455,000 for each of fiscal years 2019
4 through 2023”.

5 (b) TECHNICAL CHANGES.—Subsection (e) of section
6 712 of the American Jobs Creation Act of 2004 (Public
7 Law 108–357; 42 U.S.C. 300b–1 note), as amended by
8 subsection (a), is—

9 (1) transferred to the Public Health Service Act
10 (42 U.S.C. 201 et seq.); and

11 (2) inserted at the end of section 399V–11 of
12 such Act, as added and amended by sections 796A
13 and 796B.

14 **SEC. 796D. COLLABORATION WITH COMMUNITY-BASED EN-**
15 **TITIES.**

16 Section 399V–11 of the Public Health Service Act,
17 as amended by section 796C, is further amended by add-
18 ing at the end the following:

19 “(d) COLLABORATION WITH COMMUNITY-BASED EN-
20 TITIES.—To be eligible to receive a grant or other assist-
21 ance under subsection (b) or (c), an entity shall have in
22 effect a collaborative agreement with a community-based
23 organization with 5 or more years of experience in pro-
24 viding services to sickle cell disease patients.”.

1 **TITLE VIII—HEALTH**
2 **INFORMATION TECHNOLOGY**

3 **SEC. 800. DEFINITIONS.**

4 In this title:

5 (1) **CERTIFIED ELECTRONIC HEALTH RECORD**
6 **TECHNOLOGY.**—The term “certified EHR tech-
7 nology” has the meaning given such term in section
8 3000 of the Public Health Service Act (42 U.S.C.
9 300jj).

10 (2) **EHR.**—The term “EHR” means an elec-
11 tronic health record.

12 **Subtitle A—Reducing Health**
13 **Disparities Through Health IT**

14 **SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR**
15 **PROMOTION OF HEALTH IT.**

16 The Secretary of Health and Human Services, acting
17 through the Administrator of the Health Resources and
18 Services Administration, shall expand and intensify the
19 programs and activities of the Administration (directly or
20 through grants or contracts) to provide technical assist-
21 ance and resources to health centers (as defined in section
22 330(a) of the Public Health Service Act (42 U.S.C.
23 254b(a))) to adopt and meaningfully use certified EHR
24 technology for the management of chronic diseases and
25 health conditions and reduction of health disparities.

1 **SEC. 802. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**
2 **CIAL AND ETHNIC MINORITY COMMUNITIES;**
3 **OUTREACH AND ADOPTION OF HEALTH IT IN**
4 **SUCH COMMUNITIES.**

5 (a) NATIONAL COORDINATOR FOR HEALTH INFOR-
6 MATION TECHNOLOGY.—

7 (1) IN GENERAL.—The National Coordinator
8 for Health Information Technology (referred to in
9 this section as the “National Coordinator”) shall—

10 (A) conduct an evaluation of the level of
11 use and accessibility of electronic health records
12 in racial and ethnic minority communities, fo-
13 cusing on whether patients in such communities
14 have providers who use electronic health
15 records, and indicating whether such pro-
16 viders—

17 (i) are participating in the Medicare
18 program under title XVIII of the Social
19 Security Act (42 U.S.C. 1395 et seq.) or
20 a State plan under title XIX of such Act
21 (42 U.S.C. 1396 et seq.) (or a waiver of
22 such plan);

23 (ii) have received incentive payments
24 or incentive payment adjustments under
25 Medicare and Medicaid Electronic Health

1 Records Incentive Programs (as defined in
2 subsection (c)(2));

3 (iii) are MIPS eligible professionals,
4 as defined in paragraph (1)(C) of section
5 1848(q) of the Social Security Act (42
6 U.S.C. 1395w-4(q)), for purposes of the
7 Merit-Based Incentive Payment System
8 under such section; or

9 (iv) have been recruited by any of the
10 Health Information Technology Regional
11 Extension Centers established under sec-
12 tion 3012 of the Public Health Service Act
13 (42 U.S.C. 300jj-32); and

14 (2) publish the results of such evaluation in-
15 cluding the race and ethnicity of such providers and
16 the populations served by such providers.

17 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—

18 As soon as practicable after the date of enactment of this
19 Act, the Director of the National Center for Health Statis-
20 tics shall provide to Congress a more detailed analysis of
21 the data presented in National Center for Health Statis-
22 tics data brief entitled “Adoption of Certified Electronic
23 Health Record Systems and Electronic Information Shar-
24 ing in Physician Offices: United States, 2013 and 2014”
25 (NCHS Data Brief No. 236).

1 (c) CENTERS FOR MEDICARE & MEDICAID SERV-
2 ICES.—

3 (1) IN GENERAL.—As part of the process of
4 collecting information, with respect to a provider, at
5 registration and attestation for purposes of Medicare
6 and Medicaid Electronic Health Records Incentive
7 Programs (as defined in paragraph (2)) or the
8 Merit-Based Incentive Payment System under sec-
9 tion 1848(q) of the Social Security Act (42 U.S.C.
10 1395w-4(q)), the Secretary of Health and Human
11 Services shall collect the race and ethnicity of such
12 provider.

13 (2) MEDICARE AND MEDICAID ELECTRONIC
14 HEALTH RECORDS INCENTIVE PROGRAMS DE-
15 FINED.—For purposes of paragraph (1), the term
16 “Medicare and Medicaid Electronic Health Records
17 Incentive Programs” means the incentive programs
18 under section 1814(l)(3), subsections (a)(7) and (o)
19 of section 1848, subsections (l) and (m) of section
20 1853, subsections (b)(3)(B)(ix)(I) and (n) of section
21 1886, and subsections (a)(3)(F) and (t) of section
22 1903 of the Social Security Act (42 U.S.C.
23 1395f(l)(3), 1395w-4, 1395w-23, 1395ww, and
24 1396b).

1 (d) NATIONAL COORDINATOR'S ASSESSMENT OF IM-
2 PACT OF HIT.—Section 3001(e)(6)(C) of the Public
3 Health Service Act (42 U.S.C. 300jj–11(e)(6)(C)) is
4 amended—

5 (1) in the heading by inserting “, RACIAL AND
6 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
7 DISPARITIES”;

8 (2) by inserting “, in communities with a high
9 proportion of individuals from racial and ethnic mi-
10 nority groups (as defined in section 1707(g)), in-
11 cluding people with disabilities in these groups,”
12 after “communities with health disparities”;

13 (3) by striking “The National Coordinator” and
14 inserting the following:

15 “(i) IN GENERAL.—The National Co-
16 ordinator”; and

17 (4) by adding at the end the following:

18 “(ii) CRITERIA.—In any publication
19 under clause (i), the National Coordinator
20 shall include best practices for encouraging
21 partnerships between the Federal Govern-
22 ment, States, and private entities to ex-
23 pand outreach for and the adoption of cer-
24 tified EHR technology in communities with
25 a high proportion of individuals from racial

1 and ethnic minority groups (as so defined),
2 while also maintaining the accessibility re-
3 quirements of section 508 of the Rehabili-
4 tation Act of 1973 to encourage patient in-
5 volvement in patient health care. The Na-
6 tional Coordinator shall—

7 “(I) not later than 6 months
8 after the submission of the report re-
9 quired under section 822 of the
10 Health Equity and Accountability Act
11 of 2018, establish criteria for evalu-
12 ating the impact of health information
13 technology on communities with a
14 high proportion of individuals from
15 racial and ethnic minority groups (as
16 so defined) taking into account the
17 findings in such report; and

18 “(II) not later than 1 year after
19 the submission of such report, conduct
20 and publish the results of an evalua-
21 tion 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), in the matter preceding
10 paragraph (1), by inserting “, including with respect
11 to communities with a high proportion of individuals
12 from racial and ethnic minority groups (as defined
13 in section 1707(g))” before the colon; and

14 (2) by adding at the end the following new sub-
15 section:

16 “(e) ANNUAL REPORT ON EXPENDITURES.—The
17 National Coordinator shall report annually to Congress on
18 activities and expenditures under this section.”.

19 **SEC. 812. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
20 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
21 **TATE ADOPTION OF CERTIFIED EHR TECH-**
22 **NOLOGY BY PROVIDERS SERVING RACIAL**
23 **AND ETHNIC MINORITY GROUPS.**

24 Section 3014(e) of the Public Health Service Act (42
25 U.S.C. 300jj–34(e)) is amended, in the matter preceding

1 paragraph (1), by inserting “, including with respect to
 2 communities with a high proportion of individuals from
 3 racial and ethnic minority groups (as defined in section
 4 1707(g))” after “health care provider to”.

5 **SEC. 813. AUTHORIZATION OF APPROPRIATIONS.**

6 Section 3018 of the Public Health Service Act (42
 7 U.S.C. 300jj–38) is amended by striking “fiscal years
 8 2009 through 2013” and inserting “fiscal years 2019
 9 through 2024”.

10 **Subtitle C—Additional Research**
 11 **and Studies**

12 **SEC. 821. DATA COLLECTION AND ASSESSMENTS CON-**
 13 **DUCTED IN COORDINATION WITH MINORITY-**
 14 **SERVING INSTITUTIONS.**

15 Section 3001(c)(6) of the Public Health Service Act
 16 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
 17 end the following new subparagraph:

18 “(F) DATA COLLECTION AND ASSESS-

19 MENTS CONDUCTED IN COORDINATION WITH

20 MINORITY-SERVING INSTITUTIONS.—

21 “(i) IN GENERAL.—In carrying out

22 subparagraph (C) with respect to commu-

23 nities with a high proportion of individuals

24 from racial and ethnic minority groups (as

25 defined in section 1707(g)), the National

1 Coordinator shall, to the greatest extent
2 possible, coordinate with an entity de-
3 scribed in clause (ii).

4 “(ii) MINORITY-SERVING INSTITU-
5 TIONS.—For purposes of clause (i), an en-
6 tity described in this clause is a historically
7 black college or university, a Hispanic-serv-
8 ing institution, a tribal college or univer-
9 sity, or an Asian-American-, Native Amer-
10 ican-, or Pacific Islander-serving institu-
11 tion with an accredited public health,
12 health policy, or health services research
13 program.”.

14 **SEC. 822. STUDY OF HEALTH INFORMATION TECHNOLOGY**
15 **IN MEDICALLY UNDERSERVED COMMU-**
16 **NITIES.**

17 (a) IN GENERAL.—Not later than 2 years after the
18 date of enactment of this Act, the Secretary of Health and
19 Human Services shall—

20 (1) enter into an agreement with the National
21 Academies of Sciences, Engineering, and Medicine to
22 conduct a study on the development, implementa-
23 tion, and effectiveness of health information tech-
24 nology within medically underserved areas (as de-
25 scribed in subsection (c)); and

1 (2) submit a report to Congress describing the
2 results of such study, including any recommenda-
3 tions for legislative or administrative action.

4 (b) STUDY.—The study described in subsection
5 (a)(1) shall—

6 (1) identify barriers to successful implementa-
7 tion of health information technology in medically
8 underserved areas;

9 (2) examine the impact of health information
10 technology on providing quality care and reducing
11 the cost of care to individuals in such areas, includ-
12 ing the impact of such technology on improved
13 health outcomes for individuals, including which
14 technology worked for which population and how it
15 improved health outcomes for that population;

16 (3) examine the impact of health information
17 technology on improving health care-related deci-
18 sions by both patients and providers in such areas;

19 (4) identify specific best practices for using
20 health information technology to foster the con-
21 sistent provision of physical accessibility and reason-
22 able policy accommodations in health care to individ-
23 uals with disabilities in such areas;

1 (5) assess the feasibility and costs associated
2 with the use of health information technology in
3 such areas;

4 (6) evaluate whether the adoption and use of
5 qualified electronic health records (as defined in sec-
6 tion 3000 of the Public Health Service Act (42
7 U.S.C. 300jj)) is effective in reducing health dispari-
8 ties, including analysis of clinical quality measures
9 reported by providers who are participating in the
10 Medicare program under title XVIII of the Social
11 Security Act (42 U.S.C. 1395 et seq.) or a State
12 plan under title XIX of such Act (42 U.S.C. 1396
13 et seq.) (or a waiver of such plan), pursuant to pro-
14 grams to encourage the adoption and use of certified
15 EHR technology;

16 (7) identify providers in medically underserved
17 areas that are not electing to adopt and use elec-
18 tronic health records and determine what barriers
19 are preventing those providers from adopting and
20 using such records; and

21 (8) examine urban and rural community health
22 systems and determine the impact that health infor-
23 mation technology may have on the capacity of pri-
24 mary health providers in those systems.

1 (c) MEDICALLY UNDERSERVED AREA.—The term
2 “medically underserved area” means—

3 (1) a population that has been designated as a
4 medically underserved population under section
5 330(b)(3) of the Public Health Service Act (42
6 U.S.C. 254b(b)(3));

7 (2) an area that has been designated as a
8 health professional shortage area under section 332
9 of the Public Health Service Act (42 U.S.C. 254e);

10 (3) an area or population that has been des-
11 ignated as a medically underserved community under
12 section 799B of the Public Health Service Act (42
13 U.S.C. 295p); or

14 (4) another area or population that—

15 (A) experiences significant barriers to ac-
16 cessing quality health services; and

17 (B) has a high prevalence of diseases or
18 conditions described in title VII, with such dis-
19 eases or conditions having a disproportionate
20 impact on racial and ethnic minority groups (as
21 defined in section 1707(g) of the Public Health
22 Service Act (42 U.S.C. 300u–6(g))) or a sub-
23 group of people with disabilities who have spe-
24 cific functional impairments.

1 **Subtitle D— Closing Gaps in**
2 **Funding To Adopt Certified EHRs**

3 **SEC. 831. EXTENDING MEDICAID EHR INCENTIVE PAY-**
4 **MENTS TO REHABILITATION FACILITIES,**
5 **LONG-TERM CARE FACILITIES, AND HOME**
6 **HEALTH AGENCIES.**

7 (a) IN GENERAL.—Section 1903(t)(2)(B) of the So-
8 cial Security Act (42 U.S.C. 1396b(t)(2)(B)) is amend-
9 ed—

10 (1) in clause (i), by striking “, or” and insert-
11 ing a semicolon;

12 (2) in clause (ii), by striking the period at the
13 end and inserting a semicolon; and

14 (3) by inserting after clause (ii) the following
15 new clauses:

16 “(iii) a rehabilitation facility (as defined in sec-
17 tion 1886(j)(1)) that furnishes acute or subacute re-
18 habilitation services;

19 “(iv) a long-term care hospital (as defined in
20 section 1886(d)(1)(B)(iv)(I)); or

21 “(v) a home health agency (as defined in sec-
22 tion 1861(o)).”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall apply with respect to amounts ex-
25 pended under section 1903(a)(3)(F) of the Social Security

1 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
 2 ginning on or after the date of the enactment of this Act.

3 **SEC. 832. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**
 4 **FOR MEDICAID ELECTRONIC HEALTH**
 5 **RECORD INCENTIVE PAYMENTS.**

6 (a) IN GENERAL.—Section 1903(t)(3)(B)(v) of the
 7 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is
 8 amended to read as follows:

9 “(v) physician assistant.”.

10 (b) EFFECTIVE DATE.—The amendment made by
 11 subsection (a) shall apply with respect to amounts ex-
 12 pended under section 1903(a)(3)(F) of the Social Security
 13 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
 14 ginning on or after the date of the enactment of this Act.

15 **TITLE IX—ACCOUNTABILITY**
 16 **AND EVALUATION**

17 **SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL**
 18 **ASSISTED HEALTH CARE SERVICES AND RE-**
 19 **SEARCH PROGRAMS ON THE BASIS OF SEX,**
 20 **RACE, COLOR, NATIONAL ORIGIN, MARITAL**
 21 **STATUS, FAMILIAL STATUS, SEXUAL ORI-**
 22 **ENTATION, GENDER IDENTITY, OR DIS-**
 23 **ABILITY STATUS.**

24 (a) IN GENERAL.—No person in the United States
 25 shall, on the basis of sex, race, color, national origin, mar-

1 ital status, familial status, sexual orientation, gender iden-
2 tity, or disability status, be excluded from participation
3 in, be denied the benefits of, or be subjected to discrimina-
4 tion under any health program or activity, including any
5 health research program or activity, receiving Federal fi-
6 nancial assistance.

7 (b) DEFINITION.—In this section, the term “familial
8 status” means, with respect to one or more individuals—

9 (1) being domiciled with any individual related
10 by blood or affinity whose close association with the
11 individual is the equivalent of a family relationship;

12 (2) being in the process of securing legal cus-
13 tody of any individual; or

14 (3) being pregnant.

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 C the following:

7 **“Subtitle D—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 that receive Federal financial as-
17 sistance are in compliance with title VI of the Civil Rights
18 Act, including through the following activities:

19 “(1) The development and implementation of
20 an action plan to address racial and ethnic health
21 care disparities, which shall address concerns relat-
22 ing to the Office for Civil Rights as released by the
23 United States Commission on Civil Rights in the re-
24 port entitled ‘Health Care Challenge: Acknowledging
25 Disparity, Confronting Discrimination, and Ensuring
26 Equity’ (September 1999) in conjunction with

1 the reports by the National Academy of Sciences
2 (formerly known as the Institute of Medicine) enti-
3 tled ‘Unequal Treatment: Confronting Racial and
4 Ethnic Disparities in Health Care’, ‘Crossing the
5 Quality Chasm: A New Health System for the 21st
6 Century’, ‘In the Nation’s Compelling Interest: En-
7 suring Diversity in the Health Care Workforce’,
8 ‘The National Partnership for Action to End Health
9 Disparities’, and ‘The Health of Lesbian, Gay, Bi-
10 sexual, and Transgender People’, and other related
11 reports by the National Academy of Sciences. This
12 plan shall be publicly disclosed for review and com-
13 ment and the final plan shall address any comments
14 or concerns that are received 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, gender iden-
19 tity, sexual orientation, sex, disability status, socio-
20 economic status, and primary language health data
21 collected by Federal health agencies to assess health
22 care disparities related to intentional discrimination
23 and policies and practices that have a disparate im-
24 pact on minorities.

1 “(4) Outreach and education activities relating
2 to compliance with title VI of the Civil Rights Act.

3 “(5) The provision of technical assistance for
4 health entities to facilitate compliance with title VI
5 of the Civil Rights Act.

6 “(6) Coordination and oversight of activities of
7 the civil rights compliance offices established under
8 section 3442.

9 “(7) Ensuring—

10 “(A) at a minimum, compliance with the
11 most recent version of the Office of Manage-
12 ment and Budget statistical policy directive en-
13 titled ‘Standards for Maintaining, Collecting,
14 and Presenting Federal Data on Race and Eth-
15 nicity’; and

16 “(B) consideration of available data and
17 language standards such as—

18 “(i) the standards for collecting and
19 reporting data under section 3101; and

20 “(ii) the National Standards on Cul-
21 turally and Linguistically Appropriate
22 Services of the Office of Minority Health.

23 “(c) FUNDING AND STAFF.—The Secretary shall en-
24 sure the effectiveness of the Office of Health Disparities
25 by ensuring that the Office is provided with—

1 “(1) adequate funding to enable the Office to
2 carry out its duties under this section; and

3 “(2) staff with expertise in—

4 “(A) epidemiology;

5 “(B) statistics;

6 “(C) health quality assurance;

7 “(D) minority health and health dispari-
8 ties;

9 “(E) cultural and linguistic competency;

10 “(F) civil rights; and

11 “(G) social, behavioral, and economic de-
12 terminants of health.

13 “(d) REPORT.—Not later than December 31, 2019,
14 and annually thereafter, the Secretary, in collaboration
15 with the Director of the Office for Civil Rights and the
16 Deputy Assistant Secretary for Minority Health, shall
17 submit a report to the Committee on Health, Education,
18 Labor, and Pensions of the Senate and the Committee on
19 Energy and Commerce of the House of Representatives
20 that includes—

21 “(1) the number of cases filed, broken down by
22 category;

23 “(2) the number of cases investigated and
24 closed by the office;

25 “(3) the outcomes of cases investigated;

1 “(4) the staffing levels of the office including
2 staff credentials;

3 “(5) the number of other lingering and emerg-
4 ing cases in which civil rights inequities can be dem-
5 onstrated; and

6 “(6) the number of cases remaining open and
7 an explanation for their open status.

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 2019 through 2024.

12 **“SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OF-**
13 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**
14 **HEALTH AND HUMAN SERVICES AGENCIES.**

15 “(a) IN GENERAL.—The Secretary shall establish
16 civil rights compliance offices in each agency within the
17 Department of Health and Human Services that admin-
18 isters health programs.

19 “(b) PURPOSE OF OFFICES.—Each office established
20 under subsection (a) shall ensure that recipients of Fed-
21 eral financial assistance under Federal health programs
22 administer programs, services, and activities in a manner
23 that—

24 “(1) does not discriminate, either intentionally
25 or in effect, on the basis of race, national origin, lan-

1 guage, ethnicity, sex, age, disability, sexual orienta-
2 tion, and gender identity; and

3 “(2) promotes the reduction and elimination of
4 disparities in health and health care based on race,
5 national origin, language, ethnicity, sex, age, dis-
6 ability, sexual orientation, and gender identity.

7 “(c) POWERS AND DUTIES.—The offices established
8 in subsection (a) shall have the following powers and du-
9 ties:

10 “(1) The establishment of compliance and pro-
11 gram participation standards for recipients of Fed-
12 eral financial assistance under each program admin-
13 istered by the applicable agency, including the estab-
14 lishment of disparity reduction standards to encom-
15 pass disparities in health and health care related to
16 race, national origin, language, ethnicity, sex, age,
17 disability, sexual orientation, and gender identity.

18 “(2) The development and implementation of
19 program-specific guidelines that interpret and apply
20 Department of Health and Human Services guid-
21 ance under title VI of the Civil Rights Act of 1964
22 and section 1557 of the Patient Protection and Af-
23 fordable Care Act to each Federal health program
24 administered by the agency.

1 “(3) The development of a disparity-reduction
2 impact analysis methodology that shall be applied to
3 every rule issued by the agency and published as
4 part of the formal rulemaking process under sections
5 555, 556, and 557 of title 5, United States Code.

6 “(4) Oversight of data collection, analysis, and
7 publication requirements for all recipients of Federal
8 financial assistance under each Federal health pro-
9 gram administered by the agency; compliance with,
10 at a minimum, the most recent version of the Office
11 of Management and Budget statistical policy direc-
12 tive entitled ‘Standards for Maintaining, Collecting,
13 and Presenting Federal Data on Race and Eth-
14 nicity’; and consideration of available data and lan-
15 guage standards such as—

16 “(A) the standards for collecting and re-
17 porting data under section 3101; and

18 “(B) the National Standards on Culturally
19 and Linguistically Appropriate Services of the
20 Office of Minority Health.

21 “(5) The conduct of publicly available studies
22 regarding discrimination within Federal health pro-
23 grams administered by the agency as well as dis-
24 parity reduction initiatives by recipients of Federal
25 financial assistance under Federal health programs.

1 “(6) Annual reports to the Committee on
2 Health, Education, Labor, and Pensions and the
3 Committee on Finance of the Senate and the Com-
4 mittee on Energy and Commerce and the Committee
5 on Ways and Means of the House of Representatives
6 on the progress in reducing disparities in health and
7 health care through the Federal programs adminis-
8 tered by the agency.

9 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
10 IN THE DEPARTMENT OF JUSTICE.—

11 “(1) DEPARTMENT OF HEALTH AND HUMAN
12 SERVICES.—The Office for Civil Rights of the De-
13 partment of Health and Human Services shall pro-
14 vide standard-setting and compliance review inves-
15 tigation support services to the Civil Rights Compli-
16 ance Office for each agency described in subsection
17 (a), subject to paragraph (2).

18 “(2) DEPARTMENT OF JUSTICE.—The Office
19 for Civil Rights of the Department of Justice may,
20 as appropriate, institute formal proceedings when a
21 civil rights compliance office established under sub-
22 section (a) determines that a recipient of Federal fi-
23 nancial assistance is not in compliance with the dis-
24 parity reduction standards of the applicable agency.

1 “(e) DEFINITION.—In this section, the term ‘Federal
2 health programs’ mean programs—

3 “(1) under the Social Security Act (42 U.S.C.
4 301 et seq.) that pay for health care and services;
5 and

6 “(2) under this Act that provide Federal finan-
7 cial assistance for health care, biomedical research,
8 health services research, and programs designed to
9 improve the public’s health, including health service
10 programs.”.

11 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

12 (a) COORDINATION WITHIN DEPARTMENT OF JUS-
13 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-
14 TIES.—Section 3(a) of the Civil Rights Commission Act
15 of 1983 (42 U.S.C. 1975a(a)) is amended—

16 (1) in paragraph (1), by striking “and” at the
17 end;

18 (2) in paragraph (2), by striking the period at
19 the end and inserting “; and”; and

20 (3) by adding at the end the following:

21 “(3) shall, with respect to activities carried out
22 in health care and correctional facilities toward the
23 goal of eliminating health disparities between the
24 general population and members of minority groups

1 based on race or color, promote coordination of such
2 activities of—

3 “(A) the Office for Civil Rights within the
4 Office of Justice Programs of the Department
5 of Justice;

6 “(B) the Office of Justice Programs within
7 the Department of Justice;

8 “(C) the Office for Civil Rights within the
9 Department of Health and Human Services;
10 and

11 “(D) the Office of Minority Health within
12 the Department of Health and Human Services
13 (headed by the Deputy Assistant Secretary for
14 Minority Health).”.

15 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
16 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
17 1975c) is amended by striking the first sentence and in-
18 serting the following: “For the purpose of carrying out
19 this Act, there are authorized to be appropriated
20 \$30,000,000 for fiscal year 2019, and such sums as may
21 be necessary for each of the fiscal years 2020 through
22 2024.”.

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 population of the
7 United States is declining and the United States
8 currently ranks below most industrialized nations in
9 health status measured by longevity, sickness, and
10 mortality.

11 (2) Racial and ethnic minority populations tend
12 to have the poorest health status and face substan-
13 tial cultural, social, and economic barriers to obtain-
14 ing quality health care.

15 (3) Lesbian, gay, bisexual, transgender, queer,
16 and questioning populations experience significant
17 personal and structural barriers to obtaining high-
18 quality health care.

19 (4) Efforts to improve minority health have
20 been limited by inadequate resources (funding, staff-
21 ing, and stewardship) and lack of accountability.

22 (b) SENSE OF CONGRESS.—It is the sense of Con-
23 gress that—

24 (1) health disparities negatively impact out-
25 comes for health and human security of the Nation;

1 (2) reducing racial, ethnic, sexual, and gender
2 disparities in prevention and treatment are unique
3 civil and human rights challenges and, as such, Fed-
4 eral agencies and health care entities and systems
5 receiving Federal funds should be accountable for
6 their role in causing disparities and inequity;

7 (3) funding for the National Institute for Mi-
8 nority Health Disparities, the Office of Civil Rights
9 in the Department of Health and Human Services,
10 the National Institute of Nursing Research, and the
11 Office of Minority Health should be doubled by fiscal
12 year 2020;

13 (4) adequate funding by fiscal year 2020, and
14 subsequent funding increases, should be provided for
15 health and human service professions training pro-
16 grams, the Racial and Ethnic Approaches to Com-
17 munity Health Initiative at the Centers for Disease
18 Control and Prevention, the Minority HIV/AIDS
19 Initiative, and the Excellence Centers to Eliminate
20 Ethnic/Racial Disparities Program at the Agency for
21 Healthcare Research and Quality;

22 (5) funding should be fully restored to the Ra-
23 cial and Ethnic Approaches to Community Health
24 Initiative at the Centers for Disease Control and
25 Prevention, which has been a successful program at

1 the community health level, and efforts should con-
2 tinue to place a strong emphasis on building commu-
3 nity capacity to secure financial resources and tech-
4 nical assistance to eliminate health disparities;

5 (6) adequate funding for fiscal year 2020 and
6 increased funding for future years should be pro-
7 vided for the Racial and Ethnic Approaches to Com-
8 munity Health Initiative's United States Risk Fac-
9 tor Survey to ensure adequate data collection to
10 track health disparities, and there should be appro-
11 priate avenues provided to disseminate findings to
12 the general public;

13 (7) 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 2020; and

18 (8) 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 on January 1, 2006, and ending De-
8 cember 31, 2017.

9 (B) All recipients of such grants, con-
10 tracts, and cooperative agreements during such
11 period.

12 (C) All members of the peer review panels
13 of such applicants and recipients, respectively.

14 (2) REPORT.—Not later than 6 months after
15 the date of the enactment of this Act, the Comp-
16 troller General shall complete the study under para-
17 graph (1) and submit to Congress a report con-
18 taining the results of such study.

19 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
20 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
21 DISPARITIES.—Not later than 6 months after the date of
22 the enactment of this Act, and biennially thereafter, the
23 Director of the National Institutes of Health, in collabora-
24 tion with the Director of the National Institute on Minor-

1 ity Health and Health Disparities, shall submit to Con-
2 gress a report that details and evaluates—

3 (1) the steps taken during the applicable report
4 period by the Director of the National Institutes of
5 Health to enforce the expanded planning, coordina-
6 tion, review, and evaluation authority provided the
7 National Institute on Minority Health and Health
8 Disparities under section 464z–3(h) of the Public
9 Health Service Act (42 U.S.C. 285(h)) over all mi-
10 nority health and health disparity research that is
11 conducted or supported by the Institutes and Cen-
12 ters at the National 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 2022, the Comptroller General of the United States
18 shall submit to Congress a report that identifies—

19 (1) the racial and ethnic diversity of commu-
20 nity-based organizations that applied for Federal en-
21 rollment funding provided pursuant to the Patient
22 Protection and Affordable Care Act (Public Law
23 111–148) (including the amendments made by such
24 Act);

1 (2) the percentage of such organizations that
2 were awarded such funding; and

3 (3) the impact of such community-based organi-
4 zations' enrollment efforts on the insurance status of
5 their communities.

6 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
7 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
8 PARITIES.—The Director of the National Institute on Mi-
9 nority Health and Health Disparities shall prepare an an-
10 nual report on the activities carried out or to be carried
11 out by such institute, and shall submit each such report
12 to the Committee on Health, Education, Labor, and Pen-
13 sions of the Senate, the Committee on Energy and Com-
14 merce of the House of Representatives, the Secretary of
15 Health and Human Services, and the Director of the Na-
16 tional Institutes of Health. With respect to the fiscal year
17 involved, the report shall—

18 (1) describe and evaluate the progress made in
19 health disparities research conducted or supported
20 by institutes and centers of the National Institutes
21 of Health;

22 (2) summarize and analyze expenditures made
23 for activities with respect to health disparities re-
24 search conducted or supported by the National Insti-
25 tutes of Health;

1 (3) include a separate statement applying the
 2 requirements of paragraphs (1) and (2) specifically
 3 to minority health disparities research; and

4 (4) contain such recommendations as the Direc-
 5 tor of the Institute considers appropriate.

6 **TITLE X—ADDRESSING SOCIAL**
 7 **DETERMINANTS AND IM-**
 8 **PROVING ENVIRONMENTAL**
 9 **JUSTICE**

10 **Subtitle A—In General**

11 **SEC. 1001. DEFINITIONS.**

12 In this title:

13 (1) DETERMINANTS OF HEALTH.—The term
 14 “determinants of health”—

15 (A) means the range of personal, social,
 16 economic, and environmental factors that influ-
 17 ence health status; and

18 (B) includes social determinants of health
 19 (which are sometimes referred to as “social and
 20 economic determinants of health” or “socio-
 21 economic determinants of health”), environ-
 22 mental determinants of health, and personal de-
 23 terminants of health.

24 (2) ENVIRONMENTAL DETERMINANTS OF
 25 HEALTH.—The term “environmental determinants

1 of health” means the broad physical, psychological,
2 social, and aesthetic environment.

3 (3) PERSONAL DETERMINANTS OF HEALTH.—

4 The term “personal determinants of health” means
5 an individual’s behavior, biology, and genetics.

6 (4) SOCIAL DETERMINANTS OF HEALTH.—The

7 term “social determinants of health” means a subset
8 of determinants of the health of individuals and en-
9 vironments (such as communities, neighborhoods,
10 and societies) that describe an individual’s or group
11 of people’s social identity, describe the social and
12 economic resources to which such individual or
13 group has access, and describe the conditions in
14 which an individual or group of people works, lives,
15 and plays.

16 **SEC. 1002. FINDINGS.**

17 Congress finds as follows:

18 (1) There are more opportunities to improve
19 health for everyone when we understand that health
20 starts, first, not in a medical setting, but in our
21 families, in our schools and workplaces, in our
22 neighborhoods, in the air we breathe, and in the
23 water we drink.

24 (2) The social determinants of health are the
25 largest predictors of health outcomes.

1 (3)(A) Healthy People 2020 identifies health
2 and health care quality as a function of not only ac-
3 cess to health care, but also the social determinants
4 of health, categorized into the following: neighbor-
5 hoods and the built environment; social and commu-
6 nity context; education; and economic stability.

7 (B) The following examples illustrate the nexus
8 between the unequal distribution of the social deter-
9 minants of health and health disparities:

10 (i) The built environment influences resi-
11 dents' level of physical activity. Neighborhoods
12 with high levels of poverty are significantly less
13 likely to have places where children can be
14 physically active, such as parks, green spaces,
15 and bike paths and lanes. Neighborhoods and
16 communities can provide opportunities for phys-
17 ical activity and support active lifestyles
18 through accessible and safe parks and open
19 spaces and through land use policy, zoning, and
20 healthy community design.

21 (ii) Emotional and physical health and
22 well-being are directly impacted by perceived
23 levels of safety, such as unlit streets at night.
24 Community members have expressed that safety
25 is not only a barrier to accessing programs and

1 services that increase quality of life but they
2 are also not able to access physical activity in
3 their community through the built environment.

4 (iii) In many workplace environments,
5 toxic chemicals have lasting detrimental effects
6 on employees' health. The hazardous com-
7 pounds found in most nail salon products affect
8 the respiratory system, reproductive system,
9 and central nervous system, and also cause kid-
10 ney and liver damage. Recognizing the impor-
11 tance of addressing occupational hazards as a
12 matter of public health, especially for Viet-
13 nameese women who constitute 48 percent of
14 nail salon technicians, the White House Initia-
15 tive on Asian American Pacific Islanders has
16 created an interagency working group to coordi-
17 nate efforts by the Environmental Protection
18 Agency, Occupational and Safety Health Ad-
19 ministration, Food and Drug Administration,
20 and other Federal agencies to create program-
21 ming, draft regulations, and conduct more out-
22 reach on educating workers on health and safe-
23 ty issues.

24 (iv) Historical and institutional discrimina-
25 tion against certain racial groups in the United

1 States has shaped the way in which social and
2 economic resources and exposure to health pro-
3 moting environments are distributed. Income,
4 education, occupation, neighborhood conditions,
5 schools, workplaces, the use of health and social
6 services, and experiences with the criminal jus-
7 tice system are all highly patterned by race,
8 with non-White racial groups experiencing more
9 that is health harming. Finding ways to uncou-
10 ple the link between race and access to re-
11 sources and healthy environments is a principal
12 means of reducing health disparities. Addition-
13 ally, the anticipation of racism itself causes
14 higher psychological and cardiovascular stress
15 levels that are linked to poor health outcomes.
16 Remediating discriminatory practices at the indi-
17 vidual and systemic levels will likely reduce
18 health disparities caused by this unequal dis-
19 tribution of stress.

20 (v) Poor health among Native Americans
21 has largely been driven by post-colonial oppres-
22 sion and historical trauma. The expropriation of
23 native lands and territories to the American
24 state had severe consequences on Native Amer-
25 ican health. This resulted in the deprivation of

1 traditional food sources—and nutrients—for
2 Native Americans and also the destruction of
3 traditional economies and community organiza-
4 tion. Today, Native Americans have twice the
5 rate of diabetes of non-Hispanic Whites. Rec-
6 ognition of the origins of the diabetes as having
7 a social and community context, rather than
8 just individual responsibility and genetic pre-
9 disposition, will shape better policy to provide
10 food security.

11 (vi) In the context of prisons, overcrowding
12 has led to the deterioration of the physical and
13 mental health of individuals after they leave
14 prison. In particular, the mass incarceration of
15 African-American males as a result of unequal
16 contact with and treatment in the criminal jus-
17 tice system has contributed to an overburdening
18 of certain infectious diseases within the African-
19 American community. As a social institution,
20 incarceration amplifies existing adverse health
21 conditions by concentrating diseases and harm-
22 ful health behaviors such as tobacco use, drug
23 use, and violence.

24 (vii) Educational attainment is the strong-
25 est predictor of adult mortality. It is a basic

1 component of socioeconomic status that shapes
2 earning potential to access resources that pro-
3 mote health. People with more education are
4 less likely to report that they are in poor health,
5 and are also less likely to have diabetes and
6 other chronic diseases.

7 (viii) Similarly, reading ability is a strong
8 predictor of adult health status and greater
9 reading ability is negatively correlated with
10 other child health issues, such as developmental
11 problems, vision and hearing impairments, and
12 frequent school absence due to illness.

13 (ix) Individuals with lower levels of edu-
14 cational attainment are much more likely to re-
15 port to be current smokers. In 2015, smoking
16 prevalence was 34.1 percent among adults with
17 a GED diploma, 24.2 percent with less than a
18 high school diploma, and 19.8 percent with a
19 high school diploma, while dropping signifi-
20 cantly to 7.4 percent among adults with an un-
21 dergraduate college degree and 3.6 percent with
22 a postgraduate college degree.

23 (x) Social class differences account for a
24 large part of health disparities. For example,
25 children living in poverty experience poorer

1 housing conditions, increased exposure to in-
2 door allergens and toxins (such as pesticides,
3 lead, mercury, radon, air pollution, and carcino-
4 gens), and more psychological stress. These ex-
5 periences culminate in worse adult health as
6 compared with children with higher socio-
7 economic status. Specifically, children living in
8 socioeconomic neighborhoods have higher rates
9 of asthma due to higher rates of psychological
10 stress resulting from higher rates of violence.

11 (xi) Lesbian, gay, bisexual, transgender,
12 queer, questioning, questioning and intersex
13 (LGBTQIA) individuals face health disparities
14 linked to societal stigma, discrimination, and
15 denial of their civil and human rights. Discrimi-
16 nation against LGBTQIA individuals has been
17 associated with high rates of psychiatric dis-
18 orders, substance abuse, and suicide. Experi-
19 ences of violence and victimization are frequent
20 for LGBTQIA individuals, and have long-last-
21 ing effects on the individual and the commu-
22 nity. Personal, family, and social acceptance of
23 sexual orientation and gender identity affects
24 the mental health and personal safety of
25 LGBTQIA individuals.

1 (xii) Individuals in older and cheaper hous-
2 ing are at higher risks to be exposed to lead,
3 particularly in housing built prior to 1960. The
4 threat of lead poisoning disproportionately af-
5 fects vulnerable populations, with children living
6 in poverty (5.6 percent) and Black children
7 (5.6) experiencing the highest rates. According
8 to the Department of Housing and Urban De-
9 velopment, about 3,600,000 homes nationwide
10 that house young children have lead hazards
11 such as peeling paint, contaminated dust, or
12 toxic soil. The combined cost of medical treat-
13 ment and special education for lead poisoned
14 children averages about \$5,600 per child per
15 year, and lead poisoning costs the United
16 States an estimated \$50,000,000,000 annually.

17 (4) Laws and regulations that improve opportu-
18 nities to live in safe neighborhoods, with more social
19 cohesion, attain higher education, sustain stable em-
20 ployment, and bridge class differences help foster
21 the health and safety of individuals.

22 (5) The global public health community has
23 reached consensus through the Rio Political Declara-
24 tion of Social Determinants of Health adopted by
25 the World Health Organisation in October 2011 that

1 “[c]ollaboration in coordinated and intersectoral pol-
2 icy actions has proven to be effective. Health in All
3 Policies, an initiative of the American Public Health
4 Association, together with intersectoral cooperation
5 and action, is one promising approach to enhance
6 accountability in other sectors of health, as well as
7 the promotion of health equity and more inclusive
8 and productive societies.”.

9 **SEC. 1003. HEALTH IMPACT ASSESSMENTS.**

10 (a) FINDINGS.—Congress makes the following find-
11 ings:

12 (1) Health Impact Assessment is a tool to help
13 planners, health officials, decisionmakers, and the
14 public make more informed decisions about the po-
15 tential health effects of proposed plans, policies, pro-
16 grams, and projects in order to maximize health
17 benefits and minimize harms.

18 (2) Health Impact Assessments can be done at
19 a fraction of the cost and time typically required for
20 other planning and permitting reviews.

21 (3) Health Impact Assessments can build com-
22 munity support and reduce opposition to a project or
23 policy, thereby facilitating economic growth by aid-
24 ing the development of consensus regarding new de-
25 velopment proposals.

1 (4) Health Impact Assessments facilitate col-
2 laboration across sectors.

3 (b) PURPOSES.—It is the purpose of this section to—

4 (1) provide more information about the poten-
5 tial human health effects of policy decisions and the
6 distribution of those effects;

7 (2) improve how health is considered in plan-
8 ning and decisionmaking processes; and

9 (3) build stronger, healthier communities
10 through the use of Health Impact Assessment.

11 (c) HEALTH IMPACT ASSESSMENTS.—Part P of title
12 III of the Public Health Service Act (42 U.S.C. 280g et
13 seq.), as amended by section 796A, is further amended
14 by adding at the end the following:

15 **“SEC. 399V-12. HEALTH IMPACT ASSESSMENTS.**

16 “(a) DEFINITIONS.—In this section:

17 “(1) ADMINISTRATOR.—The term ‘Adminis-
18 trator’ means the Administrator of the Environ-
19 mental Protection Agency.

20 “(2) BUILT ENVIRONMENT.—The term ‘built
21 environment’ means the components of the environ-
22 ment, and the location of these components in a geo-
23 graphically defined space, that are created or modi-
24 fied by individuals to form the physical and social

1 characteristics of a community or enhance quality of
2 human life, including—

3 “(A) homes, schools, and places of work
4 and worship;

5 “(B) parks, recreation areas, and green-
6 ways;

7 “(C) transportation systems;

8 “(D) business, industry, and agriculture;
9 and

10 “(E) land-use plans, projects, and policies
11 that impact the physical or social characteris-
12 tics of a community, including access to services
13 and amenities.

14 “(3) DIRECTOR.—The term ‘Director’ means
15 the Director of the Centers for Disease Control and
16 Prevention.

17 “(4) HEALTH IMPACT ASSESSMENT.—The term
18 ‘health impact assessment’ means a systematic proc-
19 ess that uses an array of data sources and analytic
20 methods and considers input from stakeholders to
21 determine the potential effects of a proposed policy,
22 plan, program, or project on the health of a popu-
23 lation and the distribution of those effects within the
24 population. Such term includes identifying and rec-
25 ommending appropriate actions on monitoring and

1 maximizing potential benefits and minimizing the
2 potential harms.

3 “(5) HEALTH DISPARITY.—The term ‘health
4 disparity’ means a particular type of health dif-
5 ference that is closely linked with social, economic,
6 or environmental disadvantage and that adversely
7 affects groups of people who have systematically ex-
8 perience greater obstacles to health based on their
9 racial or ethnic group; religion; socioeconomic status;
10 gender; age; mental health; cognitive, sensory, or
11 physical disability; sexual orientation or gender iden-
12 tity; geographic location; or other characteristics his-
13 torically linked to discrimination or exclusion.

14 “(b) ESTABLISHMENT.—The Secretary, acting
15 through the Director and in collaboration with the Admin-
16 istrator, shall—

17 “(1) in consultation with the Director of the
18 National Center for Chronic Disease Prevention and
19 Health Promotion and relevant offices within the
20 Department of Housing and Urban Development,
21 the Department of Transportation, and the Depart-
22 ment of Agriculture, establish a program at the Na-
23 tional Center for Environmental Health at the Cen-
24 ters for Disease Control and Prevention focused on

1 advancing the field of health impact assessment that
2 includes—

3 “(A) collecting and disseminating best
4 practices;

5 “(B) administering capacity building
6 grants to States to support grantees in initi-
7 ating health impact assessments, in accordance
8 with subsection (d);

9 “(C) providing technical assistance;

10 “(D) developing training tools and pro-
11 viding training on conducting health impact as-
12 sessment and the implementation of built envi-
13 ronment and health indicators;

14 “(E) making information available, as ap-
15 propriate, regarding the existence of other com-
16 munity healthy living tools, checklists, and indi-
17 ces that help connect public health to other sec-
18 tors, and tools to help examine the effect of the
19 indoor built environment and building codes on
20 population health;

21 “(F) conducting research and evaluations
22 of health impact assessments; and

23 “(G) awarding competitive extramural re-
24 search grants;

1 “(2) develop guidance and guidelines to conduct
2 health impact assessments in accordance with sub-
3 section (c); and

4 “(3) establish a grant program to allow States
5 to fund eligible entities to conduct health impact as-
6 sessments.

7 “(c) GUIDANCE.—

8 “(1) IN GENERAL.—Not later than 1 year after
9 the date of enactment of the Health Equity and Ac-
10 countability Act of 2018, the Secretary, acting
11 through the Director, shall issue final guidance for
12 conducting the health impact assessments. In devel-
13 oping such guidance the Secretary shall—

14 “(A) consult with the Director of the Na-
15 tional Center for Environmental Health and,
16 the Director of the National Center for Chronic
17 Disease Prevention and Health Promotion, and
18 relevant offices within the Department of Hous-
19 ing and Urban Development, the Department of
20 Transportation, and the Department of Agri-
21 culture; and

22 “(B) consider available international health
23 impact assessment guidance, North American
24 health impact assessment practice standards,

1 and recommendations from the National Acad-
2 emy of Science.

3 “(2) CONTENT.—The guidance under this sub-
4 section shall include—

5 “(A) background on national and inter-
6 national efforts to bridge urban planning and
7 public health institutions and disciplines, in-
8 cluding a review of health impact assessment
9 best practices internationally;

10 “(B) evidence-based direct and indirect
11 pathways that link land-use planning, transpor-
12 tation, and housing policy and objectives to
13 human health outcomes;

14 “(C) data resources and quantitative and
15 qualitative forecasting methods to evaluate both
16 the status of health determinants and health ef-
17 fects, including identification of existing pro-
18 grams that can disseminate these resources;

19 “(D) best practices for inclusive public in-
20 volvement in conducting health impact assess-
21 ments; and

22 “(E) technical assistance for other agen-
23 cies seeking to develop their own guidelines and
24 procedures for health impact assessment.

25 “(d) GRANT PROGRAM.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Director and in collaboration with the
3 Administrator, shall—

4 “(A) award grants to States to fund eligi-
5 ble entities for capacity building or to prepare
6 health impact assessments; and

7 “(B) ensure that States receiving a grant
8 under this subsection further support training
9 and technical assistance for grantees under the
10 program by funding and overseeing appropriate
11 local, State, Tribal, Federal, institution of high-
12 er education, or nonprofit health impact assess-
13 ment experts to provide such technical assist-
14 ance.

15 “(2) APPLICATIONS.—

16 “(A) IN GENERAL.—To be eligible to re-
17 ceive a grant under this section, an eligible enti-
18 ty shall—

19 “(i) be a State, Indian tribe, or tribal
20 organization that includes individuals or
21 populations the health of which are, or will
22 be, affected by an activity or a proposed
23 activity; and

24 “(ii) submit to the Secretary an appli-
25 cation in accordance with this subsection,

1 at such time, in such manner, and con-
2 taining such additional information as the
3 Secretary may require.

4 “(B) INCLUSION.—An application under
5 this subsection shall include a list of proposed
6 activities that require or would benefit from
7 conducting a health impact assessment within
8 six months of awarding funds. The list should
9 be accompanied by supporting documentation,
10 including letters of support, from potential con-
11 ductors of health impact assessments for the
12 listed proposed activities. Each application
13 should also include an assessment by the eligi-
14 ble entity of the health of the population of its
15 jurisdiction and describe potential adverse or
16 positive effects on health that the proposed ac-
17 tivities may create.

18 “(C) PREFERENCE.—Preference in award-
19 ing funds under this section may be given to el-
20 igible entities that demonstrate the potential to
21 significantly improve population health or lower
22 health care costs as a result of potential health
23 impact assessment work.

24 “(3) USE OF FUNDS.—

1 “(A) IN GENERAL.—An entity receiving a
2 grant under this section shall use such grant
3 funds to conduct health impact assessment ca-
4 pacity building or to fund subgrantees in con-
5 ducting a health impact assessment for a pro-
6 posed activity in accordance with this sub-
7 section.

8 “(B) PURPOSES.—The purposes of a
9 health impact assessment under this subsection
10 are—

11 “(i) to facilitate the involvement of
12 tribal, State, and local public health offi-
13 cials in community planning, transpor-
14 tation, housing, and land use decisions and
15 other decisions affecting the built environ-
16 ment to identify any potential health con-
17 cern or health benefit relating to an activ-
18 ity or proposed activity;

19 “(ii) to provide for an investigation of
20 any health-related issue of concern raised
21 in a planning process, an environmental
22 impact assessment process, or policy ap-
23 praisal relating to a proposed activity;

24 “(iii) to describe and compare alter-
25 natives (including no-action alternatives) to

1 a proposed activity to provide clarification
2 with respect to the potential health out-
3 comes associated with the proposed activity
4 and, where appropriate, to the related ben-
5 efit-cost or cost-effectiveness of the pro-
6 posed activity and alternatives;

7 “(iv) to contribute, when applicable,
8 to the findings of a planning process, pol-
9 icy appraisal, or an environmental impact
10 statement with respect to the terms and
11 conditions of implementing a proposed ac-
12 tivity or related mitigation recommenda-
13 tions, as necessary;

14 “(v) to ensure that the dispropor-
15 tionate distribution of negative impacts
16 among vulnerable populations is minimized
17 as much as possible;

18 “(vi) to engage affected community
19 members and ensure adequate opportunity
20 for public comment on all stages of the
21 health impact assessment;

22 “(vii) where appropriate, to consult
23 with local and county health departments
24 and appropriate organizations, including
25 planning, transportation, and housing or-

1 organizations and providing them with infor-
2 mation and tools regarding how to conduct
3 and integrate health impact assessment
4 into their work; and

5 “(viii) to inspect homes, water sys-
6 tems, and other elements that pose risks to
7 lead exposure, with an emphasis on areas
8 that pose a higher risk to children.

9 “(4) ASSESSMENTS.—Health impact assess-
10 ments carried out using grant funds under this sec-
11 tion shall—

12 “(A) take appropriate health factors into
13 consideration as early as practicable during the
14 planning, review, or decisionmaking processes;

15 “(B) assess the effect on the health of in-
16 dividuals and populations of proposed policies,
17 projects, or plans that result in modifications to
18 the built environment; and

19 “(C) assess the distribution of health ef-
20 fects across various factors, such as race, in-
21 come, ethnicity, age, disability status, gender,
22 and geography.

23 “(5) ELIGIBLE ACTIVITIES.—

24 “(A) IN GENERAL.—Eligible entities fund-
25 ed under this subsection shall conduct an eval-

1 uation of any proposed activity to determine
2 whether it will have a significant adverse or
3 positive effect on the health of the affected pop-
4 ulation in the jurisdiction of the eligible entity,
5 based on the criteria described in subparagraph
6 (B).

7 “(B) CRITERIA.—The criteria described in
8 this subparagraph include, as applicable to the
9 proposed activity, the following:

10 “(i) Any substantial adverse effect or
11 significant health benefit on health out-
12 comes or factors known to influence health,
13 including the following:

14 “(I) Physical activity.

15 “(II) Injury.

16 “(III) Mental health.

17 “(IV) Accessibility to health-pro-
18 moting goods and services.

19 “(V) Respiratory health.

20 “(VI) Chronic disease.

21 “(VII) Nutrition.

22 “(VIII) Land use changes that
23 promote local, sustainable food
24 sources.

25 “(IX) Infectious disease.

1 “(X) Health disparities.

2 “(XI) Existing air quality,
3 ground or surface water quality or
4 quantity, or noise levels.

5 “(XII) Lead exposure.

6 “(ii) Other factors that may be con-
7 sidered, including—

8 “(I) the potential for a proposed
9 activity to result in systems failure
10 that leads to a public health emer-
11 gency;

12 “(II) the probability that the pro-
13 posed activity will result in a signifi-
14 cant increase in tourism, economic de-
15 velopment, or employment in the ju-
16 risdiction of the eligible entity;

17 “(III) any other significant po-
18 tential hazard or enhancement to
19 human health, as determined by the
20 eligible entity; or

21 “(IV) whether the evaluation of a
22 proposed activity would duplicate an-
23 other analysis or study being under-
24 taken in conjunction with the pro-
25 posed activity.

1 “(C) FACTORS FOR CONSIDERATION.—In
2 evaluating a proposed activity under subpara-
3 graph (A), an eligible entity may take into con-
4 sideration any reasonable, direct, indirect, or
5 cumulative effect that can be clearly related to
6 potential health effects and that is related to
7 the proposed activity, including the effect of
8 any action that is—

9 “(i) included in the long-range plan
10 relating to the proposed activity;

11 “(ii) likely to be carried out in coordi-
12 nation with the proposed activity;

13 “(iii) dependent on the occurrence of
14 the proposed activity; or

15 “(iv) likely to have a disproportionate
16 impact on high-risk or vulnerable popu-
17 lations.

18 “(6) REQUIREMENTS.—A health impact assess-
19 ment prepared with funds awarded under this sub-
20 section shall incorporate the following, after con-
21 ducting the screening phase (identifying projects or
22 policies for which a health impact assessment would
23 be valuable and feasible) through the application
24 process:

1 “(A) SCOPING.—Identifying which health
2 effects to consider and the research methods to
3 be utilized.

4 “(B) ASSESSING RISKS AND BENEFITS.—
5 Assessing the baseline health status and factors
6 known to influence the health status in the af-
7 fected community, which may include aggreg-
8 ating and synthesizing existing health assess-
9 ment evidence and data from the community.

10 “(C) DEVELOPING RECOMMENDATIONS.—
11 Suggesting changes to proposals to promote
12 positive or mitigate adverse health effects.

13 “(D) REPORTING.—Synthesizing the as-
14 sessment and recommendations and commu-
15 nicating the results to decisionmakers.

16 “(E) MONITORING AND EVALUATING.—
17 Tracking the decision and implementation effect
18 on health determinants and health status.

19 “(7) PLAN.—An eligible entity that is awarded
20 a grant under this section shall develop and imple-
21 ment a plan, to be approved by the Director, for
22 meaningful and inclusive stakeholder involvement in
23 all phases of the health impact assessment. Stake-
24 holders may include community-based organizations,
25 youth-serving organizations, planners, public health

1 experts, State and local public health departments
2 and officials, health care experts or officials, housing
3 experts or officials, and transportation experts or of-
4 ficials.

5 “(8) SUBMISSION OF FINDINGS.—An eligible
6 entity that is awarded a grant under this section
7 shall submit the findings of any funded health im-
8 pact assessment activities to the Secretary and make
9 these findings publicly available.

10 “(9) ASSESSMENT OF IMPACTS.—An eligible en-
11 tity that is awarded a grant under this section shall
12 ensure the assessment of the distribution of health
13 impacts (related to the proposed activity) across
14 race, ethnicity, income, age, gender, disability status,
15 and geography.

16 “(10) CONDUCT OF ASSESSMENT.—To the
17 greatest extent feasible, a health impact assessment
18 shall be conducted under this section in a manner
19 that respects the needs and timing of the decision-
20 making process it evaluates.

21 “(11) METHODOLOGY.—In preparing a health
22 impact assessment under this subsection, an eligible
23 entity or partner shall follow the guidance published
24 under subsection (c).

1 “(e) HEALTH IMPACT ASSESSMENT DATABASE.—
2 The Secretary, acting through the Director and in collabo-
3 ration with the Administrator, shall establish, maintain,
4 and make publicly available a health impact assessment
5 database, including—

6 “(1) a catalog of health impact assessments re-
7 ceived under this section;

8 “(2) an inventory of tools used by eligible enti-
9 ties to conduct health impact assessments; and

10 “(3) guidance for eligible entities with respect
11 to the selection of appropriate tools described in
12 paragraph (2).

13 “(f) EVALUATION OF GRANTEE ACTIVITIES.—The
14 Secretary shall award competitive grants to Prevention
15 Research Centers, or nonprofit organizations or academic
16 institutions with expertise in health impact assessments
17 to—

18 “(1) assist grantees with the provision of train-
19 ing and technical assistance in the conducting of
20 health impact assessments;

21 “(2) evaluate the activities carried out with
22 grants under subsection (d); and

23 “(3) assist the Secretary in disseminating evi-
24 dence, best practices, and lessons learned from
25 grantees.

1 “(g) REPORT TO CONGRESS.—Not later than 1 year
2 after the date of enactment of the Health Equity and Ac-
3 countability Act of 2018, the Secretary shall submit to
4 Congress a report concerning the evaluation of the pro-
5 grams under this section, including recommendations as
6 to how lessons learned from such programs can be incor-
7 porated into future guidance documents developed and
8 provided by the Secretary and other Federal agencies, as
9 appropriate.

10 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section
12 such sums as may be necessary.

13 **“SEC. 399V-13. IMPLEMENTATION OF RESEARCH FINDINGS**
14 **TO IMPROVE HEALTH OUTCOMES THROUGH**
15 **THE BUILT ENVIRONMENT.**

16 “(a) RESEARCH GRANT PROGRAM.—The Secretary,
17 in collaboration with the Administrator of the Environ-
18 mental Protection Agency (referred to in this section as
19 the ‘Administrator’), shall award grants to public agencies
20 or private nonprofit institutions to implement evidence-
21 based programming to improve human health through im-
22 provements to the built environment and subsequently
23 human health, by addressing—

24 “(1) levels of physical activity;

25 “(2) consumption of nutritional foods;

- 1 “(3) rates of crime;
- 2 “(4) air, water, and soil quality;
- 3 “(5) risk or rate of injury;
- 4 “(6) accessibility to health-promoting goods and
- 5 services;
- 6 “(7) chronic disease rates;
- 7 “(8) community design;
- 8 “(9) housing; or
- 9 “(10) other factors, as the Secretary determines
- 10 appropriate.

11 “(b) APPLICATIONS.—A public agency or private

12 nonprofit institution desiring a grant under this section

13 shall submit to the Secretary an application at such time,

14 in such manner, and containing such agreements, assur-

15 ances, and information as the Secretary, in consultation

16 with the Administrator, may require.

17 “(c) RESEARCH.—The Secretary, in consultation

18 with the Administrator, shall support, through grants

19 awarded under this section, research that—

20 “(1) uses evidence-based research to improve

21 the built environment and human health;

22 “(2) examines—

23 “(A) the scope and intensity of the impact

24 that the built environment (including the var-

1 ious characteristics of the built environment)

2 has on the human health; or

3 “(B) the distribution of such impacts by—

4 “(i) location; and

5 “(ii) population subgroup;

6 “(3) is used to develop—

7 “(A) measures and indicators to address

8 health impacts and the connection of health to

9 the built environment;

10 “(B) efforts to link the measures to trans-

11 portation, land use, and health databases; and

12 “(C) efforts to enhance the collection of

13 built environment surveillance data;

14 “(4) distinguishes carefully between personal

15 attitudes and choices and external influences on be-

16 havior to determine how much the association be-

17 tween the built environment and the health of resi-

18 dents, versus the lifestyle preferences of the people

19 that choose to live in the neighborhood, reflects the

20 physical characteristics of the neighborhood; and

21 “(5)(A) identifies or develops effective interven-

22 tion strategies focusing on enhancements to the built

23 environment that promote increased use physical ac-

24 tivity, access to nutritious foods, or other health-pro-

25 moting activities by residents; and

1 “(B) in developing the intervention strategies
2 under subparagraph (A), ensures that the interven-
3 tion strategies will reach out to high-risk or vulner-
4 able populations, including low-income urban and
5 rural communities and aging populations, in addi-
6 tion to the general population.

7 “(d) SURVEYS.—The Secretary may allow recipients
8 of grants under this section to use such grant funds to
9 support the expansion of national surveys and data track-
10 ing systems to provide more detailed information about
11 the connection between the built environment and health.

12 “(e) PRIORITY.—In awarding grants under this sec-
13 tion, the Secretary and the Administrator shall give pri-
14 ority to entities with programming that incorporates—

15 “(1) interdisciplinary approaches; or

16 “(2) the expertise of the public health, physical
17 activity, urban planning, land use, and transpor-
18 tation research communities in the United States
19 and abroad.

20 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated such sums as may be
22 necessary to carry out this section. The Secretary may al-
23 locate not more than 20 percent of the amount so appro-
24 priated for a fiscal year for purposes of conducting re-
25 search under subsection (c).”.

1 **SEC. 1004. IMPLEMENTATION OF RECOMMENDATIONS BY**
2 **ENVIRONMENTAL PROTECTION AGENCY.**

3 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The
4 Administrator of the Environmental Protection Agency
5 (referred to in this section as the “Administrator”) shall,
6 as promptly as practicable, carry out each of the following
7 recommendations of the Inspector General of the Environ-
8 mental Protection Agency as described in the report enti-
9 tled “EPA needs to conduct environmental justice reviews
10 of its programs, policies and activities” (Report No. 2006–
11 P–00034):

12 (1) The recommendation that the program and
13 regional offices of the Environmental Protection
14 Agency identify which programs, policies, and activi-
15 ties need environmental justice reviews and the Ad-
16 ministrator require those offices to establish a plan
17 to complete the necessary reviews.

18 (2) The recommendation that the Administrator
19 ensure that the reviews described in paragraph (1)
20 determine whether the programs, policies, and activi-
21 ties may have a disproportionately high and adverse
22 health or environmental impact on minority and low-
23 income populations.

24 (3) The recommendation that each program
25 and regional office of the Environmental Protection
26 Agency develop specific environmental justice review

1 guidance for conducting environmental justice re-
2 views.

3 (4) The recommendation that the Administrator
4 designate a responsible office to compile results of
5 environmental justice reviews and recommend appro-
6 priate actions.

7 (b) GAO RECOMMENDATIONS.—In promulgating reg-
8 ulations of the Environmental Protection Agency, the Ad-
9 ministrator shall, as promptly as practicable, carry out
10 each of the following recommendations of the Comptroller
11 General of the United States as described in the report
12 entitled “EPA Should Devote More Attention to Environ-
13 mental Justice when Developing Clean Air Rules” (GAO-
14 05-289):

15 (1) The recommendation that the Administrator
16 ensure that workgroups involved in developing a rule
17 devote attention to environmental justice while draft-
18 ing and finalizing the rule.

19 (2) The recommendation that the Administrator
20 enhance the ability of the workgroups described in
21 paragraph (1) to identify potential environmental
22 justice issues through steps such as—

23 (A) providing workgroup members with
24 guidance and training to help those members

1 identify potential environmental justice prob-
2 lems; and

3 (B) involving environmental justice coordi-
4 nators in the workgroups if appropriate.

5 (3) The recommendation that the Administrator
6 improve assessments of potential environmental jus-
7 tice impacts in economic reviews by identifying the
8 data and developing the modeling techniques needed
9 to assess those impacts.

10 (4) The recommendation that the Administrator
11 direct appropriate officers and employees of the En-
12 vironmental Protection Agency, if feasible, to re-
13 spond fully to public comments on environmental
14 justice, including by—

15 (A) improving the explanation by the Ad-
16 ministrator of the basis for any conclusions re-
17 lating to environmental justice; and

18 (B) including in an explanation under sub-
19 paragraph (A) supporting data.

20 (c) 2004 INSPECTOR GENERAL REPORT.—

21 (1) IN GENERAL.—The Administrator shall, as
22 promptly as practicable, carry out each of the fol-
23 lowing recommendations of the Inspector General of
24 the Environmental Protection Agency as described
25 in the report entitled “EPA Needs to Consistently

1 Implement the Intent of the Executive Order on En-
2 vironmental Justice” (Report No. 2004–P–00007):

3 (A) The recommendation that the Admin-
4 istrator clearly define the mission of the Office
5 of Environmental Justice and provide Environ-
6 mental Protection Agency staff with an under-
7 standing of the roles and responsibilities of that
8 Office.

9 (B) The recommendation that the Admin-
10 istrator—

11 (i) establish, through the issuance of
12 guidance or a policy statement, specific
13 timeframes for the development of defini-
14 tions, goals, and measurements regarding
15 environmental justice; and

16 (ii) provide the regions and program
17 offices a standard and consistent definition
18 for a minority and low-income community,
19 with instructions on how the Environ-
20 mental Protection Agency will implement
21 and put into operation environmental jus-
22 tice in the daily activities of the Environ-
23 mental Protection Agency.

24 (C) The recommendation that the Adminis-
25 trator ensure that the comprehensive training

1 program under development (as of the date of
2 enactment of this Act) includes standard and
3 consistent definitions of the key environmental
4 justice concepts, such as “low-income”, “minor-
5 ity”, and “disproportionately impacted”, and
6 instructions for implementation of those con-
7 cepts.

8 (2) REPORTS.—

9 (A) INITIAL REPORT.—Not later than 180
10 days after the date of enactment of this Act,
11 the Administrator shall submit to Congress an
12 initial report on the strategy of the Adminis-
13 trator for implementing the recommendations
14 described in subparagraphs (A), (B), and (C) of
15 paragraph (1).

16 (B) SUBSEQUENT REPORTS.—After sub-
17 mitting the initial report under subparagraph
18 (A), the Administrator shall submit to Congress
19 semiannual reports on the progress of the Ad-
20 ministrator in—

21 (i) implementing the recommendations
22 referred to in subparagraph (A); and

23 (ii) modifying the emergency manage-
24 ment procedures of the Administrator to
25 incorporate environmental justice in the

1 Incident Command Structure of the Envi-
2 ronmental Protection Agency, in accord-
3 ance with the December 18, 2006, letter
4 from the Deputy Administrator to the Act-
5 ing Inspector General of the Environ-
6 mental Protection Agency.

7 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,
8 PROTECTING PEOPLE AND THEIR FAMILIES FROM
9 RADON.—

10 (1) FINDINGS.—Congress finds that radon is a
11 naturally occurring radioactive gas that is—

12 (A) recognized as the leading cause of lung
13 cancer among nonsmokers; and

14 (B) a particular environmental threat for
15 low-income and minority individuals because of
16 the lack of information about radon levels in
17 the homes of those individuals.

18 (2) IMPLEMENTATION.—Not later than 180
19 days after the date of the enactment of this Act, the
20 Administrator shall implement the action plan enti-
21 tled “Protecting People and Families from Radon: A
22 Federal Action Plan for Saving Lives” (June 20,
23 2011), in consultation with the Director of the Cen-
24 ters for Disease Control and Prevention and any
25 other Federal agencies referred to in the action plan.

1 (3) SPECIFIC STEPS.—In carrying out para-
2 graph (2), the Administrator shall ensure that—

3 (A) the workgroup comprised of the Fed-
4 eral agencies participating in the development
5 of the action plan referred to in paragraph (2)
6 implements specific steps within the existing
7 authority and activities of each Federal agency
8 to reduce exposure to radon; and

9 (B) not later than the date that is 1 year
10 after the date on which the Administrator be-
11 gins implementation of the action plan de-
12 scribed in paragraph (2), the workgroup de-
13 scribed in subparagraph (A) meets to assess
14 and recognize achievements of the plan.

15 (4) REPORT.—After the progress meeting of
16 the workgroup under paragraph (3)(B), the Admin-
17 istrator shall submit to Congress a report on the im-
18 plementation of the action plan described in para-
19 graph (2), including the challenges remaining and
20 the progress in reducing radon exposure, particularly
21 for low-income and minority families.

22 (e) FEDERAL ACTION PLAN FOR PREVENTING
23 CHILDHOOD LEAD POISONING.—

24 (1) FINDINGS.—Congress finds that—

1 (A) the effects of lead poisoning are irre-
2 versible and cost the United States millions an-
3 nually in medical and education costs;

4 (B) the cognitive effects suffered by chil-
5 dren exposed to lead result in a lifetime of
6 health and behavioral problems, which makes
7 prevention efforts more critical; and

8 (C) the risk is especially high for vulner-
9 able minority populations who are more likely
10 to live in older homes, where lead-based paint
11 is more likely to be present.

12 (2) ACTION PLAN.—Not later than 180 days
13 after the date of enactment of this Act, the Adminis-
14 trator, in consultation with the Director of the Cen-
15 ters for Disease Control and Prevention and other
16 relevant Federal agencies, shall develop an action
17 plan to reduce exposure to lead.

18 (3) SPECIFIC STEPS.—In carrying out para-
19 graph (2), the Administrator shall—

20 (A) establish a working group, comprised
21 of representatives of the Federal agencies par-
22 ticipating in the development of the action plan
23 described in paragraph (2), to make rec-
24 ommendations for the implementation of spe-
25 cific steps within the existing authority and ac-

1 activities of each Federal agency to reduce expo-
2 sure to lead; and

3 (B) assist other Federal agencies in the de-
4 velopment of materials on the hazards of lead-
5 based paint for the purpose of educating ten-
6 ants and landlords, how to recognize potential
7 sources of exposure, and how to remediate those
8 sources.

9 **SEC. 1005. GRANT PROGRAM TO CONDUCT ENVIRON-**
10 **MENTAL HEALTH IMPROVEMENT ACTIVITIES**
11 **AND TO IMPROVE SOCIAL DETERMINANTS OF**
12 **HEALTH.**

13 (a) DEFINITIONS.—In this section:

14 (1) DIRECTOR.—The term “Director” means
15 the Director of the Centers for Disease Control and
16 Prevention, acting in collaboration with the Adminis-
17 trator of the Environmental Protection Agency and
18 the Director of the National Institute of Environ-
19 mental Health Sciences.

20 (2) ELIGIBLE ENTITY.—The term “eligible enti-
21 ty” means a State or local community that—

22 (A) bears a disproportionate burden of ex-
23 posure to environmental health hazards;

24 (B) bears a disproportionate burden of ex-
25 posure to unhealthy living conditions, low

1 standard housing conditions, low socioeconomic
2 status, poor nutrition, less opportunity for edu-
3 cational attainment, disproportionately high un-
4 employment rates, or lower literacy levels;

5 (C) has established a coalition—

6 (i) with not less than 1 community-
7 based organization or demonstration pro-
8 gram; and

9 (ii) with not less than 1—

10 (I) public health entity;

11 (II) health care provider organi-
12 zation;

13 (III) academic institution, includ-
14 ing any minority-serving institution
15 (including a Hispanic-serving institu-
16 tion, a historically black college or
17 university, or a tribal college or uni-
18 versity);

19 (IV) child-serving institution; or

20 (V) landlord or housing provider
21 working on lead remediation;

22 (D) ensures planned activities and funding
23 streams are coordinated to improve community
24 health; and

1 (E) submits an application in accordance
2 with subsection (c).

3 (b) ESTABLISHMENT.—The Director shall establish a
4 grant program under which eligible entities shall receive
5 grants to conduct environmental health improvement ac-
6 tivities and to improve social determinants of health.

7 (c) APPLICATION.—To receive a grant under this sec-
8 tion, an eligible entity shall submit an application to the
9 Director at such time, in such manner, and accompanied
10 by such information as the Director may require.

11 (d) USE OF GRANT FUNDS.—An eligible entity may
12 use a grant under this section—

13 (1) to promote environmental health;

14 (2) to address environmental health disparities
15 among all populations, including children; and

16 (3) to address racial and ethnic disparities in
17 social determinants of health.

18 (e) AMOUNT OF COOPERATIVE AGREEMENT.—The
19 Director shall award grants to eligible entities at the fol-
20 lowing 3 funding levels:

21 (1) LEVEL 1 COOPERATIVE AGREEMENTS.—

22 (A) IN GENERAL.—An eligible entity
23 awarded a grant under this paragraph shall use
24 the funds to identify environmental health prob-
25 lems and solutions by—

1 (i) establishing a planning and
2 prioritizing council in accordance with sub-
3 paragraph (B); and

4 (ii) conducting an environmental
5 health assessment in accordance with sub-
6 paragraph (C).

7 (B) PLANNING AND PRIORITIZING COUN-
8 CIL.—

9 (i) IN GENERAL.—A prioritizing and
10 planning council established under sub-
11 paragraph (A)(i) (referred to in this para-
12 graph as a “PPC”) shall assist the envi-
13 ronmental health assessment process and
14 environmental health promotion activities
15 of the eligible entity.

16 (ii) MEMBERSHIP.—Membership of a
17 PPC shall consist of representatives from
18 various organizations within public health,
19 planning, development, and environmental
20 services and shall include stakeholders
21 from vulnerable groups such as children,
22 the elderly, disabled, and minority ethnic
23 groups that are often not actively involved
24 in democratic or decisionmaking processes.

25 (iii) DUTIES.—A PPC shall—

1 (I) identify key stakeholders and
2 engage and coordinate potential part-
3 ners in the planning process;

4 (II) establish a formal advisory
5 group to plan for the establishment of
6 services;

7 (III) conduct an in-depth review
8 of the nature and extent of the need
9 for an environmental health assess-
10 ment, including a local epidemiological
11 profile, an evaluation of the service
12 provider capacity of the community,
13 and a profile of any target popu-
14 lations; and

15 (IV) define the components of
16 care and form essential programmatic
17 linkages with related providers in the
18 community.

19 (C) ENVIRONMENTAL HEALTH ASSESS-
20 MENT.—

21 (i) IN GENERAL.—A PPC shall carry
22 out an environmental health assessment to
23 identify environmental health concerns.

24 (ii) ASSESSMENT PROCESS.—The
25 PPC shall—

- 1 (I) define the goals of the assess-
2 ment;
- 3 (II) generate the environmental
4 health issue list;
- 5 (III) analyze issues with a sys-
6 tems framework;
- 7 (IV) develop appropriate commu-
8 nity environmental health indicators;
- 9 (V) rank the environmental
10 health issues;
- 11 (VI) set priorities for action;
- 12 (VII) develop an action plan;
- 13 (VIII) implement the plan; and
- 14 (IX) evaluate progress and plan-
15 ning for the future.

16 (D) EVALUATION.—Each eligible entity
17 that receives a grant under this paragraph shall
18 evaluate, report, and disseminate program find-
19 ings and outcomes.

20 (E) TECHNICAL ASSISTANCE.—The Direc-
21 tor may provide such technical and other non-
22 financial assistance to eligible entities as the
23 Director determines to be necessary.

24 (2) LEVEL 2 COOPERATIVE AGREEMENTS.—

25 (A) ELIGIBILITY.—

1 (i) IN GENERAL.—The Director shall
2 award grants under this paragraph to eli-
3 gible entities that have already—

4 (I) established broad-based col-
5 laborative partnerships; and

6 (II) completed environmental as-
7 sessments.

8 (ii) NO LEVEL 1 REQUIREMENT.—To
9 be eligible to receive a grant under this
10 paragraph, an eligible entity is not re-
11 quired to have successfully completed a
12 Level 1 Cooperative Agreement (as de-
13 scribed in paragraph (1)).

14 (B) USE OF GRANT FUNDS.—An eligible
15 entity awarded a grant under this paragraph
16 shall use the funds to further activities to carry
17 out environmental health improvement activi-
18 ties, including—

19 (i) addressing community environ-
20 mental health priorities in accordance with
21 paragraph (1)(C)(ii), including—

22 (I) geography;

23 (II) the built environment;

24 (III) air quality;

25 (IV) water quality;

- 1 (V) land use;
2 (VI) solid waste;
3 (VII) housing;
4 (VIII) crime;
5 (IX) socioeconomic status;
6 (X) ethnicity, social construct
7 and language preference;
8 (XI) educational attainment;
9 (XII) employment;
10 (XIII) food safety;
11 (XIV) nutrition;
12 (XV) health care services; and
13 (XVI) injuries;
- 14 (ii) building partnerships between
15 planning, public health, and other sectors,
16 including child-serving institutions, to ad-
17 dress how the built environment impacts
18 food availability and access and physical
19 activity to promote healthy behaviors and
20 lifestyles and reduce overweight and obe-
21 sity, musculoskeletal diseases, respiratory
22 conditions, dental, oral and mental health
23 conditions, poverty, and related co-
24 morbidities;

1 (iii) establishing programs to ad-
2 dress—

3 (I) how environmental and social
4 conditions of work and living choices
5 influence physical activity and dietary
6 intake; or

7 (II) how the conditions described
8 in subclause (I) influence the concerns
9 and needs of people who have im-
10 paired mobility and use assistance de-
11 vices, including wheelchairs, lower
12 limb prostheses, and hip, knee, and
13 other joint replacements; and

14 (iv) convening intervention and dem-
15 onstration programs that examine the role
16 of the social environment in connection
17 with the physical and chemical environ-
18 ment in—

19 (I) determining access to nutri-
20 tional food;

21 (II) improving physical activity to
22 reduce overweight, obesity, and co-
23 morbidities and increase quality of
24 life; and

1 (III) location and access to med-
2 ical facilities.

3 (3) LEVEL 3 COOPERATIVE AGREEMENTS.—

4 (A) IN GENERAL.—An eligible entity
5 awarded a grant under this paragraph shall use
6 the funds to identify and address racial and
7 ethnic disparities in social determinants of
8 health by creating demonstration programs that
9 assess the feasibility of establishing a federally
10 funded comprehensive program and describe
11 key outcomes that address racial and ethnic dis-
12 parities in social determinants of health.

13 (B) PROGRAM DESIGN.—

14 (i) EVALUATION.—No later than 1
15 year after enactment of this Act, the Di-
16 rector shall evaluate the best practices of
17 existing programs from the private, public,
18 community based, and academically sup-
19 ported initiatives focused on reducing dis-
20 parities in the social determinants of
21 health for racial and ethnic populations.

22 (ii) DEMONSTRATION PROJECTS.—
23 Not later than two years after the date of
24 enactment of this Act, the Director shall
25 implement at least ten demonstration

1 projects including at least one project for
2 each major racial and ethnic minority
3 group, each of which is unique to the cul-
4 tural and linguistic needs of each of the
5 following groups:

6 (I) Native Americans and Alaska
7 Natives.

8 (II) Asian Americans.

9 (III) African Americans/Blacks.

10 (IV) Hispanic/Latino-Americans.

11 (V) Native Hawaiians and Pacific
12 Islanders.

13 (iii) REPORT TO CONGRESS.—No later
14 than 2 years after the implementation of
15 the initial demonstration projects, the Di-
16 rector shall submit to Congress a report
17 which includes—

18 (I) a description of each dem-
19 onstration project and design;

20 (II) an evaluation of the cost-ef-
21 fectiveness of each project's preven-
22 tion and treatment efforts;

23 (III) an evaluation of the cultural
24 and linguistic appropriateness of each

1 project by racial and ethnic group;
2 and

3 (IV) an evaluation of the bene-
4 ficiary's health status improvement
5 under the demonstration project.

6 (iv) ANY OTHER INFORMATION
7 DEEMED APPROPRIATE BY THE DIREC-
8 TOR.—The Director shall require eligible
9 entities awarded a grant under this para-
10 graph to report any other information the
11 Director determines appropriate to be
12 shared by or developed by such entity, in-
13 cluding the following:

14 (I) Developing models and evalu-
15 ating methods that improve the cul-
16 tural and linguistically appropriate
17 services provided through the Centers
18 for Disease Control and Prevention to
19 target individuals impacted by health
20 disparities based on their race, eth-
21 nicity, and gender.

22 (II) Promoting the collaboration
23 between primary and specialty care
24 health care providers and patients, to
25 ensure patients impacted by health

1 disparities based on race, ethnicity,
2 and gender are receiving comprehen-
3 sive and organized treatment and
4 care.

5 (III) Educating health care pro-
6 fessionals on the causes and effects of
7 disparities in the social determinants
8 of health as it relates to minority and
9 racial and ethnic communities and the
10 need for culturally and linguistically
11 appropriate care in the prevention and
12 treatment of high-impact diseases.

13 (IV) Encouraging collaboration
14 among community and patient-based
15 organizations which work to address
16 disparities in the social determinants
17 of health as it relates to high-impact
18 diseases in minority and racial and
19 ethnic populations.

20 (f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this sec-
22 tion—

23 (1) \$25,000,000 for fiscal year 2019; and

24 (2) such sums as may be necessary for fiscal
25 years 2020 through 2022.

1 **SEC. 1006. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
2 **BETWEEN THE BUILT ENVIRONMENT AND**
3 **THE HEALTH OF COMMUNITY RESIDENTS.**

4 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
5 section, the term “eligible institution” means a public or
6 private nonprofit institution that submits to the Secretary
7 of Health and Human Services (in this section referred
8 to as the “Secretary”) and the Administrator of the Envi-
9 ronmental Protection Agency (in this section referred to
10 as the “Administrator”) an application for a grant under
11 the grant program authorized under subsection (b)(2) at
12 such time, in such manner, and containing such agree-
13 ments, assurances, and information as the Secretary and
14 Administrator may require.

15 (b) RESEARCH GRANT PROGRAM.—

16 (1) DEFINITION OF HEALTH.—In this section,
17 the term “health” includes—

18 (A) levels of physical activity;

19 (B) degree of mobility due to factors such
20 as musculoskeletal diseases, arthritis, and obe-
21 sity;

22 (C) consumption of nutritional foods;

23 (D) rates of crime;

24 (E) air, water, and soil quality;

25 (F) risk of injury;

26 (G) accessibility to health care services;

1 (H) levels of educational attainment; and

2 (I) other indicators as determined appro-
3 priate by the Secretary.

4 (2) GRANTS.—The Secretary, in collaboration
5 with the Administrator, shall provide grants to eligi-
6 ble institutions to conduct and coordinate research
7 on the built environment and its influence on indi-
8 vidual and population-based health.

9 (3) RESEARCH.—The Secretary shall support
10 research that—

11 (A) investigates and defines the causal
12 links between all aspects of the built environ-
13 ment and the health of residents;

14 (B) examines—

15 (i) the extent of the impact of the
16 built environment (including the various
17 characteristics of the built environment) on
18 the health of residents;

19 (ii) the variance in the health of resi-
20 dents by—

21 (I) location (such as inner cities,
22 inner suburbs, and outer suburbs);
23 and

1 (II) population subgroup (includ-
2 ing children, the elderly, the disadvan-
3 tagged); or

4 (iii) the importance of the built envi-
5 ronment to the total health of residents,
6 which is the primary variable of interest
7 from a public health perspective;

8 (C) is used to develop—

9 (i) measures to address health and the
10 connection of health to the built environ-
11 ment; and

12 (ii) efforts to link the measures to
13 travel and health databases;

14 (D) distinguishes carefully between per-
15 sonal attitudes and choices and external influ-
16 ences on observed behavior to determine how
17 much an observed association between the built
18 environment and the health of residents, versus
19 the lifestyle preferences of the people that
20 choose to live in the neighborhood, reflects the
21 physical characteristics of the neighborhood;
22 and

23 (E)(i) identifies or develops effective inter-
24 vention strategies to promote better health
25 among residents with a focus on behavioral

1 interventions and enhancements of the built en-
2 vironment that promote increased use by resi-
3 dents; and

4 (ii) in developing the intervention strate-
5 gies under clause (i), ensures that the interven-
6 tion strategies will reach out to high-risk popu-
7 lations, including racial and ethnic minorities,
8 low-income urban and rural communities, and
9 children.

10 (4) PRIORITY.—In providing assistance under
11 the grant program authorized under paragraph (2),
12 the Secretary and the Administrator shall give pri-
13 ority to research that incorporates—

14 (A) minority-serving institutions as grant-
15 ees;

16 (B) interdisciplinary approaches; or

17 (C) the expertise of the public health,
18 physical activity, nutrition and health care (in-
19 cluding child health), urban planning, and
20 transportation research communities in the
21 United States and abroad.

22 **SEC. 1007. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**
23 **TION.**

24 (a) FINDINGS.—

1 (1) GENERAL FINDINGS.—Congress finds
2 that—

3 (A) humans share an environment with a
4 wide variety of habitats and ecosystems that
5 nurture and sustain a diversity of species;

6 (B) the abundance of natural resources in
7 the environment forms the basis for the econ-
8 omy and has greatly contributed to human de-
9 velopment throughout history;

10 (C) the accelerated pace of human develop-
11 ment over the last several hundred years has
12 significantly impacted—

13 (i) the natural environment and its re-
14 sources;

15 (ii) the health and diversity of plant
16 and animal life;

17 (iii) the availability of critical habi-
18 tats;

19 (iv) the quality of the air and water;
20 and

21 (v) the global climate;

22 (D) the intervention of the Federal Gov-
23 ernment is necessary to minimize and mitigate
24 human impact on the environment—

25 (i) for the benefit of public health;

1 (ii) to maintain air quality and water
2 quality;

3 (iii) to sustain the diversity of plants
4 and animals;

5 (iv) to combat global climate change;
6 and

7 (v) to protect the environment;

8 (E) laws and regulations in the United
9 States have been enacted and promulgated to
10 minimize and mitigate human impact on the en-
11 vironment for the benefit of public health, to
12 maintain air quality and water quality, to sus-
13 tain wildlife, and to protect the environment, in-
14 cluding—

15 (i) chapter 3203 of title 54, United
16 States Code (commonly known as the “An-
17 tiquities Act of 1906”), which was initiated
18 by President Theodore Roosevelt to create
19 the National Park System;

20 (ii) the National Environmental Policy
21 Act of 1969 (42 U.S.C. 4321 et seq.);

22 (iii) the Clean Air Act (42 U.S.C.
23 7401 et seq.);

24 (iv) the Federal Water Pollution Con-
25 trol Act (33 U.S.C. 1251 et seq.);

1 (v) the Comprehensive Environmental
2 Response, Compensation, and Liability Act
3 of 1980 (42 U.S.C. 9601 et seq.);

4 (vi) the Endangered Species Act of
5 1973 (16 U.S.C. 1531 et seq.); and

6 (vii) the National Forest Management
7 Act of 1976 (Public Law 94–588; 90 Stat.
8 2949) and the amendments made by that
9 Act; and

10 (F) attempts to repeal or weaken key envi-
11 ronmental safeguards pose dangers to the pub-
12 lic health, air quality, water quality, wildlife,
13 and the environment.

14 (2) FINDINGS ON CHANGES AND PROPOSED
15 CHANGES IN LAW.—Congress finds that, since 2001,
16 the following changes and proposed changes to exist-
17 ing law or regulations have negatively impacted or
18 will negatively impact the environment and public
19 health:

20 (A) CLEAN WATER.—

21 (i) FILL MATERIAL.—

22 (I) On May 9, 2002, the Envi-
23 ronmental Protection Agency and the
24 Corps of Engineers issued a final rule,
25 entitled “Final Revisions to the Clean

1 Water Act Regulatory Definitions of
2 ‘Fill Material’ and ‘Discharge of Fill
3 Material’” (67 Fed. Reg. 31129),
4 that reconciled regulations imple-
5 menting section 404 of the Federal
6 Water Pollution Control Act (33
7 U.S.C. 1344) by redefining the term
8 “fill material” and amending the defi-
9 nition of the term “discharge of fill
10 material”, reversing a 25-year-old reg-
11 ulation.

12 (II) The rule described in sub-
13 clause (I)—

14 (aa) fails to restrict the
15 dumping of hardrock mining
16 waste, construction debris, and
17 other industrial wastes into riv-
18 ers, streams, lakes, and wetlands;
19 and

20 (bb) allows destructive
21 mountaintop removal coal mining
22 companies to dump waste into
23 streams and lakes, polluting the
24 surrounding natural habitat and
25 poisoning plants and animals

1 that depend on those water
2 sources.

3 (ii) LIVESTOCK WASTE REGULA-
4 TIONS.—

5 (I) On February 12, 2003, the
6 Environmental Protection Agency
7 published the rule entitled “National
8 Pollutant Discharge Elimination Sys-
9 tem Permit Regulation and Effluent
10 Limitation Guidelines and Standards
11 for Concentrated Animal Feeding Op-
12 erations (CAFOs)” (68 Fed. Reg.
13 7176), new livestock waste regulations
14 that aimed to control factory farm
15 pollution but which would severely un-
16 dermine then-existing protections
17 under the Federal Water Pollution
18 Control Act (33 U.S.C. 1251 et seq.).

19 (II) The regulation described in
20 subclause (I) allows large-scale animal
21 factories to foul waters in the United
22 States with animal waste, allows live-
23 stock owners to draft their own pollu-
24 tion-management plans and avoid
25 ground water monitoring, legalizes the

1 discharge of contaminated runoff
2 water rich in nitrogen, phosphorus,
3 bacteria, and metals, and ensures that
4 large factory farms are not held liable
5 for the environmental damage they
6 cause.

7 (III) In a 2005 Federal court de-
8 cision, *Waterkeeper Alliance, et al. v.*
9 *Environmental Protection Agency*,
10 399 F.3d 486 (2nd Cir. 2005), major
11 parts of the rule were upheld, others
12 vacated, and still others remanded
13 back to the Environmental Protection
14 Agency.

15 (IV) On November 20, 2008, the
16 Environmental Protection Agency
17 published a revised final rule, entitled
18 “Revised National Pollutant Dis-
19 charge Elimination System Permit
20 Regulation and Effluent Limitations
21 Guidelines for Concentrated Animal
22 Feeding Operations in Response to
23 the Waterkeeper Decision” (73 Fed.
24 Reg. 70418), that undermines envi-
25 ronmental protection provisions by re-

1 moving mandatory permitting require-
2 ments and allowing large animal
3 farms to self-certify the absence of
4 pollutant discharge activity.

5 (iii) TOTAL MAXIMUM DAILY LOAD.—

6 (I) On March 19, 2003, the En-
7 vironmental Protection Agency pub-
8 lished a new rule regarding the total
9 maximum daily load program under
10 section 303(d) of the Federal Water
11 Pollution Control Act (33 U.S.C.
12 1313(d)), entitled “Withdrawal of Re-
13 visions to the Water Quality Planning
14 and Management Regulation and Re-
15 visions to the National Pollutant Dis-
16 charge Elimination System Program
17 in Support of Revisions to the Water
18 Quality Planning and Management
19 Regulation” (68 Fed. Reg. 13608),
20 that regulates the maximum amount
21 of a particular pollutant that can be
22 present in a body of water and still
23 meet water quality standards.

24 (II) The new rule described in
25 subclause (I) withdrew the then-exist-

1 ing regulation issued on July 13,
2 2000, and entitled “Revisions to the
3 Water Quality Planning and Manage-
4 ment Regulation and Revisions to the
5 National Pollutant Discharge Elim-
6 ination System Program in Support of
7 Revisions to the Water Quality Plan-
8 ning and Management Regulation”
9 (65 Fed. Reg. 43586) and halted mo-
10 mentum in cleaning up polluted wa-
11 terways throughout the United States.

12 (III) By abandoning the then-ex-
13 isting rule, the Environmental Protec-
14 tion Agency is undermining the effec-
15 tiveness of cleanup plans and is allow-
16 ing States to avoid cleaning polluted
17 waters entirely by dropping them from
18 their cleanup lists.

19 (IV) Waterways play a crucial
20 role in the lives of the people of the
21 United States and are critical to the
22 livelihood of fish and wildlife.

23 (V) The result of dropping the
24 rule described in subclause (II) is that
25 the restoration of polluted rivers,

1 shorelines, and lakes will be delayed,
2 harming more fish and wildlife and
3 worsening the quality of drinking
4 water.

5 (iv) WATERS OF THE UNITED
6 STATES.—

7 (I) On December 2, 2008, the
8 Environmental Protection Agency and
9 the Corps of Engineers jointly issued
10 a guidance document, entitled “Clean
11 Water Act Jurisdiction Following the
12 U.S. Supreme Court’s Decision in
13 *Rapanos v. United States & Carabell*
14 *v. United States*”.

15 (II) The guidance described in
16 subclause (I) dictates enforcement ac-
17 tions under the Federal Water Pollu-
18 tion Control Act (33 U.S.C. 1251 et
19 seq.) and calls for a complicated
20 “case-by-case” analysis to determine
21 jurisdiction for waterways that do not
22 flow all year.

23 (III) Enforcement actions de-
24 scribed in subclause (II) endanger
25 small streams and wetlands that serve

1 as important habitats for aquatic life,
2 which play a fundamental role in safe-
3 guarding sources of clean drinking
4 water and mitigate the risks and ef-
5 fects of floods and droughts.

6 (IV) The definition provided in
7 the guidance described in subclause
8 (I) for “waters of the United States”
9 is applicable to the Federal Water
10 Pollution Control Act (33 U.S.C.
11 1251 et seq.) as a whole, potentially
12 affecting programs that control indus-
13 trial pollution and sewage levels, pre-
14 vent oil spills, and set water quality
15 standards for all waters in the United
16 States protected under that Act.

17 (B) FORESTS AND LAND MANAGEMENT.—

18 (i) HEALTHY FORESTS RESTORATION
19 ACT OF 2003.—

20 (I) On December 3, 2003, the
21 President signed into law the Healthy
22 Forests Restoration Act of 2003 (16
23 U.S.C. 6501 et seq.) (referred to in
24 this clause as the “law”).

1 (II) Although the law attempts to
2 reduce the risk of catastrophic forest
3 fires, the law provides a boon to tim-
4 ber companies by accelerating the ag-
5 gressive thinning of backcountry for-
6 ests that are located far from at-risk
7 communities.

8 (III) The law allows for increased
9 logging of large, fire-resistant trees
10 that are not in close proximity to
11 homes and communities.

12 (IV) The law undermines critical
13 protections for endangered species by
14 exempting Federal land management
15 agencies from consulting with the
16 United States Fish and Wildlife Serv-
17 ice before approving any action that
18 could harm endangered plants or wild-
19 life.

20 (V) The law limits public partici-
21 pation by reducing the number of en-
22 vironmental reviews for projects car-
23 ried out under the law.

1 (ii) NFS LAND MANAGEMENT PLAN-
2 NING FINAL PLANNING RULE AND RECORD
3 OF DECISION.—

4 (I) On April 21, 2008, the Sec-
5 retary of Agriculture issued a final
6 rule entitled “National Forest System
7 Land Management Planning” (73
8 Fed. Reg. 21486 (April 21, 2008))
9 (referred to in this clause as the “re-
10 vised rule”).

11 (II) The revised rule is a revision
12 of a similar final rule entitled “Na-
13 tional Forest System Land Manage-
14 ment Planning” (70 Fed Reg. 1022
15 (January 5, 2005)), which the United
16 States District Court for the Northern
17 District of California remanded to the
18 Secretary of Agriculture in the case
19 styled *Citizens for Better Forestry v.*
20 *United States Department of Agri-*
21 *culture* (481 F. Supp. 2d 1059 (N.D.
22 Cal. 2007)) for violating—

23 (aa) the National Environ-
24 mental Policy Act of 1969 (42
25 U.S.C. 4321 et seq.);

1 (bb) the Endangered Species
2 Act of 1973 (16 U.S.C. 1531 et
3 seq.); and

4 (cc) subchapter II of chapter
5 5, and chapter 7, of title 5,
6 United States Code (commonly
7 known as the “Administrative
8 Procedure Act”).

9 (III) The revised rule eliminates
10 strict forest planning standards estab-
11 lished in 1982.

12 (IV) The revised rule opens mil-
13 lions of acres of public land to dam-
14 aging and invasive logging, mining,
15 and drilling operations.

16 (V) The revised rule would re-
17 verse more than 20 years of protec-
18 tions for wildlife and national forests
19 by—

20 (aa) removing the overall
21 goal of ensuring ecological sus-
22 tainability in managing the Na-
23 tional Forest System;

24 (bb) weakening the effect of
25 the National Forest Management

1 Act of 1976 (Public Law 94–588;
2 90 Stat. 2949) and the amend-
3 ments made by that Act; and

4 (cc) effectively ending the
5 review of forest management
6 plans under the National Envi-
7 ronmental Policy Act of 1969 (42
8 U.S.C. 4321 et seq.).

9 (iii) INVENTORIED ROADLESS AREA
10 RULES.—

11 (I) On September 20, 2006, the
12 United States District Court for the
13 Northern District of California va-
14 cated the final rule entitled “Special
15 Areas; State Petitions for Inventoried
16 Roadless Area Management” (70 Fed.
17 Reg. 25654 (May 13, 2005)) (referred
18 to in this clause as the “2005 rule”),
19 which gave each Governor of a State
20 18 months to petition the Federal
21 Government—

22 (aa) to restore the inven-
23 toried roadless area rules applica-
24 ble to the State of the Governor
25 before the effective date of the

1 final rule entitled “Special Areas;
2 Roadless Area Conservation” (66
3 Fed. Reg. 3244 (January 12,
4 2001)) (referred to in this clause
5 as the “2001 rule”); or

6 (bb) to submit a new man-
7 agement and development plan
8 for National Forest System
9 inventoried roadless areas within
10 the State.

11 (II) Despite the enjoinder of
12 the 2005 rule and the subsequent res-
13 toration of the 2001 rule, the Forest
14 Service has continued to allow States
15 to petition for a special rule under the
16 authority of section 553(e) of title 5,
17 United States Code, and has issued a
18 final rule entitled “Special Areas;
19 Roadless Area Conservation; Applica-
20 bility to the National Forests in
21 Idaho” (73 Fed. Reg. 61456 (October
22 16, 2008)).

23 (III) As a result, 58,500,000
24 acres of wild National Forest System
25 land are still vulnerable to logging,

1 road building, and other developments
2 that may fragment natural habitats
3 and negatively impact fish and wild-
4 life.

5 (iv) BLM RESOURCE MANAGEMENT
6 PLANS.—

7 (I) On November 28, 2008, the
8 Bureau of Land Management an-
9 nounced the record of decision entitled
10 “Record of Decision for Oil Shale and
11 Tar Sands Resources to Address
12 Land Use Allocations in Colorado,
13 Utah, and Wyoming” (73 Fed. Reg.
14 72519 (November 28, 2008)), which
15 amended 12 resource management
16 plans in the States of Colorado, Utah,
17 and Wyoming, opening 2,000,000
18 acres of public land to commercial tar
19 sands and oil shale exploration and
20 development.

21 (II) On November 18, 2008, the
22 Bureau of Land Management issued
23 the final rule entitled “Oil Shale Man-
24 agement—General” (73 Fed. Reg.
25 69414 (November 18, 2008)), setting

1 the policies and procedures for a com-
2 mercial leasing program for the man-
3 agement of federally owned oil shale
4 in the States referred to in subclause
5 (I).

6 (III) Previously barred by a con-
7 gressional moratorium on the com-
8 mercial leasing regulations for oil
9 shale until September 30, 2008, the
10 development of oil shale on public
11 land poses a serious threat to land
12 conservation, endangered and threat-
13 ened species, and critical habitat.

14 (IV) Domestic shale oil produc-
15 tion authorized by the final rules de-
16 scribed in subclauses (I) and (II)—

17 (aa) is water- and energy-in-
18 tensive; and

19 (bb) will intensify existing
20 water scarcity in the arid West-
21 ern United States and potentially
22 degrade air and water quality for
23 surrounding populations.

24 (C) SCIENTIFIC REVIEW.—

1 (i) On December 16, 2008, the United
2 States Fish and Wildlife Service and the
3 National Marine Fisheries Service jointly
4 issued a new rule, entitled “Interagency
5 Cooperation Under the Endangered Spe-
6 cies Act” (73 Fed. Reg. 76272) amending
7 regulations governing interagency coopera-
8 tion under section 7 of the Endangered
9 Species Act of 1973 (16 U.S.C. 1536).

10 (ii) The rule described in clause (i)
11 undermines the intention of the Endan-
12 gered Species Act (16 U.S.C. 1531 et seq.)
13 to protect species and the ecosystems on
14 which those species depend by allowing
15 Federal agencies to carry out, permit, or
16 fund an action without proper environ-
17 mental review and expert third-party con-
18 sultation from Federal wildlife experts.

19 (iii) Under the rule described in
20 clause (i), Federal agencies can unilaterally
21 circumvent the formal review process,
22 eliminating longstanding and scientifically
23 grounded safeguards that serve to protect
24 the biodiversity of ecosystems in the
25 United States and avert harm to thou-

1 sands of endangered and threatened spe-
2 cies.

3 (b) STATEMENT OF POLICY.—It is the policy of the
4 Federal Government to work in conjunction with States,
5 territories, Tribal governments, international organiza-
6 tions, and foreign governments as a steward of the envi-
7 ronment for the benefit of public health, to maintain air
8 quality and water quality, to sustain the diversity of plant
9 and animal species, to combat global climate change, and
10 to protect the environment for future generations.

11 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
12 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
13 TIONS, LAWS, OR PROPOSED LAWS.—

14 (1) STUDY.—Not later than 30 days after the
15 date of enactment of this Act, the President shall
16 enter into an arrangement under which the National
17 Academy of Sciences shall conduct a study to deter-
18 mine the impact on public health, air quality, water
19 quality, wildlife, and the environment of the fol-
20 lowing regulations, laws, and proposed laws:

21 (A) CLEAN WATER.—

22 (i) The final rule of the Environ-
23 mental Protection Agency and the Corps of
24 Engineers entitled “Final Revisions to the
25 Clean Water Act Regulatory Definitions of

1 ‘Fill Material’ and ‘Discharge of Fill Mate-
2 rial’” (67 Fed. Reg. 31129 (May 9,
3 2002)).

4 (ii) The final rule of the Environ-
5 mental Protection Agency entitled “Re-
6 vised National Pollutant Discharge Elim-
7 nation System Permit Regulation and Ef-
8 fluent Limitations Guidelines for Con-
9 centrated Animal Feeding Operations in
10 Response to the Waterkeeper Decision”
11 (73 Fed. Reg. 70418 (November 20,
12 2008)).

13 (iii) The final rule entitled “With-
14 drawal of Revisions to the Water Quality
15 Planning and Management Regulation and
16 Revisions to the National Pollutant Dis-
17 charge Elimination System Program in
18 Support of Revisions to the Water Quality
19 Planning and Management Regulation”
20 (68 Fed. Reg. 13608 (March 19, 2003)).

21 (iv) The guidance document of the
22 Environmental Protection Agency and the
23 Corps of Engineers entitled “Clean Water
24 Act Jurisdiction Following the U.S. Su-
25 preme Court’s Decision in *Rapanos v.*

1 United States & Carabell v. United States”
2 (December 2, 2008).

3 (B) FORESTS AND LAND MANAGEMENT.—

4 (i) The Healthy Forests Restoration
5 Act of 2003 (16 U.S.C. 6501 et seq.).

6 (ii) The application of section 553(e)
7 of title 5, United States Code, such that a
8 State may petition for a special rule for
9 the National Forest System inventoried
10 roadless areas within the State.

11 (iii) The final rule entitled “National
12 Forest System Land Management Plan-
13 ning” (73 Fed. Reg. 21486 (April 21,
14 2008)).

15 (iv) The final rule entitled “Oil Shale
16 Management—General” (73 Fed. Reg.
17 69414 (November 18, 2008)).

18 (v) The record of decision entitled
19 “Record of Decision for Oil Shale and Tar
20 Sands Resources To Address Land Use Al-
21 locations in Colorado, Utah, and Wyo-
22 ming” (73 Fed. Reg. 72519 (November
23 28, 2008)).

24 (C) SCIENTIFIC REVIEW.—The final rule
25 of the United States Fish and Wildlife Service

1 and the National Marine Fisheries Service enti-
2 tled “Interagency Cooperation Under the En-
3 dangered Species Act” (73 Fed. Reg. 76272
4 (December 16, 2008)).

5 (2) METHOD.—In conducting the study under
6 paragraph (1), the National Academy of Sciences
7 may use and compare existing scientific studies re-
8 garding the regulations, laws, and proposed laws de-
9 scribed in paragraph (1).

10 (3) REPORT.—Not later than 270 days after
11 the date on which the President enters into the ar-
12 rangement under paragraph (1), the National Acad-
13 emy of Sciences shall make publicly available and
14 shall submit to the Congress and to the head of each
15 department and agency of the Federal Government
16 that issued, implements, or would implement a regu-
17 lation, law, or proposed law described in paragraph
18 (1), a report that includes—

19 (A) a description of the impact of each
20 regulation, law, or proposed law described in
21 paragraph (1) on public health, air quality,
22 water quality, wildlife, and the environment,
23 compared to the impact of preexisting regula-
24 tions, or laws in effect, as applicable, includ-
25 ing—

1 (i) any negative impacts to air quality
2 or water quality;

3 (ii) any negative impacts to wildlife;

4 (iii) any delays in hazardous waste
5 cleanup that are projected to be hazardous
6 to public health; and

7 (iv) any other negative impact on pub-
8 lic health or the environment; and

9 (B) any recommendations that the Na-
10 tional Academy of Sciences considers appro-
11 priate to maintain, restore, or improve in whole
12 or in part protections for public health, air
13 quality, water quality, wildlife, and the environ-
14 ment for each of the regulations, laws, and pro-
15 posed laws described in paragraph (1), which
16 may include recommendations for the adoption
17 of any regulation or law in place or proposed
18 prior to January 1, 2001.

19 (d) DEPARTMENT AND AGENCY REVISION OF EXIST-
20 ING RULES, REGULATIONS, OR LAWS.—Not later than
21 180 days after the date on which the report is submitted
22 pursuant to subsection (c)(3), the head of each depart-
23 ment or agency that has issued or implemented a regula-
24 tion or law described in subsection (c)(1) shall submit to
25 Congress a plan describing the steps the department or

1 agency will take, or has taken, to restore or improve pro-
2 tections for public health and the environment in whole
3 or in part that were in existence prior to the issuance of
4 the applicable regulation or law.

5 **SEC. 1008. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
6 **WATER HORIZON OIL RIG EXPLOSION IN THE**
7 **GULF COAST.**

8 (a) STUDY.—The Comptroller General of the United
9 States (referred to in this section as the “Comptroller
10 General”) shall conduct a study on the type and scope of
11 health care services administered through the Department
12 of Health and Human Services addressing the provision
13 of health care to racial and ethnic minorities, including
14 residents, cleanup workers, and volunteers, affected by the
15 blowout and explosion of the mobile offshore drilling unit
16 Deepwater Horizon that occurred on April 20, 2010, and
17 resulting hydrocarbon releases into the environment.

18 (b) SPECIFIC COMPONENTS.—In carrying out sub-
19 section (a), the Comptroller General shall—

20 (1) assess the type, size, and scope of programs
21 administered by the Secretary of Health and Human
22 Services that focus on the provision of health care
23 to communities on the Gulf Coast;

24 (2) identify the merits and disadvantages asso-
25 ciated with each of the programs;

1 (3) perform an analysis of the costs and bene-
2 fits of the programs; and

3 (4) determine whether there is any duplication
4 of programs.

5 (c) REPORT.—Not later than 180 days after the date
6 of enactment of this Act, the Comptroller General shall
7 submit to Congress a report that includes—

8 (1) the findings of the study conducted under
9 subsection (a); and

10 (2) recommendations for improving access to
11 health care for racial and ethnic minorities.

12 **Subtitle B—Gun Violence**

13 **SEC. 1011. FINDINGS.**

14 Congress finds as follows:

15 (1) On average, 86 Americans are killed by
16 guns each day.

17 (2) An estimated 15,549 people were killed by
18 guns in 2017, not including suicides.

19 (3) Gun violence disproportionately affects com-
20 munities of color, especially African Americans (who
21 comprise around 14 percent of the United States
22 population but account for more than half the coun-
23 try’s gun homicide victims).

24 (4) On average, there is more than one mass
25 shooting each day in the United States.

1 **SEC. 1012. REAFFIRMING RESEARCH AUTHORITY OF THE**
2 **CENTERS FOR DISEASE CONTROL AND PRE-**
3 **VENTION.**

4 (a) IN GENERAL.—Section 391 of the Public Health
5 Service Act (42 U.S.C. 280b) is amended—

6 (1) in subsection (a)(1), by striking “research
7 relating to the causes, mechanisms, prevention, diag-
8 nosis, treatment of injuries, and rehabilitation from
9 injuries;” and inserting “research, including data
10 collection, relating to—

11 “(A) the causes, mechanisms, prevention,
12 diagnosis, and treatment of injuries, including
13 with respect to gun violence; and

14 “(B) rehabilitation from such injuries;”;
15 and

16 (2) by adding at the end the following new sub-
17 section:

18 “(c) NO ADVOCACY OR PROMOTION OF GUN CON-
19 TROL.—Nothing in this section shall be construed to—

20 “(1) authorize the Secretary to give assistance,
21 make grants, or enter into cooperative agreements or
22 contracts for the purpose of advocating or promoting
23 gun control; or

24 “(2) permit a recipient of any assistance, grant,
25 cooperative agreement, or contract under this section
26 to use such assistance, grant, agreement, or contract

1 for the purpose of advocating or promoting gun con-
2 trol.”.

3 **SEC. 1013. NATIONAL VIOLENT DEATH REPORTING SYSTEM.**

4 The Secretary of Health and Human Services, acting
5 through the Director of the Centers for Disease Control
6 and Prevention, shall improve, particularly through the in-
7 clusion of additional States, the National Violent Death
8 Reporting System, as authorized by sections 301(a) and
9 391(a) of the Public Service Health Act (42 U.S.C.
10 241(a), 280(b)). Participation in the system by the States
11 shall be voluntary.

12 **SEC. 1014. REPORT ON EFFECTS OF GUN VIOLENCE ON**
13 **PUBLIC HEALTH.**

14 Not later than one year after the date of the enact-
15 ment of this Act, and annually thereafter, the Surgeon
16 General shall submit to Congress a report on the effects
17 on public health, including mental health, of gun violence
18 in the United States during the preceding year, and the
19 status of actions taken to address such effects.

20 **SEC. 1015. REPORT ON EFFECTS OF GUN VIOLENCE ON**
21 **MENTAL HEALTH IN MINORITY COMMU-**
22 **NITIES.**

23 Not later than one year after the date of the enact-
24 ment of this Act, the Deputy Assistant Secretary for Mi-
25 nority Health in the Office of the Secretary of Health and

1 Human Services shall submit to the Congress a report on
2 the effects of gun violence on public health, including men-
3 tal health, in minority communities in the United States,
4 and the status of actions taken to address such effects.

