

116TH CONGRESS
2D SESSION

S. 4819

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

IN THE SENATE OF THE UNITED STATES

OCTOBER 20 (legislative day, OCTOBER 19), 2020

Ms. HIRONO (for herself, Mrs. GILLIBRAND, Mr. MERKLEY, Ms. DUCKWORTH, Mr. BLUMENTHAL, Mr. SANDERS, Mr. BOOKER, Mr. CARDIN, and Mr. KAINE) 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 2020”.

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

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

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

- Sec. 101. Amendment to the Public Health Service Act.
- Sec. 102. Elimination of prerequisite of direct appropriations for data collection and analysis.
- Sec. 103. Collection of data for the Medicare program.
- Sec. 104. Revision of HIPAA claims standards.
- Sec. 105. National Center for Health Statistics.
- Sec. 106. Disparities data collected by the Federal Government.
- Sec. 107. Data collection and analysis grants to minority-serving institutions.
- Sec. 108. Standards for measuring sexual orientation, gender identity, and socioeconomic status in collection of health data.
- Sec. 109. Safety and effectiveness of drugs with respect to racial and ethnic background.
- Sec. 110. Improving health data regarding Native Hawaiians and other Pacific Islanders.
- Sec. 111. Clarification of simplified administrative reporting requirement.

TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH AND HEALTH CARE

- Sec. 201. Definitions; findings.
- Sec. 202. Improving access to services for individuals with limited English proficiency.
- Sec. 203. Ensuring standards for culturally and linguistically appropriate services in health care.
- Sec. 204. Culturally and linguistically appropriate health care in the Public Health Service Act.
- Sec. 205. Pilot program for improvement and development of State medical interpreting services.
- Sec. 206. Training tomorrow's doctors for culturally and linguistically appropriate care: graduate medical education.
- Sec. 207. Federal reimbursement for culturally and linguistically appropriate services under the Medicare, Medicaid, and State Children's Health Insurance Programs.
- Sec. 208. Increasing understanding of and improving health literacy.
- Sec. 209. Requirements for health programs or activities receiving Federal funds.
- Sec. 210. Report on Federal efforts to provide culturally and linguistically appropriate health care services.
- Sec. 211. English for speakers of other languages.
- Sec. 212. Implementation.
- Sec. 213. Language access services.
- Sec. 214. Medically underserved populations.

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- Sec. 302. Hispanic-serving institutions, historically black colleges and universities, Asian American and Native American Pacific Islander-serving institutions, Tribal colleges, regional community-based organizations, and national minority medical associations.
- Sec. 303. Loan repayment program of Centers for Disease Control and Prevention.
- Sec. 304. Cooperative agreements for online degree programs at schools of public health and schools of allied health.
- Sec. 305. Sense of Congress on the mission of the National Health Care Workforce Commission.

- Sec. 306. Scholarship and fellowship programs.
- Sec. 307. McNair Postbaccalaureate Achievement Program.
- Sec. 308. Rules for determination of full-time equivalent residents for cost-reporting periods.
- Sec. 309. Developing and implementing strategies for local health equity.
- Sec. 310. Loan forgiveness for mental and behavioral health social workers.
- Sec. 311. Health Professions Workforce Fund.
- Sec. 312. Findings; sense of Congress relating to graduate medical education.
- Sec. 313. Career support for skilled, internationally educated health professionals.
- Sec. 314. Study and report on strategies for increasing diversity.
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- Sec. 402. Removing citizenship and immigration barriers to access to affordable health care under ACA.
- Sec. 403. Study on the uninsured.
- Sec. 404. Medicaid in the territories.
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- Sec. 406. Indian defined in title I of the Patient Protection and Affordable Care Act.
- Sec. 407. Removing Medicare barrier to health care.
- Sec. 408. 100 percent FMAP for medical assistance provided by urban Indian health centers.
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- Sec. 410. Medicaid coverage for citizens of freely associated states.

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- Sec. 1002. Findings.
- Sec. 1003. Health impact assessments.
- Sec. 1004. Implementation of recommendations by Environmental Protection Agency.
- Sec. 1005. Grant program to conduct environmental health improvement activities and to improve social determinants of health.
- Sec. 1006. Additional research on the relationship between the built environment and the health of community residents.
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- Sec. 1010. Correcting hurtful and alienating names in government expression (CHANGE).

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- Sec. 1012. Reaffirming research authority of the Centers for Disease Control and Prevention.
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1 **SEC. 3. FINDINGS.**

2 The Congress finds as follows:

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

9 (2) Health disparities are a function of not only
 10 access to health care, but also the social deter-
 11 minants of health—including the environment, the
 12 physical structure of communities, nutrition and
 13 food options, educational attainment, employment,

1 race, ethnicity, sex, geography, language preference,
2 immigrant or citizenship status, sexual orientation,
3 gender identity, socioeconomic status, or disability
4 status—that directly and indirectly affect the health,
5 health care, and wellness of individuals and commu-
6 nities.

7 (3) Over the next few decades, the United
8 States will face a shortage of health care providers
9 and allied health workers.

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

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

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

20 (7) Efforts to improve minority health have
21 been limited by inadequate resources in funding,
22 staffing, stewardship, and accountability. Targeted
23 investments that are focused on disparities elimi-
24 nation must be made in providing care and services

1 that are community-based, including prevention and
2 policies addressing social determinants of health.

3 (8) In 2011, the Department of Health and
4 Human Services developed the HHS Action Plan to
5 Reduce Racial and Ethnic Health Disparities and
6 the National Stakeholder Strategy for Achieving
7 Health Equity, which are 2 strategic plans that rep-
8 resent the first coordinated roadmap in the United
9 States to reducing health disparities. These com-
10 prehensive plans, along with the National Prevention
11 Strategy issued by the National Prevention Council
12 of the Department of Health and Human Services,
13 Healthy People 2030, and the National Quality
14 Strategy of the Agency for Healthcare Research and
15 Quality, as well as critical resources such as the
16 2012 National Healthcare Quality and Disparities
17 Reports, will work to increase the number of people
18 in the United States who are healthy at every stage
19 of life.

20 (9) The Secretary of Health and Human Serv-
21 ices has also reviewed and advanced updated clinical
22 guidelines and developed other strategic planning
23 documents to combat health disparities with a high
24 impact on minority populations and to provide high-
25 quality family planning services. Such guidelines and

1 documents include the National HIV/AIDS Strategy,
2 the Action Plan for the Prevention, Care, and Treat-
3 ment of Viral Hepatitis, and recommendations of the
4 Centers for Disease Control and Prevention and the
5 Office of Population Affairs.

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

12 (11) The Health Information Technology for
13 Economic and Clinical Health Act of 2009, part of
14 the American Recovery and Reinvestment Act of
15 2009 (Public Law 111–5), provides that the nation-
16 wide health information exchange infrastructure be
17 developed and used to reduce health disparities,
18 among other purposes.

19 **TITLE I—DATA COLLECTION** 20 **AND REPORTING**

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

22 **ACT.**

23 (a) **PURPOSE.**—It is the purpose of the amendment
24 made by this section to promote data collection, analysis,
25 and reporting by race, ethnicity, sex, primary language,

1 sexual orientation, disability status, gender identity, age,
 2 and socioeconomic status among federally supported
 3 health programs.

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

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

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

13 “(a) REQUIREMENTS.—

14 “(1) IN GENERAL.—Each health-related pro-
 15 gram shall—

16 “(A) require the collection, by the agency
 17 or program involved, of data on the race, eth-
 18 nicity, sex, primary language, sexual orienta-
 19 tion, disability status, gender identity, age, and
 20 socioeconomic status of each applicant for and
 21 recipient of health-related assistance under such
 22 program, including—

23 “(i) using, at a minimum, standards
 24 for data collection on race, ethnicity, sex,
 25 primary language, sexual orientation, gen-

1 der identity, age, socioeconomic status, and
2 disability status as each are developed
3 under section 3101;

4 “(ii) collecting data for additional
5 population groups if such groups can be
6 aggregated into the race and ethnicity cat-
7 egories outlined by standards developed
8 under section 3101;

9 “(iii) using, where practicable, the
10 standards developed by the Health and
11 Medicine Division of the National Acad-
12 emies of Sciences, Engineering, and Medi-
13 cine (formerly known as the ‘Institute of
14 Medicine’) in the 2009 publication, entitled
15 ‘Race, Ethnicity, and Language Data:
16 Standardization for Health Care Quality
17 Improvement’; and

18 “(iv) where practicable, collecting
19 such data through self-reporting;

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

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

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

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

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

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

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

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

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

12 “(B) diminish any requirements, including
13 such requirements in effect on or after the date
14 of enactment of this section, on health care pro-
15 viders to collect data.

16 “(3) NO COMPELLED DISCLOSURE OF DATA.—
17 This title does not authorize any health care pro-
18 vider, Federal official, or other entity to compel the
19 disclosure of any data collected under this title. The
20 disclosure of any such data by an individual pursu-
21 ant to this title shall be strictly voluntary.

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

1 “(1) under the same privacy protections as the
2 Secretary applies to other health data under the reg-
3 ulations promulgated under section 264(c) of the
4 Health Insurance Portability and Accountability Act
5 of 1996 relating to the privacy of individually identi-
6 fiable health information and other protections; and

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

13 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
14 Secretary shall develop and implement a national plan to
15 ensure the collection of data in a culturally and linguis-
16 tically appropriate manner, to improve the collection, anal-
17 ysis, and reporting of racial, ethnic, sex, primary lan-
18 guage, sexual orientation, disability status, gender iden-
19 tity, age, and socioeconomic status data at the Federal,
20 State, territorial, Tribal, and local levels, including data
21 to be collected under subsection (a), and to ensure that
22 data collection activities carried out under this section are
23 in compliance with standards developed under section
24 3101. The Data Council of the Department of Health and
25 Human Services, in consultation with the National Com-

1 mittee on Vital Health Statistics, the Office of Minority
2 Health, Office on Women’s Health, and other appropriate
3 public and private entities, shall make recommendations
4 to the Secretary concerning the development, implementa-
5 tion, and revision of the national plan. Such plan shall
6 include recommendations on how to—

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

10 “(2) expand knowledge among Federal agen-
11 cies, States, territories, Indian Tribes, counties, mu-
12 nicipalities, health providers, health plans, and the
13 general public that data collection, analysis, and re-
14 porting by race, ethnicity, sex, primary language,
15 sexual orientation, gender identity, age, socio-
16 economic status, and disability status is legal and
17 necessary to assure equity and nondiscrimination in
18 the quality of health care services;

19 “(3) ensure that future patient record systems
20 follow Federal standards promulgated under the
21 Health Information Technology for Economic and
22 Clinical Health Act for the collection and meaningful
23 use of electronic health data on race, ethnicity, sex,
24 primary language, sexual orientation, gender iden-
25 tity, age, socioeconomic status, and disability status;

1 “(4) improve health and health care data collec-
2 tion and analysis for more population groups if such
3 groups can be aggregated into the minimum race
4 and ethnicity categories, including exploring the fea-
5 sibility of enhancing collection efforts in States,
6 counties, and municipalities for racial and ethnic
7 groups that comprise a significant proportion of the
8 population of the State, county, or municipality;

9 “(5) provide researchers with greater access to
10 racial, ethnic, primary language, sex, sexual orienta-
11 tion, gender identity, age, socioeconomic status data,
12 and disability status data, subject to all applicable
13 privacy and confidentiality requirements, including
14 HIPAA privacy and security law as defined in sec-
15 tion 3009; and

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

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

22 “(e) ANALYSIS OF HEALTH DISPARITY DATA.—The
23 Secretary, acting through the Director of the Agency for
24 Healthcare Research and Quality and in coordination with
25 the Assistant Secretary for Planning and Evaluation, the

1 Administrator of the Centers for Medicare & Medicaid
2 Services, the Director of the National Center for Health
3 Statistics, and the Director of the National Institutes of
4 Health, shall provide technical assistance to agencies of
5 the Department of Health and Human Services in meeting
6 Federal standards for health disparity data collection and
7 for analysis of racial, ethnic, and other disparities in
8 health and health care in programs conducted or sup-
9 ported by such agencies by—

10 “(1) identifying appropriate quality assurance
11 mechanisms to monitor for health disparities;

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

14 “(3) developing new quality measures relating
15 to racial and ethnic disparities and their overlap
16 with other disparity factors in health and health
17 care;

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

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

22 “(f) DEFINITION OF HEALTH-RELATED PROGRAM.—

23 In this section, the term ‘health-related program’ means
24 a program that is operated by the Secretary, or that re-

1 ceives funding or reimbursement, in whole or in part, ei-
2 ther directly or indirectly from the Secretary—

3 “(1) for activities under the Social Security Act
4 for health care services; or

5 “(2) for providing Federal financial assistance
6 for health care, biomedical research, or health serv-
7 ices research or for otherwise improving the health
8 of the public.

9 “(g) 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 2021 through 2025.

13 **“SEC. 3432. ESTABLISHING GRANTS FOR DATA COLLECTION**
14 **IMPROVEMENT ACTIVITIES.**

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

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

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

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

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

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

23 “(c) ELIGIBLE ENTITY.—To be eligible for grants
24 under this section, an entity shall be a State, territory,
25 Indian Tribe, municipality, county, health provider, health

1 care organization, or health plan making a demonstrated
2 effort to bring data collections into compliance with sec-
3 tion 3431.

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

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

10 “(a) NATIONAL STRATEGY.—

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

1 Asian Americans, Native Hawaiians, and Pacific Is-
2 landers.

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

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

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

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

22 “(b) PROGRESS REPORT.—Not later than 2 years
23 after the date of the enactment of this section, the Sec-
24 retary shall submit to the Congress a progress report,

1 which shall include the national strategy described in sub-
2 section (a)(1).

3 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out this section, there are authorized to be appro-
5 priated such sums as may be necessary for fiscal years
6 2021 through 2025.”.

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

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

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

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

15 **SEC. 103. COLLECTION OF DATA FOR THE MEDICARE PRO-**
16 **GRAM.**

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

20 “COLLECTION OF DATA FOR THE MEDICARE PROGRAM

21 “SEC. 1150C.

22 “(a) REQUIREMENT.—

23 “(1) IN GENERAL.—The Commissioner of So-
24 cial Security, in consultation with the Administrator
25 of the Centers for Medicare & Medicaid Services,
26 shall collect data on the race, ethnicity, sex, primary

1 language, sexual orientation, gender identity, socio-
2 economic status, and disability status of all appli-
3 cants for Social Security benefits under title II or
4 Medicare benefits under title XVIII.

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

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

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

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

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

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

17 “(6) TRANSMISSION OF DATA.—Upon an indi-
18 vidual’s entitlement to, or enrollment for, benefits
19 under title XVIII, the Commissioner of Social Secu-
20 rity shall transmit the demographic data of the indi-
21 vidual as collected under paragraph (1) to the Cen-
22 ters for Medicare & Medicaid Services.

23 “(7) ANALYSIS AND REPORTING OF DATA.—
24 With respect to data transmitted under paragraph
25 (6), the Administrator of the Centers for Medicare

1 & Medicaid Services, in consultation with the Com-
2 missioner of Social Security shall—

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

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

9 “(C) make such data available to research-
10 ers, under the protections outlined in paragraph
11 (8);

12 “(D) provide opportunities to individuals
13 entitled to, or enrolled for, benefits under title
14 XVIII to submit updated data; and

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

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

1 “(A) under the same privacy protections as
2 the Secretary applies to health data under the
3 regulations promulgated under section 264(e) of
4 the Health Insurance Portability and Account-
5 ability Act of 1996 (relating to the privacy of
6 individually identifiable health information and
7 other protections); and

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

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

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

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

1 \$500,000,000 for fiscal year 2021 and \$100,000,000 for
2 each fiscal year thereafter.”.

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

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

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

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

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

1 technical assistance with respect to the collection of the
2 data involved.

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

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

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

11 (1) in paragraph (1), by striking “2003” and
12 inserting “2022”;

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

15 (3) in paragraph (3), by striking “2002” and
16 inserting “2022”.

17 **SEC. 106. DISPARITIES DATA COLLECTED BY THE FEDERAL**
18 **GOVERNMENT.**

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

1 (b) COLLECTION; SUBMISSION.—Not later than 180
2 days after the date of the enactment of this Act, and Jan-
3 uary 31 of each year thereafter, each department, agency,
4 and office of the Federal Government that has collected
5 data on race, ethnicity, sex, primary language, sexual ori-
6 entation, disability status, gender identity, age, or socio-
7 economic status during the preceding calendar year shall
8 submit such data to the repository of Government data
9 established under subsection (a).

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

21 (1) prepare and make available datasets for
22 public use that relate to disparities in health status,
23 health care access, health care quality, health out-
24 comes, public health, and other areas of health and
25 well-being by factors that include race, ethnicity,

1 sex, primary language, sexual orientation, disability
2 status, gender identity, and socioeconomic status;

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

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

9 **SEC. 107. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**
10 **NORITY-SERVING INSTITUTIONS.**

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

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

1 (1) A part B institution, as defined in section
2 322 of the Higher Education Act of 1965 (20
3 U.S.C. 1061).

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

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

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

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

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

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

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

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

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

7 **SEC. 109. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
8 **RESPECT TO RACIAL AND ETHNIC BACK-**
9 **GROUND.**

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

13 **“SEC. 505H. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
14 **RESPECT TO RACIAL AND ETHNIC BACK-**
15 **GROUND.**

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

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

24 “(B) in the case of a biological product, the evi-
25 dence required under section 351(a) of the Public

1 Health Service Act for approval of a biologics license
2 application for the biological product shall include
3 adequate and well-controlled investigations of the
4 disparity; and

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

10 “(b) POSTMARKET STUDIES.—

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

22 “(2) LABELING.—If the Secretary determines
23 that the postmarket studies confirm that there is a
24 disparity described in paragraph (1), the labeling of

1 the drug or biological product shall include appro-
2 priate information about the disparity.

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

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

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

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

20 “(1) IN GENERAL.—A drug for which an appli-
21 cation has been submitted or approved under section
22 505(j) shall not be considered ineligible for approval
23 under that section or misbranded under section 502
24 on the basis that the labeling of the drug omits in-
25 formation relating to a disparity on the basis of ra-

1 cial or ethnic background as to the safety or effec-
2 tiveness of the drug, whether derived from investiga-
3 tions or studies required under this section or de-
4 rived from other sources, when the omitted informa-
5 tion is protected by patent or by exclusivity under
6 section 505(j)(5)(F).

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

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

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

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

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

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

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

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

19 **SEC. 110. IMPROVING HEALTH DATA REGARDING NATIVE**
20 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

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

1 **“SEC. 317V. 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 the Northern
12 Mariana Islands, American Samoa, the United
13 States Virgin Islands, the Federated States of Mi-
14 cronisia, the Republic of Palau, or the Republic of
15 the Marshall 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 2020, 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 2020.

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 2020, 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 seek to
6 enter into an agreement with the Health and Medi-
7 cine Division of the National Academies of Sciences,
8 Engineering, and Medicine to conduct a study, with
9 input from stakeholders in insular areas, on each of
10 the 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 2020, 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 2021 through 2025.”.

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 carrying out the supplemental nutrition

1 assistance program to comply with the notification
 2 requirement under paragraph (2) of section 421(e)
 3 of the Personal Responsibility and Work Oppor-
 4 tunity Reconciliation Act of 1996 (8 U.S.C.
 5 1631(e)), notwithstanding the requirement to in-
 6 clude in that notification the names of the sponsor
 7 and the sponsored alien involved, the State agency
 8 shall be considered to have complied with the notifi-
 9 cation requirement if the State agency submits to
 10 the Attorney General a report that includes the ag-
 11 gregate number of exceptions granted by the State
 12 agency under paragraph (1) of that section.”.

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

16 **SEC. 201. DEFINITIONS; FINDINGS.**

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

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

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

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

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

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

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

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

1 steps to ensure that their policies and procedures do
2 not deny or have the effect of denying individuals
3 with limited English proficiency with equal access to
4 benefits and services for which such persons qualify.

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

1 cision as to what measures to take rests with the
2 public accommodation, provided that the method
3 chosen results in effective communication.

4 (7) Section 1557 of the Patient Protection and
5 Affordable Care Act (42 U.S.C. 18116) builds on
6 title VI of the Civil Rights Act of 1964 (42 U.S.C.
7 2000d et seq.) and section 504 of the Rehabilitation
8 Act of 1973 (29 U.S.C. 794), prohibits discrimina-
9 tion on the basis of race, color, national origin, dis-
10 ability, sex, and age, requires the provision of lan-
11 guage services to ensure effective communication
12 with individuals with limited English proficiency,
13 and requires the provision of appropriate auxiliary
14 aids and services necessary to ensure effective com-
15 munication with individuals with disabilities.

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

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

1 English proficiency and individuals with communica-
2 tion disabilities such as cognitive, hearing, vision, or
3 print impairments.

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

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

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

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

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

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

1 proficiency can obtain culturally competence services
2 and meaningful access to those services consistent
3 with, and without substantially burdening, the fun-
4 damental mission of the agency;

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

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

20 (5) to ensure compliance with title VI of the
21 Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
22 and section 1557 of the Patient Protection and Af-
23 fordable Care Act (42 U.S.C. 18116) as published in
24 the Federal Register on May 18, 2016, that health

1 care providers and organizations do not discriminate
2 in the provision of services.

3 (b) **FEDERALLY CONDUCTED PROGRAMS AND AC-**
4 **TIVITIES.—**

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

16 (2) **PLAN REQUIREMENT.—**Each plan under
17 paragraph (1) shall include—

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

23 (B) the policies and procedures for identi-
24 fying, assessing, and meeting the culturally and
25 linguistically appropriate language needs of its

1 beneficiaries that are individuals with limited
2 English proficiency served by such program or
3 activity;

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

14 (D) the steps the agency will take for such
15 program or activity to provide reasonable ac-
16 commodations necessary for individuals with
17 limited English proficiency, including those in-
18 dividuals with a communication disability, to
19 understand communications from the agency;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (C) signage; and

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

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

7 (6) shall conduct initial and ongoing, at least
8 annually, organizational assessments of culturally
9 and linguistically appropriate services-related activi-
10 ties and integrate valid linguistic, competence-related
11 National Standards for Culturally and Linguistically
12 Appropriate Services (CLAS) measures into the in-
13 ternal audits, performance improvement programs,
14 patient satisfaction assessments, continuous quality
15 improvement activities, and outcomes-based evalua-
16 tions of the program or activity and develop ways to
17 standardize the assessments;

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

1 (A) collected in health records;

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

4 (C) periodically updated;

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

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

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

24 (11) shall regularly make available to the public
25 information about their progress and successful in-

1 novations in implementing the standards under this
2 section and provide public notice in their commu-
3 nities about the availability of this information; and

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

10 (c) COMMENTS ACCEPTED THROUGH NOTICE AND
11 COMMENT RULEMAKING.—An agency carrying out a pro-
12 gram described in subsection (a)—

13 (1) shall ensure that comments with respect to
14 such program that are accepted through notice and
15 comment rulemaking are accepted in all languages;

16 (2) may not require such comments to be sub-
17 mitted only in English; and

18 (3) shall ensure that any such comments that
19 are not submitted in English are considered, during
20 the agency's review of such comments, equally as
21 such comments that are submitted 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 an individual who
 13 has 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 INDIVIDUAL WITH A DIS-
15 ABILITY.—The term ‘qualified individual with a dis-
16 ability’ means, with respect to a health program or
17 activity, an individual with a disability who, with or
18 without reasonable modifications to policies, prac-
19 tices, or procedures, the removal of architectural,
20 communication, or transportation barriers, or the
21 provision of auxiliary aids and services, meets the es-
22 sential eligibility requirements for the receipt of aids,
23 benefits, or services offered or provided by the health
24 program or activity.

1 “(21) QUALIFIED INTERPRETER FOR AN INDI-
2 VIDUAL WITH A DISABILITY.—The term ‘qualified
3 interpreter for an individual with a disability’, with
4 respect to an individual with a disability—

5 “(A) means an interpreter for such indi-
6 vidual who by means of a remote interpreting
7 service or an onsite appearance;

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

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

16 “(B) may include—

17 “(i) sign language interpreters;

18 “(ii) oral transliterators, which are in-
19 dividuals who represent or spell in the
20 characters of another alphabet; and

21 “(iii) cued language transliterators,
22 which are individuals who represent or
23 spell by using a small number of
24 handshapes.

1 “(22) QUALIFIED INTERPRETER FOR AN INDI-
2 VIDUAL WITH LIMITED ENGLISH PROFICIENCY.—
3 The term ‘qualified interpreter for an individual with
4 limited English proficiency’ means an interpreter
5 who by means of a remote interpreting service or an
6 onsite appearance—

7 “(A) adheres to generally accepted inter-
8 preter ethics principles, including client con-
9 fidentiality;

10 “(B) has demonstrated proficiency in
11 speaking and understanding both spoken
12 English and one or more other spoken lan-
13 guages; and

14 “(C) is able to interpret effectively, accu-
15 rately, and impartially, both receptively and ex-
16 pressly, to and from such languages and
17 English, using any necessary specialized vocab-
18 ulary, terminology, and phraseology.

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

21 “(A) adheres to generally accepted trans-
22 lator ethics principles, including client confiden-
23 tiality;

24 “(B) has demonstrated proficiency in writ-
25 ing and understanding both written English

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

3 “(C) is able to translate effectively, accu-
4 rately, and impartially to and from such lan-
5 guages and English, using any necessary spe-
6 cialized vocabulary, terminology, and phrase-
7 ology.

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

9 The term ‘racial and ethnic minority group’ means
10 Indians and Alaska Natives, African Americans (in-
11 cluding Caribbean Blacks, Africans, and other
12 Blacks), Asian Americans, Hispanics (including
13 Latinos), and Native Hawaiians and other Pacific
14 Islanders.

15 “(25) SEXUAL AND GENDER MINORITY

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

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

23 translation’ means the transmission of a written
24 message in one language into a spoken or signed

1 message in another language, or an alternative for-
2 mat in English or another language.

3 “(27) STATE.—Notwithstanding section 2, the
4 term ‘State’ means each of the several States, the
5 District of Columbia, the Commonwealth of Puerto
6 Rico, the United States Virgin Islands, Guam,
7 American Samoa, and the Commonwealth of the
8 Northern Mariana Islands.

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

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

1 “(30) VIDEO REMOTE INTERPRETING SERV-
2 ICES.—The term ‘video remote interpreting services’
3 means the provision, in health care services or
4 health-care-related services, through a qualified in-
5 terpreter for an individual with limited English pro-
6 ficiency, of video remote interpreting services that
7 are—

8 “(A) in real-time, full-motion video, and
9 audio over a dedicated high-speed, wide-band-
10 width video connection or wireless connection
11 that delivers high quality video images that do
12 not produce lags, choppy, blurry, or grainy im-
13 ages, or irregular pauses in communication; and

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

16 “(31) VITAL DOCUMENT.—The term ‘vital doc-
17 ument’ includes applications for government pro-
18 grams that provide health care services, medical or
19 financial consent forms, financial assistance docu-
20 ments, letters containing important information re-
21 garding patient instructions (such as prescriptions,
22 referrals to other providers, and discharge plans)
23 and participation in a program (such as a Medicaid
24 managed care program), notices pertaining to the
25 reduction, denial, or termination of services or bene-

1 fits, notices of the right to appeal such actions, and
 2 notices advising individuals with limited English pro-
 3 ficiency with communication disabilities of the avail-
 4 ability of free language services, alternative formats,
 5 and other outreach materials.

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

11 **“Subtitle A—Resources and Innova-**
 12 **tion for Culturally and Linguis-**
 13 **tically Appropriate Health Care**

14 **“SEC. 3401. ROBERT T. MATSUI CENTER FOR CULTURALLY**
 15 **AND LINGUISTICALLY APPROPRIATE HEALTH**
 16 **CARE.**

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

24 “(1) INTERPRETATION SERVICES.—The Center
 25 shall provide resources via the internet to identify

1 and link health care providers to competent inter-
2 preter and translation services.

3 “(2) TRANSLATION OF WRITTEN MATERIAL.—

4 “(A) VITAL DOCUMENTS.—The Center
5 shall provide, directly or through contract, vital
6 documents from competent translation services
7 for providers of health care services and health-
8 care-related services at no cost to such pro-
9 viders. Such documents may be submitted by
10 covered entities (as defined in section 92.4 of
11 title 45, Code of Federal Regulations, as in ef-
12 fect on May 18, 2016) for translation into non-
13 English languages or alternative formats at a
14 fifth-grade reading level. Such translation serv-
15 ices shall be provided in a timely and reason-
16 able manner. The quality of such translation
17 services shall be monitored and reported pub-
18 licly.

19 “(B) FORMS.—For each form developed or
20 revised by the Secretary that will be used by in-
21 dividuals with limited English proficiency in
22 health care or health-care-related settings, the
23 Center shall translate the form, at a minimum,
24 into the top 15 non-English languages in the
25 United States according to the most recent data

1 from the American Community Survey or its re-
2 placement. The translation shall be completed
3 within 45 calendar days of the Secretary receiv-
4 ing final approval of the form from the Office
5 of Management and Budget. The Center shall
6 post all translated forms on its website so that
7 other entities may use the same translations.

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

12 “(A) to obtain information about federally
13 conducted or funded health programs, including
14 the Medicare program under title XVIII of the
15 Social Security Act, the Medicaid program
16 under title XIX of such Act, and the State Chil-
17 dren’s Health Insurance Program under title
18 XXI of such Act, and coverage available
19 through an Exchange established under title I
20 of the Patient Protection and Affordable Care
21 Act, and other sources of free or reduced care
22 including through federally qualified health cen-
23 ters, entities receiving assistance under title X,
24 and public health departments;

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

4 “(C) to learn how to access language serv-
5 ices.

6 “(4) HEALTH INFORMATION CLEARING-
7 HOUSE.—

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

22 “(B) DOCUMENT TEMPLATES.—The Cen-
23 ter shall collect and evaluate for accuracy, de-
24 velop, and make available templates for stand-
25 ard documents that are necessary for patients

1 and consumers to access and make educated de-
2 cisions about their health care, including tem-
3 plates for each of the following:

4 “(i) Administrative and legal docu-
5 ments, including—

6 “(I) intake forms;

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

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

22 “(IV) documents concerning in-
23 formed consent, advanced directives,
24 and waivers of rights.

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

5 “(iii) Public health, patient education,
6 and outreach materials, such as immuniza-
7 tion notices, health warnings, or screening
8 notices.

9 “(iv) Additional health or health-care-
10 related materials as determined appro-
11 priate by the Director of the Center.

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

14 “(i) ensure that the documents posted
15 in English and non-English languages are
16 culturally and linguistically appropriate;

17 “(ii) allow public review of the docu-
18 ments before dissemination in order to en-
19 sure that the documents are understand-
20 able and culturally and linguistically ap-
21 propriate for the target populations;

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

24 “(iv) facilitate access to these docu-
25 ments;

1 “(v) provide technical assistance with
2 respect to the access and use of such infor-
3 mation; and

4 “(vi) carry out any other activities the
5 Secretary determines to be useful to fulfill
6 the purposes of the clearinghouse.

7 “(D) LANGUAGE ASSISTANCE PRO-
8 GRAMS.—The Center shall provide for the col-
9 lection and dissemination of information on cur-
10 rent examples of language assistance programs
11 and strategies to improve language services for
12 individuals with limited English proficiency, in-
13 cluding case studies using de-identified patient
14 information, program summaries, and program
15 evaluations.

16 “(E) CULTURALLY AND LINGUISTICALLY
17 APPROPRIATE MATERIALS.—The Center shall
18 provide information relating to culturally and
19 linguistically appropriate health care for minor-
20 ity populations residing in the United States to
21 all health care providers and health-care-related
22 services at no cost. Such information shall in-
23 clude—

24 “(i) tenets of culturally and linguis-
25 tically appropriate care;

1 “(ii) culturally and linguistically ap-
2 propriate self-assessment tools;

3 “(iii) culturally and linguistically ap-
4 propriate training tools;

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

11 “(v) culturally and linguistically ap-
12 propriate information for educators, practi-
13 tioners, and researchers.

14 “(F) TRANSLATION GLOSSARIES.—The
15 Center shall—

16 “(i) develop and publish on its website
17 translation glossaries that provide stand-
18 ardized translations of commonly used
19 terms and phrases utilized in documents
20 translated by the Center; and

21 “(ii) make these glossaries available—

22 “(I) free of charge;

23 “(II) in each language in which
24 the Center translates forms under
25 paragraph (2)(B); and

1 “(III) in alternative formats in
2 accordance with the Americans with
3 Disabilities Act of 1990 (42 U.S.C.
4 12101 et seq.).

5 “(G) INFORMATION ABOUT PROGRESS.—
6 The Center shall regularly collect and make
7 publicly available information about the
8 progress of entities receiving grants under sec-
9 tion 3402 regarding successful innovations in
10 implementing the obligations under this sub-
11 section and provide public notice in the entities’
12 communities about the availability of this infor-
13 mation.

14 “(b) DIRECTOR.—The Center shall be headed by a
15 Director who shall be appointed by, and who shall report
16 to, the Director of the Agency for Healthcare Research
17 and Quality.

18 “(c) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
19 rector shall collaborate with the Deputy Assistant Sec-
20 retary for Minority Health, the Administrator of the Cen-
21 ters for Medicare & Medicaid Services, and the Adminis-
22 trator of the Health Resources and Services Administra-
23 tion to notify health care providers and health care organi-
24 zations about the availability of language access services
25 by the Center.

1 “(d) EDUCATION.—The Secretary, directly or
2 through contract, shall undertake a national education
3 campaign to inform providers, individuals with limited
4 English proficiency, individuals with hearing or vision im-
5 pairments, health professionals, graduate schools, and
6 community health centers about—

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

9 “(2) the value of using trained and competent
10 interpreters and the risks associated with using fam-
11 ily members, friends, minors, and untrained bilin-
12 gual staff;

13 “(3) funding sources for developing and imple-
14 menting language services; and

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

17 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section
19 \$5,000,000 for each of fiscal years 2021 through 2025.

20 **“SEC. 3402. INNOVATIONS IN CULTURALLY AND LINGUIS-**
21 **TICALLY APPROPRIATE HEALTH CARE**
22 **GRANTS.**

23 “(a) IN GENERAL.—

24 “(1) GRANTS.—The Secretary, acting through
25 the Director of the Agency for Healthcare Research

1 and Quality, shall award grants to eligible entities to
2 enable such entities to design, implement, and evalu-
3 ate innovative, cost-effective programs to improve
4 culturally and linguistically appropriate access to
5 health care services for individuals with limited
6 English proficiency.

7 “(2) COORDINATION.—The Director of the
8 Agency for Healthcare Research and Quality shall
9 coordinate with, and ensure the participation of,
10 other agencies including the Health Resources and
11 Services Administration, the National Institute on
12 Minority Health and Health Disparities at the Na-
13 tional Institutes of Health, and the Office of Minor-
14 ity Health, regarding the design and evaluation of
15 the grants program.

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

18 “(1) be—

19 “(A) a city, county, Indian Tribe, State, or
20 subdivision thereof;

21 “(B) an organization described in section
22 501(c)(3) of the Internal Revenue Code of 1986
23 and exempt from tax under section 501(a) of
24 such Code;

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

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

4 “(E) an integrated health care delivery
5 system;

6 “(F) a public hospital;

7 “(G) a health care group, university, or
8 college; or

9 “(H) any other entity designated by the
10 Secretary; and

11 “(2) prepare and submit to the Secretary an
12 application, at such time, in such manner, and con-
13 taining such additional information as the Secretary
14 may reasonably require.

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

17 “(1) develop, implement, and evaluate models of
18 providing competent interpretation services through
19 onsite interpretation, telephonic interpretation, or
20 video remote interpreting services;

21 “(2) implement strategies to recruit, retain, and
22 promote individuals at all levels of the organization
23 to maintain a diverse staff and leadership that can
24 promote and provide language services to patient
25 populations of the service area of the entity;

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

6 “(4) develop a strategic plan to implement lan-
7 guage services;

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

13 “(6) develop and implement grievance resolu-
14 tion processes that are culturally and linguistically
15 appropriate and capable of identifying, preventing,
16 and resolving complaints by individuals with limited
17 English proficiency;

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

22 “(8) develop formal training programs, includ-
23 ing continued professional development and edu-
24 cation programs as well as supervision, for individ-
25 uals interested in becoming dedicated health care in-

1 interpreters and culturally and linguistically appro-
2 priate providers;

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

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

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

11 “(12) develop, implement, and evaluate models
12 of improving cultural competence, including cultural
13 competence programs for community health workers;
14 and

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

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

6 “(e) EVALUATION.—

7 “(1) BY GRANTEES.—An entity that receives a
8 grant under this section shall submit to the Sec-
9 retary an evaluation that describes, in the manner
10 and to the extent required by the Secretary, the ac-
11 tivities carried out with funds received under the
12 grant, and how such activities improved access to
13 health care services and health-care-related services
14 and the quality of health care for individuals with
15 limited English proficiency. Such evaluation shall be
16 collected and disseminated through the Robert T.
17 Matsui Center for Culturally and Linguistically Ap-
18 propriate Health Care established under section
19 3401. The Director of the Agency for Healthcare
20 Research and Quality shall notify grantees of the
21 availability of technical assistance for the evaluation
22 and provide such assistance upon request.

23 “(2) BY SECRETARY.—The Director of the
24 Agency for Healthcare Research and Quality shall
25 evaluate or arrange with other individuals or organi-

1 zations to evaluate projects funded under this sec-
2 tion.

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

6 **“SEC. 3403. RESEARCH ON CULTURAL AND LANGUAGE COM-
7 PETENCE.**

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

12 “(b) ELIGIBILITY.—The Director of the Agency for
13 Healthcare Research and Quality may conduct the re-
14 search described in subsection (a) or enter into contracts
15 with other individuals or organizations to conduct such re-
16 search.

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

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

23 “(2) To identify health care providers’ and
24 health administrators’ attitudes, knowledge, and
25 awareness of the barriers to quality health care serv-

1 ices that are faced by individuals with limited
2 English proficiency.

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

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

7 “(A) the collection by providers of health
8 care services and health-care-related services of
9 data on the race, ethnicity, and primary lan-
10 guage of recipients of such services, taking into
11 account existing research conducted by the Gov-
12 ernment or private sector;

13 “(B) the development and implementation
14 of data collection and reporting systems; and

15 “(C) effective privacy safeguards for col-
16 lected data.

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

19 “(6) To evaluate the most effective ways in
20 which the Secretary can create or coordinate, and
21 subsidize or otherwise fund, telephonic interpretation
22 services for health care providers, taking into consid-
23 eration, among other factors, the flexibility necessary
24 for such a system to accommodate variations in—

25 “(A) provider type;

1 “(B) languages needed and their frequency
2 of use;

3 “(C) type of encounter;

4 “(D) time of encounter, including regular
5 business hours and after hours; and

6 “(E) location of encounter.

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

10 **SEC. 205. PILOT PROGRAM FOR IMPROVEMENT AND DE-**
11 **VELOPMENT OF STATE MEDICAL INTER-**
12 **PRETING SERVICES.**

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

19 (b) GRANT PERIOD.—A grant awarded under this
20 section is authorized for the period of 3 fiscal years begin-
21 ning on October 1, 2021, and ending on September 30,
22 2024.

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

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

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

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

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

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

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

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

22 (A) a statewide health care information
23 technology system that is designed to achieve
24 efficiencies and economies of scale with respect
25 to onsite interpreter services provided to health

1 care providers in the State participating in the
2 State Medicaid plan; and

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

5 (i) procuring and scheduling inter-
6 preter services for qualified LEP enrollees;

7 (ii) procuring and scheduling inter-
8 preter services for individuals with limited
9 English proficiency seeking to enroll in the
10 State Medicaid plan;

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

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

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

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

1 (1) A description of the language access needs
2 of individuals in the State enrolled in the State Med-
3 icaid plan.

4 (2) A description of the extent to which the
5 program will—

6 (A) use the grant funds for the purposes
7 described in subsection (d);

8 (B) meet the health care needs of rural
9 populations of the State; and

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

15 (3) A description of how the program will be
16 evaluated, including a proposal for collaboration with
17 organizations representing interpreters, consumers,
18 and individuals with limited English proficiency.

19 (f) DEFINITIONS.—In this section:

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

22 (A) who is limited English proficient; and

23 (B) who is enrolled in a State Medicaid
24 plan.

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

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

10 (4) UNITED STATES.—The term “United
11 States” has the meaning given the term in section
12 1101(a)(2) of the Social Security Act (42 U.S.C.
13 1301(a)(2)), for purposes of title XIX of such Act
14 (42 U.S.C. 1396 et seq.).

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

19 (h) FUNDING.—

20 (1) AUTHORIZATION OF APPROPRIATIONS.—
21 There is authorized to be appropriated \$5,000,000
22 to carry out this section.

23 (2) AVAILABILITY OF FUNDS.—Amounts appro-
24 priated pursuant to the authorization in paragraph

1 (1) are authorized to remain available without fiscal
2 year limitation.

3 (3) INCREASED FEDERAL FINANCIAL PARTICI-
4 PATION.—Section 1903(a)(2)(E) of the Social Secu-
5 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended by
6 inserting “(or, in the case of a State that was
7 awarded a grant under section 205 of the Health
8 Equity and Accountability Act of 2020, 100 percent
9 for each quarter occurring during the grant period
10 specified in subsection (b) of such section)” after
11 “75 percent”.

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

15 **SEC. 206. TRAINING TOMORROW’S DOCTORS FOR CUL-**
16 **TURALLY AND LINGUISTICALLY APPRO-**
17 **PRIATE CARE: GRADUATE MEDICAL EDU-**
18 **CATION.**

19 (a) DIRECT GRADUATE MEDICAL EDUCATION.—Sec-
20 tion 1886(h)(4) of the Social Security Act (42 U.S.C.
21 1395ww(h)(4)) is amended by adding at the end the fol-
22 lowing new subparagraph:

23 “(L) TREATMENT OF CULTURALLY AND
24 LINGUISTICALLY APPROPRIATE TRAINING.—In
25 determining a hospital’s number of full-time

1 equivalent residents for purposes of this sub-
2 section, all the time that is spent by an intern
3 or resident in an approved medical residency
4 training program for education and training in
5 culturally and linguistically appropriate service
6 delivery, which shall include all diverse popu-
7 lations including people with disabilities and the
8 Lesbian, gay, bisexual, transgender, queer,
9 questioning, questioning and intersex
10 (LGBTQIA) community, shall be counted to-
11 ward the determination of full-time equiva-
12 lency.”.

13 (b) INDIRECT MEDICAL EDUCATION.—Section
14 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
15 1395ww(d)(5)(B)) is amended—

16 (1) by redesignating the clause (x) added by
17 section 5505(b) of the Patient Protection and Af-
18 fordable Care Act as clause (xi) and moving the left
19 margin of such clause and each subclause and item
20 therein 2 ems to the left; and

21 (2) by adding at the end the following new
22 clause:

23 “(xii) The provisions of subparagraph (L) of
24 subsection (h)(4) shall apply under this subpara-

1 graph in the same manner as they apply under such
2 subsection.”.

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

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

12 (a) LANGUAGE ACCESS GRANTS FOR MEDICARE
13 PROVIDERS.—

14 (1) ESTABLISHMENT.—

15 (A) IN GENERAL.—Not later than 6
16 months after the date of the enactment of this
17 Act, the Secretary of Health and Human Serv-
18 ices, acting through the Centers for Medicare &
19 Medicaid Services and in consultation with the
20 Center for Medicare and Medicaid Innovation
21 (as referred to in section 1115A of the Social
22 Security Act (42 U.S.C. 1315a)), shall establish
23 a demonstration program under which the Sec-
24 retary shall award grants to eligible Medicare
25 service providers to improve communication be-

1 tween such providers and Medicare beneficiaries
2 who are limited English proficient, including
3 beneficiaries who live in diverse and under-
4 served 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
25 (42 U.S.C. 1395c et seq.);

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

3 (iii) a Medicare Advantage organiza-
4 tion offering a Medicare Advantage plan
5 under part C of such title (42 U.S.C.
6 1395w-21 et seq.); or

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

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

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

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

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

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

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

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

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

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

17 (4) CONSIDERATIONS IN AWARDING GRANTS.—

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

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

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

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

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

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

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

14 (B) PRIORITY FOR PARTNERSHIPS WITH
15 COMMUNITY ORGANIZATIONS AND AGENCIES.—

16 In awarding grants under this subsection, the
17 Secretary shall give priority to eligible entities
18 that have a partnership with—

19 (i) a community organization; or

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

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

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

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

10 (i) interpreter and translation services
11 that—

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

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

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

1 Standards of Practice and com-
2 ply with the requirements of sec-
3 tion 1557 of the Patient Protec-
4 tion and Affordable Care Act (42
5 U.S.C. 18116) as published in
6 the Federal Register on May 18,
7 2016; and

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

11 (aa) onsite interpretation;

12 (bb) telephonic interpreta-
13 tion; or

14 (cc) video interpretation;
15 and

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

19 (C) EXCEPTIONS.—The requirements of
20 subparagraph (B)(i)(I) do not apply, with re-
21 spect to interpreter and translation services and
22 a grantee—

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

1 (I) such beneficiary has been in-
2 formed, in the beneficiary's primary
3 language, of the availability of free in-
4 terpreter and translation services and
5 the beneficiary instead requests that a
6 family member, friend, or other per-
7 son provide such services; and

8 (II) the grantee documents such
9 request in the beneficiary's medical
10 record; or

11 (ii) in the case of a medical emergency
12 where the delay directly associated with ob-
13 taining a competent interpreter or trans-
14 lation services would jeopardize the health
15 of the patient.

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

24 (D) MEDICARE ADVANTAGE ORGANIZA-
25 TIONS AND PDP SPONSORS.—If a grantee is a

1 Medicare Advantage organization offering a
2 Medicare Advantage plan under part C of title
3 XVIII of the Social Security Act (42 U.S.C.
4 1395w-21 et seq.) or a PDP sponsor offering
5 a prescription drug plan under part D of such
6 title (42 U.S.C. 1395w-101 et seq.), such entity
7 must provide at least 50 percent of the grant
8 funds that the entity receives under this sub-
9 section directly to the entity's network providers
10 (including all health providers and pharmacists)
11 for the purpose of providing support for such
12 providers to provide competent language serv-
13 ices to Medicare beneficiaries who are English
14 learners.

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

21 (6) DETERMINATION OF AMOUNT OF GRANT
22 PAYMENTS.—

23 (A) IN GENERAL.—Payments to grantees
24 under this subsection shall be calculated based
25 on the estimated numbers of Medicare bene-

1 beneficiaries who are English learners in a grantee’s
2 service area utilizing—

3 (i) data on the numbers of English
4 learners who speak English less than “very
5 well” from the most recently available data
6 from the Bureau of the Census or other
7 State-based study the Secretary determines
8 likely to yield accurate data regarding the
9 number of such individuals in such service
10 area; or

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

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

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

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

8 (A) ensure that clinical and support staff
9 receive appropriate ongoing education and
10 training in linguistically appropriate service de-
11 livery;

12 (B) ensure the linguistic competence of bi-
13 lingual providers;

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

19 (D) notify Medicare beneficiaries of their
20 right to receive language services in their pri-
21 mary language;

22 (E) post signage in the primary languages
23 commonly used by the patient population in the
24 service area of the organization; and

25 (F) ensure that—

1 (i) primary language data are col-
2 lected for recipients of language services
3 and such data are consistent with stand-
4 ards developed under title XXXIV of the
5 Public Health Service Act, as added by
6 section 202 of this Act, to the extent such
7 standards are available upon the initiation
8 of the demonstration program; and

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

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

22 (9) REPORTING REQUIREMENTS FOR GRANT-
23 EES.—Not later than the end of each calendar year,
24 a grantee that receives funds under this subsection

1 in such year shall submit to the Secretary a report
2 that includes the following information:

3 (A) The number of Medicare beneficiaries
4 to whom competent language services are pro-
5 vided.

6 (B) The primary languages of those Medi-
7 care beneficiaries.

8 (C) The types of language services pro-
9 vided to such beneficiaries.

10 (D) Whether such language services were
11 provided by employees of the grantee or
12 through a contract with external contractors or
13 agencies.

14 (E) The types of interpretation services
15 provided to such beneficiaries, and the approxi-
16 mate length of time such service is provided to
17 such beneficiaries.

18 (F) The costs of providing competent lan-
19 guage services.

20 (G) An account of the training or accredi-
21 tation of bilingual staff, interpreters, and trans-
22 lators providing services funded by the grant
23 under this subsection.

24 (10) EVALUATION AND REPORT TO CON-
25 GRESS.—Not later than 1 year after the completion

1 of a 3-year grant under this subsection, the Sec-
2 retary shall conduct an evaluation of the demonstra-
3 tion program under this subsection and shall submit
4 to the Congress a report that includes the following:

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

13 (B) The effect of delivering language serv-
14 ices on—

15 (i) Medicare beneficiary access to care
16 and utilization of services;

17 (ii) the efficiency and cost effective-
18 ness of health care delivery;

19 (iii) patient satisfaction;

20 (iv) health outcomes; and

21 (v) the provision of culturally appro-
22 priate services provided to such bene-
23 ficiaries.

24 (C) The extent to which bilingual staff, in-
25 terpreters, and translators providing services

1 under such demonstration were trained or ac-
2 credited and the nature of accreditation or
3 training needed by type of provider, service, or
4 other category as determined by the Secretary
5 to ensure the provision of high-quality interpre-
6 tation, translation, or other language services to
7 Medicare beneficiaries if such services are ex-
8 panded pursuant to section 1115A(c) of the So-
9 cial Security Act (42 U.S.C. 1315a(c)).

10 (D) Recommendations, if any, regarding
11 the extension of such project to the entire Medi-
12 care Program, subject to the provisions of such
13 section 1115A(c).

14 (11) APPROPRIATIONS.—There is appropriated
15 to carry out this subsection, in equal parts from the
16 Federal Hospital Insurance Trust Fund under sec-
17 tion 1817 of the Social Security Act (42 U.S.C.
18 1395i) and the Federal Supplementary Medical In-
19 surance Trust Fund under section 1841 of such Act
20 (42 U.S.C. 1395t), \$16,000,000 for each fiscal year
21 of the demonstration program.

22 (12) ENGLISH LEARNER DEFINED.—In this
23 subsection, the term “English learner” has the
24 meaning given such term in section 8101(20) of the
25 Elementary and Secondary Education Act of 1965,

1 except that subparagraphs (A), (B), and (D) of such
2 section shall not apply.

3 (b) LANGUAGE ASSISTANCE SERVICES UNDER THE
4 MEDICARE PROGRAM.—

5 (1) INCLUSION AS RURAL HEALTH CLINIC
6 SERVICES.—Section 1861 of the Social Security Act
7 (42 U.S.C. 1395x) is amended—

8 (A) in subsection (aa)(1)—

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

11 (ii) by adding “and” at the end of
12 subparagraph (C); and

13 (iii) by inserting after subparagraph
14 (C) the following new subparagraph:

15 “(D) language assistance services as defined in
16 subsection (kkk)(1),”; and

17 (B) by adding at the end the following new
18 subsection:

19 “Language Assistance Services and Related Terms

20 “(kkk)(1) The term ‘language assistance services’
21 means ‘language access’ or ‘language assistance services’
22 (as those terms are defined in section 3400 of the Public
23 Health Service Act) furnished by a ‘qualified interpreter
24 for an individual with limited English proficiency’ or a
25 ‘qualified translator’ (as those terms are defined in such

1 section 3400) to an ‘individual with limited English pro-
 2 ficiency’ (as defined in such section 3400) or an ‘English
 3 learner’ (as defined in paragraph (2)).

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

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

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

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

15 (C) by adding at the end the following new
 16 subparagraph:

17 “(K) language assistance services (as de-
 18 fined in section 1861(kkk)(1)).”.

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

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

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

1 (C) by inserting after paragraph (9) the
2 following new paragraph:

3 “(10) in the case of language assistance serv-
4 ices (as defined in section 1861(kkk)(1)), 100 per-
5 cent of the reasonable charges for such services, as
6 determined in consultation with the Medicare Pay-
7 ment Advisory Commission.”.

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

15 (c) MEDICARE PARTS C AND D.—

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

1 (2) MEDICARE ADVANTAGE PLANS AND PRE-
2 SCRIPTION DRUG PLANS REPORTING REQUIRE-
3 MENT.—Section 1857(e) of the Social Security Act
4 (42 U.S.C. 1395w–27(e)) is amended by adding at
5 the end the following new paragraph:

6 “(6) REPORTING REQUIREMENTS RELATING TO
7 EFFECTIVE LANGUAGE SERVICES.—A contract under
8 this part shall require a Medicare Advantage organi-
9 zation (and, through application of section 1860D–
10 12(b)(3)(D), a contract under section 1860D–12
11 shall require a PDP sponsor) to annually submit
12 (for each year of the contract) a report that contains
13 information on the internal policies and procedures
14 of the organization (or sponsor) related to recruit-
15 ment and retention efforts directed to workforce di-
16 versity and linguistically and culturally appropriate
17 provision of services in each of the following con-
18 texts:

19 “(A) The collection of data in a manner
20 that meets the requirements of title I of the
21 Health Equity and Accountability Act of 2020,
22 regarding the enrollee population.

23 “(B) Education of staff and contractors
24 who have routine contact with enrollees regard-

1 ing the various needs of the diverse enrollee
2 population.

3 “(C) Evaluation of the language services
4 programs and services offered by the organiza-
5 tion (or sponsor) with respect to the enrollee
6 population, such as through analysis of com-
7 plaints or satisfaction survey results.

8 “(D) Methods by which the plan provides
9 to the Secretary information regarding the eth-
10 nic diversity of the enrollee population.

11 “(E) The periodic provision of educational
12 information to plan enrollees on the language
13 services and programs offered by the organiza-
14 tion (or sponsor).”.

15 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID
16 AND CHIP.—

17 (1) PAYMENTS TO STATES.—Section
18 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
19 1396b(a)(2)(E)), as amended by section 205(h)(3),
20 is further amended by—

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

22 (B) striking “translation or interpretation
23 services” and inserting “language assistance
24 services”; and

1 (C) striking “children of families” and in-
2 serting “individuals”.

3 (2) STATE PLAN REQUIREMENTS.—Section
4 1902(a)(10)(A) of the Social Security Act (42
5 U.S.C. 1396a(a)(10)(A)) is amended by striking
6 “and (29)” and inserting “(29), and (30)”.

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

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

12 (B) by redesignating paragraph (30) as
13 paragraph (31); and

14 (C) by inserting after paragraph (29) the
15 following new paragraph:

16 “(30) language assistance services, as such
17 term is defined in section 1861(kkk)(1), provided in
18 a timely manner to individuals with limited English
19 proficiency as defined in section 3400 of the Public
20 Health Service Act; and”.

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

24 (A) by striking “or” at the end of subpara-
25 graph (F);

1 (B) by striking “; and” at the end of sub-
2 paragraph (G) and inserting “, or”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(H) language assistance services de-
6 scribed in section 1905(a)(30); and”.

7 (5) CHIP COVERAGE REQUIREMENTS.—Section
8 2103 of the Social Security Act (42 U.S.C. 1397cc)
9 is amended—

10 (A) in subsection (a), in the matter before
11 paragraph (1), by striking “(7) and (8)” and
12 inserting “(7), (10), and (11)”;

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

15 “(11) LANGUAGE ASSISTANCE SERVICES.—The
16 child health assistance provided to a targeted low-in-
17 come child shall include coverage of language assist-
18 ance services, as such term is defined in section
19 1861(kkk)(1), provided in a timely manner to indi-
20 viduals with limited English proficiency (as defined
21 in section 3400 of the Public Health Service Act).”;
22 and

23 (C) in subsection (e)(2)—

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

1 (ii) by inserting “language assistance
2 services described in subsection (e)(11),”
3 before “visits described in”.

4 (6) DEFINITION OF CHILD HEALTH ASSIST-
5 ANCE.—Section 2110(a)(27) of the Social Security
6 Act (42 U.S.C. 1397jj(a)(27)) is amended by strik-
7 ing “translation” and inserting “language assistance
8 services as described in section 2103(c)(11)”.

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

14 (A) the primary language of individuals re-
15 ceiving child health assistance under title XXI
16 of the Social Security Act (42 U.S.C. 1397aa et
17 seq.); and

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

21 (8) CHIP PAYMENTS TO STATES.—Section
22 2105 of the Social Security Act (42 U.S.C. 1397ee)
23 is amended—

24 (A) in subsection (a)(1)—

1 (i) in the matter preceding subpara-
 2 graph (A), by striking “75” and inserting
 3 “95”; and

4 (ii) in subparagraph (D)(iv), by strik-
 5 ing “translation or interpretation services”
 6 and inserting “language assistance serv-
 7 ices”; and

8 (B) in subsection (c)(2)(A), by inserting
 9 before the period at the end the following: “,
 10 except that expenditures pursuant to clause (iv)
 11 of subparagraph (D) of such paragraph shall
 12 not count towards this total”.

13 (e) FUNDING LANGUAGE ASSISTANCE SERVICES
 14 FURNISHED BY PROVIDERS OF HEALTH CARE AND
 15 HEALTH-CARE-RELATED SERVICES THAT SERVE HIGH
 16 RATES OF UNINSURED LEP INDIVIDUALS.—

17 (1) PAYMENT OF COSTS.—

18 (A) IN GENERAL.—Subject to subpara-
 19 graph (B), the Secretary of Health and Human
 20 Services (referred to in this subsection as the
 21 “Secretary”) shall make payments (on a quar-
 22 terly basis) directly to eligible entities to sup-
 23 port the provision of language assistance serv-
 24 ices to English learners in an amount equal to

1 an eligible entity's eligible costs for providing
2 such services for the quarter.

3 (B) FUNDING.—Out of any funds in the
4 Treasury not otherwise appropriated, there are
5 appropriated to the Secretary of Health and
6 Human Services such sums as may be nec-
7 essary for each of fiscal years 2021 through
8 2025.

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

17 (2) METHODOLOGY FOR PAYMENT OF
18 CLAIMS.—

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

22 (B) DIFFERENT ENTITIES.—In estab-
23 lishing such methodology, the Secretary may es-
24 tablish different methodologies for different
25 types of eligible entities.

1 (C) NO INDIVIDUAL CLAIMS.—The Sec-
2 retary may not require eligible entities to sub-
3 mit individual claims for language assistance
4 services for individual patients as a requirement
5 for payment under this subsection.

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

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

17 (5) REPORTING REQUIREMENTS.—

18 (A) REPORT TO SECRETARY.—Entities re-
19 ceiving payment under this subsection shall pro-
20 vide the Secretary with a quarterly report on
21 how the entity used such funds. Such report
22 shall contain aggregate (and may not contain
23 individualized) data collected using the instru-
24 ment under paragraph (3) and shall otherwise

1 be in a form and manner determined by the
2 Secretary.

3 (B) REPORT TO CONGRESS.—Not later
4 than 2 years after the date of enactment of this
5 Act, and every 2 years thereafter, the Secretary
6 shall submit a report to Congress concerning
7 the implementation of this subsection.

8 (6) DEFINITIONS.—In this subsection:

9 (A) ELIGIBLE COSTS.—The term “eligible
10 costs” means, with respect to an eligible entity
11 that provides language assistance services to
12 English learners, the product of—

13 (i) the average per person cost of lan-
14 guage assistance services, determined ac-
15 cording to the methodology devised under
16 paragraph (2); and

17 (ii) the number of English learners
18 who are provided language assistance serv-
19 ices by the entity and for whom no reim-
20 bursement is available for such services
21 under the amendments made by subsection
22 (a), (b), (c), or (d) or by private health in-
23 surance.

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

1 (i) is a Medicaid provider that is—

2 (I) a physician;

3 (II) a hospital with a low-income
4 utilization rate (as defined in section
5 1923(b)(3) of the Social Security Act
6 (42 U.S.C. 1396r-4(b)(3))) of greater
7 than 25 percent; or

8 (III) a federally qualified health
9 center (as defined in section
10 1905(l)(2)(B) of the Social Security
11 Act (42 U.S.C. 1396d(l)(2)(B)));

12 (ii) not later than 6 months after the
13 date of the enactment of this Act, provides
14 language assistance services to not less
15 than 8 percent of the entity's total number
16 of patients; and

17 (iii) prepares and submits an applica-
18 tion to the Secretary, at such time, in such
19 manner, and accompanied by such infor-
20 mation as the Secretary may require, to
21 ascertain the entity's eligibility for funding
22 under this subsection.

23 (C) ENGLISH LEARNER.—The term
24 “English learner” has the meaning given such
25 term in section 8101(20) of the Elementary

1 and Secondary Education Act of 1965 (20
2 U.S.C. 7801(20)), except that subparagraphs
3 (A), (B), and (D) of such section shall not
4 apply.

5 (D) LANGUAGE ASSISTANCE SERVICES.—
6 The term “language assistance services” has
7 the meaning given such term in section
8 1861(kkk)(1) of the Social Security Act, as
9 added by subsection (b).

10 (f) APPLICATION OF CIVIL RIGHTS ACT OF 1964,
11 SECTION 1557 OF THE AFFORDABLE CARE ACT, AND
12 OTHER LAWS.—Nothing in this section shall be construed
13 to limit otherwise existing obligations of recipients of Fed-
14 eral financial assistance under title VI of the Civil Rights
15 Act of 1964 (42 U.S.C. 2000d et seq.), section 1557 of
16 the Affordable Care Act, or other laws that protect the
17 civil rights of individuals.

18 (g) EFFECTIVE DATE.—

19 (1) IN GENERAL.—Except as otherwise pro-
20 vided and subject to paragraph (2), the amendments
21 made by this section shall take effect on January 1,
22 2021.

23 (2) EXCEPTION IF STATE LEGISLATION RE-
24 QUIRED.—In the case of a State plan for medical as-
25 sistance under title XIX of the Social Security Act

1 (42 U.S.C. 1396 et seq.) or a State plan for child
2 health assistance under title XXI of such Act (42
3 U.S.C. 1397aa et seq.) which the Secretary of
4 Health and Human Services determines requires
5 State legislation (other than legislation appro-
6 priating funds) in order for the plan to meet the ad-
7 ditional requirement imposed by the amendments
8 made by this section, such State plan shall not be
9 regarded as failing to comply with the requirements
10 of such title solely on the basis of its failure to meet
11 this additional requirement before the first day of
12 the first calendar quarter beginning after the close
13 of the first regular session of the State legislature
14 that begins after the date of the enactment of this
15 Act. For purposes of the previous sentence, in the
16 case of a State that has a 2-year legislative session,
17 each year of such session shall be deemed to be a
18 separate regular session of the State legislature.

19 **SEC. 208. INCREASING UNDERSTANDING OF AND IMPROV-**
20 **ING HEALTH LITERACY.**

21 (a) IN GENERAL.—The Secretary of Health and
22 Human Services, acting through the Director of the Agen-
23 cy for Healthcare Research and Quality with respect to
24 grants under subsection (c)(1) and through the Adminis-
25 trator of the Health Resources and Services Administra-

1 tion with respect to grants under subsection (c)(2), in con-
2 sultation with the Director of the National Institute on
3 Minority Health and Health Disparities and the Deputy
4 Assistant Secretary for Minority Health, shall award
5 grants to eligible entities to improve health care for pa-
6 tient populations that have low functional health literacy.

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

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

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

16 (c) USE OF FUNDS.—

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

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

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

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

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

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

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

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

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

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

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

1 (F) the conduct of educational campaigns
2 concerning health directed specifically at pa-
3 tients with mental disabilities, including those
4 with cognitive and intellectual disabilities, de-
5 signed to reduce the incidence of low health lit-
6 eracy among these populations, which shall
7 have instructional materials in the plain lan-
8 guage standards promulgated under the Plain
9 Writing Act of 2010 (5 U.S.C. 301 note) for
10 Federal agencies; and

11 (G) other activities determined appropriate
12 by the Administrator.

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

17 (e) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section,
19 such sums as may be necessary for each of fiscal years
20 2021 through 2025.

21 **SEC. 209. REQUIREMENTS FOR HEALTH PROGRAMS OR AC-**
22 **TIVITIES RECEIVING FEDERAL FUNDS.**

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

1 (1) the term “covered entity” has the meaning
2 given such term in section 92.4 of title 45, Code of
3 Federal Regulations, as in effect on May 18, 2016
4 (81 Fed. Reg. 31466 (May 18, 2016)); and

5 (2) the term “health program or activity” has
6 the meaning given such term in section 92.4 of title
7 45, Code of Federal Regulations, as in effect on May
8 18, 2016 (81 Fed. Reg. 31466 (May 18, 2016)).

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

13 (1) ensure that appropriate clinical and support
14 staff receive ongoing education and training in cul-
15 turally and linguistically appropriate service delivery;

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

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

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

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

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

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

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

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

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

1 (E) If the covered entity has reason to be-
2 lieve that there is a conflict of interest between
3 the interpreter and patient, the covered entity
4 may not use the patient's interpreter.

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

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

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

1 **SEC. 210. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
2 **TURALLY AND LINGUISTICALLY APPRO-**
3 **PRIATE HEALTH CARE SERVICES.**

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

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

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

19 (3) recommendations on the development and
20 implementation of policies and practices by providers
21 of health care services and health-care-related serv-
22 ices for individuals with limited English proficiency,
23 including people with cognitive, hearing, vision, or
24 print impairments;

25 (4) recommend guidelines or standards for
26 health literacy and plain language, informed consent,

1 discharge instructions, and written communications,
2 and for improvement of health care access;

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

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

8 (b) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2021 through 2025.

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

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

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

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

1 as the Secretary of Education may require and in such
2 form and manner as the Secretary may require.

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

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

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

16 (3) maintain current ESL instruction efforts by
17 using funds available under this section to supple-
18 ment rather than supplant any funds expended for
19 ESL instruction in the State as of January 1, 2020.

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

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

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

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

7 (B) the extent of waiting lists for ESL in-
8 struction, including how many programs main-
9 tain waiting lists and, for programs that do not
10 have waiting lists, the reasons why not;

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

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

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

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

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

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

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

6 (4) not later than 1 year after the date of en-
7 actment of this Act, issue a report to Congress that
8 assesses the information collected in paragraphs (1),
9 (2), and (3) and makes recommendations on steps
10 that should be taken to progressively realize the goal
11 of making ESL instruction available to all English
12 language learners seeking instruction.

13 (f) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to the Secretary of Edu-
15 cation \$250,000,000 for each of fiscal years 2021 through
16 2024 to carry out this section.

17 **SEC. 212. IMPLEMENTATION.**

18 (a) GENERAL PROVISIONS.—

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

24 (2) REMEDIES.—In a suit against a State for
25 a violation of this title (including an amendment

1 made by this title), remedies (including remedies
2 both at law and in equity) are available for such a
3 violation to the same extent as such remedies are
4 available for such a violation in a suit against any
5 public or private entity other than a State.

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

11 **SEC. 213. LANGUAGE ACCESS SERVICES.**

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

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

18 (b) **EMPLOYER-SPONSORED MINIMUM ESSENTIAL**
19 **COVERAGE.**—

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

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

11 (2) CONFORMING AMENDMENTS.—

12 (A) Section 36B(c)(2)(C) of such Code is
13 amended by striking “clause (iii)” each place it
14 appears in clauses (i) and (ii) and inserting
15 “clause (iv)”.

16 (B) Section 36B(c)(2)(C)(iv) of such Code,
17 as redesignated by this subsection, is amended
18 by striking “(i) and (ii)” and inserting “(i), (ii),
19 and (iii)”.

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

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

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

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

5 “(E) reduce health disparities through the
6 provision of language access services, including
7 oral interpretation and written translations.”.

8 (d) REGULATIONS REGARDING INTERNAL CLAIMS
9 AND APPEALS AND EXTERNAL REVIEW PROCESSES FOR
10 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

11 The Secretary of the Treasury, the Secretary of Labor,
12 and the Secretary of Health and Human Services shall
13 amend the regulations in section 54.9815–2719(e) of title
14 26, Code of Federal Regulations, section 2590.715–
15 2719(e) of title 29, Code of Federal Regulations, and sec-
16 tion 147.136(e) of title 45, Code of Federal Regulations
17 (or a successor regulation), respectively, to require group
18 health plans and health insurance issuers offering group
19 or individual health insurance coverage to which such sec-
20 tions apply—

21 (1) to provide oral interpretation services with-
22 out any threshold requirements;

23 (2) to provide in the English versions of all no-
24 tices a statement prominently displayed in not less
25 than 15 non-English languages clearly indicating

1 how to access the language services provided by the
2 plan or issuer; and

3 (3) with respect to the requirements for pro-
4 viding relevant notices in a culturally and linguis-
5 tically appropriate manner in the applicable non-
6 English languages, to apply a threshold that 5 per-
7 cent of the population, or not less than 500 individ-
8 uals, in the county is literate only in the same non-
9 English language in order for the language to be
10 considered an applicable non-English language.

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

13 (1) amend the single streamlined application
14 form developed pursuant to section 1413 of the Pa-
15 tient Protection and Affordable Care Act (42 U.S.C.
16 18083) to collect the preferred spoken and written
17 language for each household member applying for
18 coverage under a qualified health plan through an
19 Exchange under title I of such Act (42 U.S.C.
20 18001 et seq.);

21 (2) require navigators, certified application
22 counselors, and other individuals assisting with en-
23 rollment to collect and report requests for language
24 assistance; and

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

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

15 **SEC. 214. MEDICALLY UNDERSERVED POPULATIONS.**

16 Section 330(b)(3)(A) of the Public Health Service
17 Act (42 U.S.C. 254b(b)(3)(A)) is amended to read as fol-
18 lows:

19 “(A) IN GENERAL.—The term ‘medically
20 underserved’, with respect to a population,
21 means—

22 “(i) the population of an urban or
23 rural area designated by the Secretary
24 as—

1 “(I) an area with a shortage of
2 personal health services; or

3 “(II) a population group having a
4 shortage of such services; or

5 “(ii) a population of individuals, not
6 confined to a particular urban or rural
7 area, who are designated by the Secretary
8 as having a shortage of personal health
9 services due to a specific demographic
10 trait.”.

11 **TITLE III—HEALTH WORKFORCE**
12 **DIVERSITY**

13 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
14 **ACT.**

15 Title XXXIV of the Public Health Service Act, as
16 added by section 204, is amended by adding at the end
17 the following:

18 **“Subtitle B—Diversifying the**
19 **Health Care Workplace**

20 **“SEC. 3411. NATIONAL WORKING GROUP ON WORKFORCE**
21 **DIVERSITY.**

22 “(a) IN GENERAL.—The Secretary, acting through
23 the Bureau of Health Workforce of the Health Resources
24 and Services Administration, shall award a grant to an
25 entity determined appropriate by the Secretary for the es-

1 tablishment of a national working group on workforce di-
2 versity.

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

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

7 “(A) The Health Resources and Services
8 Administration.

9 “(B) The Department of Health and
10 Human Services Data Council.

11 “(C) The Office of Minority Health of the
12 Department of Health and Human Services.

13 “(D) The Substance Abuse and Mental
14 Health Services Administration.

15 “(E) The Bureau of Labor Statistics of
16 the Department of Labor.

17 “(F) The National Institute on Minority
18 Health and Health Disparities.

19 “(G) The Agency for Healthcare Research
20 and Quality.

21 “(H) The Institute of Medicine Study
22 Committee for the 2004 workforce diversity re-
23 port.

24 “(I) The Indian Health Service.

25 “(J) The Department of Education.

1 “(K) Minority-serving academic institu-
2 tions.

3 “(L) Consumer organizations.

4 “(M) Health professional associations, in-
5 cluding those that represent underrepresented
6 minority populations.

7 “(N) Researchers in the area of health
8 workforce.

9 “(O) Health workforce accreditation enti-
10 ties.

11 “(P) Private (including nonprofit) founda-
12 tions that have sponsored workforce diversity
13 initiatives.

14 “(Q) Local and State health departments.

15 “(R) Representatives of community mem-
16 bers to be included on admissions committees
17 for health profession schools pursuant to sub-
18 section (c)(9).

19 “(S) National community-based organiza-
20 tions that serve as a national intermediary to
21 their urban affiliate members and have dem-
22 onstrated capacity to train health care profes-
23 sionals.

24 “(T) The Veterans Health Administration.

1 “(U) Other entities determined appropriate
2 by the Secretary.

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

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

11 “(1) Review public and private health workforce
12 diversity initiatives.

13 “(2) Identify successful health workforce diver-
14 sity programs and practices.

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

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

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

24 “(6) Develop recommended standards for work-
25 force diversity that could be applicable to all health

1 professions programs and programs funded under
2 this Act.

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

5 “(8) Develop a workforce data collection or
6 tracking system to identify where racial and ethnic
7 minority health professionals practice.

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

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

13 “(11) Other activities determined appropriate
14 by the Secretary.

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

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

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

3 **“SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH**
4 **WORKFORCE DIVERSITY.**

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

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

17 “(1) Information on the importance of health
18 workforce diversity.

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

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

1 “(4) Admissions policies that promote health
2 workforce diversity and are in compliance with Fed-
3 eral and State laws.

4 “(5) Retainment policies that promote comple-
5 tion of health profession degrees for underserved
6 populations.

7 “(6) Lists of scholarship, loan repayment, and
8 loan cancellation grants as well as fellowship infor-
9 mation for underserved populations for health pro-
10 fessions schools.

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

13 “(c) CONSULTATION.—In carrying out this section,
14 the Secretary shall consult with non-Federal entities which
15 may include minority health professional associations and
16 minority sections of major health professional associations
17 to ensure the adequacy and accuracy of information.

18 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to carry out this section
20 such sums as may be necessary for each of fiscal years
21 2021 through 2025.

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

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Administrator of the Health Resources and Services
6 Administration and the Director of the Centers for Dis-
7 ease Control and Prevention, shall award grants to eligible
8 entities that demonstrate a commitment to health work-
9 force diversity.

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

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

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

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

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

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

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

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

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

9 “(H) institutions, including national and
10 regional community-based organizations with
11 demonstrated commitment to a diversified
12 workforce—

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

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

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

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

1 “(c) USE OF FUNDS.—Amounts received under a
2 grant under subsection (a) shall be used to expand existing
3 workforce diversity programs, implement new workforce
4 diversity programs, or evaluate existing or new workforce
5 diversity programs, including with respect to mental
6 health care professions. Such programs shall enhance di-
7 versity by considering minority status as part of an indi-
8 vidualized consideration of qualifications. Possible activi-
9 ties may include—

10 “(1) educational outreach programs relating to
11 opportunities in the health professions;

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

14 “(3) postbaccalaureate programs;

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

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

21 “(6) mentoring programs;

22 “(7) internship or rotation programs involving
23 hospitals, health systems, health plans, and other
24 health entities;

1 “(8) community partnership development for
2 purposes relating to workforce diversity; or

3 “(9) leadership training.

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

9 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
10 is authorized to be appropriated to carry out this section,
11 such sums as may be necessary for each of fiscal years
12 2021 through 2025.

13 **“SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND**
14 **RESEARCHERS.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Director of the National Institutes of Health, the Di-
17 rector of the Centers for Disease Control and Prevention,
18 the Commissioner of Food and Drugs, the Director of the
19 Agency for Healthcare Research and Quality, and the Ad-
20 ministrator of the Health Resources and Services Admin-
21 istration, shall award grants that expand existing opportu-
22 nities for scientists and researchers and promote the inclu-
23 sion of underrepresented minorities in the health profes-
24 sions.

1 “(b) RESEARCH FUNDING.—The head of each agency
2 listed in subsection (a) shall establish or expand existing
3 programs to provide research funding to scientists and re-
4 searchers in training. Under such programs, the head of
5 each such entity shall give priority in allocating research
6 funding to support health research in traditionally under-
7 served communities, including underrepresented minority
8 communities, and research classified as community or
9 participatory.

10 “(c) DATA COLLECTION.—The head of each agency
11 listed in subsection (a) shall collect data on the number
12 (expressed as an absolute number and a percentage) of
13 underrepresented minority and nonminority applicants
14 who receive and are denied agency funding at every stage
15 of review. Such data shall be reported annually to the Sec-
16 retary and the appropriate committees of Congress.

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

24 “(e) STUDENT LOAN CANCELLATION.—The Sec-
25 retary shall establish a student loan cancellation program

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

8 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to carry out this section,
10 such sums as may be necessary for each of fiscal years
11 2021 through 2025.

12 **“SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH**
13 **PROFESSIONALS.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Director of the Centers for Disease Control and Pre-
16 vention, the Assistant Secretary for Mental Health and
17 Substance Use, the Administrator of the Health Resources
18 and Services Administration, and the Administrator of the
19 Centers for Medicare & Medicaid Services, shall establish
20 a program to award grants to eligible individuals for ca-
21 reer support in nonresearch-related health and wellness
22 professions.

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

1 “(1) be a student in a health professions school,
2 a graduate of such a school who is working in a
3 health profession, an individual working in a health
4 or wellness profession (including mental and behav-
5 ioral health), or a faculty member of such a school;
6 and

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

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

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

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

17 “(3) pay, or as reimbursement for payments of,
18 student loans or training or credentialing costs for
19 individuals who are health professionals and are fo-
20 cused on health issues affecting underserved commu-
21 nities, including racial and ethnic minority commu-
22 nities; and

23 “(4) establish and promote leadership training
24 programs to decrease health disparities and to in-

1 crease cultural competence with the goal of increas-
2 ing diversity in leadership positions.

3 “(d) DEFINITION.—In this section, the term ‘career
4 in nonresearch-related health and wellness professions’
5 means employment or intended employment in the field
6 of public health, health policy, health management, health
7 administration, medicine, nursing, pharmacy, psychology,
8 social work, psychiatry, other mental and behavioral
9 health, allied health, community health, social work, or
10 other fields determined appropriate by the Secretary,
11 other than in a position that involves research.

12 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2021 through 2025.

16 **“SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DI-
17 VERSITY ON QUALITY.**

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

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

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

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

9 “(c) USE OF FUNDS.—Amounts received under a
10 grant awarded under subsection (a) shall be used to sup-
11 port research that investigates the effect of health work-
12 force diversity on—

13 “(1) language access;

14 “(2) cultural competence;

15 “(3) patient satisfaction;

16 “(4) timeliness of care;

17 “(5) safety of care;

18 “(6) effectiveness of care;

19 “(7) efficiency of care;

20 “(8) patient outcomes;

21 “(9) community engagement;

22 “(10) resource allocation;

23 “(11) organizational structure;

24 “(12) compliance of care; or

1 “(13) other topics determined appropriate by
2 the Director.

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

8 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2021 through 2025.

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

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

1 “(b) ACTIVITIES.—The Secretary, through the edu-
2 cation program established under subsection (a), shall,
3 through the use of public awareness and outreach cam-
4 paigns targeting the general public and the medical com-
5 munity at large—

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

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

22 “(3) disseminate information about the impact
23 of linguistic and cultural barriers on health care
24 quality and the obligation of health providers who
25 receive Federal financial assistance to ensure that

1 individuals with limited English proficiency have ac-
2 cess to language access services;

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

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

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

15 “(7) design and implement specific educational
16 initiatives to educate the health care workforce relat-
17 ing to unconscious bias.

18 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to carry out this section
20 such sums as may be necessary for each of fiscal years
21 2021 through 2025.”.

1 **SEC. 302. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
2 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
3 **ASIAN AMERICAN AND NATIVE AMERICAN PA-**
4 **CIFIC ISLANDER-SERVING INSTITUTIONS,**
5 **TRIBAL COLLEGES, REGIONAL COMMUNITY-**
6 **BASED ORGANIZATIONS, AND NATIONAL MI-**
7 **NORITY MEDICAL ASSOCIATIONS.**

8 (a) IN GENERAL.—Part B of title VII of the Public
9 Health Service Act (42 U.S.C. 293 et seq.) is amended
10 by adding at the end the following:

11 **“SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
12 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
13 **ASIAN AMERICAN AND NATIVE AMERICAN PA-**
14 **CIFIC ISLANDER-SERVING INSTITUTIONS,**
15 **AND TRIBAL COLLEGES.**

16 “(a) IN GENERAL.—The Secretary, acting through
17 the Administrator of the Health Resources and Services
18 Administration and in consultation with the Secretary of
19 Education, shall award grants to Hispanic-serving institu-
20 tions, historically black colleges and universities, Asian
21 American and Native American Pacific Islander-serving
22 institutions, Tribal Colleges or Universities, regional com-
23 munity-based organizations, and national minority med-
24 ical associations, for counseling, mentoring, and providing
25 information on financial assistance to prepare underrep-
26 resented minority individuals to enroll in and graduate

1 from health professional schools and to increase services
2 for underrepresented minority students including—

3 “(1) mentoring with underrepresented health
4 professionals; and

5 “(2) providing financial assistance information
6 for continued education and applications to health
7 professional schools.

8 “(b) DEFINITIONS.—In this section:

9 “(1) ASIAN AMERICAN AND NATIVE AMERICAN
10 PACIFIC ISLANDER-SERVING INSTITUTION.—The
11 term ‘Asian American and Native American Pacific
12 Islander-serving institution’ has the meaning given
13 such term in section 320(b) of the Higher Education
14 Act of 1965.

15 “(2) HISPANIC-SERVING INSTITUTION.—The
16 term ‘Hispanic-serving institution’ means an entity
17 that—

18 “(A) is a school or program for which
19 there is a definition under section 799B;

20 “(B) has an enrollment of full-time equiva-
21 lent students that is made up of at least 9 per-
22 cent Hispanic students;

23 “(C) has been effective in carrying out pro-
24 grams to recruit Hispanic individuals to enroll
25 in and graduate from the school;

1 “(D) has been effective in recruiting and
2 retaining Hispanic faculty members;

3 “(E) has a significant number of graduates
4 who are providing health services to medically
5 underserved populations or to individuals in
6 health professional shortage areas; and

7 “(F) is a Hispanic Center of Excellence in
8 Health Professions Education designated under
9 section 736(d)(2) of the Public Health Service
10 Act (42 U.S.C. 293(d)(2)).

11 “(3) HISTORICALLY BLACK COLLEGES AND
12 UNIVERSITY.—The term ‘historically black college
13 and university’ has the meaning given the term ‘part
14 B institution’ as defined in section 322 of the High-
15 er Education Act of 1965.

16 “(4) TRIBAL COLLEGE OR UNIVERSITY.—The
17 term ‘Tribal College or University’ has the meaning
18 given such term in section 316(b) of the Higher
19 Education Act of 1965.

20 “(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In
21 carrying out the National Health Service Corps Loan Re-
22 payment Program established under subpart III of part
23 D of title III and the loan repayment program under sec-
24 tion 317F, the Secretary shall ensure, notwithstanding
25 such subpart or section, that loan repayments of not less

1 than \$50,000 per year per person are awarded for repay-
2 ment of loans incurred for enrollment or participation of
3 underrepresented minority individuals in health profes-
4 sional schools and other health programs described in this
5 section.

6 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2021 through 2026.”.

10 **SEC. 303. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
11 **DISEASE CONTROL AND PREVENTION.**

12 Section 317F(c)(1) of the Public Health Service Act
13 (42 U.S.C. 247b–7(c)(1)) is amended—

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

15 (2) by inserting before the period at the end the
16 following: “, \$750,000 for fiscal year 2021, and such
17 sums as may be necessary for each of the fiscal
18 years 2022 through 2026”.

19 **SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
20 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
21 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

22 Part B of title VII of the Public Health Service Act
23 (42 U.S.C. 293 et seq.), as amended by section 302, is
24 further amended by adding at the end the following:

1 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
2 **GREE PROGRAMS.**

3 “(a) COOPERATIVE AGREEMENTS.—The Secretary,
4 acting through the Administrator of the Health Resources
5 and Services Administration, in consultation with the Di-
6 rector of the Centers for Disease Control and Prevention,
7 the Director of the Agency for Healthcare Research and
8 Quality, and the Deputy Assistant Secretary for Minority
9 Health, shall enter into cooperative agreements with
10 schools of public health and schools of allied health to de-
11 sign and implement online degree programs.

12 “(b) PRIORITY.—In entering into cooperative agree-
13 ments under this section, the Secretary shall give priority
14 to any school of public health or school of allied health
15 that has an established track record of serving medically
16 underserved communities.

17 “(c) REQUIREMENTS.—As a condition of entering
18 into a cooperative agreement with the Secretary under this
19 section, a school of public health or school of allied health
20 shall agree to design and implement an online degree pro-
21 gram that meets the following restrictions:

22 “(1) Enrollment of individuals who have ob-
23 tained a secondary school diploma or its recognized
24 equivalent.

1 “(2) Maintaining a significant enrollment of
2 underrepresented minority or disadvantaged stu-
3 dents.

4 “(3) Achieving a high completion rate of en-
5 rolled underrepresented minority or disadvantaged
6 students.

7 “(d) PERIOD OF COOPERATIVE AGREEMENTS.—The
8 period during which payments are made through a cooper-
9 ative agreement entered into under this section may not
10 exceed 3 years.

11 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section
13 such sums as may be necessary for each of fiscal years
14 2021 through 2025.”.

15 **SEC. 305. SENSE OF CONGRESS ON THE MISSION OF THE**
16 **NATIONAL HEALTH CARE WORKFORCE COM-**
17 **MISSION.**

18 It is the sense of Congress that the National Health
19 Care Workforce Commission established by section 5101
20 of the Patient Protection and Affordable Care Act (42
21 U.S.C. 294q) should, in carrying out its assigned duties
22 under that section, give attention to the needs of racial
23 and ethnic minorities, individuals with lower socio-
24 economic status, individuals with mental, developmental,
25 and physical disabilities, lesbian, gay, bisexual,

1 transgender, queer, and questioning populations, and indi-
 2 viduals who are members of multiple minority or special
 3 population groups.

4 **SEC. 306. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

5 Subtitle B of title XXXIV of the Public Health Serv-
 6 ice Act, as added by section 301, is further amended by
 7 inserting after section 3417 the following:

8 **“SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
 9 **SERVICES CORPS.**

10 “(a) IN GENERAL.—The Director of the Centers for
 11 Disease Control and Prevention, in collaboration with the
 12 Administrator of the Health Resources and Services Ad-
 13 ministration and the Deputy Assistant Secretary for Mi-
 14 nority Health, shall award grants to eligible entities to in-
 15 crease awareness among secondary and postsecondary stu-
 16 dents of career opportunities in the health professions.

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

19 “(1) be a clinical, public health, or health serv-
 20 ices organization, community-based or nonprofit en-
 21 tity, or other entity determined appropriate by the
 22 Director of the Centers for Disease Control and Pre-
 23 vention;

24 “(2) serve a health professional shortage area,
 25 as determined by the Secretary;

1 “(3) work with students, including those from
2 racial and ethnic minority backgrounds, that have
3 expressed an interest in the health professions; and

4 “(4) submit to the Secretary an application at
5 such time, in such manner, and containing such in-
6 formation as the Secretary may require.

7 “(c) USE OF FUNDS.—Grant awards under sub-
8 section (a) shall be used to support internships that will
9 increase awareness among students of non-research-based,
10 career opportunities in the following health professions:

11 “(1) Medicine.

12 “(2) Nursing.

13 “(3) Public health.

14 “(4) Pharmacy.

15 “(5) Health administration and management.

16 “(6) Health policy.

17 “(7) Psychology.

18 “(8) Dentistry.

19 “(9) International health.

20 “(10) Social work.

21 “(11) Allied health.

22 “(12) Psychiatry.

23 “(13) Hospice care.

24 “(14) Community health, patient navigation,
25 and peer support.

1 “(15) Other professions determined appropriate
2 by the Director of the Centers for Disease Control
3 and Prevention.

4 “(d) PRIORITY.—In awarding grants under sub-
5 section (a), the Director of the Centers for Disease Con-
6 trol and Prevention shall give priority to those entities
7 that—

8 “(1) serve a high proportion of individuals from
9 disadvantaged backgrounds;

10 “(2) have experience in health disparity elimi-
11 nation programs;

12 “(3) facilitate the entry of disadvantaged indi-
13 viduals into institutions of higher education; and

14 “(4) provide counseling or other services de-
15 signed to assist disadvantaged individuals in success-
16 fully completing their education at the postsecondary
17 level.

18 “(e) STIPENDS.—

19 “(1) IN GENERAL.—Subject to paragraph (2),
20 an entity receiving a grant under this section may
21 use the funds made available through such grant to
22 award stipends for educational and living expenses
23 to students participating in the internship supported
24 by the grant.

1 “(2) LIMITATIONS.—A stipend awarded under
2 paragraph (1) to an individual—

3 “(A) may not be provided for a period that
4 exceeds 6 months; and

5 “(B) may not exceed \$20 per day for an
6 individual (notwithstanding any other provision
7 of law regarding the amount of a stipend).

8 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2021 through 2026.

12 **“SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
13 **PROGRAM.**

14 “(a) IN GENERAL.—The Director of the Centers for
15 Disease Control and Prevention, in collaboration with the
16 Deputy Assistant Secretary for Minority Health, shall
17 award scholarships to eligible individuals under subsection
18 (b) who seek a career in public health.

19 “(b) ELIGIBILITY.—To be eligible to receive a schol-
20 arship under subsection (a), an individual shall—

21 “(1) have interest, knowledge, or skill in public
22 health research or public health practice, or other
23 health professions as determined appropriate by the
24 Director of the Centers for Disease Control and Pre-
25 vention;

1 “(2) reside in a health professional shortage
2 area as determined by the Secretary;

3 “(3) demonstrate promise for becoming a leader
4 in public health;

5 “(4) secure admission to a 4-year institution of
6 higher education; and

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

10 “(c) USE OF FUNDS.—Amounts received under an
11 award under subsection (a) shall be used to support oppor-
12 tunities for students to become public health professionals.

13 “(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Director shall give priority to those stu-
15 dents that—

16 “(1) are from disadvantaged backgrounds;

17 “(2) have secured admissions to a minority-
18 serving institution; and

19 “(3) have identified a health professional as a
20 mentor at their school or institution and an aca-
21 demic advisor to assist in the completion of their
22 baccalaureate degree.

23 “(e) SCHOLARSHIPS.—The Secretary may approve
24 payment of scholarships under this section for such indi-
25 viduals for any period of education in student under-

1 graduate tenure, except that such a scholarship may not
2 be provided to an individual for more than 4 years, and
3 such a scholarship may not exceed \$10,000 per academic
4 year for an individual (notwithstanding any other provi-
5 sion of law regarding the amount of a scholarship).

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

10 **“SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH**
11 **FELLOWSHIP PROGRAM.**

12 “(a) IN GENERAL.—The Director of the Centers for
13 Disease Control and Prevention, in collaboration with the
14 Deputy Assistant Secretary for Minority Health, the As-
15 sistant Secretary for Mental Health and Substance Use,
16 and the Director of the Indian Health Services, shall
17 award research fellowships to eligible individuals under
18 subsection (b) to conduct research that will examine gen-
19 der and health disparities and to pursue a career in the
20 health professions.

21 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
22 ship under subsection (a), an individual shall—

23 “(1) have experience in health research or pub-
24 lic health practice;

1 “(2) reside in a health professional shortage
2 area as designated by the Secretary under section
3 332;

4 “(3) have expressed an interest in the health
5 professions;

6 “(4) demonstrate promise for becoming a leader
7 in the field of women’s health;

8 “(5) secure admission to a health professions
9 school or graduate program with an emphasis in
10 gender studies; and

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

14 “(c) USE OF FUNDS.—A fellowship awarded under
15 subsection (a) to an eligible individual shall be used to
16 support an opportunity for the individual to become a re-
17 searcher and advance the research base on the intersection
18 between gender and health.

19 “(d) PRIORITY.—In awarding fellowships under sub-
20 section (a), the Director of the Centers for Disease Con-
21 trol and Prevention shall give priority to those applicants
22 that—

23 “(1) are from disadvantaged backgrounds; and

24 “(2) have identified a mentor and academic ad-
25 visor who will assist in the completion of their grad-

1 uate or professional degree and have secured a re-
2 search assistant position with a researcher working
3 in the area of gender and health.

4 “(e) FELLOWSHIPS.—The Director of the Centers for
5 Disease Control and Prevention may approve fellowships
6 for individuals under this section for any period of edu-
7 cation in the student’s graduate or health profession ten-
8 ure, except that such a fellowship may not be provided
9 to an individual for more than 3 years, and such a fellow-
10 ship may not exceed \$18,000 per academic year for an
11 individual (notwithstanding any other provision of law re-
12 garding the amount of a fellowship).

13 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
14 is authorized to be appropriated to carry out this section
15 such sums as may be necessary for each of fiscal years
16 2021 through 2025.

17 **“SEC. 3421. PAUL DAVID WELLSTONE INTERNATIONAL**
18 **HEALTH FELLOWSHIP PROGRAM.**

19 “(a) IN GENERAL.—The Director of the Agency for
20 Healthcare Research and Quality, in collaboration with
21 the Deputy Assistant Secretary for Minority Health, shall
22 award research fellowships to eligible individuals under
23 subsection (b) to advance their understanding of inter-
24 national health.

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

3 “(1) have educational experience in the field of
4 international health;

5 “(2) reside in a health professional shortage
6 area as determined by the Secretary;

7 “(3) demonstrate promise for becoming a leader
8 in the field of international health;

9 “(4) be a college senior or recent graduate of
10 a 4-year institution of higher education; and

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

14 “(c) USE OF FUNDS.—A fellowship awarded under
15 subsection (a) to an eligible individual shall be used to
16 support an opportunity for the individual to become a
17 health professional and to advance the knowledge of the
18 individual about international issues relating to health
19 care access and quality.

20 “(d) PRIORITY.—In awarding fellowships under sub-
21 section (a), the Director shall give priority to eligible indi-
22 viduals that—

23 “(1) are from a disadvantaged background; and

24 “(2) have identified a mentor at a health pro-
25 fessions school or institution, an academic advisor to

1 assist in the completion of their graduate or profes-
2 sional degree, and an advisor from an international
3 health non-governmental organization, private volun-
4 teer organization, or other international institution
5 or program that focuses on increasing health care
6 access and quality for residents in developing coun-
7 tries.

8 “(e) FELLOWSHIPS.—A fellowship awarded under
9 this section may not—

10 “(1) be provided to an eligible individual for
11 more than a period of 6 months;

12 “(2) be awarded to a graduate of a 4-year insti-
13 tution of higher education that has not been enrolled
14 in such institution for more than 1 year; and

15 “(3) exceed \$4,000 per academic year (notwith-
16 standing any other provision of law regarding the
17 amount of a fellowship).

18 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to carry out this section,
20 such sums as may be necessary for each of fiscal years
21 2021 through 2025.

22 **“SEC. 3422. EDWARD R. ROYBAL HEALTH SCHOLAR PRO-**
23 **GRAM.**

24 “(a) IN GENERAL.—The Director of the Agency for
25 Healthcare Research and Quality, the Director of the Cen-

1 ters for Medicare & Medicaid Services, and the Adminis-
2 trator of the Health Resources and Services Administra-
3 tion, in collaboration with the Deputy Assistant Secretary
4 for Minority Health, shall award grants to eligible entities
5 to expose entering graduate students to the health profes-
6 sions.

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

9 “(1) be a clinical, public health, or health serv-
10 ices organization, community-based, academic, or
11 nonprofit entity, or other entity determined appro-
12 priate by the Director of the Agency for Healthcare
13 Research and Quality;

14 “(2) serve in a health professional shortage
15 area as designated by the Secretary under section
16 332;

17 “(3) work with students obtaining a degree in
18 the health professions; and

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

22 “(c) USE OF FUNDS.—Amounts received under a
23 grant awarded under subsection (a) shall be used to sup-
24 port opportunities that expose students to non-research-
25 based health professions, including—

1 “(1) public health policy;

2 “(2) health care and pharmaceutical policy;

3 “(3) health care administration and manage-
4 ment;

5 “(4) health economics; and

6 “(5) other professions determined appropriate
7 by the Director of the Agency for Healthcare Re-
8 search and Quality, the Director of the Centers for
9 Medicare & Medicaid Services, or the Administrator
10 of the Health Resources and Services Administra-
11 tion.

12 “(d) PRIORITY.—In awarding grants under sub-
13 section (a), the Director of the Agency for Healthcare Re-
14 search and Quality, the Director of the Centers for Medi-
15 care & Medicaid Services, and the Administrator of the
16 Health Resources and Services Administration, in collabo-
17 ration with the Deputy Assistant for Secretary for Minor-
18 ity Health, shall give priority to those entities that—

19 “(1) have experience with health disparity elimi-
20 nation programs;

21 “(2) facilitate training in the fields described in
22 subsection (c); and

23 “(3) provide counseling or other services de-
24 signed to assist students in successfully completing
25 their education at the postsecondary level.

1 “(e) STIPENDS.—

2 “(1) IN GENERAL.—Subject to paragraph (2),
3 an entity receiving a grant under this section may
4 use the funds made available through such grant to
5 award stipends for educational and living expenses
6 to students participating in the opportunities sup-
7 ported by the grant.

8 “(2) LIMITATIONS.—A stipend awarded under
9 paragraph (1) to an individual—

10 “(A) may not be provided for a period that
11 exceeds 2 months; and

12 “(B) may not exceed \$100 per day (not-
13 withstanding any other provision of law regard-
14 ing the amount of a stipend).

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

19 **“SEC. 3423. LEADERSHIP FELLOWSHIP PROGRAMS.**

20 “(a) IN GENERAL.—The Secretary shall award
21 grants to national minority medical or health professional
22 associations to develop leadership fellowship programs for
23 underrepresented health professionals in order to—

1 “(1) assist such professionals in becoming fu-
2 ture leaders in public health and health care delivery
3 institutions; and

4 “(2) increase diversity in decision-making posi-
5 tions that can improve the health of underserved
6 communities.

7 “(b) USE OF FUNDS.—A leadership fellowship pro-
8 gram supported under this section shall—

9 “(1) focus on training mid-career physicians
10 and health care executives who have documented
11 leadership experience and a commitment to public
12 health services in underserved communities; and

13 “(2) support Federal public health policy and
14 budget programs, and priorities that impact health
15 equity, through activities such as didactic lectures
16 and leader site visits.

17 “(c) PERIOD OF GRANTS.—The period during which
18 payments are made under a grant awarded under sub-
19 section (a) may not exceed 3 years.

20 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2021 through 2026.”.

1 **SEC. 307. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
2 **PROGRAM.**

3 Section 402E of the Higher Education Act of 1965
4 (20 U.S.C. 1070a–15) is amended by striking subsection
5 (g) and inserting the following:

6 “(g) **COLLABORATION IN HEALTH PROFESSION DI-**
7 **VERSITY TRAINING PROGRAMS.**—The Secretary shall co-
8 ordinate with the Secretary of Health and Human Serv-
9 ices to ensure that there is collaboration between the goals
10 of the program under this section and programs of the
11 Health Resources and Services Administration that pro-
12 mote health workforce diversity. The Secretary of Edu-
13 cation shall take such measures as may be necessary to
14 encourage students participating in projects assisted
15 under this section to consider health profession careers.

16 “(h) **FUNDING.**—From amounts appropriated pursu-
17 ant to the authority of section 402A(g), the Secretary
18 shall, to the extent practicable, allocate funds for projects
19 authorized by this section in an amount that is not less
20 than \$31,000,000 for each of the fiscal years 2021
21 through 2026.”.

1 **SEC. 308. RULES FOR DETERMINATION OF FULL-TIME**
2 **EQUIVALENT RESIDENTS FOR COST-REPORT-**
3 **ING PERIODS.**

4 (a) DGME DETERMINATIONS.—Section 1886(h)(4)
5 of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as
6 amended by section 206(a), is amended—

7 (1) in subparagraph (E), by striking “Subject
8 to subparagraphs (J) and (K), such rules” and in-
9 serting “Subject to subparagraphs (J), (K), and
10 (M), such rules”;

11 (2) in subparagraph (J), by striking “Such
12 rules” and inserting “Subject to subparagraph (M),
13 such rules”;

14 (3) in subparagraph (K), by striking “In deter-
15 mining” and inserting “Subject to subparagraph
16 (M), in determining”; and

17 (4) by adding at the end the following new sub-
18 paragraph:

19 “(M) TREATMENT OF CERTAIN RESIDENTS
20 AND INTERNS.—For purposes of cost-reporting
21 periods beginning on or after October 1, 2021,
22 in determining the hospital’s number of full-
23 time equivalent residents for purposes of this
24 paragraph, all the time spent by an intern or
25 resident in an approved medical residency train-
26 ing program shall be counted toward the deter-

1 mination of full-time equivalency if the hos-
2 pital—

3 “(i) is recognized as a subsection (d)
4 hospital;

5 “(ii) is recognized as a subsection (d)
6 Puerto Rico hospital;

7 “(iii) is reimbursed under a reim-
8 bursement system authorized under section
9 1814(b)(3); or

10 “(iv) is a provider-based hospital out-
11 patient department.”.

12 (b) IME DETERMINATIONS.—Section
13 1886(d)(5)(B)(xi) of the Social Security Act (42 U.S.C.
14 1395ww(d)(5)(B)(xi)), as redesignated by section 206(b),
15 is amended—

16 (1) in subclause (II), by striking “In deter-
17 mining” and inserting “Subject to subclause (IV), in
18 determining”;

19 (2) in subclause (III), by striking “In deter-
20 mining” and inserting “Subject to subclause (IV), in
21 determining”; and

22 (3) by inserting after subclause (III) the fol-
23 lowing new subclause:

24 “(IV) For purposes of cost-reporting peri-
25 ods beginning on or after October 1, 2021, the

1 provisions of subparagraph (M) of subsection
2 (h)(4) shall apply under this subparagraph in
3 the same manner as they apply under such sub-
4 section.”.

5 **SEC. 309. DEVELOPING AND IMPLEMENTING STRATEGIES**
6 **FOR LOCAL HEALTH EQUITY.**

7 (a) GRANTS.—The Secretary of Health and Human
8 Services, acting jointly with the Secretary of Education
9 and the Secretary of Labor, shall make grants to institu-
10 tions of higher education for the purposes of—

11 (1) in accordance with subsection (b), devel-
12 oping capacity—

13 (A) to build an evidence base for successful
14 strategies for increasing local health equity; and

15 (B) to serve as national models of driving
16 local health equity;

17 (2) in accordance with subsection (c), devel-
18 oping a strategic partnership with the community in
19 which the institution is located; and

20 (3) collecting data on, and periodically evalu-
21 ating, the effectiveness of the institution’s programs
22 funded through this section to enable the institution
23 to adapt accordingly for maximum efficiency and
24 success.

1 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
2 HEALTH EQUITY.—As a condition on receipt of a grant
3 under subsection (a), an institution of higher education
4 shall agree to use the grant to build an evidence base for
5 successful strategies for increasing local health equity, and
6 to serve as a national model of driving local health equity,
7 by supporting—

8 (1) resources to strengthen institutional metrics
9 and capacity to execute institution-wide health work-
10 force goals that can serve as models for increasing
11 health equity in communities across the United
12 States;

13 (2) collaborations among a cohort of institu-
14 tions in implementing systemic change, partnership
15 development, and programmatic efforts supportive of
16 health equity goals across disciplines and popu-
17 lations; and

18 (3) enhanced or newly developed data systems
19 and research infrastructure capable of informing
20 current and future workforce efforts and building a
21 foundation for a broader research agenda targeting
22 urban health disparities.

23 (c) STRATEGIC PARTNERSHIPS.—As a condition on
24 receipt of a grant under subsection (a), an institution of
25 higher education shall agree to use the grant to develop

1 a strategic partnership with the community in which the
2 institution is located for the purposes of—

3 (1) strengthening connections between the insti-
4 tution and the community—

5 (A) to improve evaluation of and address
6 the community's health and health workforce
7 needs; and

8 (B) to engage the community in health
9 workforce development;

10 (2) developing, enhancing, or accelerating inno-
11 vative undergraduate and graduate programs in the
12 biomedical sciences and health professions; and

13 (3) strengthening pipeline programs in the bio-
14 medical sciences and health professions, including by
15 developing partnerships between institutions of high-
16 er education and elementary schools and secondary
17 schools to recruit the next generation of health pro-
18 fessionals earlier in the pipeline to a health care ca-
19 reer.

20 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
21 authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2021 through 2026.

1 **SEC. 310. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**
2 **IORAL HEALTH SOCIAL WORKERS.**

3 Section 455 of the Higher Education Act of 1965 (20
4 U.S.C. 1087e) is amended by adding at the end the fol-
5 lowing:

6 “(r) REPAYMENT PLAN FOR MENTAL AND BEHAV-
7 IORAL HEALTH SOCIAL WORKERS.—

8 “(1) IN GENERAL.—The Secretary shall cancel
9 the balance of interest and principal due, in accord-
10 ance with paragraph (2), on any eligible Federal Di-
11 rect Loan not in default for a borrower who—

12 “(A) has made 120 monthly payments on
13 the eligible Federal Direct Loan after October
14 1, 2020, pursuant to any one or a combination
15 of the following—

16 “(i) payments under an income-based
17 repayment plan under section 493C;

18 “(ii) payments under a standard re-
19 payment plan under subsection (d)(1)(A),
20 based on a 10-year repayment period;

21 “(iii) monthly payments under a re-
22 payment plan under subsection (d)(1) or
23 (g) of not less than the monthly amount
24 calculated under subsection (d)(1)(A),
25 based on a 10-year repayment period; or

1 “(iv) payments under an income con-
2 tingent repayment plan under subsection
3 (d)(1)(D); and

4 “(B)(i) is employed as a mental health or
5 behavioral health social worker, as defined by
6 the Secretary by regulation, at the time of such
7 forgiveness; and

8 “(ii) has been employed as such a mental
9 health or behavioral health social worker during
10 the period in which the borrower makes each of
11 the 120 payments as described in subparagraph
12 (A).

13 “(2) LOAN CANCELLATION AMOUNT.—After the
14 conclusion of the employment period described in
15 paragraph (1), the Secretary shall cancel the obliga-
16 tion to repay the balance of principal and interest
17 due as of the time of such cancellation, on the eligi-
18 ble Federal Direct Loans made to the borrower
19 under this part.

20 “(3) INELIGIBILITY FOR DOUBLE BENEFITS.—
21 No borrower may, for the same employment as a
22 mental health or behavioral health social worker, re-
23 ceive a reduction of loan obligations under both this
24 subsection and subsection (m), 428J, 428K, 428L,
25 or 460.

1 “(4) DEFINITION OF ELIGIBLE FEDERAL DI-
 2 RECT LOAN.—In this subsection, the term ‘eligible
 3 Federal Direct Loan’ means a Federal Direct Staf-
 4 ford Loan, Federal Direct PLUS Loan, Federal Di-
 5 rect Unsubsidized Stafford Loan, or a Federal Di-
 6 rect Consolidation Loan.”.

7 **SEC. 311. HEALTH PROFESSIONS WORKFORCE FUND.**

8 (a) ESTABLISHMENT.—There is established in the
 9 Health Resources and Services Administration of the De-
 10 partment of Health and Human Services a Health Profes-
 11 sions Workforce Fund to provide for expanded and sus-
 12 tained national investment in the health professions and
 13 nursing workforce development programs under title VII
 14 and title VIII of the Public Health Service Act (42 U.S.C.
 15 292 et seq.; 42 U.S.C. 296 et seq.).

16 (b) FUNDING.—

17 (1) IN GENERAL.—There is authorized to be
 18 appropriated, and there is appropriated, out of any
 19 monies in the Treasury not otherwise appropriated,
 20 to the Health Professions Workforce Fund—

21 (A) \$355,000,000 for fiscal year 2021;

22 (B) \$375,000,000 for fiscal year 2022;

23 (C) \$392,000,000 for fiscal year 2023;

24 (D) \$412,000,000 for fiscal year 2024;

25 (E) \$432,000,000 for fiscal year 2025;

- 1 (F) \$454,000,000 for fiscal year 2026;
2 (G) \$476,000,000 for fiscal year 2027;
3 (H) \$500,000,000 for fiscal year 2028;
4 (I) \$525,000,000 for fiscal year 2029; and
5 (J) \$552,000,000 for fiscal year 2030.

6 (2) HEALTH PROFESSIONS EDUCATION PRO-
7 GRAMS.—For the purpose of carrying out health
8 professions education programs authorized under
9 title VII of the Public Health Service Act, in addi-
10 tion to any other amounts authorized to be appro-
11 priated for such purpose, there is authorized to be
12 appropriated out of any monies in the Health Pro-
13 fessions Workforce Fund, the following:

- 14 (A) \$240,000,000 for fiscal year 2021.
15 (B) \$253,000,000 for fiscal year 2022.
16 (C) \$265,000,000 for fiscal year 2023.
17 (D) \$278,000,000 for fiscal year 2024.
18 (E) \$292,000,000 for fiscal year 2025.
19 (F) \$307,000,000 for fiscal year 2026.
20 (G) \$322,000,000 for fiscal year 2027.
21 (H) \$338,000,000 for fiscal year 2028.
22 (I) \$355,000,000 for fiscal year 2029.
23 (J) \$373,000,000 for fiscal year 2030.

24 (3) NURSING WORKFORCE DEVELOPMENT PRO-
25 GRAMS.—For the purpose of carrying out nursing

1 workforce development programs authorized under
2 title VIII of the Public Health Service Act, in addi-
3 tion to any other amounts authorized to be appro-
4 priated for such purpose, there is authorized to be
5 appropriated out of any monies in the Health Pro-
6 fessions Workforce Fund, the following:

7 (A) \$115,000,000 for fiscal year 2021.

8 (B) \$122,000,000 for fiscal year 2022.

9 (C) \$127,000,000 for fiscal year 2023.

10 (D) \$134,000,000 for fiscal year 2024.

11 (E) \$140,000,000 for fiscal year 2025.

12 (F) \$147,000,000 for fiscal year 2026.

13 (G) \$154,000,000 for fiscal year 2027.

14 (H) \$162,000,000 for fiscal year 2028.

15 (I) \$170,000,000 for fiscal year 2029.

16 (J) \$179,000,000 for fiscal year 2030.

17 **SEC. 312. FINDINGS; SENSE OF CONGRESS RELATING TO**
18 **GRADUATE MEDICAL EDUCATION.**

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

20 (1) Projections by the Association of American
21 Medical Colleges and other expert entities, such as
22 the Health Resources and Services Administration,
23 have indicated a nationwide shortage of up to
24 121,900 physicians, split evenly between primary
25 care and specialists, by 2032.

1 (2) Primarily due to the growing and aging
2 population, over the next decade, physician demand
3 is expected to grow up to 17 percent.

4 (3) The United States Census Bureau estimates
5 that the United States population will grow from
6 321,000,000 in 2015 to 347,000,000 in 2025. Fur-
7 ther, the number of Medicare beneficiaries is esti-
8 mated to increase from 47,800,000 in 2015 to ap-
9 proximately 66,000,000 in 2025.

10 (4) Approximately 36 percent of practicing phy-
11 sicians are over the age of 55 and are likely to retire
12 within the next decade.

13 (5) A nationwide physician shortage will result
14 in many people in the United States waiting longer
15 and traveling farther for health care; seeking non-
16 emergent care in emergency departments; and delay-
17 ing treatment until their health care needs become
18 more serious, complex, and costly.

19 (6) Changing demographics (such as an aging
20 population), new health care delivery models (such
21 as medical homes), and other factors (such as dis-
22 aster preparedness) are contributing to a shortage of
23 both generalist and specialist physicians.

24 (7) These shortages will have the most severe
25 impact on vulnerable and underserved populations,

1 including racial and ethnic minorities and the ap-
2 proximately 20 percent of people in the United
3 States who live in rural or inner-city locations des-
4 ignated as health professional shortage areas.

5 (8) The health care utilization equity model of
6 the Association of American Medical Colleges esti-
7 mates that if racial and ethnic minorities and indi-
8 viduals from rural areas utilized health care in a
9 similar way to their Caucasian counterparts living in
10 metropolitan areas, the physician shortage would re-
11 quire an additional 96,000 physicians.

12 (9) To address the physician shortage in rural
13 and medically underserved areas, medical education
14 and training need to be accessible to underrep-
15 resented minorities (including individuals who are
16 African American, Hispanic, Native American, or
17 Native Hawaiian), and need to increase pathway
18 programs for such underrepresented minorities who
19 make up less than 12 percent of individuals enrolled
20 in graduate medical education and for international
21 students who make up 25 percent of individuals en-
22 rolled in graduate medical education. Immigration
23 pathways like student, exchange-visitor, and employ-
24 ment visas, and programs like the National Interest

1 Waiver and Conrad 30 J-1 Visa Waiver, help im-
2 prove health access across the United States.

3 (10) United States medical school enrollment
4 was expected to grow by 30 percent from 2018 to
5 2019 to help reduce the shortage of quality physi-
6 cians in the United States.

7 (11) An increase in United States medical
8 school graduates must be accompanied by an in-
9 crease of 4,000 graduate medical education training
10 positions each year.

11 (12) Graduate medical education programs and
12 teaching hospitals provide venues in which the next
13 generation of physicians learns to work collabo-
14 ratively with other physicians and health profes-
15 sionals, adopt more efficient care delivery models
16 (such as care coordination and medical homes), in-
17 corporate health information technology and elec-
18 tronic health records in every aspect of their work,
19 apply new methods of assuring quality and safety,
20 and participate in groundbreaking clinical and public
21 health research.

22 (13) The Medicare program under title XVIII
23 of the Social Security Act (42 U.S.C. 1395 et seq.)
24 (having more beneficiaries than any other health

1 care program) supports its “fair share” of the costs
2 associated with graduate medical education.

3 (14) In general, the level of support of graduate
4 medical education by the Medicare program has
5 been capped since 1997 and has not been increased
6 to support the expansion of graduate medical edu-
7 cation programs needed to avert the projected physi-
8 cian shortage or to accommodate the increase in
9 United States medical school graduates.

10 (b) SENSE OF CONGRESS.—It is the sense of Con-
11 gress that eliminating the limit of the number of residency
12 positions that receive some level of Medicare support
13 under section 1886(h) of the Social Security Act (42
14 U.S.C. 1395ww(h)), also referred to as the Medical grad-
15 uate medical education cap, is critical to—

16 (1) ensuring an appropriate supply of physi-
17 cians to meet the health care needs in the United
18 States;

19 (2) facilitating equitable access for all who seek
20 health care; and

21 (3) mitigating disparities in health and health
22 care.

23 **SEC. 313. CAREER SUPPORT FOR SKILLED, INTERNATION-**
24 **ALLY EDUCATED HEALTH PROFESSIONALS.**

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

1 (1) According to a 2018 study, the State and
2 local public health workforce has shrunk by more
3 than 50,000 individuals since the beginning of the
4 2008 Great Recession and almost one quarter of in-
5 dividuals comprising the governmental public health
6 workforce plan to leave or retire in the coming years.

7 (2) Shortages are projected for other health
8 professions, including within the fields of nursing
9 (500,000 by 2025), dentistry (15,000 by 2025),
10 pharmacy (38,000 by 2030), mental and behavioral
11 health, primary care (46,000 by 2025), and commu-
12 nity and allied health.

13 (3) A nationwide health workforce shortage will
14 result in serious health threats and more severe and
15 costly health care needs, due to, in part, a delayed
16 response to food-borne outbreaks, emerging infec-
17 tious diseases, natural disasters, fewer cancer
18 screenings, and delayed treatment.

19 (4) Vulnerable and underserved populations and
20 health professional shortage areas will be most se-
21 verely impacted by the health workforce shortage.

22 (5) According to the Migration Policy Institute,
23 more than 2,000,000 college-educated immigrants in
24 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 **SEC. 314. STUDY AND REPORT ON STRATEGIES FOR IN-**
2 **CREASING DIVERSITY.**

3 (a) STUDY.—The Comptroller General of the United
4 States shall conduct a study on strategies for increasing
5 the diversity of the health professional workforce. Such
6 study shall include an analysis of strategies for increasing
7 the number of health professionals from rural, lower in-
8 come, and underrepresented minority communities, includ-
9 ing which strategies are most effective for achieving such
10 goal.

11 (b) REPORT.—Not later than 2 years after the date
12 of enactment of this Act, the Comptroller General shall
13 submit to Congress a report on the study conducted under
14 subsection (a), together with recommendations for such
15 legislation and administrative action as the Comptroller
16 General determines appropriate.

17 **SEC. 315. CONRAD STATE 30 PROGRAM; PHYSICIAN RETEN-**
18 **TION.**

19 (a) CONRAD STATE 30 PROGRAM EXTENSION.—Sec-
20 tion 220(c) of the Immigration and Nationality Technical
21 Corrections Act of 1994 (Public Law 103–416; 8 U.S.C.
22 1182 note) is amended by striking “September 30, 2015”
23 and inserting “September 30, 2021”.

24 (b) RETAINING PHYSICIANS WHO HAVE PRACTICED
25 IN MEDICALLY UNDERSERVED COMMUNITIES.—Section
26 201(b)(1) of the Immigration and Nationality Act (8

1 U.S.C. 1151(b)(1)) is amended by adding at the end the
2 following:

3 “(F)(i) Alien physicians who have completed
4 service requirements for a national interest waiver
5 requested under section 203(b)(2)(B)(ii), includ-
6 ing—

7 “(I) alien physicians who completed such
8 service before the date of the enactment of the
9 Health Equity and Accountability Act of 2020;
10 and

11 “(II) the spouse or children of an alien
12 physician described in subclause (I).

13 “(ii) Nothing in this subparagraph may be con-
14 strued—

15 “(I) to prevent the filing of a petition with
16 the Secretary of Homeland Security for classi-
17 fication under section 204(a) or the filing of an
18 application for adjustment of status under sec-
19 tion 245 by an alien physician described in
20 clause (i) before the date on which such alien
21 physician completes the service described in sec-
22 tion 214(l) or worked full-time as a physician
23 for an aggregate of 5 years at the location iden-
24 tified in the waiver of the 2-year foreign resi-
25 dence requirement under section 214(l) or in an

1 area or areas designated by the Secretary of
2 Health and Human Services as having a short-
3 age of health care professionals; or

4 “(II) to permit the Secretary of Homeland
5 Security to grant a petition or application de-
6 scribed in subclause (I) until the alien has sat-
7 isfied all of the requirements of the waiver re-
8 ceived under section 214(l).”.

9 (c) EMPLOYMENT PROTECTIONS FOR PHYSICIANS.—

10 (1) EXCEPTIONS TO 2-YEAR FOREIGN RESI-
11 DENCY REQUIREMENT.—Section 214(l)(1) of the
12 Immigration and Nationality Act (8 U.S.C.
13 1184(l)(1)) is amended—

14 (A) in the matter preceding subparagraph
15 (A), by striking “Attorney General shall not”
16 and inserting “Secretary of Homeland Security
17 may not”;

18 (B) in subparagraph (A), by striking “Di-
19 rector of the United States Information Agen-
20 cy” and inserting “Secretary of State”;

21 (C) in subparagraph (B), by inserting “,
22 except as provided in paragraphs (7) and (8)”
23 before the semicolon at the end;

24 (D) in subparagraph (C), by amending
25 clauses (i) and (ii) to read as follows:

1 “(i) the alien demonstrates a bona fide
2 offer of full-time employment at a health facil-
3 ity or health care organization, which employ-
4 ment has been determined by the Secretary of
5 Homeland Security to be in the public interest;
6 and

7 “(ii) the alien—

8 “(I) has accepted employment with
9 the health facility or health care organiza-
10 tion in a geographic area or areas which
11 are designated by the Secretary of Health
12 and Human Services as having a shortage
13 of health care professionals;

14 “(II) begins employment by the later
15 of the date that is—

16 “(aa) 120 days after receiving
17 such waiver;

18 “(bb) 120 days after completing
19 graduate medical education or train-
20 ing under a program approved pursu-
21 ant to section 212(j)(1); or

22 “(cc) 120 days after receiving
23 nonimmigrant status or employment
24 authorization, if the alien or the
25 alien’s employer petitions for such

1 nonimmigrant status or employment
2 authorization not later than 120 days
3 after the date on which the alien com-
4 pletes his or her graduate medical
5 education or training under a pro-
6 gram approved pursuant to section
7 212(j)(1); and

8 “(III) agrees to continue to work for
9 a total of not less than 3 years in the sta-
10 tus authorized for such employment under
11 this subsection, except as provided in para-
12 graph (8).”; and

13 (E) in subparagraph (D), in the matter
14 preceding clause (i), by inserting “subject to
15 paragraph (8),” before “in the case”.

16 (2) ALLOWABLE VISA STATUS FOR PHYSICIANS
17 FULFILLING WAIVER REQUIREMENTS IN MEDICALLY
18 UNDERSERVED AREAS.—Section 214(l)(2)(A) of
19 such Act (8 U.S.C. 1184(l)(2)(A)) is amended to
20 read as follows:

21 “(A) Upon the request of an interested Federal
22 agency or an interested State agency for rec-
23 ommendation of a waiver under this section by a
24 physician who is maintaining valid nonimmigrant
25 status under section 101(a)(15)(J) and received a

1 favorable recommendation by the Secretary of State,
2 the Secretary of Homeland Security may change the
3 status of such physician to any status authorized for
4 employment under this Act. The numerical limita-
5 tions set forth in subsection (g)(1)(A) shall not
6 apply to any alien whose status is changed under
7 this subparagraph.”.

8 (3) VIOLATION OF AGREEMENTS.—Section
9 214(l)(3)(A) of such Act (8 U.S.C. 1184(l)(3)(A)) is
10 amended by inserting “substantial requirement of
11 an” before “agreement entered into”.

12 (4) PHYSICIAN EMPLOYMENT IN UNDERSERVED
13 AREAS.—Section 214(l) of such Act (8 U.S.C.
14 1184(l)), as amended by this section, is further
15 amended by adding at the end the following:

16 “(4)(A) If an interested State agency denies the ap-
17 plication for a waiver under paragraph (1)(B) from a phy-
18 sician pursuing graduate medical education or training
19 pursuant to section 101(a)(15)(J) because the State has
20 requested the maximum number of waivers permitted for
21 that fiscal year, the physician’s nonimmigrant status shall
22 be extended for up to 6 months if the physician agrees
23 to seek a waiver under this subsection (except for para-
24 graph (1)(D)(ii)) to work for an employer described in

1 paragraph (1)(C) in a State that has not yet requested
2 the maximum number of waivers.

3 “(B) A physician described in subparagraph (A) may
4 only work for the employer referred to in subparagraph
5 (A) during the period beginning on the date on which a
6 new waiver application is filed with such State and ending
7 on the earlier of—

8 “(i) the date on which the Secretary of Home-
9 land Security denies such waiver; or

10 “(ii) the date on which the Secretary approves
11 an application for change of status under paragraph
12 (2)(A) pursuant to the approval of such waiver.”.

13 (5) CONTRACT REQUIREMENTS.—Section 214(l)
14 of such Act, as amended by this section, is further
15 amended by adding at the end the following:

16 “(5) An alien granted a waiver under paragraph
17 (1)(C) shall enter into an employment agreement with the
18 contracting health facility or health care organization
19 that—

20 “(A) specifies the maximum number of on-call
21 hours per week (which may be a monthly average)
22 that the alien will be expected to be available and
23 the compensation the alien will receive for on-call
24 time;

25 “(B) specifies—

1 “(i) whether the contracting facility or or-
2 ganization will pay the alien’s malpractice in-
3 surance premiums;

4 “(ii) whether the employer will provide
5 malpractice insurance; and

6 “(iii) the amount of such insurance that
7 will be provided;

8 “(C) describes all of the work locations that the
9 alien will work, including a statement that the con-
10 tracting facility or organization will not add addi-
11 tional work locations without the approval of the
12 Federal agency or State agency that requested the
13 waiver; and

14 “(D) does not include a non-compete provision.

15 “(6) An alien granted a waiver under this subsection
16 whose employment relationship with a health facility or
17 health care organization terminates under paragraph
18 (1)(C)(ii) during the 3-year service period required under
19 paragraph (1) shall be considered to be maintaining lawful
20 status in an authorized period of stay during the 120-day
21 period referred to in items (aa) and (bb) of subclause (III)
22 of paragraph (1)(C)(ii) or the 45-day period referred to
23 in subclause (III)(cc) of such paragraph.”.

24 (6) RECAPTURING WAIVER SLOTS LOST TO
25 OTHER STATES.—Section 214(l) of such Act, as

1 amended by this section, is further amended by add-
2 ing at the end the following:

3 “(7) If a recipient of a waiver under this subsection
4 terminates the recipient’s employment with a health facil-
5 ity or health care organization pursuant to paragraph
6 (1)(C)(ii), including termination of employment because of
7 circumstances described in paragraph (1)(C)(ii)(III), and
8 accepts new employment with such a facility or organiza-
9 tion in a different State, the State from which the alien
10 is departing may be accorded an additional waiver by the
11 Secretary of State for use in the fiscal year in which the
12 alien’s employment was terminated.”.

13 (7) EXCEPTION TO 3-YEAR WORK REQUIRE-
14 MENT.—Section 214(l) of such Act, as amended by
15 this section, is further amended by adding at the
16 end the following:

17 “(8) The 3-year work requirement set forth in sub-
18 paragraphs (C) and (D) of paragraph (1) shall not apply
19 if—

20 “(A)(i) the Secretary of Homeland Security de-
21 termines that extenuating circumstances, including
22 violations by the employer of the employment agree-
23 ment with the alien or of labor and employment
24 laws, exist that justify a lesser period of employment
25 at such facility or organization; and

1 “(ii) not later than 120 days after the employ-
2 ment termination date (unless the Secretary deter-
3 mines that extenuating circumstances would justify
4 an extension), the alien demonstrates another bona
5 fide offer of employment at a health facility or
6 health care organization in a geographic area or
7 areas which are designated by the Secretary of
8 Health and Human Services as having a shortage of
9 health care professionals, for the remainder of such
10 3-year period;

11 “(B)(i) the interested State agency that re-
12 quested the waiver attests that extenuating cir-
13 cumstances, including violations by the employer of
14 the employment agreement with the alien or of labor
15 and employment laws, exist that justify a lesser pe-
16 riod of employment at such facility or organization;
17 and

18 “(ii) not later than 120 days after the employ-
19 ment termination date (unless the Secretary deter-
20 mines that extenuating circumstances would justify
21 an extension), the alien demonstrates another bona
22 fide offer of employment at a health facility or
23 health care organization in a geographic area or
24 areas which are designated by the Secretary of
25 Health and Human Services as having a shortage of

1 health care professionals, for the remainder of such
2 3-year period; or

3 “(C) the alien—

4 “(i) elects not to pursue a determination of
5 extenuating circumstances pursuant to sub-
6 clause (A) or (B);

7 “(ii) terminates the alien’s employment re-
8 lationship with the health facility or health care
9 organization at which the alien was employed;

10 “(iii) not later than 45 days after the em-
11 ployment termination date, demonstrates an-
12 other bona fide offer of employment at a health
13 facility or health care organization in a geo-
14 graphic area or areas, in the State that re-
15 quested the alien’s waiver, which are designated
16 by the Secretary of Health and Human Services
17 as having a shortage of health care profes-
18 sionals; and

19 “(iv) agrees to be employed for the remain-
20 der of such 3-year period, and 1 additional year
21 for each termination under clause (ii).”.

22 (d) ALLOTMENT OF CONRAD 30 WAIVERS.—

23 (1) IN GENERAL.—Section 214(l) of the Immi-
24 gration and Nationality Act (8 U.S.C. 1184(l)), as

1 amended by subsection (c), is further amended by
2 adding at the end the following:

3 “(9)(A)(i) All States shall be allotted 35 waivers
4 under paragraph (1)(B) for each fiscal year if 90 percent
5 of the waivers available to the States receiving at least
6 5 waivers were used in the previous fiscal year.

7 “(ii) When an allotment occurs under clause (i), all
8 States shall be allotted an additional 5 waivers under
9 paragraph (1)(B) for each subsequent fiscal year if 90
10 percent of the waivers available to the States receiving at
11 least 5 waivers were used in the previous fiscal year. If
12 the States are allotted 45 or more waivers for a fiscal year,
13 the States will only receive an additional increase of 5
14 waivers the following fiscal year if 95 percent of the waiv-
15 ers available to the States receiving at least 1 waiver were
16 used in the previous fiscal year.

17 “(B) Any increase in allotments under subparagraph
18 (A) shall be maintained indefinitely, unless in a fiscal year,
19 the total number of such waivers granted is 5 percent
20 lower than in the last year in which there was an increase
21 in the number of waivers allotted pursuant to this para-
22 graph. In such case—

23 “(i) the number of waivers allotted beginning in
24 the next fiscal year shall be decreased by 5 for all
25 States; and

1 “(ii) each additional 5 percent decrease in such
2 waivers granted from the last year in which there
3 was an increase in the allotment, shall result in an
4 additional decrease of 5 waivers allotted for all
5 States, provided that the number of waivers allotted
6 for all States shall not drop below 30.”.

7 (2) ACADEMIC MEDICAL CENTERS.—Section
8 214(l)(1)(D) of such Act, as amended by subsection
9 (c)(1)(E), is further amended—

10 (A) in clause (ii), by striking “and” at the
11 end;

12 (B) in clause (iii), by striking the period at
13 the end and inserting “; and”; and

14 (C) by adding at the end the following:

15 “(iv) in the case of a request by an inter-
16 ested State agency—

17 “(I) the head of such agency deter-
18 mines that the alien is to practice medicine
19 in, or be on the faculty of a residency pro-
20 gram at, an academic medical center (as
21 defined in section 411.355(e)(2) of title 42,
22 Code of Federal Regulations), without re-
23 gard to whether such facility is located
24 within an area designated by the Secretary

1 of Health and Human Services as having
2 a shortage of health care professionals; and

3 “(II) the head of such agency deter-
4 mines that—

5 “(aa) the alien physician’s work
6 is in the public interest; and

7 “(bb) subject to paragraph (6),
8 the grant of such waiver would not
9 cause the number of the waivers
10 granted on behalf of aliens for such
11 State for a fiscal year to exceed 3,
12 within the limitation under subpara-
13 graph (B).”.

14 (e) AMENDMENTS TO THE PROCEDURES, DEFINI-
15 TIONS, AND OTHER PROVISIONS RELATED TO PHYSICIAN
16 IMMIGRATION.—

17 (1) DUAL INTENT FOR PHYSICIANS SEEKING
18 GRADUATE MEDICAL TRAINING.—Section 214(b) of
19 the Immigration and Nationality Act (8 U.S.C.
20 1184(b)) is amended by striking “and other than a
21 nonimmigrant described in any provision of section
22 101(a)(15)(H)(i) except subclause (b1) of such sec-
23 tion)” and inserting “a nonimmigrant described in
24 any provision of section 101(a)(15)(H)(i) (except
25 subclause (b1) of such section), and an alien coming

1 to the United States to receive graduate medical
2 education or training as described in section 212(j)
3 or to take examinations required to receive graduate
4 medical education or training as described in section
5 212(j))”.

6 (2) PHYSICIAN NATIONAL INTEREST WAIVER
7 CLARIFICATIONS.—

8 (A) PRACTICE AND GEOGRAPHIC AREA.—

9 Section 203(b)(2)(B)(ii)(I) of the Immigration
10 and Nationality Act (8 U.S.C.
11 1153(b)(2)(B)(ii)(I)) is amended by striking
12 items (aa) and (bb) and inserting the following:

13 “(aa) the alien physician agrees to
14 work on a full-time basis practicing pri-
15 mary care, specialty medicine, or a com-
16 bination thereof, in an area or areas des-
17 ignated by the Secretary of Health and
18 Human Services as having a shortage of
19 health care professionals, or at a health
20 care facility under the jurisdiction of the
21 Secretary of Veterans Affairs; or

22 “(bb) the alien physician is pursuing
23 such waiver based upon service at a facility
24 or facilities that serve patients who reside
25 in a geographic area or areas designated

1 by the Secretary of Health and Human
2 Services as having a shortage of health
3 care professionals (without regard to
4 whether such facility or facilities are lo-
5 cated within such an area) and a Federal
6 agency, or a local, county, regional, or
7 State department of public health deter-
8 mines the alien physician's work was or
9 will be in the public interest.”.

10 (B) FIVE-YEAR SERVICE REQUIREMENT.—

11 Section 203(b)(2)(B)(ii) of such Act is amend-
12 ed—

13 (i) by moving subclauses (II), (III),
14 and (IV) 4 ems to the left; and

15 (ii) in subclause (II)—

16 (I) by inserting “(aa)” after
17 “(II)”; and

18 (II) by adding at the end the fol-
19 lowing:

20 “(bb) The 5-year service requirement
21 described in item (aa) shall begin on the
22 date on which the alien physician begins
23 work in the shortage area in any legal sta-
24 tus and not on the date on which an immi-
25 grant visa petition is filed or approved.

1 Such service shall be aggregated without
2 regard to when such service began and
3 without regard to whether such service
4 began during or in conjunction with a
5 course of graduate medical education.

6 “(cc) An alien physician shall not be
7 required to submit an employment contract
8 with a term exceeding the balance of the 5-
9 year commitment yet to be served or an
10 employment contract dated within a min-
11 imum time period before filing a visa peti-
12 tion under this subsection.

13 “(dd) An alien physician shall not be
14 required to file additional immigrant visa
15 petitions upon a change of work location
16 from the location approved in the original
17 national interest immigrant petition.”.

18 (3) TECHNICAL CLARIFICATION REGARDING AD-
19 VANCED DEGREE FOR PHYSICIANS.—Section
20 203(b)(2)(A) of such Act (8 U.S.C. 1153(b)(2)(A))
21 is amended by adding at the end the following: “An
22 alien physician holding a foreign medical degree that
23 has been deemed sufficient for acceptance by an ac-
24 credited United States medical residency or fellow-
25 ship program shall be considered a member of the

1 professions holding an advanced degree or its equiv-
2 alent for purposes of this paragraph.”.

3 (4) SHORT-TERM WORK AUTHORIZATION FOR
4 PHYSICIANS COMPLETING THEIR RESIDENCIES.—

5 (A) IN GENERAL.—A physician completing
6 graduate medical education or training de-
7 scribed in section 212(j) of the Immigration
8 and Nationality Act (8 U.S.C. 1182(j)) as a
9 nonimmigrant described in section
10 101(a)(15)(H)(i) of such Act (8 U.S.C.
11 1101(a)(15)(H)(i))—

12 (i) shall have such nonimmigrant sta-
13 tus automatically extended until October 1
14 of the fiscal year for which a petition for
15 a continuation of such nonimmigrant sta-
16 tus has been submitted in a timely manner
17 and the employment start date for the ben-
18 efiary of such petition is October 1 of
19 that fiscal year; and

20 (ii) shall be authorized to be employed
21 incident to status during the period be-
22 tween the filing of such petition and Octo-
23 ber 1 of such fiscal year.

24 (B) TERMINATION.—The status and em-
25 ployment authorization of a physician described

1 in subparagraph (A) shall terminate on the date
2 that is 30 days after the date on which a peti-
3 tion described in clause (i)(I) is rejected, denied
4 or revoked.

5 (C) AUTOMATIC EXTENSION.—The status
6 and employment authorization of a physician
7 described in subparagraph (A) will automati-
8 cally extend to October 1 of the next fiscal year
9 if all of the visas described in section
10 101(a)(15)(H)(i) of the Immigration and Na-
11 tionality Act (8 U.S.C. 1101(a)(15)(H)(i)) that
12 were authorized to be issued for the fiscal year
13 have been issued.

14 (5) APPLICABILITY OF SECTION 212(e) TO
15 SPOUSES AND CHILDREN OF J-1 EXCHANGE VISI-
16 TORS.—A spouse or child of an exchange visitor de-
17 scribed in section 101(a)(15)(J) of the Immigration
18 and Nationality Act (8 U.S.C. 1101(a)(15)(J)) shall
19 not be subject to the requirements under section
20 212(e) of such Act (8 U.S.C. 1182(e)).

1 **TITLE IV—IMPROVING HEALTH**
 2 **CARE ACCESS AND QUALITY**
 3 **Subtitle A—Improvement of**
 4 **Coverage**

5 **SEC. 401. 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) STATE PAYMENTS FOR MEDICAL ASSIST-
 13 ANCE.—Section 1902 of the Social Security Act (42
 14 U.S.C. 1396a) is amended—

15 (A) by amending paragraph (46) of sub-
 16 section (a) to read as follows:

17 “(46) provide that information is requested and
 18 exchanged for purposes of income and eligibility
 19 verification in accordance with a State system which
 20 meets the requirements of section 1137 of this
 21 Act;”;

22 (B) in subsection (e)(13)(A)(i)—

23 (i) in the matter preceding subclause

24 (I), by striking “sections 1902(a)(46)(B)

1 and 1137(d)” and inserting “section
2 1137(d)”;

3 (ii) in subclause (IV), by striking
4 “1902(a)(46)(B) or”; and
5 (C) by striking subsection (ee).

6 (2) PAYMENT TO STATES.—Section 1903 of the
7 Social Security Act (42 U.S.C. 1396b) is amended—

8 (A) in subsection (i), by redesignating
9 paragraphs (23) through (27) as paragraphs
10 (22) through (26), respectively; and

11 (B) by redesignating subsections (y), (z),
12 and (aa) as subsections (x), (y), and (z), respec-
13 tively.

14 (3) REPEAL.—Subsection (c) of section 6036 of
15 the Deficit Reduction Act of 2005 (42 U.S.C. 1396b
16 note) is repealed.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall take effect on the date of enactment of
19 this Act.

20 **SEC. 402. REMOVING CITIZENSHIP AND IMMIGRATION BAR-**
21 **RIERS TO ACCESS TO AFFORDABLE HEALTH**
22 **CARE UNDER ACA.**

23 (a) IN GENERAL.—

24 (1) PREMIUM TAX CREDITS.—Section 36B of
25 the Internal Revenue Code of 1986 is amended—

1 (A) in subsection (c)(1)(B)—

2 (i) by amending the heading to read
3 as follows: “SPECIAL RULE FOR CERTAIN
4 INDIVIDUALS INELIGIBLE FOR MEDICAID
5 DUE TO STATUS”; and

6 (ii) in clause (ii), by striking “lawfully
7 present in the United States, but” and in-
8 serting “who”; and

9 (B) by striking subsection (e).

10 (2) COST-SHARING REDUCTIONS.—Section 1402
11 of the Patient Protection and Affordable Care Act
12 (42 U.S.C. 18071) is amended by striking sub-
13 section (e).

14 (3) BASIC HEALTH PROGRAM ELIGIBILITY.—
15 Section 1331(e)(1)(B) of the Patient Protection and
16 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
17 amended by striking “lawfully present in the United
18 States”.

19 (4) RESTRICTIONS ON FEDERAL PAYMENTS.—
20 Section 1412 of the Patient Protection and Afford-
21 able Care Act (42 U.S.C. 18082) is amended by
22 striking subsection (d).

23 (5) REQUIREMENT TO MAINTAIN MINIMUM ES-
24 SENTIAL COVERAGE.—Section 5000A(d) of the In-
25 ternal Revenue Code of 1986 is amended by striking

1 paragraph (3) and by redesignating paragraph (4)
2 as paragraph (3).

3 (b) CONFORMING AMENDMENTS.—

4 (1) Section 1411(a) of the Patient Protection
5 and Affordable Care Act (42 U.S.C. 18081(a)) is
6 amended by striking paragraph (1) and redesignig-
7 nating paragraphs (2), (3), and (4) as paragraphs
8 (1), (2), and (3), respectively.

9 (2) Section 1312(f) of the Patient Protection
10 and Affordable Care Act (42 U.S.C. 18032(f)) is
11 amended—

12 (A) in the heading, by striking “; ACCESS
13 LIMITED TO CITIZENS AND LAWFUL RESI-
14 DENTS”; and

15 (B) by striking paragraph (3).

16 **SEC. 403. STUDY ON THE UNINSURED.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services (in this section referred to as the “Sec-
19 retary”) shall—

20 (1) conduct a study, in accordance with the
21 standards under section 3101 of the Public Health
22 Service Act (42 U.S.C. 300kk), on the demographic
23 characteristics of the population of individuals who
24 do not have health insurance coverage or oral health
25 coverage; and

1 (2) predict, based on such study, the demo-
2 graphic characteristics of the population of individ-
3 uals who would remain without health insurance cov-
4 erage after the end of any annual open enrollment
5 or any special enrollment period or upon enactment
6 and implementation of any legislative changes to the
7 Patient Protection and Affordable Care Act (Public
8 Law 111–148) that affect the number of persons eli-
9 gible for coverage.

10 (b) REPORTING REQUIREMENTS.—

11 (1) IN GENERAL.—Not later than 12 months
12 after the date of the enactment of this Act, the Sec-
13 retary shall submit to the Congress the results of
14 the study under subsection (a)(1) and the prediction
15 made under subsection (a)(2).

16 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
17 ISTICS.—The Secretary shall—

18 (A) report the demographic characteristics
19 under paragraphs (1) and (2) of subsection (a)
20 on the basis of racial and ethnic group, and
21 shall stratify the reporting on each racial and
22 ethnic group by other demographic characteris-
23 tics that can impact access to health insurance
24 coverage, such as sexual orientation, gender
25 identity, primary language, disability status,

1 sex, socioeconomic status, age group, and citi-
2 zenship and immigration status, in a manner
3 consistent with title I of this Act, including the
4 amendments made by such title; and

5 (B) not use such report to engage in or an-
6 ticipate any deportation or immigration related
7 enforcement action by any entity, including the
8 Department of Homeland Security.

9 **SEC. 404. MEDICAID IN THE TERRITORIES.**

10 (a) **ELIMINATION OF GENERAL MEDICAID FUNDING**
11 **LIMITATIONS (“CAP”) FOR TERRITORIES.—**

12 (1) **REPEAL OF PROVISIONS RELATED TO CAP**
13 **AFTER 2019.—**Subsections (a), (b), and (d) of section
14 202 of subtitle B of title I of division N of the Fur-
15 ther Consolidated Appropriations Act, 2020 (Public
16 Law 116–94) and section 6009 of the Families First
17 Coronavirus Response Act (Public Law 116–127)
18 are repealed and the provisions of law amended by
19 such subsections and section are restored as if such
20 subsections and section had not been enacted.

21 (2) **SUNSET OF MEDICAID FUNDING LIMITA-**
22 **TIONS FOR TERRITORIES.—**Section 1108 of the So-
23 cial Security Act (42 U.S.C. 1308) (as restored by
24 paragraph (1)) is amended—

1 (A) in subsection (f), in the matter pre-
2 ceding paragraph (1), by striking “subsection
3 (g)” and inserting “subsections (g) and (h)”;

4 (B) in subsection (g)(2), in the matter pre-
5 ceding subparagraph (A), by inserting “and
6 subsection (h)” after “paragraphs (3) and (5)”;
7 and

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

10 “(h) SUNSET OF MEDICAID FUNDING LIMITATIONS
11 FOR PUERTO RICO, THE VIRGIN ISLANDS OF THE
12 UNITED STATES, GUAM, THE NORTHERN MARIANA IS-
13 LANDS, AND AMERICAN SAMOA.—Subsections (f) and (g)
14 shall not apply to Puerto Rico, the Virgin Islands of the
15 United States, Guam, the Northern Mariana Islands, and
16 American Samoa beginning with fiscal year 2020.”.

17 (3) CONFORMING AMENDMENTS.—

18 (A) Section 1902(j) of the Social Security
19 Act (42 U.S.C. 1396a(j)) is amended by strik-
20 ing “, the limitation in section 1108(f),”.

21 (B) Section 1903(u) of the Social Security
22 Act (42 U.S.C. 1396b(u)) is amended by strik-
23 ing paragraph (4).

1 (4) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply beginning with fiscal
3 year 2020.

4 (b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL
5 ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR
6 TERRITORIES.—Section 1905 of the Social Security Act
7 (42 U.S.C. 1396d) is amended—

8 (1) in clause (2) of subsection (b), by inserting
9 “for fiscal years before fiscal year 2020” after
10 “American Samoa”; and

11 (2) in subsection (ff)—

12 (A) by striking “(z)(2)—” and all that fol-
13 lows through “beginning October 1, 2019” and
14 inserting “(z)(2), for the period beginning Octo-
15 ber 1, 2019”;

16 (B) by striking “100 percent;” and insert-
17 ing “100 percent.”; and

18 (C) by striking paragraphs (2) and (3).

19 (c) APPLICATION OF MEDICAID WAIVER AUTHORITY
20 TO ALL OF THE TERRITORIES.—

21 (1) IN GENERAL.—Section 1902(j) of the Social
22 Security Act (42 U.S.C. 1396a(j)), as amended by
23 subsection (a)(3)(A), is amended—

24 (A) by striking “American Samoa and the
25 Northern Mariana Islands” and inserting

1 “Puerto Rico, the Virgin Islands of the United
2 States, Guam, the Northern Mariana Islands,
3 and American Samoa”;

4 (B) by striking “American Samoa or the
5 Northern Mariana Islands” and inserting
6 “Puerto Rico, the Virgin Islands of the United
7 States, Guam, the Northern Mariana Islands,
8 or American Samoa”;

9 (C) by inserting “(1)” after “(j)”;

10 (D) by inserting “except as otherwise pro-
11 vided in this subsection,” after “Notwith-
12 standing any other requirement of this title”;
13 and

14 (E) by adding at the end the following:

15 “(2) The Secretary may not waive under this
16 subsection the requirement of subsection
17 (a)(10)(A)(i)(IX) (relating to coverage of adults for-
18 merly under foster care) with respect to any terri-
19 tory.”.

20 (2) EFFECTIVE DATE.—The amendments made
21 by this subsection shall apply beginning October 1,
22 2021.

23 (d) PERMITTING MEDICAID DSH ALLOTMENTS FOR
24 TERRITORIES.—Section 1923(f) of the Social Security Act
25 (42 U.S.C. 1396r–4) is amended—

1 (1) in paragraph (6), by adding at the end the
2 following new subparagraph:

3 “(C) TERRITORIES.—

4 “(i) FISCAL YEAR 2020.—For fiscal
5 year 2020, the DSH allotment for Puerto
6 Rico, the Virgin Islands of the United
7 States, Guam, the Northern Mariana Is-
8 lands, and American Samoa shall bear the
9 same ratio to \$300,000,000 as the ratio of
10 the number of individuals who are low-in-
11 come or uninsured and residing in such re-
12 spective territory (as estimated from time
13 to time by the Secretary) bears to the
14 sums of the number of such individuals re-
15 siding in all of the territories.

16 “(ii) SUBSEQUENT FISCAL YEAR.—

17 For each subsequent fiscal year, the DSH
18 allotment for each such territory is subject
19 to an increase in accordance with para-
20 graph (2).”;

21 (2) in paragraph (9), by inserting before the pe-
22 riod at the end the following: “, and includes, begin-
23 ning with fiscal year 2020, Puerto Rico, the Virgin
24 Islands of the United States, Guam, the Northern
25 Mariana Islands, and American Samoa”.

1 **SEC. 405. EXTENSION OF MEDICARE SECONDARY PAYER.**

2 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
3 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
4 ed—

5 (1) in the last sentence, by inserting “, and be-
6 fore January 1, 2021” after “prior to such date”;
7 and

8 (2) by adding at the end the following new sen-
9 tence: “Effective for items and services furnished on
10 or after January 1, 2021 (with respect to periods
11 beginning on or after the date that is 42 months
12 prior to such date), clauses (i) and (ii) shall be ap-
13 plied by substituting ‘42-month’ for ‘12-month’ each
14 place it appears.”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect on the date of enactment of
17 this Act. For purposes of determining an individual’s sta-
18 tus under section 1862(b)(1)(C) of the Social Security Act
19 (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection
20 (a), an individual who is within the coordinating period
21 as of the date of enactment of this Act shall have that
22 period extended to the full 42 months described in the last
23 sentence of such section, as added by the amendment
24 made by subsection (a)(2).

1 **SEC. 406. INDIAN DEFINED IN TITLE I OF THE PATIENT**
2 **PROTECTION AND AFFORDABLE CARE ACT.**

3 (a) DEFINITION OF INDIAN.—Section 1304 of the
4 Patient Protection and Affordable Care Act (42 U.S.C.
5 18024) is amended by adding at the end the following:

6 “(f) INDIAN.—

7 “(1) IN GENERAL.—In this title, the term ‘In-
8 dian’ means any individual—

9 “(A) described in paragraph (13) or (28)
10 of section 4 of the Indian Health Care Improve-
11 ment Act (25 U.S.C. 1603);

12 “(B) who is eligible for health services pro-
13 vided by the Indian Health Service under sec-
14 tion 809 of the Indian Health Care Improve-
15 ment Act (25 U.S.C. 1679);

16 “(C) who is of Indian descent and belongs
17 to an Indian community served by a local facil-
18 ity or program of the Indian Health Service; or

19 “(D) who is otherwise described in para-
20 graph (2).

21 “(2) INCLUSIONS.—An individual is described
22 in this paragraph if the individual is any of the fol-
23 lowing:

24 “(A) A member of a federally recognized
25 Indian Tribe.

1 “(B) A resident of an urban center who
2 meets any of the following criteria:

3 “(i) Membership in a Tribe, band, or
4 other organized group of Indians, including
5 those Tribes, bands, or groups terminated
6 since 1940 and those recognized as of the
7 date of enactment of the Health Equity
8 and Accountability Act of 2018 or later by
9 the State in which they reside, or being a
10 descendant, in the first or second degree,
11 of any such member.

12 “(ii) Is an Eskimo or Aleut or other
13 Alaska Native.

14 “(iii) Is considered by the Secretary of
15 the Interior to be an Indian for any pur-
16 pose.

17 “(iv) Is determined to be an Indian
18 under regulations promulgated by the Sec-
19 retary.

20 “(C) An individual who is considered by
21 the Secretary of the Interior to be an Indian for
22 any purpose.

23 “(D) An individual who is considered by
24 the Secretary to be an Indian for purposes of
25 eligibility for Indian health care services, includ-

1 ing as a California Indian, Eskimo, Aleut, or
2 other Alaska Native.”.

3 (b) CONFORMING AMENDMENTS.—

4 (1) AFFORDABLE CHOICES HEALTH BENEFIT
5 PLANS.—Section 1311(c)(6)(D) of the Patient Pro-
6 tection and Affordable Care Act (42 U.S.C.
7 18031(c)(6)(D)) is amended by striking “(as defined
8 in section 4 of the Indian Health Care Improvement
9 Act)”.

10 (2) REDUCED COST-SHARING FOR INDIVIDUALS
11 ENROLLING IN QUALIFIED HEALTH PLANS.—Section
12 1402(d) of the Patient Protection and Affordable
13 Care Act (42 U.S.C. 18071(d)) is amended—

14 (A) in paragraph (1), in the matter pre-
15 ceding subparagraph (A), by striking “(as de-
16 fined in section 4(d) of the Indian Self-Deter-
17 mination and Education Assistance Act (25
18 U.S.C. 450b(d))”; and

19 (B) in paragraph (2), in the matter pre-
20 ceding subparagraph (A), by striking “(as so
21 defined)”.

22 (3) EXEMPTION FROM PENALTY FOR NOT
23 MAINTAINING MINIMUM ESSENTIAL COVERAGE.—
24 Section 5000A(e) of the Internal Revenue Code of

1 1986 is amended by striking paragraph (3) and in-
2 serting the following:

3 “(3) INDIANS.—Any applicable individual who
4 is an Indian (as defined in section 1304(f) of the
5 Patient Protection and Affordable Care Act).”.

6 **SEC. 407. REMOVING MEDICARE BARRIER TO HEALTH**
7 **CARE.**

8 (a) PART A.—Section 1818(a)(3) of the Social Secu-
9 rity Act (42 U.S.C. 1395i-2(a)(3)) is amended by striking
10 “an alien” and all that follows through “under this sec-
11 tion” and inserting “an individual who is lawfully present
12 in the United States”.

13 (b) PART B.—Section 1836(2) of the Social Security
14 Act (42 U.S.C. 1395o(2)) is amended by striking “an
15 alien” and all that follows through “under this part” and
16 inserting “an individual who is lawfully present in the
17 United States”.

18 **SEC. 408. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
19 **PROVIDED BY URBAN INDIAN HEALTH CEN-**
20 **TERS.**

21 (a) IN GENERAL.—The third sentence of section
22 1905(b) of the Social Security Act (42 U.S.C. 1396(b))
23 is amended by inserting “or are received through a pro-
24 gram operated by an urban Indian organization through
25 a grant or contract under title V of the Indian Health

1 Care Improvement Act” after “(as defined in section 4
2 of the Indian Health Care Improvement Act)”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 this section shall apply to medical assistance provided on
5 or after the date of enactment of this Act.

6 **SEC. 409. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
7 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
8 **A FEDERALLY QUALIFIED HEALTH CENTER**
9 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
10 **TEM UNDER THE MEDICAID PROGRAM.**

11 (a) IN GENERAL.—The third sentence of section
12 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),
13 as amended by section 408(a), is amended by inserting
14 before the period the following: “, and with respect to
15 medical assistance provided to a Native Hawaiian (as de-
16 fined in section 12(2) of the Native Hawaiian Health Care
17 Improvement Act) through a federally qualified health
18 center or a Native Hawaiian health care system (as de-
19 fined in section 12(6) of such Act), whether directly, by
20 referral, or under contract or other arrangement between
21 such federally qualified health center or Native Hawaiian
22 health care system and another health care provider”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 this section shall apply to medical assistance provided on
25 or after the date of enactment of this Act.

1 **SEC. 410. MEDICAID COVERAGE FOR CITIZENS OF FREELY**
2 **ASSOCIATED STATES.**

3 (a) IN GENERAL.—Section 402(b)(2) of the Personal
4 Responsibility and Work Opportunity Reconciliation Act
5 of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at
6 the end the following new subparagraph:

7 “(G) MEDICAID EXCEPTION FOR CITIZENS
8 OF FREELY ASSOCIATED STATES.—With respect
9 to eligibility for benefits for the designated Fed-
10 eral program described in paragraph (3)(C),
11 section 401(a) and paragraph (1) shall not
12 apply to any individual who lawfully resides in
13 1 of the 50 States or the District of Columbia
14 in accordance with the Compacts of Free Asso-
15 ciation between the Government of the United
16 States and the Governments of the Federated
17 States of Micronesia, the Republic of the Mar-
18 shall Islands, and the Republic of Palau and
19 shall not apply, at the option of the Governors
20 of Puerto Rico, the Virgin Islands, Guam, the
21 Northern Mariana Islands, or American Samoa,
22 respectively, as communicated to the Secretary
23 of Health and Human Services in writing, to
24 any individual who lawfully resides in the re-
25 spective territory in accordance with such Com-
26 pacts.”.

1 (b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—
2 Section 403(d) of the Personal Responsibility and Work
3 Opportunity Reconciliation Act of 1996 (8 U.S.C.
4 1613(d)) is amended—

5 (1) in paragraph (1), by striking “or” at the
6 end;

7 (2) in paragraph (2), by striking the period at
8 the end and inserting “; or”; and

9 (3) by adding at the end the following new
10 paragraph:

11 “(3) an individual described in section
12 402(b)(2)(G), but only with respect to the des-
13 ignated Federal program described in section
14 402(b)(3)(C).”.

15 (c) DEFINITION OF QUALIFIED ALIEN.—Section
16 431(b) of the Personal Responsibility and Work Oppor-
17 tunity Reconciliation Act of 1996 (8 U.S.C. 1641(b)) is
18 amended—

19 (1) in paragraph (6), by striking “; or” at the
20 end and inserting a comma;

21 (2) in paragraph (7), by striking the period at
22 the end and inserting “, or”; and

23 (3) by adding at the end the following new
24 paragraph:

1 “(8) an individual who lawfully resides in the
 2 United States in accordance with a Compact of Free
 3 Association referred to in section 402(b)(2)(G), but
 4 only with respect to the designated Federal program
 5 described in section 402(b)(3)(C) (relating to the
 6 Medicaid program).”.

7 (d) EFFECTIVE DATE.—The amendments made by
 8 this section take effect on October 1, 2021.

9 **Subtitle B—Expansion of Access**

10 **SEC. 412. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

11 **ACT.**

12 Title XXXIV of the Public Health Service Act, as
 13 amended by titles I, II, III, and IX of this Act, is further
 14 amended by inserting after subtitle D the following:

15 **“Subtitle E—Reconstruction and** 16 **Improvement Grants for Public** 17 **Health Care Facilities Serving** 18 **Pacific Islanders and the Insu-** 19 **lar Areas**

20 **“SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT** 21 **INITIATIVES.**

22 “(a) IN GENERAL.—The Secretary, in collaboration
 23 with the Administrator of the Health Resources and Serv-
 24 ices Administration, the Director of the Agency for
 25 Healthcare Research and Quality, and the Administrator

1 of the Centers for Medicare & Medicaid Services, shall
2 award grants to eligible entities for the conduct of dem-
3 onstration projects to improve the quality of and access
4 to health care.

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

7 “(1) be a health center, hospital, health plan,
8 health system, community clinic, or other health en-
9 tity determined appropriate by the Secretary—

10 “(A) that, by legal mandate or explicitly
11 adopted mission, provides patients with access
12 to services regardless of their ability to pay;

13 “(B) that provides care or treatment for a
14 substantial number of patients who are unin-
15 sured, are receiving assistance under a State
16 plan under title XIX of the Social Security Act
17 (or under a waiver of such plan), or are mem-
18 bers of vulnerable populations, as determined
19 by the Secretary; and

20 “(C)(i) with respect to which, not less than
21 50 percent of the entity’s patient population is
22 made up of racial and ethnic minority groups;
23 or

24 “(ii) that—

1 “(I) serves a disproportionate percent-
2 age of local patients that are from a racial
3 and ethnic minority group, or that has a
4 patient population, at least 50 percent of
5 which is composed of individuals with lim-
6 ited English proficiency; and

7 “(II) provides an assurance that
8 amounts received under the grant will be
9 used only to support quality improvement
10 activities in the racial and ethnic minority
11 population served; and

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

16 “(c) PRIORITY.—In awarding grants under sub-
17 section (a), the Secretary shall give priority to applicants
18 meeting the criteria under subsection (b) that—

19 “(1) demonstrate an intent to operate as part
20 of a health care partnership, network, collaborative,
21 coalition, or alliance where each member entity con-
22 tributes to the design, implementation, and evalua-
23 tion of the proposed intervention; or

1 “(2) intend to use funds to carry out system-
2 wide changes with respect to health care quality im-
3 provement, including—

4 “(A) improved systems for data collection
5 and reporting;

6 “(B) innovative collaborative or similar
7 processes;

8 “(C) group programs with behavioral or
9 self-management interventions;

10 “(D) case management services;

11 “(E) physician or patient reminder sys-
12 tems;

13 “(F) educational interventions; or

14 “(G) other activities determined appro-
15 priate by the Secretary.

16 “(d) USE OF FUNDS.—An entity shall use amounts
17 received under a grant under subsection (a) to support
18 the implementation and evaluation of health care quality
19 improvement activities or minority health and health care
20 disparity reduction activities that include—

21 “(1) with respect to health care systems, activi-
22 ties relating to improving—

23 “(A) patient safety;

24 “(B) timeliness of care;

25 “(C) effectiveness of care;

- 1 “(D) efficiency of care;
- 2 “(E) patient centeredness; and
- 3 “(F) health information technology; and
- 4 “(2) with respect to patients, activities relating
- 5 to—
- 6 “(A) staying healthy;
- 7 “(B) getting well, mentally and physically;
- 8 “(C) living effectively with illness or dis-
- 9 ability;
- 10 “(D) coping with end-of-life issues; and
- 11 “(E) shared decision making.

12 “(e) COMMON DATA SYSTEMS.—The Secretary shall

13 provide financial and other technical assistance to grant-

14 ees under this section for the development of common data

15 systems.

16 “(f) AUTHORIZATION OF APPROPRIATIONS.—There

17 are authorized to be appropriated to carry out this section

18 such sums as may be necessary for each of fiscal years

19 2021 through 2026.

20 **“SEC. 3452. CENTERS OF EXCELLENCE.**

21 “(a) IN GENERAL.—The Secretary, acting through

22 the Administrator of the Health Resources and Services

23 Administration, shall designate centers of excellence at

24 public hospitals, and other health systems serving large

25 numbers of minority patients, that—

1 “(1) meet the requirements of section
2 3451(b)(1);

3 “(2) demonstrate excellence in providing care to
4 minority populations; and

5 “(3) demonstrate excellence in reducing dispari-
6 ties in health and health care.

7 “(b) REQUIREMENTS.—A hospital or health system
8 that serves as a center of excellence under subsection (a)
9 shall—

10 “(1) design, implement, and evaluate programs
11 and policies relating to the delivery of care in ra-
12 cially, ethnically, and linguistically diverse popu-
13 lations;

14 “(2) provide training and technical assistance
15 to other hospitals and health systems relating to the
16 provision of quality health care to minority popu-
17 lations; and

18 “(3) develop activities for graduate or con-
19 tinuing medical education that institutionalize a
20 focus on cultural competence training for health care
21 providers.

22 “(c) 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 2021 through 2026.

1 **“SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**
2 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
3 **ING PACIFIC ISLANDERS AND THE INSULAR**
4 **AREAS.**

5 “(a) IN GENERAL.—The Secretary shall provide di-
6 rect financial assistance to designated health care pro-
7 viders and community health centers in American Samoa,
8 Guam, the Commonwealth of the Northern Mariana Is-
9 lands, the United States Virgin Islands, Puerto Rico, and
10 Hawaii for the purposes of reconstructing and improving
11 health care facilities and services in a culturally competent
12 and sustainable manner.

13 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
14 nancial assistance under subsection (a), an entity shall be
15 a public health facility or community health center located
16 in American Samoa, Guam, the Commonwealth of the
17 Northern Mariana Islands, the United States Virgin Is-
18 lands, Puerto Rico, or Hawaii that—

19 “(1) is owned or operated by—

20 “(A) the Government of American Samoa,
21 Guam, the Commonwealth of the Northern
22 Mariana Islands, the United States Virgin Is-
23 lands, Puerto Rico, or Hawaii or a unit of local
24 government; or

25 “(B) a nonprofit organization; and

1 “(2)(A) provides care or treatment for a sub-
2 stantial number of patients who are uninsured, re-
3 ceiving assistance under title XVIII of the Social Se-
4 curity Act, or a State plan under title XIX of such
5 Act (or under a waiver of such plan), or who are
6 members of a vulnerable population, as determined
7 by the Secretary; or

8 “(B) serves a disproportionate percentage of
9 local patients that are from a racial and ethnic mi-
10 nority group.

11 “(c) REPORT.—Not later than 180 days after the
12 date of enactment of this title and annually thereafter, the
13 Secretary shall submit to the Congress and the President
14 a report that includes an assessment of health resources
15 and facilities serving populations in American Samoa,
16 Guam, the Commonwealth of the Northern Mariana Is-
17 lands, the United States Virgin Islands, Puerto Rico, and
18 Hawaii. In preparing such report, the Secretary shall—

19 “(1) consult with and obtain information on all
20 health care facilities needs from the entities receiv-
21 ing direct financial assistance under subsection (a);

22 “(2) include all amounts of Federal assistance
23 received by each such entity in the preceding fiscal
24 year;

1 “(3) review the total unmet needs of health care
2 facilities serving American Samoa, Guam, the Com-
3 monwealth of the Northern Mariana Islands, the
4 United States Virgin Islands, Puerto Rico, and Ha-
5 waii, including needs for renovation and expansion
6 of existing facilities;

7 “(4) include a strategic plan for addressing the
8 needs of each such population identified in the re-
9 port; and

10 “(5) evaluate the effectiveness of the care pro-
11 vided by measuring patient outcomes and cost meas-
12 ures.

13 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated such sums as necessary
15 to carry out this section.”.

16 **SEC. 413. PROTECTING SENSITIVE LOCATIONS.**

17 Section 287 of the Immigration and Nationality Act
18 (8 U.S.C. 1357) is amended—

19 (1) by striking “Service” each place such term
20 appears and inserting “Department of Homeland
21 Security”;

22 (2) by striking “Attorney General” each place
23 such term appears and inserting “Secretary of
24 Homeland Security”;

1 (3) in subsection (f)(1), by striking “Commis-
2 sioner” and inserting “Director of U.S. Citizenship
3 and Immigration Services”;

4 (4) in subsection (h)—

5 (A) by striking “of the Immigration and
6 Nationality Act”; and

7 (B) by striking “of such Act”; and

8 (5) by adding at the end the following:

9 “(i)(1) In this subsection:

10 “(A) The term ‘appropriate congressional com-
11 mittees’ means—

12 “(i) the Committee on Homeland Security
13 and Governmental Affairs of the Senate;

14 “(ii) the Committee on the Judiciary of the
15 Senate;

16 “(iii) the Committee on Homeland Security
17 of the House of Representatives; and

18 “(iv) the Committee on the Judiciary of
19 the House of Representatives.

20 “(B) The term ‘enforcement action’—

21 “(i) means an apprehension, arrest, inter-
22 view, request for identification, search, or sur-
23 veillance for the purposes of immigration en-
24 forcement; and

1 “(ii) includes an enforcement action at, or
2 focused on, a sensitive location that is part of
3 a joint case led by another law enforcement
4 agency.

5 “(C) The term ‘exigent circumstances’ means a
6 situation involving—

7 “(i) the imminent risk of death, violence,
8 or physical harm to any person or property, in-
9 cluding a situation implicating terrorism or the
10 national security of the United States;

11 “(ii) the immediate arrest or pursuit of a
12 dangerous felon, terrorist suspect, or other indi-
13 vidual presenting an imminent danger; or

14 “(iii) the imminent risk of destruction of
15 evidence that is material to an ongoing criminal
16 case.

17 “(D) The term ‘prior approval’ means—

18 “(i) in the case of officers and agents of
19 U.S. Immigration and Customs Enforcement,
20 prior written approval to carry out an enforce-
21 ment action involving a specific individual or in-
22 dividuals authorized by—

23 “(I) the Assistant Director of Oper-
24 ations, Homeland Security Investigations;

1 “(II) the Executive Associate Direc-
2 tor, Homeland Security Investigations;

3 “(III) the Assistant Director for Field
4 Operations, Enforcement and Removal Op-
5 erations; or

6 “(IV) the Executive Associate Direc-
7 tor for Field Operations, Enforcement and
8 Removal Operations;

9 “(ii) in the case of officers and agents of
10 U.S. Customs and Border Protection, prior
11 written approval to carry out an enforcement
12 action involving a specific individual or individ-
13 uals authorized by—

14 “(I) a Chief Patrol Agent;

15 “(II) the Director of Field Operations;

16 “(III) the Director of Air and Marine
17 Operations; or

18 “(IV) the Internal Affairs Special
19 Agent in Charge; and

20 “(iii) in the case of other Federal, State,
21 or local law enforcement officers, to carry out
22 an enforcement action involving a specific indi-
23 vidual or individuals authorized by—

24 “(I) the head of the Federal agency
25 carrying out the enforcement action; or

1 “(II) the head of the State or local
2 law enforcement agency carrying out the
3 enforcement action.

4 “(E) The term ‘sensitive location’ includes all of
5 the physical space located within 1,000 feet of—

6 “(i) any medical treatment or health care
7 facility, including any hospital, doctor’s office,
8 accredited health clinic, alcohol or drug treat-
9 ment center, or emergent or urgent care facil-
10 ity;

11 “(ii) any public or private school, including
12 any known and licensed day care facility, pre-
13 school, other early learning program facility,
14 primary school, secondary school, postsecondary
15 school (including colleges and universities), or
16 other institution of learning (including voca-
17 tional or trade schools);

18 “(iii) any scholastic or education-related
19 activity or event, including field trips and inter-
20 scholastic events;

21 “(iv) any school bus or school bus stop
22 during periods when school children are present
23 on the bus or at the stop;

24 “(v) any organization or subdivision of
25 government that—

1 “(I) assists children, pregnant women,
2 victims of crime or abuse, or individuals
3 with significant mental or physical disabili-
4 ties; or

5 “(II) provides social services and as-
6 sistance, including emergency and disaster
7 services or assistance with food and nutri-
8 tion, housing affordability and income or
9 other services funded by State or local gov-
10 ernment, charitable giving, the Special
11 Supplemental Nutrition Program for
12 Women, Infants, and Children (WIC),
13 Supplemental Nutrition Assistance Pro-
14 gram (SNAP), Temporary Assistance for
15 Needy Families (TANF), or the United
16 States Housing Act;

17 “(vi) any church, synagogue, mosque, or
18 other place of worship, including buildings
19 rented for the purpose of religious services, re-
20 treats, counseling, workshops, instruction, and
21 education;

22 “(vii) any Federal, State, or local court-
23 house, including the office of an individual’s
24 legal counsel or representative, and a probation,
25 parole, or supervised release office;

1 “(viii) the site of a funeral, wedding, or
2 other religious ceremony or observance;

3 “(ix) any public demonstration, such as a
4 march, rally, or parade;

5 “(x) any domestic violence shelter, rape
6 crisis center, supervised visitation center, family
7 justice center, or victim services provider; or

8 “(xi) any other location specified by the
9 Secretary of Homeland Security for purposes of
10 this subsection.

11 “(2)(A) An enforcement action may not take place
12 at, or be focused on, a sensitive location unless—

13 “(i) the action involves exigent circumstances;
14 and

15 “(ii) prior approval for the enforcement action
16 was obtained from the appropriate official.

17 “(B) If an enforcement action is initiated pursuant
18 to subparagraph (A) and the exigent circumstances per-
19 mitting the enforcement action cease, the enforcement ac-
20 tion shall be discontinued until such exigent circumstances
21 reemerge.

22 “(C) If an enforcement action is carried out in viola-
23 tion of this subsection—

24 “(i) no information resulting from the enforce-
25 ment action may be entered into the record or re-

1 ceived into evidence in a removal proceeding result-
2 ing from the enforcement action; and

3 “(ii) the alien who is the subject of such re-
4 moval proceeding may file a motion for the imme-
5 diate termination of the removal proceeding.

6 “(3)(A) This subsection shall apply to any enforce-
7 ment action by officers or agents of the Department of
8 Homeland Security, including—

9 “(i) officers or agents of U.S. Immigration and
10 Customs Enforcement;

11 “(ii) officers or agents of U.S. Customs and
12 Border Protection; and

13 “(iii) any individual designated to perform im-
14 migration enforcement functions pursuant to sub-
15 section (g).

16 “(B) While carrying out an enforcement action at a
17 sensitive location, officers and agents referred to in sub-
18 paragraph (A) shall make every effort—

19 “(i) to limit the time spent at the sensitive loca-
20 tion;

21 “(ii) to limit the enforcement action at the sen-
22 sitive location to the person or persons for whom
23 prior approval was obtained; and

24 “(iii) to conduct themselves discreetly.

1 “(C) If, while carrying out an enforcement action
2 that is not initiated at or focused on a sensitive location,
3 officers or agents are led to a sensitive location, and no
4 exigent circumstance and prior approval with respect to
5 the sensitive location exists, such officers or agents shall—

6 “(i) cease before taking any further enforce-
7 ment action;

8 “(ii) conduct themselves in a discreet manner;

9 “(iii) maintain surveillance; and

10 “(iv) immediately consult their supervisor in
11 order to determine whether such enforcement action
12 should be discontinued.

13 “(D) The limitations under this paragraph shall not
14 apply to the transportation of an individual apprehended
15 at or near a land or sea border to a hospital or health
16 care provider for the purpose of providing medical care
17 to such individual.

18 “(4)(A) Each official specified in subparagraph (B)
19 shall ensure that the employees under his or her super-
20 vision receive annual training on compliance with—

21 “(i) the requirements under this subsection in
22 enforcement actions at or focused on sensitive loca-
23 tions and enforcement actions that lead officers or
24 agents to a sensitive location; and

1 “(ii) the requirements under section 239 of this
2 Act and section 384 of the Illegal Immigration Re-
3 form and Immigrant Responsibility Act of 1996 (8
4 U.S.C. 1367).

5 “(B) The officials specified in this subparagraph
6 are—

7 “(i) the Chief Counsel of U.S. Immigration and
8 Customs Enforcement;

9 “(ii) the Field Office Directors of U.S. Immi-
10 gration and Customs Enforcement;

11 “(iii) each Special Agent in Charge of U.S. Im-
12 migration and Customs Enforcement;

13 “(iv) each Chief Patrol Agent of U.S. Customs
14 and Border Protection;

15 “(v) the Director of Field Operations of U.S.
16 Customs and Border Protection;

17 “(vi) the Director of Air and Marine Operations
18 of U.S. Customs and Border Protection;

19 “(vii) the Internal Affairs Special Agent in
20 Charge of U.S. Customs and Border Protection; and

21 “(viii) the chief law enforcement officer of each
22 State or local law enforcement agency that enters
23 into a written agreement with the Department of
24 Homeland Security pursuant to subsection (g).

1 “(5) The Secretary of Homeland Security shall mod-
2 ify the Notice to Appear form (I-862)—

3 “(A) to provide the subjects of an enforcement
4 action with information, written in plain language,
5 summarizing the restrictions against enforcement
6 actions at sensitive locations set forth in this sub-
7 section and the remedies available to the alien if
8 such action violates such restrictions;

9 “(B) to ensure that the information described
10 in subparagraph (A) is accessible to individuals with
11 limited English proficiency; and

12 “(C) to ensure that subjects of an enforcement
13 action are not permitted to verify that the officers
14 or agents that carried out such action complied with
15 the restrictions set forth in this subsection.

16 “(6)(A) The Director of U.S. Immigration and Cus-
17 toms Enforcement and the Commissioner of U.S. Customs
18 and Border Protection shall each submit an annual report
19 to the appropriate congressional committees that includes
20 the information set forth in subparagraph (B) with respect
21 to the respective agency.

22 “(B) Each report submitted under subparagraph (A)
23 shall include, with respect to the submitting agency during
24 the reporting period—

1 “(i) the number of enforcement actions that
2 were carried out at, or focused on, a sensitive loca-
3 tion;

4 “(ii) the number of enforcement actions in
5 which officers or agents were subsequently led to a
6 sensitive location; and

7 “(iii) for each enforcement action described in
8 clause (i) or (ii)—

9 “(I) the date on which it occurred;

10 “(II) the specific site, city, county, and
11 State in which it occurred;

12 “(III) the components of the agency in-
13 volved in the enforcement action;

14 “(IV) a description of the enforcement ac-
15 tion, including the nature of the criminal activ-
16 ity of its intended target;

17 “(V) the number of individuals, if any, ar-
18 rested or taken into custody;

19 “(VI) the number of collateral arrests, if
20 any, and the reasons for each such arrest;

21 “(VII) a certification whether the location
22 administrator was contacted before, during, or
23 after the enforcement action; and

24 “(VIII) the percentage of all of the staff
25 members and supervisors reporting to the offi-

1 cials listed in paragraph (4)(B) who completed
2 the training required under paragraph (4)(A).

3 “(7) Nothing in the subsection may be construed—

4 “(A) to affect the authority of Federal, State,
5 or local law enforcement agencies—

6 “(i) to enforce generally applicable Federal
7 or State criminal laws unrelated to immigra-
8 tion; or

9 “(ii) to protect residents from imminent
10 threats to public safety; or

11 “(B) to limit or override the protections pro-
12 vided in—

13 “(i) section 239; or

14 “(ii) section 384 of the Illegal Immigration
15 Reform and Immigrant Responsibility Act of
16 1996 (8 U.S.C. 1367).”.

17 **SEC. 414. GRANTS FOR RACIAL AND ETHNIC APPROACHES**
18 **TO COMMUNITY HEALTH.**

19 (a) PURPOSE.—It is the purpose of this section to
20 award grants to assist communities in mobilizing and or-
21 ganizing resources in support of effective and sustainable
22 programs that will reduce or eliminate disparities in health
23 and health care experienced by racial and ethnic minority
24 individuals.

1 (b) AUTHORITY TO AWARD GRANTS.—The Secretary
2 of Health and Human Services, acting through the Ad-
3 ministrator of the Health Resources and Services Admin-
4 istration (referred to in this section as the “Secretary”),
5 shall award grants to eligible entities to assist in design-
6 ing, implementing, and evaluating culturally and linguis-
7 tically appropriate, science-based, and community-driven
8 sustainable strategies to eliminate racial and ethnic health
9 and health care disparities.

10 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
11 grant under this section, an entity shall—

12 (1) represent a coalition—

13 (A) whose principal purpose is to develop
14 and implement interventions to reduce or elimi-
15 nate a health or health care disparity in a tar-
16 geted racial or ethnic minority group in the
17 community served by the coalition; and

18 (B) that includes—

19 (i) members selected from among—

20 (I) public health departments;

21 (II) community-based organiza-
22 tions;

23 (III) university and research or-
24 ganizations;

1 (IV) Indian tribes or tribal orga-
2 nizations (as such terms are defined
3 in section 4 of the Indian Self-Deter-
4 mination and Education Assistance
5 Act (25 U.S.C. 5304)), the Indian
6 Health Service, or any other organiza-
7 tion that serves Alaska Natives; and

8 (V) interested public or private
9 health care providers or organizations
10 as determined appropriate by the Sec-
11 retary; and

12 (ii) at least 1 member from a commu-
13 nity-based organization that represents the
14 targeted racial or ethnic minority group;
15 and

16 (2) submit to the Secretary an application at
17 such time, in such manner, and containing such in-
18 formation as the Secretary may require, which shall
19 include—

20 (A) a description of the targeted racial or
21 ethnic populations in the community to be
22 served under the grant;

23 (B) a description of at least 1 health dis-
24 parity that exists in the racial or ethnic tar-
25 geted populations, including health issues such

1 as infant mortality, breast and cervical cancer
2 screening and management, musculoskeletal
3 diseases and obesity, prostate cancer screening
4 and management, cardiovascular disease, diabe-
5 tes, child and adult immunization levels, oral
6 disease, or other health priority areas as des-
7 ignated by the Secretary; and

8 (C) a demonstration of a proven record of
9 accomplishment of the coalition members in
10 serving and working with the targeted commu-
11 nity.

12 (d) SUSTAINABILITY.—The Secretary shall give pri-
13 ority to an eligible entity under this section if the entity
14 agrees that, with respect to the costs to be incurred by
15 the entity in carrying out the activities for which the grant
16 was awarded, the entity (and each of the participating
17 partners in the coalition represented by the entity) will
18 maintain its expenditures of non-Federal funds for such
19 activities at a level that is not less than the level of such
20 expenditures during the fiscal year immediately preceding
21 the first fiscal year for which the grant is awarded.

22 (e) NONDUPLICATION.—Any funds provided to an eli-
23 gible entity through a grant under this section shall—

1 (1) supplement, not supplant, any other Federal
2 funds made available to the entity for the purposes
3 of this section; and

4 (2) not be used to duplicate the activities of any
5 other health disparity grant program under this Act,
6 including an amendment made by this Act.

7 (f) TECHNICAL ASSISTANCE.—The Secretary may,
8 either directly or by grant or contract, provide any entity
9 that receives a grant under this section with technical and
10 other nonfinancial assistance necessary to meet the re-
11 quirements of this section.

12 (g) DISSEMINATION.—The Secretary shall encourage
13 and enable eligible entities receiving grants under this sec-
14 tion to share best practices, evaluation results, and reports
15 with communities not affiliated with such entities, by
16 using the internet, conferences, and other pertinent infor-
17 mation regarding the projects funded by this section, in-
18 cluding through using outreach efforts of the Office of Mi-
19 nority Health and the Centers for Disease Control and
20 Prevention.

21 (h) ADMINISTRATIVE BURDENS.—The Secretary
22 shall make every effort to minimize duplicative or unneces-
23 sary administrative burdens on eligible entities receiving
24 grants under this section.

1 (i) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out this section.

4 **SEC. 415. BORDER HEALTH GRANTS.**

5 (a) DEFINITIONS.—In this section:

6 (1) BORDER AREA.—The term “border area”
7 means the United States-Mexico Border Area, as de-
8 fined in section 8 of the United States-Mexico Bor-
9 der Health Commission Act (22 U.S.C. 290n–6).

10 (2) ELIGIBLE ENTITY.—The term “eligible enti-
11 ty” means an entity that is located in the border
12 area and is any of the following:

13 (A) A State, local government, or Tribal
14 government.

15 (B) A public institution of higher edu-
16 cation.

17 (C) A nonprofit health organization.

18 (D) A community health center.

19 (E) A community clinic that is a health
20 center receiving assistance under section 330 of
21 the Public Health Service Act (42 U.S.C.
22 254b).

23 (b) AUTHORIZATION.—From funds appropriated
24 under subsection (f), the Secretary of Health and Human
25 Services (in this section referred to as the “Secretary”),

1 acting through the United States members of the United
2 States-Mexico Border Health Commission, shall award
3 grants to eligible entities to address priorities and rec-
4 ommendations to improve the health of border area resi-
5 dents that are established by—

6 (1) the United States members of the United
7 States-Mexico Border Health Commission;

8 (2) the State border health offices; and

9 (3) the Secretary.

10 (c) APPLICATION.—An eligible entity that desires a
11 grant under subsection (b) shall submit an application to
12 the Secretary at such time, in such manner, and con-
13 taining such information as the Secretary may require.

14 (d) USE OF FUNDS.—An eligible entity that receives
15 a grant under subsection (b) shall use the grant funds
16 for—

17 (1) programs relating to—

18 (A) maternal and child health;

19 (B) primary care and preventative health;

20 (C) public health and public health infra-
21 structure;

22 (D) musculoskeletal health and obesity;

23 (E) health education and promotion;

24 (F) oral health;

25 (G) mental and behavioral health;

- 1 (H) substance use disorders;
- 2 (I) health conditions that have a high prev-
- 3 alence in the border area;
- 4 (J) medical and health services research;
- 5 (K) workforce training and development;
- 6 (L) community health workers, patient
- 7 navigators, and promotores;
- 8 (M) health care infrastructure problems in
- 9 the border area (including planning and con-
- 10 struction grants);
- 11 (N) health disparities in the border area;
- 12 (O) environmental health; and
- 13 (P) outreach and enrollment services with
- 14 respect to Federal programs (including pro-
- 15 grams authorized under titles XIX and XXI of
- 16 the Social Security Act (42 U.S.C. 1396 et seq.;
- 17 42 U.S.C. 1397aa et seq.)); and
- 18 (2) other programs determined appropriate by
- 19 the Secretary.
- 20 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
- 21 vided to an eligible entity awarded a grant under sub-
- 22 section (b) shall be used to supplement and not supplant
- 23 other funds available to the eligible entity to carry out the
- 24 activities described in subsection (d).

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated to carry out this section,
 3 \$200,000,000 for fiscal year 2021, and such sums as may
 4 be necessary for each succeeding fiscal year.

5 **SEC. 416. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

6 (a) ELIMINATION OF ISOLATION TEST FOR COST-
 7 BASED AMBULANCE REIMBURSEMENT.—

8 (1) IN GENERAL.—Section 1834(l)(8) of the
 9 Social Security Act (42 U.S.C. 1395m(l)(8)) is
 10 amended—

11 (A) in subparagraph (B)—

12 (i) by striking “owned and”; and

13 (ii) by inserting “(including when
 14 such services are provided by the entity
 15 under an arrangement with the hospital)”
 16 after “hospital”; and

17 (B) by striking the comma at the end of
 18 subparagraph (B) and all that follows and in-
 19 serting a period.

20 (2) EFFECTIVE DATE.—The amendments made
 21 by this subsection shall apply to services furnished
 22 on or after January 1, 2021.

23 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
 24 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
 25 REQUIREMENT.—

1 (1) IN GENERAL.—Section 1820(c)(2) of the
2 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
3 amended—

4 (A) in subparagraph (B)(iii), by striking
5 “provides not more than” and inserting “sub-
6 ject to subparagraph (F), provides not more
7 than”; and

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

10 “(F) ALTERNATIVE TO 25 INPATIENT BED
11 LIMIT REQUIREMENT.—

12 “(i) IN GENERAL.—A State may elect
13 to treat a facility, with respect to the des-
14 ignation of the facility for a cost-reporting
15 period, as satisfying the requirement of
16 subparagraph (B)(iii) relating to a max-
17 imum number of acute care inpatient beds
18 if the facility elects, in accordance with a
19 method specified by the Secretary and be-
20 fore the beginning of the cost reporting pe-
21 riod, to meet the requirement under clause
22 (ii).

23 “(ii) ALTERNATE REQUIREMENT.—
24 The requirement under this clause, with
25 respect to a facility and a cost-reporting

1 period, is that the total number of inpa-
2 tient bed days described in subparagraph
3 (B)(iii) during such period will not exceed
4 7,300. For purposes of this subparagraph,
5 an individual who is an inpatient in a bed
6 in the facility for a single day shall be
7 counted as one inpatient bed day.

8 “(iii) WITHDRAWAL OF ELECTION.—
9 The option described in clause (i) shall not
10 apply to a facility for a cost-reporting pe-
11 riod if the facility (for any two consecutive
12 cost-reporting periods during the previous
13 5 cost-reporting periods) was treated under
14 such option and had a total number of in-
15 patient bed days for each of such two cost-
16 reporting periods that exceeded the num-
17 ber specified in such clause.”.

18 (2) EFFECTIVE DATE.—The amendments made
19 by paragraph (1) shall apply to cost-reporting peri-
20 ods beginning on or after the date of the enactment
21 of this Act.

22 **SEC. 417. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
23 **PITAL (RCH) PROGRAM.**

24 (a) IN GENERAL.—Section 1861 of the Social Secu-
25 rity Act (42 U.S.C. 1395x), as amended by section

1 207(b)(1), is amended by adding at the end of the fol-
2 lowing new subsection:

3 “Rural Community Hospital; Rural Community Hospital
4 Services

5 “(III)(1) The term ‘rural community hospital’ means
6 a hospital (as defined in subsection (e)) that—

7 “(A) is located in a rural area (as defined in
8 section 1886(d)(2)(D)) or treated as being so lo-
9 cated pursuant to section 1886(d)(8)(E);

10 “(B) subject to paragraph (2), has less than 51
11 acute care inpatient beds, as reported in its most re-
12 cent cost report;

13 “(C) makes available 24-hour emergency care
14 services;

15 “(D) subject to paragraph (3), has a provider
16 agreement in effect with the Secretary and is open
17 to the public as of January 1, 2010; and

18 “(E) applies to the Secretary for such designa-
19 tion.

20 “(2) For purposes of paragraph (1)(B), beds in a
21 psychiatric or rehabilitation unit of the hospital which is
22 a distinct part of the hospital shall not be counted.

23 “(3) Paragraph (1)(D) shall not be construed to pro-
24 hibit any of the following from qualifying as a rural com-
25 munity hospital:

1 “(A) A replacement facility (as defined by the
2 Secretary in regulations in effect on January 1,
3 2012) with the same service area (as defined by the
4 Secretary in regulations in effect on such date).

5 “(B) A facility obtaining a new provider num-
6 ber pursuant to a change of ownership.

7 “(C) A facility which has a binding written
8 agreement with an outside, unrelated party for the
9 construction, reconstruction, lease, rental, or financ-
10 ing of a building as of January 1, 2012.

11 “(4) Nothing in this subsection shall be construed as
12 prohibiting a critical access hospital from qualifying as a
13 rural community hospital if the critical access hospital
14 meets the conditions otherwise applicable to hospitals
15 under subsection (e) and section 1866.

16 “(5) Nothing in this subsection shall be construed as
17 prohibiting a rural community hospital participating in
18 the demonstration program under section 410A of the
19 Medicare Prescription Drug, Improvement, and Mod-
20 ernization Act of 2003 (Public Law 108–173; 117 Stat.
21 2313) from qualifying as a rural community hospital if
22 the rural community hospital meets the conditions other-
23 wise applicable to hospitals under subsection (e) and sec-
24 tion 1866.”.

25 (b) PAYMENT.—

1 (1) INPATIENT HOSPITAL SERVICES.—Section
2 1814 of the Social Security Act (42 U.S.C. 1395f)
3 is amended by adding at the end the following new
4 subsection:

5 “Payment for Inpatient Services Furnished in Rural
6 Community Hospitals

7 “(m) The amount of payment under this part for in-
8 patient hospital services furnished in a rural community
9 hospital, other than such services furnished in a psy-
10 chiatric or rehabilitation unit of the hospital which is a
11 distinct part, is, at the election of the hospital in the appli-
12 cation referred to in section 1861(III)(1)(E)—

13 “(1) 101 percent of the reasonable costs of pro-
14 viding such services, without regard to the amount
15 of the customary or other charge, or

16 “(2) the amount of payment provided for under
17 the prospective payment system for inpatient hos-
18 pital services under section 1886(d).”.

19 (2) OUTPATIENT SERVICES.—Section 1834 of
20 such Act (42 U.S.C. 1395m) is amended by adding
21 at the end the following new subsection:

22 “(x) PAYMENT FOR OUTPATIENT SERVICES FUR-
23 NISHED IN RURAL COMMUNITY HOSPITALS.—The
24 amount of payment under this part for outpatient services
25 furnished in a rural community hospital is, at the election

1 of the hospital in the application referred to in section
2 1861(III)(1)(E)—

3 “(1) 101 percent of the reasonable costs of pro-
4 viding such services, without regard to the amount
5 of the customary or other charge and any limitation
6 under section 1861(v)(1)(U), or

7 “(2) the amount of payment provided for under
8 the prospective payment system for covered OPD
9 services under section 1833(t).”.

10 (3) EXEMPTION FROM 30-PERCENT REDUCTION
11 IN REIMBURSEMENT FOR BAD DEBT.—Section
12 1861(v)(1)(T) of such Act (42 U.S.C.
13 1395x(v)(1)(T)) is amended by inserting “(other
14 than for a rural community hospital)” after “In de-
15 termining such reasonable costs for hospitals”.

16 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
17 SERVICES.—Section 1834(x) of such Act (as added by
18 subsection (b)(2)) is amended—

19 (1) by redesignating paragraphs (1) and (2) as
20 subparagraphs (A) and (B), respectively;

21 (2) by inserting “(1)” after “(x)”; and

22 (3) by adding at the end the following:

23 “(2) The amounts of beneficiary cost-sharing for out-
24 patient services furnished in a rural community hospital
25 under this part shall be as follows:

1 “(A) For items and services that would have
2 been paid under section 1833(t) if furnished by a
3 hospital, the amount of cost-sharing determined
4 under paragraph (8) of such section.

5 “(B) For items and services that would have
6 been paid under section 1833(h) if furnished by a
7 provider of services or supplier, no cost-sharing shall
8 apply.

9 “(C) For all other items and services, the
10 amount of cost-sharing that would apply to the item
11 or service under the methodology that would be used
12 to determine payment for such item or service if pro-
13 vided by a physician, provider of services, or sup-
14 plier, as the case may be.”.

15 (d) CONFORMING AMENDMENTS.—

16 (1) PART A PAYMENT.—Section 1814(b) of
17 such Act (42 U.S.C. 1395f(b)) is amended in the
18 matter preceding paragraph (1) by inserting “other
19 than inpatient hospital services furnished by a rural
20 community hospital,” after “critical access hospital
21 services,”.

22 (2) PART B PAYMENT.—Section 1833(a) of
23 such Act (42 U.S.C. 1395l(a)), as amended by sec-
24 tion 207(b)(3), is amended—

1 (A) by striking “and” at the end of para-
2 graph (9);

3 (B) by striking the period at the end of
4 paragraph (10) and inserting “; and”; and

5 (C) by adding at the end the following:

6 “(11) in the case of outpatient services fur-
7 nished by a rural community hospital, the amounts
8 described in section 1834(x).”.

9 (3) TECHNICAL AMENDMENTS.—

10 (A) CONSULTATION WITH STATE AGEN-
11 CIES.—Section 1863 of such Act (42 U.S.C.
12 1395z) is amended by striking “and (dd)(2)”
13 and inserting “(dd)(2), and (lll)(1)”.

14 (B) PROVIDER AGREEMENTS.—Section
15 1866(a)(2)(A) of such Act (42 U.S.C.
16 1395cc(a)(2)(A)) is amended by inserting “sec-
17 tion 1834(x)(2),” after “section 1833(b),”.

18 (e) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to items and services furnished on
20 or after October 1, 2021.

21 **SEC. 418. MEDICARE REMOTE MONITORING PILOT**
22 **PROJECTS.**

23 (a) PILOT PROJECTS.—

24 (1) IN GENERAL.—Not later than 9 months
25 after the date of enactment of this Act, the Sec-

1 retary of Health and Human Services (in this sec-
2 tion referred to as the “Secretary”) shall conduct
3 pilot projects under title XVIII of the Social Secu-
4 rity Act (42 U.S.C. 1395 et seq.) for the purpose of
5 providing incentives to home health agencies to uti-
6 lize home monitoring and communications tech-
7 nologies that—

8 (A) enhance health outcomes for Medicare
9 beneficiaries; and

10 (B) reduce expenditures under such title.

11 (2) SITE REQUIREMENTS.—

12 (A) URBAN AND RURAL.—The Secretary
13 shall conduct the pilot projects under this sec-
14 tion in both urban and rural areas.

15 (B) SITE IN A SMALL STATE.—The Sec-
16 retary shall conduct at least 3 of the pilot
17 projects in a State with a population of less
18 than 1,000,000.

19 (3) DEFINITION OF HOME HEALTH AGENCY.—

20 In this section, the term “home health agency” has
21 the meaning given that term in section 1861(o) of
22 the Social Security Act (42 U.S.C. 1395x(o)).

23 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
24 OF PROJECTS.—The Secretary shall specify the criteria
25 for identifying those Medicare beneficiaries who shall be

1 considered within the scope of the pilot projects under this
2 section for purposes of the application of subsection (c)
3 and for the assessment of the effectiveness of the home
4 health agency in achieving the objectives of this section.
5 Such criteria may provide for the inclusion in the projects
6 of Medicare beneficiaries who begin receiving home health
7 services under title XVIII of the Social Security Act (42
8 U.S.C. 1395 et seq.) after the date of the implementation
9 of the projects.

10 (c) INCENTIVES.—

11 (1) PERFORMANCE TARGETS.—The Secretary
12 shall establish for each home health agency partici-
13 pating in a pilot project under this section a per-
14 formance target using one of the following meth-
15 odologies, as determined appropriate by the Sec-
16 retary:

17 (A) ADJUSTED HISTORICAL PERFORMANCE
18 TARGET.—The Secretary shall establish for the
19 agency—

20 (i) a base expenditure amount equal
21 to the average total payments made to the
22 agency under parts A and B of title XVIII
23 of the Social Security Act (42 U.S.C. 1395
24 et seq.) for Medicare beneficiaries deter-
25 mined to be within the scope of the pilot

1 project in a base period determined by the
2 Secretary; and

3 (ii) an annual per capita expenditure
4 target for such beneficiaries, reflecting the
5 base expenditure amount adjusted for risk
6 and adjusted growth rates.

7 (B) COMPARATIVE PERFORMANCE TAR-
8 GET.—The Secretary shall establish for the
9 agency a comparative performance target equal
10 to the average total payments under such parts
11 A and B during the pilot project for comparable
12 individuals in the same geographic area that
13 are not determined to be within the scope of the
14 pilot project.

15 (2) INCENTIVE.—Subject to paragraph (3), the
16 Secretary shall pay to each participating home care
17 agency an incentive payment for each year under the
18 pilot project equal to a portion of the Medicare sav-
19 ings realized for such year relative to the perform-
20 ance target under paragraph (1).

21 (3) LIMITATION ON EXPENDITURES.—The Sec-
22 retary shall limit incentive payments under this sec-
23 tion in order to ensure that the aggregate expendi-
24 tures under title XVIII of the Social Security Act
25 (42 U.S.C. 1395 et seq.) (including incentive pay-

1 ments under this subsection) do not exceed the
2 amount that the Secretary estimates would have
3 been expended if the pilot projects under this section
4 had not been implemented.

5 (d) WAIVER AUTHORITY.—The Secretary may waive
6 such provisions of titles XI and XVIII of the Social Secu-
7 rity Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.)
8 as the Secretary determines to be appropriate for the con-
9 duct of the pilot projects under this section.

10 (e) REPORT TO CONGRESS.—Not later than 5 years
11 after the date that the first pilot project under this section
12 is implemented, the Secretary shall submit to Congress a
13 report on the pilot projects. Such report shall contain a
14 detailed description of issues related to the expansion of
15 the projects under subsection (f) and recommendations for
16 such legislation and administrative actions as the Sec-
17 retary considers appropriate.

18 (f) EXPANSION.—If the Secretary determines that
19 any of the pilot projects under this section enhance health
20 outcomes for Medicare beneficiaries and reduce expendi-
21 tures under title XVIII of the Social Security Act (42
22 U.S.C. 1395 et seq.), the Secretary may initiate com-
23 parable projects in additional areas.

1 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
2 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
3 tive payment under this section—

4 (1) shall be in addition to the payments that a
5 home health agency would otherwise receive under
6 title XVIII of the Social Security Act for the provi-
7 sion of home health services; and

8 (2) shall have no effect on the amount of such
9 payments.

10 **SEC. 419. RURAL HEALTH QUALITY ADVISORY COMMISSION**
11 **AND DEMONSTRATION PROJECTS.**

12 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
13 SION.—

14 (1) ESTABLISHMENT.—Not later than 6
15 months after the date of the enactment of this sec-
16 tion, the Secretary of Health and Human Services
17 (in this section referred to as the “Secretary”) shall
18 establish a commission to be known as the Rural
19 Health Quality Advisory Commission (in this section
20 referred to as the “Commission”).

21 (2) DUTIES OF COMMISSION.—

22 (A) NATIONAL PLAN.—The Commission
23 shall develop, coordinate, and facilitate imple-
24 mentation of a national plan for rural health
25 quality improvement. The national plan shall—

1 (i) identify objectives for rural health
2 quality improvement;

3 (ii) identify strategies to eliminate
4 known gaps in rural health system capacity
5 and improve rural health quality; and

6 (iii) provide recommendations for
7 Federal programs to identify opportunities
8 for strengthening and aligning policies and
9 programs to improve rural health quality.

10 (B) DEMONSTRATION PROJECTS.—The
11 Commission shall design demonstration projects
12 to recommend to the Secretary to test alter-
13 native models for rural health quality improve-
14 ment, including with respect to both personal
15 and population health.

16 (C) MONITORING.—The Commission shall
17 monitor progress toward the objectives identi-
18 fied pursuant to subparagraph (A)(i).

19 (3) MEMBERSHIP.—

20 (A) NUMBER.—The Commission shall be
21 composed of 11 members appointed by the Sec-
22 retary.

23 (B) SELECTION.—The Secretary shall se-
24 lect the members of the Commission from
25 among individuals with significant rural health

1 care and health care quality expertise, including
2 expertise in clinical health care, health care
3 quality research, population or public health, or
4 purchaser organizations.

5 (4) CONTRACTING AUTHORITY.—Subject to the
6 availability of funds, the Commission may enter into
7 contracts and make other arrangements, as may be
8 necessary to carry out the duties described in para-
9 graph (2).

10 (5) STAFF.—Upon the request of the Commis-
11 sion, the Secretary may detail, on a reimbursable
12 basis, any of the personnel of the Office of Rural
13 Health Policy of the Health Resources and Services
14 Administration, the Agency for Healthcare Research
15 and Quality, or the Centers for Medicare & Medicaid
16 Services to the Commission to assist in carrying out
17 this subsection.

18 (6) REPORTS TO CONGRESS.—Not later than 1
19 year after the establishment of the Commission, and
20 annually thereafter, the Commission shall submit a
21 report to the Congress on rural health quality. Each
22 such report shall include the following:

23 (A) An inventory of relevant programs and
24 recommendations for improved coordination and
25 integration of policy and programs.

1 (B) An assessment of achievement of the
2 objectives identified in the national plan devel-
3 oped under paragraph (2) and recommenda-
4 tions for realizing such objectives.

5 (C) Recommendations on Federal legisla-
6 tion, regulations, or administrative policies to
7 enhance rural health quality and outcomes.

8 (b) RURAL HEALTH QUALITY DEMONSTRATION
9 PROJECTS.—

10 (1) IN GENERAL.—Not later than 270 days
11 after the date of the enactment of this section, the
12 Secretary, in consultation with the Rural Health
13 Quality Advisory Commission, the Office of Rural
14 Health Policy of the Health Resources and Services
15 Administration, the Agency for Healthcare Research
16 and Quality, and the Centers for Medicare & Med-
17 icaid Services, shall make grants to eligible entities
18 for a total of 5 demonstration projects to implement
19 and evaluate methods for improving the quality of
20 health care in rural communities. Each such dem-
21 onstration project shall include—

22 (A) alternative community models that—

23 (i) will achieve greater integration of
24 personal and population health services;
25 and

1 (ii) address safety, effectiveness,
2 patient- or community-centeredness, timeli-
3 ness, efficiency, and equity (the 6 aims
4 identified by the National Academy of
5 Medicine (formerly known as the “Institute
6 of Medicine”) in its report entitled “Cross-
7 ing the Quality Chasm: A New Health Sys-
8 tem for the 21st Century” released on
9 March 1, 2001);

10 (B) innovative approaches to the financing
11 and delivery of health services to achieve rural
12 health quality goals; and

13 (C) development of quality improvement
14 support structures to assist rural health sys-
15 tems and professionals (such as workforce sup-
16 port structures, quality monitoring and report-
17 ing, clinical care protocols, and information
18 technology applications).

19 (2) ELIGIBLE ENTITIES.—In this subsection,
20 the term “eligible entity” means a consortium
21 that—

22 (A) shall include—

23 (i) at least one health care provider or
24 health care delivery system located in a
25 rural area; and

1 (ii) at least one organization rep-
2 resenting multiple community stakeholders;
3 and

4 (B) may include other partners such as
5 rural research centers.

6 (3) CONSULTATION.—In developing the pro-
7 gram for awarding grants under this subsection, the
8 Secretary shall consult with the Administrator of the
9 Agency for Healthcare Research and Quality, rural
10 health care providers, rural health care researchers,
11 and private and nonprofit groups (including national
12 associations) which are undertaking similar efforts.

13 (4) EXPEDITED WAIVERS.—The Secretary shall
14 expedite the processing of any waiver that—

15 (A) is authorized under title XVIII or XIX
16 of the Social Security Act (42 U.S.C. 1395 et
17 seq.; 42 U.S.C. 1396 et seq.); and

18 (B) is necessary to carry out a demonstra-
19 tion project under this subsection.

20 (5) DEMONSTRATION PROJECT SITES.—The
21 Secretary shall ensure that the 5 demonstration
22 projects funded under this subsection are conducted
23 at a variety of sites representing the diversity of
24 rural communities in the United States.

1 (6) DURATION.—Each demonstration project
2 under this subsection shall be for a period of 4
3 years.

4 (7) INDEPENDENT EVALUATION.—The Sec-
5 retary shall enter into an arrangement with an enti-
6 ty that has experience working directly with rural
7 health systems for the conduct of an independent
8 evaluation of the program carried out under this
9 subsection.

10 (8) REPORT.—Not later than 1 year after the
11 conclusion of all of the demonstration projects fund-
12 ed under this subsection, the Secretary shall submit
13 a report to the Congress on the results of such
14 projects. The report shall include—

15 (A) an evaluation of patient access to care,
16 patient outcomes, and an analysis of the cost
17 effectiveness of each such project; and

18 (B) recommendations on Federal legisla-
19 tion, regulations, or administrative policies to
20 enhance rural health quality and outcomes.

21 (c) APPROPRIATION.—

22 (1) IN GENERAL.—Out of funds in the Treas-
23 ury not otherwise appropriated, there are appro-
24 priated to the Secretary to carry out this section

1 \$30,000,000 for the period of fiscal years 2021
2 through 2025.

3 (2) AVAILABILITY.—

4 (A) IN GENERAL.—Funds appropriated
5 under paragraph (1) shall remain available for
6 expenditure through fiscal year 2025.

7 (B) REPORT.—For purposes of carrying
8 out subsection (b)(8), funds appropriated under
9 paragraph (1) shall remain available for ex-
10 penditure through fiscal year 2026.

11 (3) RESERVATION.—Of the amount appro-
12 priated under paragraph (1), the Secretary shall re-
13 serve—

14 (A) \$5,000,000 to carry out subsection (a);

15 and

16 (B) \$25,000,000 to carry out subsection

17 (b), of which—

18 (i) 2 percent shall be for the provision
19 of technical assistance to grant recipients;

20 and

21 (ii) 5 percent shall be for independent

22 evaluation under subsection (b)(7).

23 **SEC. 420. RURAL HEALTH CARE SERVICES.**

24 Section 330A of the Public Health Service Act (42
25 U.S.C. 254c) is amended to read as follows:

1 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
 2 **RURAL HEALTH NETWORK DEVELOPMENT,**
 3 **DELTA RURAL DISPARITIES AND HEALTH**
 4 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
 5 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
 6 **MENT GRANT PROGRAMS.**

7 “(a) PURPOSE.—The purpose of this section is to
 8 provide for grants—

9 “(1) under subsection (b), to promote rural
 10 health care services outreach;

11 “(2) under subsection (c), to provide for the
 12 planning and implementation of integrated health
 13 care networks in rural areas;

14 “(3) under subsection (d), to assist rural com-
 15 munities in the Delta Region to reduce health dis-
 16 parities and to promote and enhance health system
 17 development; and

18 “(4) under subsection (e), to provide for the
 19 planning and implementation of small rural health
 20 care provider quality improvement activities.

21 “(b) RURAL HEALTH CARE SERVICES OUTREACH
 22 GRANTS.—

23 “(1) GRANTS.—The Director of the Office of
 24 Rural Health Policy of the Health Resources and
 25 Services Administration (referred to in this section
 26 as the ‘Director’) may award grants to eligible enti-

1 ties to promote rural health care services outreach
2 by expanding the delivery of health care services to
3 include new and enhanced services in rural areas.
4 The Director may award the grants for periods of
5 not more than 3 years.

6 “(2) ELIGIBILITY.—To be eligible to receive a
7 grant under this subsection for a project, an enti-
8 ty—

9 “(A) shall be a rural public or rural non-
10 profit private entity, a facility that qualifies as
11 a rural health clinic under title XVIII of the
12 Social Security Act, a public or nonprofit entity
13 existing exclusively to provide services to mi-
14 grant and seasonal farm workers in rural areas,
15 or a Tribal government whose grant-funded ac-
16 tivities will be conducted within federally recog-
17 nized Tribal areas;

18 “(B) shall represent a consortium com-
19 posed of members—

20 “(i) that include 3 or more independ-
21 ently owned health care entities; and

22 “(ii) that may be nonprofit or for-
23 profit entities; and

24 “(C) shall not previously have received a
25 grant under this subsection for the same or a

1 similar project, unless the entity is proposing to
2 expand the scope of the project or the area that
3 will be served through the project.

4 “(3) APPLICATIONS.—To be eligible to receive a
5 grant under this subsection, an eligible entity shall
6 prepare and submit to the Director an application at
7 such time, in such manner, and containing such in-
8 formation as the Director may require, including—

9 “(A) a description of the project that the
10 eligible entity will carry out using the funds
11 provided under the grant;

12 “(B) a description of the manner in which
13 the project funded under the grant will meet
14 the health care needs of rural populations in
15 the local community or region to be served;

16 “(C) a plan for quantifying how health
17 care needs will be met through identification of
18 the target population and benchmarks of service
19 delivery or health status, such as—

20 “(i) quantifiable measurements of
21 health status improvement for projects fo-
22 cusing on health promotion; or

23 “(ii) benchmarks of increased access
24 to primary care, including tracking factors
25 such as the number and type of primary

1 care visits, identification of a medical
2 home, or other general measures of such
3 access;

4 “(D) a description of how the local com-
5 munity or region to be served will be involved
6 in the development and ongoing operations of
7 the project;

8 “(E) a plan for sustaining the project after
9 Federal support for the project has ended;

10 “(F) a description of how the project will
11 be evaluated;

12 “(G) the administrative capacity to submit
13 annual performance data electronically as speci-
14 fied by the Director; and

15 “(H) other such information as the Direc-
16 tor determines to be appropriate.

17 “(c) RURAL HEALTH NETWORK DEVELOPMENT
18 GRANTS.—

19 “(1) GRANTS.—

20 “(A) IN GENERAL.—The Director may
21 award rural health network development grants
22 to eligible entities to promote, through planning
23 and implementation, the development of inte-
24 grated health care networks that have combined

1 the functions of the entities participating in the
2 networks in order to—

3 “(i) achieve efficiencies and economies
4 of scale;

5 “(ii) expand access to, coordinate, and
6 improve the quality of the health care de-
7 livery system through development of orga-
8 nizational efficiencies;

9 “(iii) implement health information
10 technology to achieve efficiencies, reduce
11 medical errors, and improve quality;

12 “(iv) coordinate care and manage
13 chronic illness; and

14 “(v) strengthen the rural health care
15 system as a whole in such a manner as to
16 show a quantifiable return on investment
17 to the participants in the network.

18 “(B) GRANT PERIODS.—The Director may
19 award such a rural health network development
20 grant—

21 “(i) for a period of 3 years for imple-
22 mentation activities; or

23 “(ii) for a period of 1 year for plan-
24 ning activities to assist in the initial devel-
25 opment of an integrated health care net-

1 work, if the proposed participants in the
2 network do not have a history of collabo-
3 rative efforts and a 3-year grant would be
4 inappropriate.

5 “(2) ELIGIBILITY.—To be eligible to receive a
6 grant under this subsection, an entity—

7 “(A) shall be a rural public or rural non-
8 profit private entity, a facility that qualifies as
9 a rural health clinic under title XVIII of the
10 Social Security Act, a public or nonprofit entity
11 existing exclusively to provide services to mi-
12 grant and seasonal farm workers in rural areas,
13 or a Tribal government whose grant-funded ac-
14 tivities will be conducted within federally recog-
15 nized Tribal areas;

16 “(B) shall represent a network composed
17 of participants—

18 “(i) that include 3 or more independ-
19 ently owned health care entities; and

20 “(ii) that may be nonprofit or for-
21 profit entities; and

22 “(C) shall not previously have received a
23 grant under this subsection (other than a 1-
24 year grant for planning activities) for the same
25 or a similar project.

1 “(3) APPLICATIONS.—To be eligible to receive a
2 grant under this subsection, an eligible entity, in
3 consultation with the appropriate State office of
4 rural health or another appropriate State entity,
5 shall prepare and submit to the Director an applica-
6 tion at such time, in such manner, and containing
7 such information as the Director may require, in-
8 cluding—

9 “(A) a description of the project that the
10 eligible entity will carry out using the funds
11 provided under the grant;

12 “(B) an explanation of the reasons why
13 Federal assistance is required to carry out the
14 project;

15 “(C) a description of—

16 “(i) the history of collaborative activi-
17 ties carried out by the participants in the
18 network;

19 “(ii) the degree to which the partici-
20 pants are ready to integrate their func-
21 tions; and

22 “(iii) how the local community or re-
23 gion to be served will benefit from and be
24 involved in the activities carried out by the
25 network;

1 “(D) a description of how the local com-
 2 munity or region to be served will experience in-
 3 creased access to quality health care services
 4 across the continuum of care as a result of the
 5 integration activities carried out by the net-
 6 work, including a description of—

7 “(i) return on investment for the com-
 8 munity and the network members; and

9 “(ii) other quantifiable performance
 10 measures that show the benefit of the net-
 11 work activities;

12 “(E) a plan for sustaining the project after
 13 Federal support for the project has ended;

14 “(F) a description of how the project will
 15 be evaluated;

16 “(G) the administrative capacity to submit
 17 annual performance data electronically as speci-
 18 fied by the Director; and

19 “(H) other such information as the Direc-
 20 tor determines to be appropriate.

21 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
 22 TEMS DEVELOPMENT GRANTS.—

23 “(1) GRANTS.—The Director may award grants
 24 to eligible entities to support reduction of health dis-
 25 parities, improve access to health care, and enhance

1 rural health system development in the Delta Re-
2 gion.

3 “(2) ELIGIBILITY.—To be eligible to receive a
4 grant under this subsection, an entity shall be a
5 rural public or rural nonprofit private entity, a facil-
6 ity that qualifies as a rural health clinic under title
7 XVIII of the Social Security Act, a public or non-
8 profit entity existing exclusively to provide services
9 to migrant and seasonal farm workers in rural
10 areas, or a Tribal government whose grant-funded
11 activities will be conducted within federally recog-
12 nized Tribal areas.

13 “(3) APPLICATIONS.—To be eligible to receive a
14 grant under this subsection, an eligible entity shall
15 prepare and submit to the Director an application at
16 such time, in such manner, and containing such in-
17 formation as the Director may require, including—

18 “(A) a description of the project that the
19 eligible entity will carry out using the funds
20 provided under the grant;

21 “(B) an explanation of the reasons why
22 Federal assistance is required to carry out the
23 project;

1 “(C) a description of the manner in which
2 the project funded under the grant will meet
3 the health care needs of the Delta Region;

4 “(D) a description of how the local com-
5 munity or region to be served will experience in-
6 creased access to quality health care services as
7 a result of the activities carried out by the enti-
8 ty;

9 “(E) a description of how health dispari-
10 ties will be reduced or the health system will be
11 improved;

12 “(F) a plan for sustaining the project after
13 Federal support for the project has ended;

14 “(G) a description of how the project will
15 be evaluated including process and outcome
16 measures related to the quality of care provided
17 or how the health care system improves its per-
18 formance;

19 “(H) a description of how the grantee will
20 develop an advisory group made up of rep-
21 resentatives of the communities to be served to
22 provide guidance to the grantee to best meet
23 community need; and

24 “(I) other such information as the Director
25 determines to be appropriate.

1 “(e) SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

2
3 “(1) GRANTS.—The Director may award grants
4 to provide for the planning and implementation of
5 small rural health care provider quality improvement
6 activities. The Director may award the grants for
7 periods of 1 to 3 years.

8 “(2) ELIGIBILITY.—To be eligible for a grant
9 under this subsection, an entity—

10 “(A) shall be—

11 “(i) a rural public or rural nonprofit
12 private health care provider or provider of
13 health care services, such as a rural health
14 clinic; or

15 “(ii) another rural provider or net-
16 work of small rural providers identified by
17 the Director as a key source of local care;
18 and

19 “(B) shall not previously have received a
20 grant under this subsection for the same or a
21 similar project.

22 “(3) PREFERENCE.—In awarding grants under
23 this subsection, the Director shall give preference to
24 facilities that qualify as rural health clinics under
25 title XVIII of the Social Security Act.

1 “(4) APPLICATIONS.—To be eligible to receive a
2 grant under this subsection, an eligible entity shall
3 prepare and submit to the Director an application at
4 such time, in such manner, and containing such in-
5 formation as the Director may require, including—

6 “(A) a description of the project that the
7 eligible entity will carry out using the funds
8 provided under the grant;

9 “(B) an explanation of the reasons why
10 Federal assistance is required to carry out the
11 project;

12 “(C) a description of the manner in which
13 the project funded under the grant will assure
14 continuous quality improvement in the provision
15 of services by the entity;

16 “(D) a description of how the local com-
17 munity or region to be served will experience in-
18 creased access to quality health care services as
19 a result of the activities carried out by the enti-
20 ty;

21 “(E) a plan for sustaining the project after
22 Federal support for the project has ended;

23 “(F) a description of how the project will
24 be evaluated including process and outcome

1 measures related to the quality of care pro-
2 vided; and

3 “(G) other such information as the Direc-
4 tor determines to be appropriate.

5 “(f) GENERAL REQUIREMENTS.—

6 “(1) PROHIBITED USES OF FUNDS.—An entity
7 that receives a grant under this section may not use
8 funds provided through the grant—

9 “(A) to build or acquire real property; or

10 “(B) for construction.

11 “(2) COORDINATION WITH OTHER AGENCIES.—

12 The Director shall coordinate activities carried out
13 under grant programs described in this section, to
14 the extent practicable, with Federal and State agen-
15 cies and nonprofit organizations that are operating
16 similar grant programs, to maximize the effect of
17 public dollars in funding meritorious proposals.

18 “(g) REPORT.—Not later than September 30, 2022,
19 the Secretary shall prepare and submit to the appropriate
20 committees of Congress a report on the progress and ac-
21 complishments of the grant programs described in sub-
22 sections (b), (c), (d), and (e).

23 “(h) DEFINITION OF DELTA REGION.—In this sec-
24 tion, the term ‘Delta Region’ has the meaning given to

1 the term ‘region’ in section 382A of the Consolidated
2 Farm and Rural Development Act (7 U.S.C. 2009aa).

3 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 \$40,000,000 for fiscal year 2021, and such sums as may
6 be necessary for each of fiscal years 2022 through 2025.”.

7 **SEC. 421. COMMUNITY HEALTH CENTER COLLABORATIVE**
8 **ACCESS EXPANSION.**

9 Section 330(r)(4) of the Public Health Service Act
10 (42 U.S.C. 254b(r)(4)) is amended—

11 (1) in subparagraph (A), by striking “primary
12 health care services” each place it appears and in-
13 sserting “primary health care and other mental, den-
14 tal, and physical health services”; and

15 (2) in subparagraph (B)—

16 (A) in clause (i), by striking “and” at the
17 end;

18 (B) in clause (ii), by striking the period at
19 the end and inserting “; and”; and

20 (C) by adding at the end the following:

21 “(iii) in the case of a rural health
22 clinic described in such subparagraph—

23 “(I) that such clinic provides, to
24 the extent possible, enabling services,
25 such as transportation and language

1 assistance (including translation and
2 interpretation); and

3 “(II) that the primary health
4 care and other services described in
5 such subparagraph are subject to full
6 reimbursement according to the pro-
7 spective payment system for Federally
8 qualified health center services under
9 section 1834(o) of the Social Security
10 Act.”.

11 **SEC. 422. FACILITATING THE PROVISION OF TELEHEALTH**
12 **SERVICES ACROSS STATE LINES.**

13 (a) IN GENERAL.—For purposes of expediting the
14 provision of telehealth services, for which payment is made
15 under the Medicare Program, across State lines, the Sec-
16 retary of Health and Human Services shall, in consulta-
17 tion with representatives of States, physicians, health care
18 practitioners, and patient advocates, encourage and facili-
19 tate the adoption of provisions allowing for multistate
20 practitioner practice across State lines.

21 (b) DEFINITIONS.—In subsection (a):

22 (1) TELEHEALTH SERVICE.—The term “tele-
23 health service” has the meaning given that term in
24 subparagraph (F) of section 1834(m)(4) of the So-
25 cial Security Act (42 U.S.C. 1395m(m)(4)).

1 (2) PHYSICIAN, PRACTITIONER.—The terms
2 “physician” and “practitioner” have the meaning
3 given those terms in subparagraphs (D) and (E), re-
4 spectively, of such section.

5 (3) MEDICARE PROGRAM.—The term “Medicare
6 Program” means the program of health insurance
7 administered by the Secretary of Health and Human
8 Services under title XVIII of the Social Security Act
9 (42 U.S.C. 1395 et seq.).

10 **SEC. 423. SCORING OF PREVENTIVE HEALTH SAVINGS.**

11 Section 202 of the Congressional Budget and Im-
12 poundment Control Act of 1974 (2 U.S.C. 602) is amend-
13 ed by adding at the end the following:

14 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

15 “(1) DETERMINATION BY THE DIRECTOR.—

16 Upon a request by the chairman or ranking minority
17 member of the Committee on the Budget of the Sen-
18 ate, or by the chairman or ranking minority member
19 of the Committee on the Budget of the House of
20 Representatives, the Director shall determine if a
21 proposed measure would result in reductions in
22 budget outlays in budgetary outyears through the
23 use of preventive health and preventive health serv-
24 ices.

1 “(2) PROJECTIONS.—If the Director determines
2 that a measure would result in substantial reduc-
3 tions in budget outlays as described in paragraph
4 (1), the Director—

5 “(A) shall include, in any projection pre-
6 pared by the Director, a description and esti-
7 mate of the reductions in budget outlays in the
8 budgetary outyears and a description of the
9 basis for such conclusions; and

10 “(B) may prepare a budget projection that
11 includes some or all of the budgetary outyears,
12 notwithstanding the time periods for projections
13 described in subsection (e) and sections 308,
14 402, and 424.

15 “(3) DEFINITIONS.—As used in this sub-
16 section—

17 “(A) the term ‘budgetary outyears’ means
18 the 2 consecutive 10-year periods beginning
19 with the first fiscal year that is 10 years after
20 the budget year provided for in the most re-
21 cently agreed to concurrent resolution on the
22 budget; and

23 “(B) the term ‘preventive health’ means an
24 action that focuses on the health of the public,
25 individuals, and defined populations in order to

1 protect, promote, and maintain health, wellness,
2 and functional ability, and prevent disease, dis-
3 ability, and premature death that is dem-
4 onstrated by credible and publicly available epi-
5 demiological projection models, incorporating
6 clinical trials or observational studies in hu-
7 mans, to avoid future health care costs.”.

8 **SEC. 424. SENSE OF CONGRESS ON MAINTENANCE OF EF-**
9 **FORT PROVISIONS REGARDING CHILDREN’S**
10 **HEALTH.**

11 It is the sense of the Congress that—

12 (1) the maintenance of effort provisions added
13 to sections 1902 and 2105(d) of the Social Security
14 Act (42 U.S.C. 1396a; 42 U.S.C. 1397ee(d)) by sec-
15 tions 2001(b) and 2101(b) of the Patient Protection
16 and Affordable Care Act were intended to maintain
17 the eligibility standards for the Medicaid program
18 under title XIX of the Social Security Act (42
19 U.S.C. 1396 et seq.) and Children’s Health Insur-
20 ance Program under title XXI of such Act (42
21 U.S.C. 1397aa et seq.) until the American Health
22 Benefit Exchanges in the States are fully oper-
23 ational;

24 (2) it is imperative that the maintenance of ef-
25 fort provisions are enforced to the strict standard in-

1 tended by the Congress through September 30,
2 2027;

3 (3) waiving the maintenance of effort provisions
4 should not be permitted;

5 (4) the maintenance of effort provisions ensure
6 the continued success of the Medicaid program and
7 Children’s Health Insurance Program and were in-
8 tended to specifically protect vulnerable and disabled
9 adults, children, and senior citizens, many of whom
10 are also members of communities of color; and

11 (5) the maintenance of effort provisions must
12 be strictly enforced and proposals to weaken the
13 maintenance of effort provisions must not be consid-
14 ered.

15 **SEC. 425. PROTECTION OF THE HHS OFFICES OF MINORITY**
16 **HEALTH.**

17 (a) IN GENERAL.—Pursuant to section 1707A of the
18 Public Health Service Act (42 U.S.C. 300u–6a), the Of-
19 fices of Minority Health established within the Centers for
20 Disease Control and Prevention, the Health Resources
21 and Services Administration, the Substance Abuse and
22 Mental Health Services Administration, the Agency for
23 Healthcare Research and Quality, the Food and Drug Ad-
24 ministration, and the Centers for Medicare & Medicaid
25 Services, are offices that, regardless of change in the

1 structure of the Department of Health and Human Serv-
 2 ices, shall report to the Secretary of Health and Human
 3 Services.

4 (b) SENSE OF CONGRESS.—It is the sense of the
 5 Congress that any effort to eliminate or consolidate such
 6 Offices of Minority Health undermines the progress
 7 achieved so far.

8 **SEC. 426. OFFICE OF MINORITY HEALTH IN VETERANS**
 9 **HEALTH ADMINISTRATION OF DEPARTMENT**
 10 **OF VETERANS AFFAIRS.**

11 (a) ESTABLISHMENT AND FUNCTIONS.—Subchapter
 12 I of chapter 73 of title 38, United States Code, is amended
 13 by inserting after section 7308 the following new section:

14 **“§ 7308A. Office of Minority Health**

15 “(a) ESTABLISHMENT.—There is established in the
 16 Department within the Office of the Under Secretary for
 17 Health an office to be known as the ‘Office of Minority
 18 Health’ (in this section referred to as the ‘Office’).

19 “(b) HEAD.—The Director of the Office of Minority
 20 Health shall be the head of the Office. The Director of
 21 the Office of Minority Health shall be appointed by the
 22 Under Secretary for Health from among individuals quali-
 23 fied to perform the duties of the position.

24 “(c) FUNCTIONS.—The functions of the Office are as
 25 follows:

1 “(1) To establish short-range and long-range
2 goals and objectives and coordinate all other activi-
3 ties within the Veterans Health Administration that
4 relate to disease prevention, health promotion, health
5 care services delivery, and health care research con-
6 cerning veterans who are members of a racial or eth-
7 nic minority group.

8 “(2) To support research, demonstrations, and
9 evaluations to test new and innovative models for
10 the discharge of activities described in paragraph
11 (1).

12 “(3) To increase knowledge and understanding
13 of health risk factors for veterans who are members
14 of a racial or ethnic minority group.

15 “(4) To develop mechanisms that support bet-
16 ter health care information dissemination, education,
17 prevention, and services delivery to veterans from
18 disadvantaged backgrounds, including veterans who
19 are members of a racial or ethnic minority group.

20 “(5) To enter into contracts or agreements with
21 appropriate public and nonprofit private entities to
22 develop and carry out programs to provide bilingual
23 or interpretive services to assist veterans who are
24 members of a racial or ethnic minority group and
25 who lack proficiency in speaking the English lan-

1 guage in accessing and receiving health care services
2 through the Veterans Health Administration.

3 “(6) To carry out programs to improve access
4 to health care services through the Veterans Health
5 Administration for veterans with limited proficiency
6 in speaking the English language, including the de-
7 velopment and evaluation of demonstration and pilot
8 projects for that purpose.

9 “(7) To advise the Under Secretary for Health
10 on matters relating to the development, implementa-
11 tion, and evaluation of health professions education
12 in decreasing disparities in health care outcomes be-
13 tween veterans who are members of a racial or eth-
14 nic minority group and other veterans, including cul-
15 tural competency as a method of eliminating such
16 health disparities.

17 “(8) To perform such other functions and du-
18 ties as the Secretary or the Under Secretary for
19 Health considers appropriate.

20 “(d) DEFINITIONS.—In this section:

21 “(1) The term ‘racial or ethnic minority group’
22 means any of the following:

23 “(A) American Indians (including Alaska
24 Natives, Eskimos, and Aleuts).

25 “(B) Asian Americans.

1 “(C) Native Hawaiians and other Pacific
2 Islanders.

3 “(D) Blacks.

4 “(E) Hispanics.

5 “(2) The term ‘Hispanic’ means individuals
6 whose origin is Mexican, Puerto Rican, Cuban, Cen-
7 tral or South American, or any other Spanish-speak-
8 ing country.”.

9 (b) CLERICAL AMENDMENT.—The table of sections
10 at the beginning of such subchapter is amended by insert-
11 ing after the item relating to section 7308 the following
12 new item:

“7308A. Office of Minority Health.”.

13 **SEC. 427. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
14 **ACCESS FOR LOW-INCOME PATIENTS.**

15 (a) IN GENERAL.—Not later than January 1, 2021,
16 the Comptroller General of the United States shall con-
17 duct a study on how amendments made by the Patient
18 Protection and Affordable Care Act (Public Law 111–
19 148) and the Health Care and Education Reconciliation
20 Act of 2010 (Public Law 111–152) to titles XVIII and
21 XIX of the Social Security Act (42 U.S.C. 1395 et seq.;
22 42 U.S.C. 1396 et seq.) relating to disproportionate share
23 hospital adjustment payments under Medicare and Med-
24icaid (and subsequent amendments made with respect to

1 such payments) affect the timely access to health care
2 services for low-income patients. Such study shall—

3 (1) evaluate and examine whether States elect-
4 ing to make medical assistance available under sec-
5 tion 1902(a)(10)(A)(i)(VIII) of the Social Security
6 Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including
7 States making such an election through a waiver of
8 the State plan) to individuals described in such sec-
9 tion mitigate the need for payments to dispropor-
10 tionate share hospitals under section 1886(d)(5)(F)
11 of the Social Security Act (42 U.S.C.
12 1395ww(d)(5)(F)) and section 1923 of such Act (42
13 U.S.C. 1396r-4), including the impact of such
14 States electing to make medical assistance available
15 to such individuals on—

16 (A) the number of individuals in the
17 United States who are without health insurance
18 and the distribution of such individuals in rela-
19 tion to areas primarily served by dispropor-
20 tionate share hospitals; and

21 (B) the low-income utilization rate of such
22 hospitals and the resulting fiscal sustainability
23 of such hospitals;

1 (2) evaluate the appropriate level and distribu-
2 tion of such payments among such disproportionate
3 share hospitals for purposes of—

4 (A) sufficiently accounting for the level of
5 uncompensated care provided by such hospitals
6 to low-income patients; and

7 (B) providing timely access to health serv-
8 ices for individuals in medically underserved
9 areas; and

10 (3) assess, with respect to such disproportionate
11 share hospitals—

12 (A) the role played by such hospitals in
13 providing critical access to emergency, inpa-
14 tient, and outpatient health services, as well as
15 the location of such hospitals in relation to
16 medically underserved areas; and

17 (B) the extent to which such hospitals sat-
18 isfy the requirements established for charitable
19 hospital organizations under section 501(r) of
20 the Internal Revenue Code of 1986 with respect
21 to community health needs assessments, finan-
22 cial assistance policy requirements, limitations
23 on charges, and billing and collection require-
24 ments.

25 (b) REPORTS.—

1 (1) REPORT TO CONGRESS.—Not later than
2 180 days after the date on which the study under
3 subsection (a) is completed, the Comptroller General
4 of the United States shall submit to the Committee
5 on Energy and Commerce of the House of Rep-
6 resentatives and the Committee on Finance of the
7 Senate a report that contains—

8 (A) the results of the study;

9 (B) recommendations to Congress for any
10 legislative changes to the payments to dis-
11 proportionate share hospitals under section
12 1886(d)(5)(F) of the Social Security Act (42
13 U.S.C. 1395ww(d)(5)(F)) and section 1923 of
14 such Act (42 U.S.C. 1396r-4) that are needed
15 to ensure access to health services for low-in-
16 come patients that—

17 (i) are based on the number of indi-
18 viduals without health insurance, the
19 amount of uncompensated care provided by
20 such hospitals, and the impact of reduced
21 payment levels on low-income communities;
22 and

23 (ii) takes into account any reports
24 submitted by the Secretary of the Treas-
25 ury, in consultation with the Secretary of

1 Health and Human Services, to congress-
2 sional committees regarding the costs in-
3 curred by charitable hospital organizations
4 for charity care, bad debt, nonreimbursed
5 expenses for services provided to individ-
6 uals under the Medicare program under
7 title XVIII of the Social Security Act and
8 the Medicaid program under title XIX of
9 such Act, and any community benefit ac-
10 tivities provided by such organizations.

11 (2) REPORT TO THE SECRETARY OF HEALTH
12 AND HUMAN SERVICES.—Not later than 180 days
13 after the date on which the study under subsection
14 (a) is completed, the Comptroller General of the
15 United States shall submit to the Secretary of
16 Health and Human Services a report that con-
17 tains—

18 (A) the results of the study; and

19 (B) any recommendations for purposes of
20 assisting in the development of the methodology
21 for the adjustment of payments to dispropor-
22 tionate share hospitals, as required under sec-
23 tion 1886(r) of the Social Security Act (42
24 U.S.C. 1395ww(r)) and the reduction of such
25 payments under section 1923(f)(7) of such Act

1 (42 U.S.C. 1396r-4(f)(7)), taking into account
2 the reports referred to in paragraph (1)(B)(ii).

3 **SEC. 428. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
4 **SERVICE.**

5 (a) REFERENCES.—Any reference in a law, regula-
6 tion, document, paper, or other record of the United
7 States to the Director of the Indian Health Service shall
8 be deemed to be a reference to the Assistant Secretary
9 of the Indian Health Service.

10 (b) EXECUTIVE SCHEDULE.—Section 5315 of title 5,
11 United States Code, is amended in the matter relating to
12 the Assistant Secretaries of Health and Human Services
13 by striking “(6)” and inserting “(7), one of whom shall
14 be the Assistant Secretary of the Indian Health Service”.

15 (c) CONFORMING AMENDMENT.—Section 5316 of
16 title 5, United States Code, is amended by striking “Direc-
17 tor, Indian Health Service, Department of Health and
18 Human Services.”.

19 **SEC. 429. REAUTHORIZATION OF THE NATIVE HAWAIIAN**
20 **HEALTH CARE IMPROVEMENT ACT.**

21 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
22 Section 6(h)(1) of the Native Hawaiian Health Care Im-
23 provement Act (42 U.S.C. 11705(h)(1)) is amended by
24 striking “may be necessary for fiscal years 1993 through
25 2019” and inserting “are necessary”.

1 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
2 LOKAHI.—Section 7(b) of the Native Hawaiian Health
3 Care Improvement Act (42 U.S.C. 11706(b)) is amended
4 by striking “may be necessary for fiscal years 1993
5 through 2019” and inserting “are necessary”.

6 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
7 Section 10(c) of the Native Hawaiian Health Care Im-
8 provement Act (42 U.S.C. 11709(c)) is amended by strik-
9 ing “may be necessary for fiscal years 1993 through
10 2019” and inserting “are necessary”.

11 **SEC. 430. AVAILABILITY OF NON-ENGLISH LANGUAGE**
12 **SPEAKING PROVIDERS.**

13 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
14 tient Protection and Affordable Care Act (42 U.S.C.
15 18031(c)(1)(B)) is amended by inserting before the semi-
16 colon the following: “and the ability of such provider to
17 provide care in a language other than English either
18 through the provider speaking such language or by the
19 provider having a qualified interpreter for an individual
20 with limited English proficiency (as defined in section
21 3400 of such Act) who speaks such language available
22 during office hours”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall not apply to any plan beginning on

1 or prior to the date that is 1 year after the date of the
2 enactment of this Act.

3 **SEC. 431. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.**

4 (a) ESSENTIAL COMMUNITY PROVIDERS.—Section
5 1311(c)(1)(C) of the Patient Protection and Affordable
6 Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

7 (1) by inserting “(i)” after “(C)”; and

8 (2) by adding at the end the following new
9 clauses:

10 “(ii) not later than January 1, 2021, in-
11 crease the percentage of essential community
12 providers as described in clause (i) included in
13 its network by 10 percent annually (based on
14 the level in the plan for 2016) until 90 percent
15 of all federally qualified health centers and 75
16 percent of all other such essential community
17 providers in the contract service area are in-net-
18 work; and

19 “(iii) include at least one essential commu-
20 nity provider in each of the essential community
21 provider categories described in section
22 156.235(a)(2)(ii)(B) of title 45, Code of Fed-
23 eral Regulations (as in effect on the date of en-
24 actment of the Health Equity and Account-

1 ability Act of 2020), in each county in the serv-
 2 ice area, where available;”.

3 (b) REPORTING REQUIREMENTS.—Section
 4 1311(e)(3) of the Patient Protection and Affordable Care
 5 Act (42 U.S.C. 18031(e)(3)) is amended by adding at the
 6 end the following new subparagraph:

7 “(E) DATA ON ESSENTIAL COMMUNITY
 8 PROVIDERS.—The Secretary shall require quali-
 9 fied health plans to submit annually to the Sec-
 10 retary data on the percentage of essential com-
 11 munity providers as described in clause (ii) of
 12 subsection (c)(1)(C), by county, that contract
 13 with each qualified health plan offered in that
 14 county and the percentage of such essential
 15 community providers, by category as described
 16 in clause (iii) of such subsection, that contract
 17 with each qualified health plan offered in that
 18 county. Such data shall be made available to
 19 the general public.”.

20 (c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS
 21 APPLIED UNDER MEDICARE AND MEDICAID.—

22 (1) MEDICARE.—Section 1852(d)(1) of the So-
 23 cial Security Act (42 U.S.C. 1395w–22(d)(1)) is
 24 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. 432. 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 430(a), is further
8 amended—

9 (1) by inserting “(i)” after “(B)”; and

10 (2) by adding at the end the following new
11 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 the Health Equity and Accountability Act of
17 2020.”.

18 **SEC. 433. IMPROVING ACCESS TO DENTAL CARE.**

19 (a) REPORTS TO CONGRESS.—

20 (1) GAO REPORTS.—Not later than 1 year
21 after the date of the enactment of this Act, the
22 Comptroller General of the United States shall sub-
23 mit to Congress—

24 (A) a report on the Alaska Dental Health
25 Aide Therapists program and the Dental Ther-

1 apist and Advanced Dental Therapist programs
2 in Minnesota, to assess the effectiveness of den-
3 tal therapists in—

4 (i) improving access to timely dental
5 care among communities of color;

6 (ii) providing high-quality care;

7 (iii) providing culturally competent
8 care; and

9 (iv) providing accessible care to people
10 with disabilities;

11 (B) a report on State variations in the use
12 of dental hygienists and the effectiveness of ex-
13 panding the scope of practice for dental hygien-
14 ists in—

15 (i) improving access to timely dental
16 care among communities of color;

17 (ii) providing high-quality care;

18 (iii) providing culturally competent
19 care; and

20 (iv) providing accessible care to people
21 with disabilities; and

22 (C) a report on the use of telehealth serv-
23 ices to enhance services provided by dental hy-
24 gienists and therapists, including recommenda-
25 tions for any modifications to the Medicare pro-

1 gram under title XVIII of the Social Security
2 Act and the Medicaid program under title XIX
3 of such Act to better provide for telehealth con-
4 sultations in conjunction with therapists' and
5 hygienists' care.

6 (2) HRSA REPORT ON DENTAL SHORTAGE
7 AREAS.—Not later than 1 year after the date of the
8 enactment of this Act, the Secretary of Health and
9 Human Services, acting through the Administrator
10 of the Health Resources and Services Administra-
11 tion, shall submit to Congress a report which details
12 geographic dental access shortages and the pre-
13 paredness of dental providers to offer culturally and
14 linguistically appropriate, affordable, accessible, and
15 timely services.

16 (b) EXPANSION OF DENTAL HEALTH AID THERA-
17 PISTS IN TRIBAL COMMUNITIES.—Section 119(d) of the
18 Indian Health Care Improvement Act (25 U.S.C.
19 1616l(d)) is amended—

20 (1) in paragraph (2), by striking “Subject to”
21 and all that follows and inserting “Subject to para-
22 graph (3), in establishing a national program under
23 paragraph (1), the Secretary shall not reduce the
24 amounts provided for the Community Health Aide
25 Program described in subsections (a) and (b).”;

1 (2) by striking paragraph (3); and

2 (3) by redesignating paragraph (4) as para-
3 graph (3).

4 (c) COVERAGE OF DENTAL SERVICES UNDER THE
5 MEDICARE PROGRAM.—

6 (1) COVERAGE.—Section 1861(s)(2) of the So-
7 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
8 ed—

9 (A) in subparagraph (GG), by striking
10 “and” at the end;

11 (B) in subparagraph (HH), by striking the
12 period and inserting “; and”; and

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

15 “(II) oral health services (as defined in sub-
16 section (mmm));”.

17 (2) ORAL HEALTH SERVICES DEFINED.—Sec-
18 tion 1861 of the Social Security Act (42 U.S.C.
19 1395x), as amended by sections 207(b)(1) and
20 417(a), is amended by adding at the end the fol-
21 lowing new subsection:

22 “Oral Health Services

23 “(mmm)(1) The term ‘oral health services’ means
24 services (as defined by the Secretary) that are necessary
25 to prevent disease and promote oral health, restore oral

1 structures to health and function, and treat emergency
2 conditions.

3 “(2) For purposes of paragraph (1), such term shall
4 include mobile and portable oral health services (as de-
5 fined by the Secretary) that—

6 “(A) are provided for the purpose of over-
7 coming mobility, transportation, and access barriers
8 for individuals; and

9 “(B) satisfy the standards and certification re-
10 quirements established under section 1902(a)(82)(B)
11 for the State in which the services are provided.”.

12 (3) PAYMENT AND COINSURANCE.—Section
13 1833(a)(1) of the Social Security Act (42 U.S.C.
14 1395l(a)(1)) is amended—

15 (A) by striking “and” before “(DD)”;

16 (B) by inserting before the semicolon at
17 the end the following: “, and (EE) with respect
18 to oral health services (as defined in section
19 1861(mmm)), the amount paid shall be (i) in
20 the case of such services that are preventive,
21 100 percent of the lesser of the actual charge
22 for the services or the amount determined
23 under the payment basis determined under sec-
24 tion 1848, and (ii) in the case of all other such
25 services, 80 percent of the lesser of the actual

1 charge for the services or the amount deter-
2 mined under the payment basis determined
3 under section 1848”.

4 (4) PAYMENT UNDER PHYSICIAN FEE SCHED-
5 ULE.—Section 1848(j)(3) of the Social Security Act
6 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
7 “(2)(II),” after “risk assessment),”.

8 (5) DENTURES.—Section 1861(s)(8) of the So-
9 cial Security Act (42 U.S.C. 1395x(s)(8)) is amend-
10 ed—

11 (A) by striking “(other than dental)” and
12 inserting “(including dentures)”; and

13 (B) by striking “internal body”.

14 (6) REPEAL OF GROUND FOR EXCLUSION.—
15 Section 1862(a) of the Social Security Act (42
16 U.S.C. 1395y) is amended by striking paragraph
17 (12).

18 (7) EFFECTIVE DATE.—The amendments made
19 by this section shall apply to services furnished on
20 or after January 1, 2021.

21 (d) COVERAGE OF DENTAL SERVICES UNDER THE
22 MEDICAID PROGRAM.—

23 (1) IN GENERAL.—Section 1905 of the Social
24 Security Act (42 U.S.C. 1396d) is amended—

1 (A) in subsection (a)(10), by striking “den-
2 tal services” and inserting “oral health services
3 (as defined in subsection (gg)(1))”; and

4 (B) by adding at the end the following new
5 subsection:

6 “(gg)(1) Subject to paragraphs (2) and (3), for pur-
7 poses of this title, the term ‘oral health services’ means
8 services (as defined by the Secretary) that are necessary
9 to prevent disease and promote oral health, restore oral
10 structures to health and function, and treat emergency
11 conditions.

12 “(2) For purposes of paragraph (1), such term shall
13 include—

14 “(A) dentures; and

15 “(B) mobile and portable oral health services
16 (as defined by the Secretary) that—

17 “(i) are provided for the purpose of over-
18 coming mobility, transportation, and access bar-
19 riers for individuals; and

20 “(ii) satisfy the standards and certification
21 requirements established under section
22 1902(a)(87)(C) for the State in which the serv-
23 ices are provided.

1 “(3) For purposes of paragraph (1), such term shall
2 not include dental care or services provided to individuals
3 under the age of 21 under subsection (r)(3).”.

4 (2) CONFORMING AMENDMENTS.—

5 (A) STATE PLAN REQUIREMENTS.—Section
6 1902(a) of the Social Security Act (42 U.S.C.
7 1396a(a)) is amended—

8 (i) in paragraph (10)(A), in the mat-
9 ter preceding clause (i), by inserting
10 “(10),” after “(5),”;

11 (ii) in paragraph (85), by striking
12 “and” at the end;

13 (iii) in paragraph (86), by striking the
14 period at the end and inserting “; and”;
15 and

16 (iv) by inserting after paragraph (86)
17 the following:

18 “(87) provide for—

19 “(A) informing, in writing, all individuals
20 who have been determined to be eligible for
21 medical assistance of the availability of oral
22 health services (as defined in section 1905(gg));

23 “(B) conducting targeted outreach to preg-
24 nant women who have been determined to be el-
25 igible for medical assistance about the avail-

1 ability of medical assistance for such dental
2 services and the importance of receiving dental
3 care while pregnant; and

4 “(C) establishing and maintaining stand-
5 ards for and certification of mobile and portable
6 oral health services (as described in subsections
7 (r)(3)(C) and (gg)(2)(B) of section 1905).”.

8 (B) DEFINITION OF MEDICAL ASSIST-
9 ANCE.—Section 1905(a)(12) of the Social Secu-
10 rity Act (42 U.S.C. 1396d(a)(12)) is amended
11 by striking “, dentures,”.

12 (3) MOBILE AND PORTABLE ORAL HEALTH
13 SERVICES UNDER EPSDT.—Section 1905(r)(3) of the
14 Social Security Act (42 U.S.C. 1396d(r)(3)) is
15 amended—

16 (A) in subparagraph (A)(ii), by striking “;
17 and” and inserting a semicolon;

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

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

22 “(C) which shall include mobile and port-
23 able oral health services (as defined by the Sec-
24 retary) that—

1 “(i) are provided for the purpose of
2 overcoming mobility, transportation, or ac-
3 cess barriers for children; and

4 “(ii) satisfy the standards and certifi-
5 cation requirements established under sec-
6 tion 1902(a)(87)(C) for the State in which
7 the services are provided.”.

8 (e) ORAL HEALTH SERVICES AS AN ESSENTIAL
9 HEALTH BENEFIT.—Section 1302(b) of the Patient Pro-
10 tection and Affordable Care Act (42 U.S.C. 18022(b)) is
11 amended—

12 (1) in paragraph (1)—

13 (A) in subparagraph (J), by striking “oral
14 and”; and

15 (B) by adding at the end the following:

16 “(K) Oral health services for children and
17 adults.”; and

18 (2) by adding at the end the following:

19 “(6) ORAL HEALTH SERVICES.—For purposes
20 of paragraph (1)(K), the term ‘oral health services’
21 means services (as defined by the Secretary) that
22 are necessary to prevent any oral disease and pro-
23 mote oral health, restore oral structures to health
24 and function, and treat emergency oral conditions.”.

1 (f) DEMONSTRATION PROGRAM ON TRAINING AND
2 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
3 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
4 VETERANS IN RURAL AND OTHER UNDERSERVED COM-
5 MUNITIES.—

6 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

7 The Secretary of Veterans Affairs may carry out a
8 demonstration program to establish programs to
9 train and employ alternative dental health care pro-
10 viders in order to increase access to dental health
11 care services for veterans who are entitled to such
12 services from the Department of Veterans Affairs
13 and reside in rural and other underserved commu-
14 nities.

15 (2) TELEHEALTH.—For purposes of alternative
16 dental health care providers and other dental care
17 providers who are licensed to provide clinical care,
18 dental services provided under the demonstration
19 program under this subsection may be administered
20 by such providers through telehealth-enabled collabo-
21 ration and supervision when appropriate and fea-
22 sible.

23 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
24 VIDERS DEFINED.—In this subsection, the term “al-
25 ternative dental health care providers” has the

1 meaning given that term in section 340G–1(a)(2) of
2 the Public Health Service Act (42 U.S.C. 256g–
3 1(a)(2)).

4 (4) AUTHORIZATION OF APPROPRIATIONS.—
5 There are authorized to be appropriated such sums
6 as are necessary to carry out the demonstration pro-
7 gram under this subsection.

8 (g) DEMONSTRATION PROGRAM ON TRAINING AND
9 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
10 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
11 MEMBERS OF THE ARMED FORCES AND DEPENDENTS
12 LACKING READY ACCESS TO SUCH SERVICES.—

13 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
14 The Secretary of Defense may carry out a dem-
15 onstration program to establish programs to train
16 and employ alternative dental health care providers
17 in order to increase access to dental health care
18 services for members of the Armed Forces and their
19 dependents who lack ready access to such services,
20 including the following:

21 (A) Members and dependents who reside in
22 rural areas or areas otherwise underserved by
23 dental health care providers.

1 (B) Members of a reserve component of
2 the Armed Forces in active status who are po-
3 tentially deployable.

4 (2) TELEHEALTH.—For purposes of alternative
5 dental health care providers and other dental care
6 providers who are licensed to provide clinical care,
7 dental services provided under the demonstration
8 program under this subsection may be administered
9 by such providers through telehealth-enabled collabo-
10 ration and supervision when appropriate and fea-
11 sible.

12 (3) DEFINITIONS.—In this subsection:

13 (A) ACTIVE STATUS.—The term “active
14 status” has the meaning given that term in sec-
15 tion 101(d) of title 10, United States Code.

16 (B) ALTERNATIVE DENTAL HEALTH CARE
17 PROVIDERS.—The term “alternative dental
18 health care providers” has the meaning given
19 that term in section 340G–1(a)(2) of the Public
20 Health Service Act (42 U.S.C. 256g–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 (h) DEMONSTRATION PROGRAM ON TRAINING AND
2 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
3 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
4 PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF
5 PRISONS.—

6 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

7 The Attorney General, acting through the Director
8 of the Bureau of Prisons, may carry out a dem-
9 onstration program to establish programs to train
10 and employ alternative dental health care providers
11 in order to increase access to dental health services
12 for prisoners within the custody of the Bureau of
13 Prisons.

14 (2) TELEHEALTH.—For purposes of alternative
15 dental health care providers and other dental care
16 providers who are licensed to provide clinical care,
17 dental services provided under the demonstration
18 program under this subsection may be administered
19 by such providers through telehealth-enabled collabo-
20 ration and supervision when appropriate and fea-
21 sible.

22 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
23 VIDERS DEFINED.—In this subsection and sub-
24 section (i), the term “alternative dental health care
25 providers” has the meaning given that term in sec-

1 tion 340G–1(a)(2) of the Public Health Service Act
2 (42 U.S.C. 256g–1(a)(2)).

3 (4) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated such sums
5 as are necessary to carry out the demonstration pro-
6 gram under this subsection.

7 (i) DEMONSTRATION PROGRAM ON TRAINING AND
8 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
9 PROVIDERS FOR DENTAL HEALTH CARE SERVICES
10 UNDER THE INDIAN HEALTH SERVICE.—

11 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

12 The Secretary of Health and Human Services, act-
13 ing through the Indian Health Service, may carry
14 out a demonstration program to establish programs
15 to train and employ alternative dental health care
16 providers in order to help eliminate oral health dis-
17 parities and increase access to dental services
18 through health programs operated by the Indian
19 Health Service, Indian tribes, tribal organizations,
20 and urban Indian organizations (as the preceding 3
21 terms are defined in section 4 of the Indian Health
22 Care Improvement Act (25 U.S.C. 1603)).

23 (2) TELEHEALTH.—For purposes of alternative
24 dental health care providers and other dental care
25 providers who are licensed to provide clinical care,

1 dental services provided under the demonstration
 2 program under this subsection may be administered
 3 by such providers through telehealth-enabled collabo-
 4 ration and supervision when appropriate and fea-
 5 sible.

6 (3) AUTHORIZATION OF APPROPRIATIONS.—

7 There are authorized to be appropriated such sums
 8 as are necessary to carry out the demonstration pro-
 9 gram under this subsection.

10 **SEC. 434. PROVIDING FOR A SPECIAL ENROLLMENT PE-**
 11 **RIOD FOR PREGNANT INDIVIDUALS.**

12 (a) PUBLIC HEALTH SERVICE ACT.—Section
 13 2702(b)(2) of the Public Health Service Act (42 U.S.C.
 14 300gg–1(b)(2)) is amended by inserting “including a spe-
 15 cial enrollment period for pregnant individuals, beginning
 16 on the date on which the pregnancy is reported to the
 17 health insurance issuer” before the period at the end.

18 (b) PATIENT PROTECTION AND AFFORDABLE CARE
 19 ACT.—Section 1311(c)(6) of the Patient Protection and
 20 Affordable Care Act (42 U.S.C. 18031(c)(6)) is amend-
 21 ed—

22 (1) in subparagraph (C), by striking “and” at
 23 the end;

24 (2) by redesignating subparagraph (D) as sub-
 25 paragraph (E); and

1 (3) by inserting after subparagraph (C) the fol-
2 lowing new subparagraph:

3 “(D) a special enrollment period for preg-
4 nant individuals, beginning on the date on
5 which the pregnancy is reported to the Ex-
6 change; and”.

7 (c) SPECIAL ENROLLMENT PERIODS.—

8 (1) INTERNAL REVENUE CODE.—Section
9 9801(f) of the Internal Revenue Code of 1986 (26
10 U.S.C. 9801(f)) is amended by adding at the end
11 the following new paragraph:

12 “(4) FOR PREGNANT INDIVIDUALS.—

13 “(A) A group health plan shall permit an
14 employee who is eligible, but not enrolled, for
15 coverage under the terms of the plan (or a de-
16 pendent of such an employee if the dependent
17 is eligible, but not enrolled, for coverage under
18 such terms) to enroll for coverage under the
19 terms of the plan upon pregnancy, with the spe-
20 cial enrollment period beginning on the date on
21 which the pregnancy is reported to the group
22 health plan or the pregnancy is confirmed by a
23 health care provider.

24 “(B) The Secretary shall promulgate regu-
25 lations with respect to the special enrollment

1 period under subparagraph (A), including es-
2 tablishing a time period for pregnant individ-
3 uals to enroll in coverage and effective date of
4 such coverage.”.

5 (2) ERISA.—Section 701(f) of the Employee
6 Retirement Income Security Act of 1974 (29 U.S.C.
7 1181(f)) is amended by adding at the end the fol-
8 lowing:

9 “(4) FOR PREGNANT INDIVIDUALS.—

10 “(A) A group health plan, and a health in-
11 surance issuer offering group health insurance
12 coverage in connection with a group health
13 plan, shall permit an employee who is eligible,
14 but not enrolled, for coverage under the terms
15 of the plan (or a dependent of such an employee
16 if the dependent is eligible, but not enrolled, for
17 coverage under such terms) to enroll for cov-
18 erage under the terms of the plan upon preg-
19 nancy, with the special enrollment period begin-
20 ning on the date on which the pregnancy is re-
21 ported to the group health plan or health insur-
22 ance issuer or the pregnancy is confirmed by a
23 health care provider.

24 “(B) The Secretary shall promulgate regu-
25 lations with respect to the special enrollment

1 period under subparagraph (A), including es-
 2 tablishing a time period for pregnant individ-
 3 uals to enroll in coverage and effective date of
 4 such coverage.”.

5 (d) EFFECTIVE DATE.—The amendments made by
 6 this section shall apply with respect to plan years begin-
 7 ning on or after January 1, 2022.

8 **SEC. 435. COVERAGE OF MATERNITY CARE FOR DEPEND-**
 9 **ENT CHILDREN.**

10 Section 2719A of the Public Health Service Act (42
 11 U.S.C. 300gg–19a) is amended by adding at the end the
 12 following:

13 “(e) COVERAGE OF MATERNITY CARE.—A group
 14 health plan, or health insurance issuer offering group or
 15 individual health insurance coverage, that provides cov-
 16 erage for dependants shall ensure that such plan or cov-
 17 erage includes coverage for maternity care associated with
 18 pregnancy, childbirth, and postpartum care for all partici-
 19 pants, beneficiaries, or enrollees, including dependants, in-
 20 cluding coverage of labor and delivery. Such coverage shall
 21 be provided to all pregnant dependents regardless of age.”.

22 **SEC. 436. FEDERAL EMPLOYEE HEALTH BENEFIT PLANS.**

23 (a) COVERAGE OF PREGNANCY.—

24 (1) IN GENERAL.—The Director of the Office of
 25 Personnel Management shall issue such regulations

1 as are necessary to ensure that pregnancy is consid-
2 ered a change in family status and a qualifying life
3 event for an individual who is eligible to enroll, but
4 is not enrolled, in a health benefit plan under chap-
5 ter 89 of title 5, United States Code.

6 (2) EFFECTIVE DATE.—The requirement in
7 paragraph (1) shall apply with respect to any con-
8 tract entered into under section 8902 of such title
9 beginning 12 months after the date of enactment of
10 this Act.

11 (b) DESIGNATING CERTAIN FEHBP-RELATED
12 SERVICES AS EXCEPTED SERVICES UNDER THE ANTI-
13 DEFICIENCY ACT.—

14 (1) IN GENERAL.—Section 8905 of title 5,
15 United States Code, is amended by adding at the
16 end the following:

17 “(i) Any services by an officer or em-
18 ployee under this chapter relating to en-
19 rolling individuals in a health benefits plan
20 under this chapter, or changing the enroll-
21 ment of an individual already so enrolled
22 due to an event described in section
23 436(a)(1) of the Health Equity and Ac-
24 countability Act of 2020, shall be deemed,
25 for purposes of section 1342 of title 31,

1 services for emergencies involving the safe-
2 ty of human life or the protection of prop-
3 erty.”.

4 (2) APPLICATION.—The amendment made by
5 paragraph (1) shall apply to any lapse in appropria-
6 tions beginning on or after the date of enactment of
7 this Act.

8 **SEC. 437. CONTINUATION OF MEDICAID INCOME ELIGI-**
9 **BILITY STANDARD FOR PREGNANT INDIVID-**
10 **UALS AND INFANTS.**

11 Section 1902(l)(2)(A) of the Social Security Act (42
12 U.S.C. 1396a(l)(2)(A)) is amended—

13 (1) in clause (i), by striking “and not more
14 than 185 percent”;

15 (2) in clause (ii)—

16 (A) in subclause (I), by striking “and”
17 after the comma;

18 (B) in subclause (II), by striking the pe-
19 riod at the end and inserting “, and”; and

20 (C) by adding at the end the following:

21 “(III) January 1, 2021, is the
22 percentage provided under clause
23 (v).”; and

24 (3) by adding at the end the following new
25 clause:

1 “(v) The percentage provided under
2 clause (ii) for medical assistance provided
3 on or after January 1, 2021, with respect
4 to individuals described in subparagraph
5 (A) or (B) of paragraph (1) shall not be
6 less than—

7 “(I) the percentage specified for
8 such individuals by the State in an
9 amendment to its State plan (whether
10 approved or not) as of January 1,
11 2014; or

12 “(II) if no such percentage is
13 specified as of January 1, 2014, the
14 percentage established for such indi-
15 viduals under the State’s authorizing
16 legislation or provided for under the
17 State’s appropriations as of that
18 date.”.

19 **Subtitle C—Advancing Health Eq-**
20 **uity Through Payment and De-**
21 **livery Reform**

22 **SEC. 441. SENSE OF CONGRESS.**

23 It is the sense of Congress that—

24 (1) the sustainability of the health care system
25 in the United States hinges on restructuring how

1 health care is paid for, shifting away from paying
2 for the volume of services provided to the value the
3 services provide;

4 (2) high value care is care that provides higher
5 quality care more efficiently, achieving greater
6 health improvement and better health outcomes at
7 lower cost (per patient and overall);

8 (3) a high value health care system must deliver
9 timely, accessible, well-coordinated, high-quality, cul-
10 turally centered, and language-appropriate care to
11 everyone;

12 (4) eliminating health disparities and achieving
13 health equity must be central to efforts to achieve a
14 high value health care system;

15 (5) eliminating such disparities and achieving
16 such equity will require tailored interventions and
17 targeted investments to address inequities in health
18 and health care to make sure that health care deliv-
19 ery and payment efforts are responsive to and inclu-
20 sive of the needs of communities of color and other
21 communities experiencing disparities; and

22 (6) new models of value-based payment and
23 care delivery should consider the holistic needs of
24 and other factors with respect to the patient popu-
25 lation, including with respect to behavioral health,

1 oral health, history of adverse childhood experiences
2 and adverse community environments, social deter-
3 minants of health, social risk factors, unmet social
4 needs, and the burden of intergenerational racial
5 and other inequities.

6 **SEC. 442. CENTERS FOR MEDICARE & MEDICAID SERVICES**
7 **REPORTING AND VALUE BASED PROGRAMS.**

8 (a) **ADVANCING HEALTH EQUITY IN REPORTING AND**
9 **VALUE BASED PAYMENT PROGRAMS.—**

10 (1) **IN GENERAL.—**The Administrator of the
11 Centers for Medicare & Medicaid Services (in this
12 section referred to as the “Administrator”) shall re-
13 quire that a clinician or other professional partici-
14 pating in any pay-for-reporting or value based pay-
15 ment program stratify clinical quality measures by
16 disparity variables, including race, ethnicity, sex, pri-
17 mary language, disability status, sexual orientation,
18 gender identity, and socioeconomic status. A clini-
19 cian or other professional may use existing demo-
20 graphic data collection fields in certified electronic
21 health record technology (as defined in section
22 1848(o)(4) of the Social Security Act (42 U.S.C.
23 1395w-4(o)(4))) to carry out such data stratifica-
24 tion under the preceding sentence. Such stratified
25 data will assist clinicians and other professionals in

1 the identification of disparities obscured in aggre-
2 gated data and assist with the provision of interven-
3 tions that target reducing those disparities.

4 (2) CLINICIAN.—In assessing performance in
5 any value-based payment program, the Adminis-
6 trator shall incorporate a clinician or other profes-
7 sional's performance in reducing disparities across
8 race, ethnicity, sex, primary language, disability sta-
9 tus, sexual orientation, gender identity, and socio-
10 economic status. Linking performance payments to
11 the reduction of health care disparities across such
12 variables will assist in holding clinicians and other
13 professionals accountable for providing quality care
14 that can lead to decreased health inequities.

15 (3) REQUIREMENT OF ADOPTION OF CERT.—All
16 entities, clinicians, or other professionals partici-
17 pating in the Quality Payment Program of the Cen-
18 ters for Medicare & Medicaid Services shall be re-
19 quired to adopt 2015 certified electronic health
20 record technology (as so defined) as a condition of
21 participating in such program.

22 (b) QUALITY IMPROVEMENT ACTIVITIES.—The Ad-
23 ministrator, upon yearly review of the Quality Payment
24 Program, shall add quality improvement activities that im-
25 plement the Culturally and Linguistically Accessible

1 Standards (CLAS) as Improvement Activities under the
2 Quality Payment Program.

3 **SEC. 443. DEVELOPMENT AND TESTING OF DISPARITY RE-**
4 **DUCING DELIVERY AND PAYMENT MODELS.**

5 (a) IN GENERAL.—The Center for Medicare and
6 Medicaid Innovation established under section 1115A of
7 the Social Security Act (42 U.S.C. 1315a) (in this section
8 referred to as the “CMI”) shall establish a dedicated fund
9 to identify, test, evaluate, and scale delivery and payment
10 models under the applicable titles (as defined in subsection
11 (a)(4)(B) of such section) that target health disparities
12 among racial and ethnic minorities, including models that
13 support high-value non-medical services that address so-
14 cially determined barriers to health, including English pro-
15 ficiency status, low health literacy, case management,
16 transportation, enrollment assistance needs, stable and af-
17 fordable housing, utility assistance, employment and ca-
18 reer development, and nutrition and food security which
19 will help to reduce disparities and impact the overall cost
20 of care.

21 (b) AMENDMENT TO SOCIAL SECURITY ACT.—The
22 second sentence of section 1115A(a)(1) of the Social Secu-
23 rity Act (42 U.S.C. 1315a(a)(1)) is amended by inserting
24 “and improve health equity” after “expenditures”.

1 (c) PILOT PROGRAMS.—The CMI shall prioritize the
2 testing of models under such section 1115A that include
3 partnerships with entities, including community based or-
4 ganizations or other nonprofit entities, to help address so-
5 cially determined barriers to health and health care.

6 (d) ALTERNATIVES.—Any model tested by the CMI
7 under such 1115A shall include measures to assess and
8 track the impact of the model on health disparities, using
9 existing measures such as the Healthcare Disparities and
10 Cultural Competency Measures endorsed by the entity
11 with a contract under section 1890(a) of the Social Secu-
12 rity Act (42 U.S.C. 1395aaa(a)), and stratified by race,
13 ethnicity, English proficiency, gender identity, sexual ori-
14 entation, and disability status.

15 **SEC. 444. DIVERSITY IN CENTERS FOR MEDICARE AND**
16 **MEDICAID CONSULTATION.**

17 (a) IN GENERAL.—In carrying out the duties under
18 this section, the CMI shall consult representatives of rel-
19 evant Federal agencies, and clinical and analytical experts
20 with expertise in medicine and health care management,
21 specifically such experts with expertise in—

22 (1) the health care needs of minority, rural, and
23 underserved populations; and

1 (2) the financial needs of safety net, community
2 based, rural, and critical access providers, including
3 federally qualified health centers.

4 (b) OPEN DOOR FORUMS.—The CMI shall use open
5 door forums or other mechanisms to seek external feed-
6 back from interested parties and incorporate that feedback
7 into the development of models.

8 **SEC. 445. SUPPORTING SAFETY NET AND COMMUNITY-**
9 **BASED PROVIDERS TO COMPETE IN VALUE-**
10 **BASED PAYMENT SYSTEMS.**

11 (a) IN GENERAL.—Any pay-for-performance or alter-
12 native payment model that is developed and tested by the
13 Center for Medicare and Medicaid Innovation established
14 under section 1115A of the Social Security Act (42 U.S.C.
15 1315a), or any other agency of the Department of Health
16 and Human Services with respect to the programs under
17 titles XVIII, XIX, or XXI of such Act, shall be assessed
18 for potential impact on safety net, community based, and
19 critical access providers, including Federally qualified
20 health centers.

21 (b) NEW MODELS.—The rollout of any such models
22 shall include training and additional up front resources for
23 community based and safety net providers to enable those
24 providers to participate in the model.

1 **Subtitle D—Health Empowerment**
2 **Zones**

3 **SEC. 451. SHORT TITLE.**

4 This subtitle may be cited as the “Health Empower-
5 ment Zone Act of 2020”.

6 **SEC. 452. FINDINGS.**

7 Congress finds the following:

8 (1) Numerous studies and reports, including
9 the 2015 National Healthcare Quality and Dispari-
10 ties Report of the Agency for Healthcare Research
11 and Quality and the 2002 report of the Institute of
12 Medicine entitled “Unequal Treatment: Confronting
13 Racial and Ethnic Disparities in Health Care”, doc-
14 ument the extensiveness to which health disparities
15 exist across the country.

16 (2) These studies have found that, on average,
17 racial and ethnic minorities are disproportionately
18 afflicted with chronic and acute conditions—such as
19 cancer, diabetes, musculoskeletal disease, obesity,
20 and hypertension—and suffer worse health out-
21 comes, worse health status, and higher mortality
22 rates than their White counterparts.

23 (3) Several recent studies also show that health
24 disparities are a function of not only access to health
25 care, but also the social determinants of health—in-

1 including the environment, the physical structure of
2 communities, nutrition and food options, educational
3 attainment and health literacy, employment, race,
4 ethnicity, immigration status, geography, and lan-
5 guage preference—that directly and indirectly affect
6 the health, health care, and wellness of individuals
7 and communities.

8 (4) Integrally involving and fully supporting the
9 communities most affected by health inequities in
10 the assessment, planning, launch, and evaluation of
11 health disparity elimination efforts are among the
12 leading recommendations made to adequately ad-
13 dress and ultimately reduce health disparities.

14 (5) Recommendations also include supporting
15 the efforts of community stakeholders from a broad
16 cross section—including local businesses, local de-
17 partments of commerce, education, labor, urban
18 planning, and transportation, and community-based
19 and other nonprofit organizations, including national
20 and regional intermediaries with demonstrated ca-
21 pacity to serve low-income urban communities—to
22 find areas of common ground around health dis-
23 parity elimination and collaborate to improve the
24 overall health and wellness of a community and its
25 residents.

1 **SEC. 453. DESIGNATION OF HEALTH EMPOWERMENT**
2 **ZONES.**

3 (a) IN GENERAL.—The Secretary may, at the request
4 of an eligible community partnership described in sub-
5 section (b)(1), designate an eligible area described in sub-
6 section (b)(2) as a health empowerment zone for the pur-
7 pose of eligibility for a grant under section 455.

8 (b) ELIGIBILITY CRITERIA.—

9 (1) ELIGIBLE COMMUNITY PARTNERSHIP.—A
10 community partnership is eligible to submit a re-
11 quest under this section if the partnership—

12 (A) demonstrates widespread public sup-
13 port from key individuals and entities in the eli-
14 gible area, including members of the target
15 community, State and local governments, non-
16 profit organizations including national and re-
17 gional intermediaries with demonstrated capac-
18 ity to serve low-income urban communities, and
19 community and industry leaders, for designa-
20 tion of the eligible area as a health empower-
21 ment zone; and

22 (B) includes representatives of—

23 (i) a broad cross section of stake-
24 holders and residents from communities in
25 the eligible area experiencing dispropor-

1 tionate disparities in health status and
2 health care; and

3 (ii) organizations, facilities, and insti-
4 tutions that have a history of working
5 within and serving such communities.

6 (2) ELIGIBLE AREA.—An area is eligible to be
7 designated as a health empowerment zone under this
8 section if one or more communities in the area expe-
9 rience disproportionate disparities in health status
10 and health care. In determining whether a commu-
11 nity experiences such disparities, the Secretary shall
12 consider data collected by the Department of Health
13 and Human Services focusing on the following areas:

14 (A) Access to affordable, high-quality
15 health services.

16 (B) The prevalence of disproportionate
17 rates of certain illnesses or diseases including
18 the following:

19 (i) Arthritis, osteoporosis, chronic
20 back conditions, and other musculoskeletal
21 diseases.

22 (ii) Cancer.

23 (iii) Chronic kidney disease.

24 (iv) Diabetes.

- 1 (v) Injury (intentional and uninten-
2 tional).
- 3 (vi) Violence (intimate and non-
4 intimate).
- 5 (vii) Maternal and paternal illnesses
6 and diseases.
- 7 (viii) Infant mortality.
- 8 (ix) Mental illness and other disabil-
9 ities.
- 10 (x) Substance use disorder treatment
11 and prevention, including underage drink-
12 ing.
- 13 (xi) Nutrition, obesity, and overweight
14 conditions.
- 15 (xii) Heart disease.
- 16 (xiii) Hypertension.
- 17 (xiv) Cerebrovascular disease or
18 stroke.
- 19 (xv) Tuberculosis.
- 20 (xvi) HIV/AIDS and other sexually
21 transmitted infections.
- 22 (xvii) Viral hepatitis.
- 23 (xviii) Asthma.
- 24 (xix) Tooth decay and other oral
25 health issues.

1 (C) Within the community, the historical
2 and persistent presence of conditions that have
3 been found to contribute to health disparities
4 including any such conditions respecting any of
5 the following:

6 (i) Poverty.

7 (ii) Educational status and the quality
8 of community schools.

9 (iii) Income.

10 (iv) Access to high-quality affordable
11 health care.

12 (v) Work and work environment.

13 (vi) Environmental conditions in the
14 community, including with respect to clean
15 water, clean air, and the presence or ab-
16 sence of pollutants.

17 (vii) Language and English pro-
18 ficiency.

19 (viii) Access to affordable healthy
20 food.

21 (ix) Access to ethnically and culturally
22 diverse health and human service providers
23 and practitioners.

24 (x) Access to culturally and linguis-
25 tically competent health and human serv-

1 ices and health and human service pro-
2 viders.

3 (xi) Health-supporting infrastructure.

4 (xii) Health insurance that is ade-
5 quate and affordable.

6 (xiii) Race, racism, and bigotry (con-
7 scious and unconscious).

8 (xiv) Sexual orientation.

9 (xv) Health literacy.

10 (xvi) Place of residence (such as
11 urban areas, rural areas, and reservations
12 of Indian tribes).

13 (xvii) Stress.

14 (c) PROCEDURE.—

15 (1) REQUEST.—A request under subsection (a)
16 shall—

17 (A) describe the bounds of the area to be
18 designated as a health empowerment zone and
19 the process used to select those bounds;

20 (B) demonstrate that the partnership sub-
21 mitting the request is an eligible community
22 partnership described in subsection (b)(1);

23 (C) demonstrate that the area is an eligible
24 area described in subsection (b)(2);

1 (D) include a comprehensive assessment of
2 disparities in health status and health care ex-
3 perience by one or more communities in the
4 area;

5 (E) set forth—

6 (i) a vision and a set of values for the
7 area; and

8 (ii) a comprehensive and holistic set of
9 goals to be achieved in the area through
10 designation as a health empowerment zone;
11 and

12 (F) include a strategic plan and an action
13 plan for achieving the goals described in sub-
14 paragraph (E)(ii).

15 (2) APPROVAL.—Not later than 60 days after
16 the receipt of a request for designation of an area
17 as a health empowerment zone under this section,
18 the Secretary shall approve or disapprove the re-
19 quest.

20 (d) MINIMUM NUMBER.—The Secretary—

21 (1) shall designate not more than 110 health
22 empowerment zones under this section; and

23 (2) of such zones designated under paragraph
24 (1), shall designate at least one health empowerment
25 zone in each of the several States, the District of

1 Columbia, and each territory or possession of the
2 United States.

3 **SEC. 454. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

4 At the request of any organization or entity seeking
5 to submit a request under section 453(a), the Secretary
6 shall provide technical assistance, and may award a grant,
7 to assist such organization or entity—

8 (1) to form an eligible community partnership
9 described in section 453(b)(1);

10 (2) to complete a health assessment, including
11 an assessment of health disparities under section
12 453(c)(1)(D); or

13 (3) to prepare and submit a request, including
14 a strategic plan, in accordance with section 453.

15 **SEC. 455. BENEFITS OF DESIGNATION.**

16 (a) PRIORITY.—In awarding a grant under sub-
17 section (b), a Federal official shall give priority to any ap-
18 plicant that—

19 (1) meets the eligibility criteria for the grant;

20 (2) proposes to use the grant for activities in a
21 health empowerment zone; and

22 (3) demonstrates that such activities will di-
23 rectly and significantly further the goals of the stra-
24 tegic plan approved for such zone under section 453.

1 (b) GRANTS FOR INITIAL IMPLEMENTATION OF
2 STRATEGIC PLAN.—

3 (1) IN GENERAL.—Upon designating an eligible
4 area as a health empowerment zone at the request
5 of an eligible community partnership, the Secretary
6 shall, subject to the availability of appropriations,
7 make a grant to the community partnership for im-
8 plementation of the strategic plan for such zone.

9 (2) GRANT PERIOD.—A grant under paragraph
10 (1) for a health empowerment zone shall be for a pe-
11 riod of 2 years and may be renewed, except that the
12 total period of grants under paragraph (1) for such
13 zone may not exceed 10 years.

14 (3) LIMITATION.—In awarding grants under
15 this subsection, the Secretary shall not give less pri-
16 ority to an applicant or reduce the amount of a
17 grant because the Secretary rendered technical as-
18 sistance or made a grant to the same applicant
19 under section 454.

20 (4) REPORTING.—The Secretary shall establish
21 metrics for measuring the progress of grantees
22 under this subsection and, based on such metrics,
23 require each such grantee to report to the Secretary
24 not less than every 6 months on the progress in im-

1 plementing the strategic plan for the health em-
2 powerment zone.

3 **SEC. 456. DEFINITION OF SECRETARY.**

4 In this subtitle, the term “Secretary” means the Sec-
5 retary of Health and Human Services, acting through the
6 Administrator of the Health Resources and Services Ad-
7 ministration and the Deputy Assistant Secretary for Mi-
8 nority Health, and in cooperation with the Director of the
9 Office of Community Services and the Director of the Na-
10 tional Institute on Minority Health and Health Dispari-
11 ties.

12 **SEC. 457. AUTHORIZATION OF APPROPRIATIONS.**

13 To carry out this subtitle, there is authorized to be
14 appropriated \$100,000,000 for fiscal year 2021.

15 **TITLE V—IMPROVING HEALTH**
16 **OUTCOMES FOR WOMEN,**
17 **CHILDREN, AND FAMILIES**
18 **Subtitle A—In General**

19 **SEC. 501. GRANTS TO PROMOTE HEALTH FOR UNDER-**
20 **SERVED COMMUNITIES.**

21 Part Q of title III of the Public Health Service Act
22 (42 U.S.C. 280h et seq.) is amended by adding at the end
23 the following:

1 **“SEC. 399Z-3. GRANTS TO PROMOTE HEALTH FOR UNDER-**
2 **SERVED COMMUNITIES.**

3 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
4 laboration with the Administrator of the Health Resources
5 and Services Administration and other Federal officials
6 determined appropriate by the Secretary, is authorized to
7 award grants to eligible entities—

8 “(1) to promote health for underserved commu-
9 nities, with preference given to projects that benefit
10 racial and ethnic minority women, racial and ethnic
11 minority children, adolescents, and lesbian, gay, bi-
12 sexual, transgender, queer, or questioning commu-
13 nities; and

14 “(2) to strengthen health outreach initiatives in
15 medically underserved communities, including lin-
16 guistically isolated populations.

17 “(b) USE OF FUNDS.—Grants awarded pursuant to
18 subsection (a) may be used to support the activities of
19 community health workers, including such activities—

20 “(1) to educate and provide outreach regarding
21 enrollment in health insurance including the State
22 Children’s Health Insurance Program under title
23 XXI of the Social Security Act, Medicare under title
24 XVIII of such Act, and Medicaid under title XIX of
25 such Act;

1 “(2) to educate and provide outreach in a com-
2 munity setting regarding health problems prevalent
3 among underserved communities, and especially
4 among racial and ethnic minority women, racial and
5 ethnic minority children, adolescents, and lesbian,
6 gay, bisexual, transgender, queer, or questioning
7 communities;

8 “(3) to educate and provide experiential learn-
9 ing opportunities and target risk factors and healthy
10 behaviors that impede or contribute to achieving
11 positive health outcomes, including—

12 “(A) healthy nutrition;

13 “(B) physical activity;

14 “(C) overweight or obesity;

15 “(D) tobacco use, including the use of e-
16 cigarettes and vaping;

17 “(E) alcohol and substance use;

18 “(F) injury and violence;

19 “(G) sexual health;

20 “(H) mental health;

21 “(I) musculoskeletal health and arthritis;

22 “(J) prenatal and postnatal care;

23 “(K) dental and oral health;

24 “(L) understanding informed consent;

25 “(M) stigma; and

1 “(N) environmental hazards;

2 “(4) to promote community wellness and aware-
3 ness; and

4 “(5) to educate and refer target populations to
5 appropriate health care agencies and community-
6 based programs and organizations in order to in-
7 crease access to quality health care services, includ-
8 ing preventive health services.

9 “(c) APPLICATION.—

10 “(1) IN GENERAL.—Each eligible entity that
11 desires to receive a grant under subsection (a) shall
12 submit an application to the Secretary, at such time,
13 in such manner, and accompanied by such additional
14 information as the Secretary may require.

15 “(2) CONTENTS.—Each application submitted
16 pursuant to paragraph (1) shall—

17 “(A) describe the activities for which as-
18 sistance under this section is sought;

19 “(B) contain an assurance that, with re-
20 spect to each community health worker pro-
21 gram receiving funds under the grant awarded,
22 such program provides in-language training and
23 supervision to community health workers to en-
24 able such workers to provide authorized pro-
25 gram activities in (at least) the most commonly

1 used languages within a particular geographic
2 region;

3 “(C) contain an assurance that the appli-
4 cant will evaluate the effectiveness of commu-
5 nity health worker programs receiving funds
6 under the grant;

7 “(D) contain an assurance that each com-
8 munity health worker program receiving funds
9 under the grant will provide culturally com-
10 petent services in the linguistic context most
11 appropriate for the individuals served by the
12 program;

13 “(E) contain a plan to document and dis-
14 seminate project descriptions and results to
15 other States and organizations as identified by
16 the Secretary; and

17 “(F) describe plans to enhance the capac-
18 ity of individuals to utilize health services and
19 health-related social services under Federal,
20 State, and local programs by—

21 “(i) assisting individuals in estab-
22 lishing eligibility under the programs and
23 in receiving the services or other benefits
24 of the programs; and

1 “(ii) providing other services, as the
2 Secretary determines to be appropriate,
3 which may include transportation and
4 translation services.

5 “(d) PRIORITY.—In awarding grants under sub-
6 section (a), the Secretary shall give priority to those appli-
7 cants—

8 “(1) who propose to target geographic areas
9 that—

10 “(A)(i) have a high percentage of residents
11 who are uninsured or underinsured (if the tar-
12 geted geographic area is located in a State that
13 has elected to make medical assistance available
14 under section 1902(a)(10)(A)(i)(VIII) of the
15 Social Security Act to individuals described in
16 such section);

17 “(ii) have a high percentage of under-
18 insured residents in a particular geographic
19 area (if the targeted geographic area is located
20 in a State that has not so elected); or

21 “(iii) have a high number of households ex-
22 periencing extreme poverty; and

23 “(B) have a high percentage of families for
24 whom English is not their primary language or
25 including smaller limited English-proficient

1 communities within the region that are not oth-
2 erwise reached by linguistically appropriate
3 health services;

4 “(2) with experience in providing health or
5 health-related social services to individuals who are
6 underserved with respect to such services; and

7 “(3) with documented community activity and
8 experience with community health workers.

9 “(e) COLLABORATION WITH ACADEMIC INSTITU-
10 TIONS.—The Secretary shall encourage community health
11 worker programs receiving funds under this section to col-
12 laborate with academic institutions, including minority-
13 serving institutions. Nothing in this section shall be con-
14 strued to require such collaboration.

15 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
16 NESS.—The Secretary shall establish guidelines for ensur-
17 ing the quality of the training and supervision of commu-
18 nity health workers under the programs funded under this
19 section and for ensuring the cost effectiveness of such pro-
20 grams.

21 “(g) MONITORING.—The Secretary shall monitor
22 community health worker programs identified in approved
23 applications and shall determine whether such programs
24 are in compliance with the guidelines established under
25 subsection (f).

1 “(h) TECHNICAL ASSISTANCE.—The Secretary may
2 provide technical assistance to community health worker
3 programs identified in approved applications with respect
4 to planning, developing, and operating programs under the
5 grant.

6 “(i) REPORT TO CONGRESS.—

7 “(1) IN GENERAL.—Not later than 4 years
8 after the date on which the Secretary first awards
9 grants under subsection (a), the Secretary shall sub-
10 mit to Congress a report regarding the grant
11 project.

12 “(2) CONTENTS.—The report required under
13 paragraph (1) shall include the following:

14 “(A) A description of the programs for
15 which grant funds were used.

16 “(B) The number of individuals served.

17 “(C) An evaluation of—

18 “(i) the effectiveness of these pro-
19 grams;

20 “(ii) the cost of these programs; and

21 “(iii) the impact of these programs on
22 the health outcomes of the community resi-
23 dents.

1 “(D) Recommendations for sustaining the
2 community health worker programs developed
3 or assisted under this section.

4 “(E) Recommendations regarding training
5 to enhance career opportunities for community
6 health workers.

7 “(j) DEFINITIONS.—In this section:

8 “(1) COMMUNITY HEALTH WORKER.—The term
9 ‘community health worker’ means an individual who
10 promotes health or nutrition within the community
11 in which the individual resides—

12 “(A) by serving as a liaison between com-
13 munities and health care agencies;

14 “(B) by providing guidance and social as-
15 sistance to community residents;

16 “(C) by enhancing community residents’
17 ability to effectively communicate with health
18 care providers;

19 “(D) by providing culturally and linguis-
20 tically appropriate health or nutrition edu-
21 cation;

22 “(E) by advocating for individual and com-
23 munity health, including dental, oral, mental,
24 and environmental health, or nutrition needs;

1 “(F) by taking into consideration the
2 needs of the communities served, including the
3 prevalence rates of risk factors that impede
4 achieving positive healthy outcomes among
5 women and children, especially among racial
6 and ethnic minority women and children; and

7 “(G) by providing referral and followup
8 services.

9 “(2) COMMUNITY SETTING.—The term ‘commu-
10 nity setting’ means a home or a community organi-
11 zation that serves a population.

12 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
13 tity’ means—

14 “(A) a unit of State, territorial, local, or
15 Tribal government (including a federally recog-
16 nized Tribe or Alaska Native village); or

17 “(B) a community-based organization.

18 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
19 The term ‘medically underserved community’ means
20 a community—

21 “(A) that has a substantial number of in-
22 dividuals who are members of a medically un-
23 derserved population, as defined by section
24 330(b)(3);

1 “(B) a significant portion of which is a
2 health professional shortage area as designated
3 under section 332; and

4 “(C) that includes populations that are lin-
5 guistically isolated, such as geographic areas
6 with a shortage of health professionals able to
7 provide linguistically appropriate services.

8 “(5) SUPPORT.—The term ‘support’ means the
9 provision of training, supervision, and materials
10 needed to effectively deliver the services described in
11 subsection (b), reimbursement for services, and
12 other benefits.

13 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to carry out this section
15 \$15,000,000 for each of fiscal years 2021 through 2025.”.

16 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
17 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
18 **NANT PERSONS, AND LAWFULLY PRESENT IN-**
19 **DIVIDUALS.**

20 (a) MEDICAID.—Section 1903(v) of the Social Secu-
21 rity Act (42 U.S.C. 1396b(v)) is amended by striking
22 paragraph (4) and inserting the following new paragraph:

23 “(4)(A) Notwithstanding sections 401(a), 402(b),
24 403, and 421 of the Personal Responsibility and Work Op-
25 portunity Reconciliation Act of 1996 and paragraph (1),

1 payment shall be made to a State under this section for
2 medical assistance furnished to an alien under this title
3 (including an alien described in such paragraph) who
4 meets any of the following conditions:

5 “(i) The alien is otherwise eligible for such as-
6 sistance under the State plan approved under this
7 title (other than the requirement of the receipt of
8 aid or assistance under title IV, supplemental secu-
9 rity income benefits under title XVI, or a State sup-
10 plementary payment) within either or both of the
11 following eligibility categories:

12 “(I) Children under 21 years of age, in-
13 cluding any optional targeted low-income child
14 (as such term is defined in section
15 1905(u)(2)(B)).

16 “(II) Pregnant persons during pregnancy
17 and during the 12-month period beginning on
18 the last day of the pregnancy.

19 “(ii) The alien is lawfully present in the United
20 States.

21 “(B) No debt shall accrue under an affidavit of sup-
22 port against any sponsor of an alien who meets the condi-
23 tions specified in subparagraph (A) on the basis of the
24 provision of medical assistance to such alien under this

1 paragraph and the cost of such assistance shall not be con-
2 sidered as an unreimbursed cost.”.

3 (b) CHIP.—Subparagraph (N) of section 2107(e)(1)
4 of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is
5 amended to read as follows:

6 “(N) Paragraph (4) of section 1903(v) (re-
7 lating to coverage of categories of children,
8 pregnant persons, and other lawfully present in-
9 dividuals).”.

10 (c) SUPPLEMENTAL NUTRITION ASSISTANCE FOR
11 LAWFULLY PRESENT INDIVIDUALS.—

12 (1) IN GENERAL.—Section 402(a)(2)(J) of the
13 Personal Responsibility and Work Opportunity Rec-
14 onciliation Act of 1996 (8 U.S.C. 1612(a)(2)(J)) is
15 amended—

16 (A) in the subparagraph heading, by strik-
17 ing “CERTAIN CHILDREN” inserting “CHILDREN
18 AND LAWFULLY PRESENT INDIVIDUALS”; and

19 (B) by striking “who is under 18 years of
20 age.” and inserting “who is—

21 “(i) under 21 years of age; or

22 “(ii) lawfully present in the United
23 States.”.

24 (2) CONFORMING AMENDMENTS.—

1 (A) Section 402(a)(3) of such Act (8
2 U.S.C. 1612(a)(3)) is amended by striking sub-
3 paragraph (B) and inserting the following:

4 “(B) SNAP (FOOD STAMP PROGRAM).—
5 The supplemental nutrition assistance program
6 established under the Food and Nutrition Act
7 of 2008 (7 U.S.C. 2011 et seq.) (referred to in
8 this title as ‘SNAP’ or the ‘food stamp pro-
9 gram’).”.

10 (B) Section 403(c)(2)(L) of such Act (42
11 U.S.C. 1613(c)(2)(L)) is amended by striking
12 “18” and all that follows through the period
13 and inserting “21, or to individuals who are
14 lawfully present in the United States, under the
15 supplemental nutrition assistance program es-
16 tablished under the Food and Nutrition Act of
17 2008 (7 U.S.C. 2011 et seq.)”.

18 (C) Section 5(i)(2)(E) of the Food and
19 Nutrition Act of 2008 (7 U.S.C. 2014(i)(2)(E))
20 is amended by striking “18 years of age.” and
21 inserting “21 years of age, or who is lawfully
22 present in the United States.”.

23 (d) NONAPPLICATION OF SPONSOR DEEMING; AS-
24 SURING ELIGIBILITY FOR FAMILIES.—Section 421(d) of
25 the Personal Responsibility and Work Opportunity Rec-

1 onconciliation Act of 1996 (8 U.S.C. 1631(d)) is amended
2 by striking paragraph (3) and inserting the following:

3 “(3) This section shall not apply to assistance
4 or benefits under the supplemental nutrition assist-
5 ance program established under the Food and Nutri-
6 tion Act of 2008 (7 U.S.C. 2011 et seq.) for a quali-
7 fied alien who is eligible under section 402(a)(2)(J)
8 and for any member of the household of such quali-
9 fied alien.”.

10 (e) ENSURING PROPER SCREENING.—Section
11 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7
12 U.S.C. 2020(e)(2)(B)) is amended—

13 (1) by redesignating clauses (vi) and (vii) as
14 clauses (vii) and (viii), respectively; and

15 (2) by inserting after clause (v) the following:

16 “(vi) shall provide a method for imple-
17 menting section 421 of the Personal Re-
18 sponsibility and Work Opportunity Rec-
19 onciliation Act of 1996 (8 U.S.C. 1631)
20 that does not require any unnecessary in-
21 formation from applicants who may be ex-
22 empt from that provision;”.

1 **SEC. 503. REPEAL OF DENIAL OF SNAP BENEFITS.**

2 Section 115 of the Personal Responsibility and Work
3 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
4 is amended—

5 (1) in subsection (a), by striking “for—” and
6 all that follows and inserting “for assistance under
7 any State program funded under part A of title IV
8 of the Social Security Act (42 U.S.C. 601 et seq.).”;

9 (2) in subsection (b)—

10 (A) by striking “(1) PROGRAM OF TEM-
11 PORARY ASSISTANCE FOR NEEDY FAMILIES.—”;

12 and

13 (B) by striking paragraph (2); and

14 (3) in subsection (e), by striking “it—” and all
15 that follows and inserting “the term in section
16 419(5) of the Social Security Act (42 U.S.C.
17 619(5)) when referring to assistance provided under
18 a State program funded under paragraph A of title
19 IV of the Social Security Act (42 U.S.C. 601 et
20 seq.)”.

21 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
22 **AND AWARENESS.**

23 (a) IN GENERAL.—The Secretary shall establish and
24 implement a birth defects prevention and public awareness
25 program, consisting of the activities described in sub-
26 sections (c) and (d).

1 (b) DEFINITIONS.—In this section:

2 (1) MATERNAL.—The term “maternal” refers
3 to persons who are pregnant or breastfeeding of all
4 gender identities.

5 (2) PREGNANCY AND BREASTFEEDING INFOR-
6 MATION SERVICES.—The term “pregnancy and
7 breastfeeding information services” includes only—

8 (A) information services to provide accu-
9 rate, evidence-based, clinical information re-
10 garding maternal exposures during pregnancy
11 that may be associated with birth defects or
12 other health risks, such as exposures to medica-
13 tions, chemicals, infections, foodborne patho-
14 gens, illnesses, nutrition, or lifestyle factors;

15 (B) information services to provide accu-
16 rate, evidence-based, clinical information re-
17 garding maternal exposures during breast-
18 feeding that may be associated with health risks
19 to a breast-fed infant, such as exposures to
20 medications, chemicals, infections, foodborne
21 pathogens, illnesses, nutrition, lifestyle, or
22 climate- and weather-related factors;

23 (C) the provision of accurate, evidence-
24 based information weighing risks of exposures

1 during breastfeeding against the benefits of
2 breastfeeding; and

3 (D) the provision of information described
4 in subparagraph (A), (B), or (C) through coun-
5 selors, websites, fact sheets, telephonic or elec-
6 tronic communication, community outreach ef-
7 forts, or other appropriate means.

8 (3) SECRETARY.—The term “Secretary” means
9 the Secretary of Health and Human Services, acting
10 through the Director of the Centers for Disease
11 Control and Prevention.

12 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
13 subsection (a), the Secretary shall conduct or support a
14 nationwide media campaign to increase awareness among
15 health care providers and at-risk populations about preg-
16 nancy and breastfeeding information services.

17 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
18 INFORMATION SERVICES.—

19 (1) IN GENERAL.—In carrying out subsection
20 (a), the Secretary shall award grants to State or re-
21 gional agencies or organizations for any of the fol-
22 lowing:

23 (A) INFORMATION SERVICES.—The provi-
24 sion of, or campaigns to increase awareness

1 about, pregnancy and breastfeeding information
2 services.

3 (B) SURVEILLANCE AND RESEARCH.—The
4 conduct or support of—

5 (i) surveillance of or research on—

6 (I) maternal exposures and ma-
7 ternal health conditions that may in-
8 fluence the risk of birth defects, pre-
9 maturity, or other adverse pregnancy
10 outcomes; and

11 (II) maternal exposures that may
12 influence health risks to a breastfed
13 infant; or

14 (ii) networking to facilitate surveil-
15 lance or research described in this sub-
16 paragraph.

17 (2) PREFERENCE FOR CERTAIN STATES.—The
18 Secretary, in making any grant under this sub-
19 section, shall give preference to States, otherwise
20 equally qualified, that have a pregnancy and
21 breastfeeding information service in place.

22 (3) MATCHING FUNDS.—The Secretary may
23 only award a grant under this subsection to a State
24 or regional agency or organization that agrees, with
25 respect to the costs to be incurred in carrying out

1 the grant activities, to make available (directly or
2 through donations from public or private entities)
3 non-Federal funds toward such costs in an amount
4 equal to not less than 25 percent of the amount of
5 the grant.

6 (4) COORDINATION.—The Secretary shall en-
7 sure that activities funded through a grant under
8 this subsection are coordinated, to the maximum ex-
9 tent practicable, with other birth defects prevention
10 and environmental health activities of the Federal
11 Government, including with respect to pediatric envi-
12 ronmental health specialty units and children’s envi-
13 ronmental health centers.

14 (e) EVALUATION.—In furtherance of the program
15 under subsection (a), the Secretary shall provide for an
16 evaluation of pregnancy and breastfeeding information
17 services to identify efficient and effective models of—

18 (1) providing information;

19 (2) raising awareness and increasing knowledge
20 about birth defects prevention measures and tar-
21 geting education to at-risk groups;

22 (3) modifying risk behaviors; or

23 (4) other outcome measures as determined ap-
24 propriate by the Secretary.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 \$5,000,000 for fiscal year 2021, \$6,000,000 for fiscal year
4 2022, \$7,000,000 for fiscal year 2023, \$8,000,000 for fis-
5 cal year 2024, and \$9,000,000 for fiscal year 2025.

6 **SEC. 505. MOMMA’S ACT.**

7 (a) SHORT TITLE.—This section may be cited as the
8 “Mothers and Offspring Mortality and Morbidity Aware-
9 ness Act” or the “MOMMA’s Act”.

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

11 (1) Every year, across the United States,
12 4,000,000 women give birth, about 700 women suf-
13 fer fatal complications during pregnancy, while giv-
14 ing birth or during the postpartum period, and
15 70,000 women suffer near-fatal, partum-related
16 complications.

17 (2) The maternal mortality rate is often used as
18 a proxy to measure the overall health of a popu-
19 lation. While the infant mortality rate in the United
20 States has reached its lowest point, the risk of death
21 for women in the United States during pregnancy,
22 childbirth, or the postpartum period is higher than
23 such risk in many other developed nations. The esti-
24 mated maternal mortality rate (per 100,000 live
25 births) for the 48 contiguous States and Wash-

1 ington, DC, increased from 18.8 percent in 2000, to
2 23.8 percent in 2014, to 26.6 percent in 2018. This
3 estimated rate is on par with such rate for under-
4 developed nations such as Iraq and Afghanistan.

5 (3) It is estimated that more than 60 percent
6 of maternal deaths in the United States are prevent-
7 able.

8 (4) According to the Centers for Disease Con-
9 trol and Prevention, the maternal mortality rate var-
10 ies drastically for women by race and ethnicity.
11 There are 12.7 deaths per 100,000 live births for
12 White women, 43.5 deaths per 100,000 live births
13 for African-American women, and 14.4 deaths per
14 100,000 live births for women of other ethnicities.
15 While maternal mortality disparately impacts Afri-
16 can-American women, this urgent public health crisis
17 traverses race, ethnicity, socioeconomic status, edu-
18 cational background, and geography.

19 (5) African-American women are 3 to 4 times
20 more likely to die from causes related to pregnancy
21 and childbirth compared to non-Hispanic White
22 women.

23 (6) The findings described in paragraphs (1)
24 through (6) are of major concern to researchers,
25 academics, members of the business community, and

1 providers across the obstetrical continuum rep-
2 resented by organizations such as March of Dimes;
3 the Preeclampsia Foundation; the American College
4 of Obstetricians and Gynecologists; the Society for
5 Maternal-Fetal Medicine; the Association of Wom-
6 en's Health, Obstetric, and Neonatal Nurses; the
7 California Maternal Quality Care Collaborative;
8 Black Women's Health Imperative; the National
9 Birth Equity Collaborative; Black Mamas Matter Al-
10 liance; EverThrive Illinois; the National Association
11 of Certified Professional Midwives; PCOS Challenge:
12 The National Polycystic Ovary Syndrome Associa-
13 tion; and the American College of Nurse Midwives.

14 (7) Hemorrhage, cardiovascular and coronary
15 conditions, cardiomyopathy, infection, embolism,
16 mental health conditions, preeclampsia and eclamp-
17 sia, polycystic ovary syndrome, infection and sepsis,
18 and anesthesia complications are the predominant
19 medical causes of maternal-related deaths and com-
20 plications. Most of these conditions are largely pre-
21 ventable or manageable.

22 (8) Oral health is an important part of
23 perinatal health. Reducing bacteria in a woman's
24 mouth during pregnancy can significantly reduce her
25 risk of developing oral diseases and spreading decay-

1 causing bacteria to her baby. Moreover, some evi-
2 dence suggests that women with periodontal disease
3 during pregnancy could be at greater risk for poor
4 birth outcomes, such as preeclampsia, pre-term
5 birth, and low-birth weight. Furthermore, a woman's
6 oral health during pregnancy is a good predictor of
7 her newborn's oral health, and since mothers can
8 unintentionally spread oral bacteria to their babies,
9 putting their children at higher risk for tooth decay,
10 prevention efforts should happen even before chil-
11 dren are born, as a matter of pre-pregnancy health
12 and prenatal care during pregnancy.

13 (9) The United States has not been able to sub-
14 mit a formal maternal mortality rate to international
15 data repositories since 2007. Thus, no official ma-
16 ternal mortality rate exists for the United States.
17 There can be no maternal mortality rate without
18 streamlining maternal mortality-related data from
19 the State level and extrapolating such data to the
20 Federal level.

21 (10) In the United States, death reporting and
22 analysis is a State function rather than a Federal
23 process. States report all deaths—including mater-
24 nal deaths—on a semi-voluntary basis, without
25 standardization across States. While the Centers for

1 Disease Control and Prevention has the capacity and
2 system for collecting death-related data based on
3 death certificates, these data are not sufficiently re-
4 ported by States in an organized and standard for-
5 mat across States such that the Centers for Disease
6 Control and Prevention is able to identify causes of
7 maternal death and best practices for the prevention
8 of such death.

9 (11) Vital statistics systems often underesti-
10 mate maternal mortality and are insufficient data
11 sources from which to derive a full scope of medical
12 and social determinant factors contributing to ma-
13 ternal deaths. While the addition of pregnancy
14 checkboxes on death certificates since 2003 have
15 likely improved States' abilities to identify preg-
16 nancy-related deaths, they are not generally com-
17 pleted by obstetrical providers or persons trained to
18 recognize pregnancy-related mortality. Thus, these
19 vital forms may be missing information or may cap-
20 ture inconsistent data. Due to varying maternal
21 mortality-related analyses, lack of reliability, and
22 granularity in data, current maternal mortality
23 informatics do not fully encapsulate the myriad med-
24 ical and socially determinant factors that contribute
25 to such high maternal mortality rates within the

1 United States compared to other developed nations.
2 Lack of standardization of data and data sharing
3 across States and between Federal entities, health
4 networks, and research institutions keep the Nation
5 in the dark about ways to prevent maternal deaths.

6 (12) Having reliable and valid State data ag-
7 gregated at the Federal level are critical to the Na-
8 tion's ability to quell surges in maternal death and
9 imperative for researchers to identify long-lasting
10 interventions.

11 (13) Leaders in maternal wellness highly rec-
12 ommend that maternal deaths be investigated at the
13 State level first, and that standardized, streamlined,
14 de-identified data regarding maternal deaths be sent
15 annually to the Centers for Disease Control and Pre-
16 vention. Such data standardization and collection
17 would be similar in operation and effect to the Na-
18 tional Program of Cancer Registries of the Centers
19 for Disease Control and Prevention and akin to the
20 Confidential Enquiry in Maternal Deaths Pro-
21 gramme in the United Kingdom. Such a maternal
22 mortalities and morbidities registry and surveillance
23 system would help providers, academicians, law-
24 makers, and the public to address questions con-
25 cerning the types of, causes of, and best practices to

1 thwart, pregnancy-related or pregnancy-associated
2 mortality and morbidity.

3 (14) The United Nations Millennium Develop-
4 ment Goal 5a aimed to reduce by 75 percent, be-
5 tween 1990 and 2015, the maternal mortality rate,
6 yet this metric has not been achieved. In fact, the
7 maternal mortality rate in the United States has
8 been estimated to have more than doubled between
9 2000 and 2014. Yet, because national data are not
10 fully available, the United States does not have an
11 official maternal mortality rate.

12 (15) Many States have struggled to establish or
13 maintain Maternal Mortality Review Committees
14 (referred to in this section as “MMRC”). On the
15 State level, MMRCs have lagged because States have
16 not had the resources to mount local reviews. State-
17 level reviews are necessary as only the State depart-
18 ments of health have the authority to request med-
19 ical records, autopsy reports, and police reports crit-
20 ical to the function of the MMRC.

21 (16) The United Kingdom regards maternal
22 deaths as a health systems failure and a national
23 committee of obstetrics experts review each maternal
24 death or near-fatal childbirth complication. Such
25 committee also establishes the predominant course of

1 maternal-related deaths from conditions such as
2 preeclampsia. Consequently, the United Kingdom
3 has been able to reduce its incidence of preeclampsia
4 to less than one in 10,000 women—its lowest rate
5 since 1952.

6 (17) The United States has no comparable, co-
7 ordinated Federal process by which to review cases
8 of maternal mortality, systems failures, or best prac-
9 tices. Many States have active MMRCs and leverage
10 their work to impact maternal wellness. For exam-
11 ple, the State of California has worked extensively
12 with their State health departments, health and hos-
13 pital systems, and research collaborative organiza-
14 tions, including the California Maternal Quality Care
15 Collaborative and the Alliance for Innovation on Ma-
16 ternal Health, to establish MMRCs, wherein such
17 State has determined the most prevalent causes of
18 maternal mortality and recorded and shared data
19 with providers and researchers, who have developed
20 and implemented safety bundles and care protocols
21 related to preeclampsia, maternal hemorrhage, and
22 the like. In this way, the State of California has
23 been able to leverage its maternal mortality review
24 board system, generate data, and apply those data
25 to effect changes in maternal care-related protocol.

1 To date, the State of California has reduced its ma-
2 ternal mortality rate, which is now comparable to
3 the low rates of the United Kingdom.

4 (18) Hospitals and health systems across the
5 United States lack standardization of emergency ob-
6 stetrical protocols before, during, and after delivery.
7 Consequently, many providers are delayed in recog-
8 nizing critical signs indicating maternal distress that
9 quickly escalate into fatal or near-fatal incidences.
10 Moreover, any attempt to address an obstetrical
11 emergency that does not consider both clinical and
12 public health approaches falls woefully under the
13 mark of excellent care delivery. State-based maternal
14 quality collaborative organizations, such as the Cali-
15 fornia Maternal Quality Care Collaborative or enti-
16 ties participating in the Alliance for Innovation on
17 Maternal Health (AIM), have formed obstetrical pro-
18 tocols, tool kits, and other resources to improve sys-
19 tem care and response as they relate to maternal
20 complications and warning signs for such conditions
21 as maternal hemorrhage, hypertension, and
22 preeclampsia.

23 (19) The Centers for Disease Control and Pre-
24 vention reports that nearly half of all maternal
25 deaths occur in the immediate postpartum period—

1 the 42 days following a pregnancy—whereas more
2 than one-third of pregnancy-related or pregnancy-as-
3 sociated deaths occur while a person is still preg-
4 nant. Yet, for women eligible for the Medicaid pro-
5 gram on the basis of pregnancy, such Medicaid cov-
6 erage lapses at the end of the month on which the
7 60th postpartum day lands.

8 (20) The experience of serious traumatic
9 events, such as being exposed to domestic violence,
10 substance use disorder, or pervasive racism, can
11 over-activate the body's stress-response system.
12 Known as toxic stress, the repetition of high doses
13 of cortisol to the brain, can harm healthy neuro-
14 logical development, which can have cascading phys-
15 ical and mental health consequences, as documented
16 in the Adverse Childhood Experiences study of the
17 Centers for Disease Control and Prevention.

18 (21) A growing body of evidence-based research
19 has shown the correlation between the stress associ-
20 ated with one's race—the stress of racism—and
21 one's birthing outcomes. The stress of sex and race
22 discrimination and institutional racism has been
23 demonstrated to contribute to a higher risk of ma-
24 ternal mortality, irrespective of one's gestational
25 age, maternal age, socioeconomic status, or indi-

1 vidual-level health risk factors, including poverty,
2 limited access to prenatal care, and poor physical
3 and mental health (although these are not nominal
4 factors). African-American women remain the most
5 at risk for pregnancy-associated or pregnancy-re-
6 lated causes of death. When it comes to
7 preeclampsia, for example, which is related to obe-
8 sity, African-American women of normal weight re-
9 main the most at risk of dying during the perinatal
10 period compared to non-African-American obese
11 women.

12 (22) The rising maternal mortality rate in the
13 United States is driven predominantly by the dis-
14 proportionately high rates of African-American ma-
15 ternal mortality.

16 (23) Compared to women from other racial and
17 ethnic demographics, African-American women
18 across the socioeconomic spectrum experience pro-
19 longed, unrelenting stress related to racial and gen-
20 der discrimination, contributing to higher rates of
21 maternal mortality, giving birth to low-weight ba-
22 bies, and experiencing pre-term birth. Racism is a
23 risk factor for these aforementioned experiences.
24 This cumulative stress often extends across the life
25 course and is situated in everyday spaces where Afri-

1 can-American women establish livelihood. Structural
2 barriers, lack of access to care, and genetic pre-
3 dispositions to health vulnerabilities exacerbate Afri-
4 can-American women's likelihood to experience poor
5 or fatal birthing outcomes, but do not fully account
6 for the great disparity.

7 (24) African-American women are twice as like-
8 ly to experience postpartum depression, and dis-
9 proportionately higher rates of preeclampsia com-
10 pared to White women.

11 (25) Racism is deeply ingrained in United
12 States systems, including in health care delivery sys-
13 tems between patients and providers, often resulting
14 in disparate treatment for pain, irreverence for cul-
15 tural norms with respect to health, and
16 dismissiveness. Research has demonstrated that pa-
17 tients respond more warmly and adhere to medical
18 treatment plans at a higher degree with providers of
19 the same race or ethnicity or with providers with
20 great ability to exercise empathy. However, the pro-
21 vider pool is not primed with many people of color,
22 nor are providers (whether student-doctors in train-
23 ing or licensed practitioners) consistently required to
24 undergo implicit bias, cultural competency, or empa-
25 thy training on a consistent, ongoing basis.

1 (c) IMPROVING FEDERAL EFFORTS WITH RESPECT
2 TO PREVENTION OF MATERNAL MORTALITY.—

3 (1) TECHNICAL ASSISTANCE FOR STATES WITH
4 RESPECT TO REPORTING MATERNAL MORTALITY.—

5 Not later than one year after the date of enactment
6 of this Act, the Director of the Centers for Disease
7 Control and Prevention (referred to in this sub-
8 section as the “Director”), in consultation with the
9 Administrator of the Health Resources and Services
10 Administration, shall provide technical assistance to
11 States that elect to report comprehensive data on
12 maternal mortality, including oral, mental, and
13 breastfeeding health information, for the purpose of
14 encouraging uniformity in the reporting of such data
15 and to encourage the sharing of such data among
16 the respective States.

17 (2) BEST PRACTICES RELATING TO PREVEN-
18 TION OF MATERNAL MORTALITY.—

19 (A) IN GENERAL.—Not later than one year
20 after the date of enactment of this Act—

21 (i) the Director, in consultation with
22 relevant patient and provider groups, shall
23 issue best practices to State maternal mor-
24 tality review committees on how best to
25 identify and review maternal mortality

1 cases, taking into account any data made
2 available by States relating to maternal
3 mortality, including data on oral, mental,
4 and breastfeeding health, and utilization of
5 any emergency services; and

6 (ii) the Director, working in collabora-
7 tion with the Health Resources and Serv-
8 ices Administration, shall issue best prac-
9 tices to hospitals, State professional society
10 groups, and perinatal quality collaboratives
11 on how best to prevent maternal mortality.

12 (B) AUTHORIZATION OF APPROPRIA-
13 TIONS.—For purposes of carrying out this
14 paragraph, there is authorized to be appro-
15 priated \$5,000,000 for each of fiscal years
16 2021 through 2025.

17 (3) ALLIANCE FOR INNOVATION ON MATERNAL
18 HEALTH GRANT PROGRAM.—

19 (A) IN GENERAL.—Not later than one year
20 after the date of enactment of this Act, the Sec-
21 retary of Health and Human Services (referred
22 to in this paragraph as the “Secretary”), acting
23 through the Associate Administrator of the Ma-
24 ternal and Child Health Bureau of the Health
25 Resources and Services Administration, shall

1 establish a grant program to be known as the
2 Alliance for Innovation on Maternal Health
3 Grant Program (referred to in this subsection
4 as “AIM”) under which the Secretary shall
5 award grants to eligible entities for the purpose
6 of—

7 (i) directing widespread adoption and
8 implementation of maternal safety bundles
9 through collaborative State-based teams;
10 and

11 (ii) collecting and analyzing process,
12 structure, and outcome data to drive con-
13 tinuous improvement in the implementa-
14 tion of such safety bundles by such State-
15 based teams with the ultimate goal of
16 eliminating preventable maternal mortality
17 and severe maternal morbidity in the
18 United States.

19 (B) ELIGIBLE ENTITIES.—In order to be
20 eligible for a grant under subparagraph (A), an
21 entity shall—

22 (i) submit to the Secretary an applica-
23 tion at such time, in such manner, and
24 containing such information as the Sec-
25 retary may require; and

1 (ii) demonstrate in such application
2 that the entity is an interdisciplinary,
3 multi-stakeholder, national organization
4 with a national data-driven maternal safety
5 and quality improvement initiative based
6 on implementation approaches that have
7 been proven to improve maternal safety
8 and outcomes in the United States.

9 (C) USE OF FUNDS.—An eligible entity
10 that receives a grant under subparagraph (A)
11 shall use such grant funds—

12 (i) to develop and implement, through
13 a robust, multi-stakeholder process, mater-
14 nal safety bundles to assist States and
15 health care systems in aligning national,
16 State, and hospital-level quality improve-
17 ment efforts to improve maternal health
18 outcomes, specifically the reduction of ma-
19 ternal mortality and severe maternal mor-
20 bidity;

21 (ii) to ensure, in developing and im-
22 plementing maternal safety bundles under
23 clause (i), that such maternal safety bun-
24 dles—

- 1 (I) satisfy the quality improve-
2 ment needs of a State or health care
3 system by factoring in the results and
4 findings of relevant data reviews, such
5 as reviews conducted by a State ma-
6 ternal mortality review committee;
7 and
- 8 (II) address topics such as—
- 9 (aa) obstetric hemorrhage;
 - 10 (bb) maternal mental health;
 - 11 (cc) the maternal venous
12 system;
 - 13 (dd) obstetric care for
14 women with substance use dis-
15 orders, including opioid use dis-
16 order;
 - 17 (ee) postpartum care basics
18 for maternal safety;
 - 19 (ff) reduction of peripartum
20 racial and ethnic disparities;
 - 21 (gg) reduction of primary
22 caesarean birth;
 - 23 (hh) severe hypertension in
24 pregnancy;

- 1 (ii) severe maternal mor-
2 bidity reviews;
3 (jj) support after a severe
4 maternal morbidity event;
5 (kk) thromboembolism;
6 (ll) optimization of support
7 for breastfeeding; and
8 (mm) maternal oral health;
9 and
10 (iii) to provide ongoing technical as-
11 sistance at the national and State levels to
12 support implementation of maternal safety
13 bundles under clause (i).

14 (D) MATERNAL SAFETY BUNDLE DE-
15 FINED.—For purposes of this paragraph, the
16 term “maternal safety bundle” means standard-
17 ized, evidence-informed processes for maternal
18 health care.

19 (E) AUTHORIZATION OF APPROPRIA-
20 TIONS.—For purposes of carrying out this
21 paragraph, there is authorized to be appro-
22 priated \$10,000,000 for each of fiscal years
23 2021 through 2025.

1 (4) FUNDING FOR STATE-BASED PERINATAL
2 QUALITY COLLABORATIVES DEVELOPMENT AND SUS-
3 TAINABILITY.—

4 (A) IN GENERAL.—Not later than one year
5 after the date of enactment of this Act, the Sec-
6 retary of Health and Human Services (referred
7 to in this paragraph as the “Secretary”), acting
8 through the Division of Reproductive Health of
9 the Centers for Disease Control and Prevention,
10 shall establish a grant program to be known as
11 the State-Based Perinatal Quality Collaborative
12 grant program under which the Secretary
13 awards grants to eligible entities for the pur-
14 pose of development and sustainability of
15 perinatal quality collaboratives in every State,
16 the District of Columbia, and eligible terri-
17 tories, in order to measurably improve perinatal
18 care and perinatal health outcomes for preg-
19 nant and postpartum women and their infants.

20 (B) GRANT AMOUNTS.—Grants awarded
21 under this paragraph shall be in amounts not to
22 exceed \$250,000 per year, for the duration of
23 the grant period.

24 (C) STATE-BASED PERINATAL QUALITY
25 COLLABORATIVE DEFINED.—For purposes of

1 this paragraph, the term “State-based perinatal
2 quality collaborative” means a network of mul-
3 tidisciplinary teams that—

4 (i) work to improve measurable out-
5 comes for maternal and infant health by
6 advancing evidence-informed clinical prac-
7 tices using quality improvement principles;

8 (ii) work with hospital-based or out-
9 patient facility-based clinical teams, ex-
10 perts, and stakeholders, including patients
11 and families, to spread best practices and
12 optimize resources to improve perinatal
13 care and outcomes;

14 (iii) employ strategies that include the
15 use of the collaborative learning model to
16 provide opportunities for hospitals and
17 clinical teams to collaborate on improve-
18 ment strategies, rapid-response data to
19 provide timely feedback to hospital and
20 other clinical teams to track progress, and
21 quality improvement science to provide
22 support and coaching to hospital and clin-
23 ical teams; and

1 (iv) have the goal of improving popu-
2 lation-level outcomes in maternal and in-
3 fant health.

4 (D) AUTHORIZATION OF APPROPRIA-
5 TIONS.—For purposes of carrying out this
6 paragraph, there is authorized to be appro-
7 priated \$14,000,000 per year for each of fiscal
8 years 2021 through 2025.

9 (5) EXPANSION OF MEDICAID AND CHIP COV-
10 ERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

11 (A) REQUIRING COVERAGE OF CERTAIN
12 ORAL HEALTH SERVICES FOR PREGNANT AND
13 POSTPARTUM WOMEN.—

14 (i) MEDICAID.—Subsection (gg) of
15 section 1905 of the Social Security Act (42
16 U.S.C. 1396d), as added by section
17 433(d), is amended—

18 (I) in paragraph (1), by striking
19 “paragraphs (2) and (3)” and insert-
20 ing “paragraphs (2), (3), and (4)”;
21 and

22 (II) by adding at the end the fol-
23 lowing new paragraph:

24 “(4) Such term shall include, in the case of a
25 woman who is pregnant (or during the 1-year period

1 beginning on the last day of her pregnancy) preven-
2 tive, diagnostic, periodontal, and restorative services
3 recommended for perinatal oral health care and den-
4 tal care during pregnancy by the American Academy
5 of Pediatric Dentistry and the American College of
6 Obstetricians and Gynecologists.”.

7 (ii) CHIP.—Section 2103(c)(5)(A) of
8 the Social Security Act (42 U.S.C.
9 1397cc(e)(5)(A)) is amended by inserting
10 “or a targeted low-income pregnant
11 woman” after “targeted low-income child”.

12 (B) EXTENDING MEDICAID COVERAGE FOR
13 PREGNANT AND POSTPARTUM WOMEN.—Section
14 1902 of the Social Security Act (42 U.S.C.
15 1396a) is amended—

16 (i) in subsection (e)—

17 (I) in paragraph (5)—

18 (aa) by inserting “(including
19 oral health services (as defined in
20 section 1905(gg) and including
21 services for pregnant and
22 postpartum women described in
23 paragraph (4) of such section)”
24 after “postpartum medical assist-
25 ance under the plan”; and

1 (bb) by striking “60-day”
2 and inserting “1-year”; and
3 (II) in paragraph (6), by striking
4 “60-day” and inserting “1-year”; and
5 (ii) in subsection (l)(1)(A), by striking
6 “60-day” and inserting “1-year”.

7 (C) EXTENDING MEDICAID COVERAGE FOR
8 LAWFUL RESIDENTS.—Section 1903(v)(4)(A) of
9 the Social Security Act (42 U.S.C.
10 1396b(v)(4)(A)) is amended by striking “60-
11 day” and inserting “1-year”.

12 (D) EXTENDING CHIP COVERAGE FOR
13 PREGNANT AND POSTPARTUM WOMEN.—Section
14 2112(d)(2)(A) of the Social Security Act (42
15 U.S.C. 1397ll(d)(2)(A)) is amended by striking
16 “60-day” and inserting “1-year”.

17 (E) MAINTENANCE OF EFFORT.—

18 (i) MEDICAID.—Section 1902(l) of the
19 Social Security Act (42 U.S.C. 1396a(l)) is
20 amended by adding at the end the fol-
21 lowing new paragraph:

22 “(5) During the period that begins on the date of
23 enactment of this paragraph and ends on the date that
24 is 5 years after such date of enactment, as a condition
25 for receiving any Federal payments under section 1903(a)

1 for calendar quarters occurring during such period, a
2 State shall not have in effect, with respect to women who
3 are eligible for medical assistance under the State plan
4 or under a waiver of such plan on the basis of being preg-
5 nant or having been pregnant, eligibility standards, meth-
6 odologies, or procedures under the State plan or waiver
7 that are more restrictive than the eligibility standards,
8 methodologies, or procedures, respectively, under such
9 plan or waiver that are in effect on the date of enactment
10 of this paragraph.”.

11 (ii) CHIP.—Section 2105(d) of the
12 Social Security Act (42 U.S.C. 1397ee(d))
13 is amended by adding at the end the fol-
14 lowing new paragraph:

15 “(4) INELIGIBILITY STANDARDS FOR TARGETED
16 LOW-INCOME PREGNANT WOMEN.—During the pe-
17 riod that begins on the date of enactment of this
18 paragraph and ends on the date that is 5 years after
19 such date of enactment, as a condition of receiving
20 payments under subsection (a) and section 1903(a),
21 a State that elects to provide assistance to women
22 on the basis of being pregnant (including pregnancy-
23 related assistance provided to targeted low-income
24 pregnant women (as defined in section 2112(d)),
25 pregnancy-related assistance provided to women who

1 are eligible for such assistance through application
2 of section 1902(v)(4)(A)(i) under section 2107(e)(1),
3 or any other assistance under the State child health
4 plan (or a waiver of such plan) which is provided to
5 women on the basis of being pregnant) shall not
6 have in effect, with respect to such women, eligibility
7 standards, methodologies, or procedures under such
8 plan (or waiver) that are more restrictive than the
9 eligibility standards, methodologies, or procedures,
10 respectively, under such plan (or waiver) that are in
11 effect on the date of enactment of this paragraph.”.

12 (F) INFORMATION ON BENEFITS.—The
13 Secretary of Health and Human Services shall
14 make publicly available on the internet website
15 of the Department of Health and Human Serv-
16 ices, information regarding benefits available to
17 pregnant and postpartum women and under the
18 Medicaid program and the Children’s Health
19 Insurance Program, including information on—

20 (i) benefits that States are required to
21 provide to pregnant and postpartum
22 women under such programs;

23 (ii) optional benefits that States may
24 provide to pregnant and postpartum
25 women under such programs; and

1 (iii) the availability of different kinds
2 of benefits for pregnant and postpartum
3 women, including oral health and mental
4 health benefits, under such programs.

5 (G) FEDERAL FUNDING FOR COST OF EX-
6 TENDED MEDICAID AND CHIP COVERAGE FOR
7 POSTPARTUM WOMEN.—

8 (i) MEDICAID.—Section 1905 of the
9 Social Security Act (42 U.S.C. 1396d), as
10 amended by section 433(d), is further
11 amended—

12 (I) in subsection (b), by striking
13 “and (ff)” and inserting “(ff), and
14 (hh)”;

15 (II) by adding at the end the fol-
16 lowing:

17 “(hh) INCREASED FMAP FOR EXTENDED MEDICAL
18 ASSISTANCE FOR POSTPARTUM WOMEN.—Notwith-
19 standing subsection (b), the Federal medical assistance
20 percentage for a State, with respect to amounts expended
21 by such State for medical assistance for a woman who is
22 eligible for such assistance on the basis of being pregnant
23 or having been pregnant that is provided during the 305-
24 day period that begins on the 60th day after the last day
25 of her pregnancy (including any such assistance provided

1 during the month in which such period ends), shall be
2 equal to—

3 “(1) 100 percent for the first 20 calendar quar-
4 ters during which this subsection is in effect; and

5 “(2) 90 percent for calendar quarters there-
6 after.”.

7 (ii) CHIP.—Section 2105(c) of the
8 Social Security Act (42 U.S.C. 1397ee(e))
9 is amended by adding at the end the fol-
10 lowing new paragraph:

11 “(12) ENHANCED PAYMENT FOR EXTENDED
12 ASSISTANCE PROVIDED TO PREGNANT WOMEN.—
13 Notwithstanding subsection (b), the enhanced
14 FMAP, with respect to payments under subsection
15 (a) for expenditures under the State child health
16 plan (or a waiver of such plan) for assistance pro-
17 vided under the plan (or waiver) to a woman who is
18 eligible for such assistance on the basis of being
19 pregnant (including pregnancy-related assistance
20 provided to a targeted low-income pregnant woman
21 (as defined in section 2112(d)), pregnancy-related
22 assistance provided to a woman who is eligible for
23 such assistance through application of section
24 1902(v)(4)(A)(i) under section 2107(e)(1), or any
25 other assistance under the plan (or waiver) provided

1 to a woman who is eligible for such assistance on the
2 basis of being pregnant) during the 305-day period
3 that begins on the 60th day after the last day of her
4 pregnancy (including any such assistance provided
5 during the month in which such period ends), shall
6 be equal to—

7 “(A) 100 percent for the first 20 calendar
8 quarters during which this paragraph is in ef-
9 fect; and

10 “(B) 90 percent for calendar quarters
11 thereafter.”.

12 (H) EFFECTIVE DATE.—

13 (i) IN GENERAL.—Subject to subpara-
14 graph (B), the amendments made by this
15 subsection shall take effect on the first day
16 of the first calendar quarter that begins on
17 or after the date that is one year after the
18 date of enactment of this Act.

19 (ii) EXCEPTION FOR STATE LEGISLA-
20 TION.—In the case of a State plan under
21 title XIX of the Social Security Act or a
22 State child health plan under title XXI of
23 such Act that the Secretary of Health and
24 Human Services determines requires State
25 legislation in order for the respective plan

1 to meet any requirement imposed by
 2 amendments made by this subsection, the
 3 respective plan shall not be regarded as
 4 failing to comply with the requirements of
 5 such title solely on the basis of its failure
 6 to meet such an additional requirement be-
 7 fore the first day of the first calendar
 8 quarter beginning after the close of the
 9 first regular session of the State legislature
 10 that begins after the date of enactment of
 11 this Act. For purposes of the previous sen-
 12 tence, in the case of a State that has a 2-
 13 year legislative session, each year of the
 14 session shall be considered to be a separate
 15 regular session of the State legislature.

16 (6) REGIONAL CENTERS OF EXCELLENCE.—
 17 Part P of title III of the Public Health Service Act
 18 (42 U.S.C. 280g et seq.) is amended by adding at
 19 the end the following new section:

20 **“SEC. 399V-7. REGIONAL CENTERS OF EXCELLENCE AD-**
 21 **DRESSING IMPLICIT BIAS AND CULTURAL**
 22 **COMPETENCY IN PATIENT-PROVIDER INTER-**
 23 **ACTIONS EDUCATION.**

24 “(a) IN GENERAL.—Not later than one year after the
 25 date of enactment of this section, the Secretary, in con-

1 sultation with such other agency heads as the Secretary
2 determines appropriate, shall award cooperative agree-
3 ments for the establishment or support of regional centers
4 of excellence addressing implicit bias and cultural com-
5 petency in patient-provider interactions education for the
6 purpose of enhancing and improving how health care pro-
7 fessionals are educated in implicit bias and delivering cul-
8 turally competent health care.

9 “(b) ELIGIBILITY.—To be eligible to receive a cooper-
10 ative agreement under subsection (a), an entity shall—

11 “(1) be a public or other nonprofit entity speci-
12 fied by the Secretary that provides educational and
13 training opportunities for students and health care
14 professionals, which may be a health system, teach-
15 ing hospital, community health center, medical
16 school, school of public health, dental school, social
17 work school, school of professional psychology, or
18 any other health professional school or program at
19 an institution of higher education (as defined in sec-
20 tion 101 of the Higher Education Act of 1965) fo-
21 cused on the prevention, treatment, or recovery of
22 health conditions that contribute to maternal mor-
23 tality and the prevention of maternal mortality and
24 severe maternal morbidity;

1 “(2) demonstrate community engagement and
2 participation, such as through partnerships with
3 home visiting and case management programs; and

4 “(3) provide to the Secretary such information,
5 at such time and in such manner, as the Secretary
6 may require.

7 “(c) DIVERSITY.—In awarding a cooperative agree-
8 ment under subsection (a), the Secretary shall take into
9 account any regional differences among eligible entities
10 and make an effort to ensure geographic diversity among
11 award recipients.

12 “(d) DISSEMINATION OF INFORMATION.—

13 “(1) PUBLIC AVAILABILITY.—The Secretary
14 shall make publicly available on the internet website
15 of the Department of Health and Human Services
16 information submitted to the Secretary under sub-
17 section (b)(3).

18 “(2) EVALUATION.—The Secretary shall evalu-
19 ate each regional center of excellence established or
20 supported pursuant to subsection (a) and dissemi-
21 nate the findings resulting from each such evalua-
22 tion to the appropriate public and private entities.

23 “(3) DISTRIBUTION.—The Secretary shall share
24 evaluations and overall findings with State depart-

1 ments of health and other relevant State level offices
2 to inform State and local best practices.

3 “(e) MATERNAL MORTALITY DEFINED.—In this sec-
4 tion, the term ‘maternal mortality’ means death of a
5 woman that occurs during pregnancy or within the one-
6 year period following the end of such pregnancy.

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
8 purposes of carrying out this section, there is authorized
9 to be appropriated \$5,000,000 for each of fiscal years
10 2021 through 2025.”.

11 (7) SPECIAL SUPPLEMENTAL NUTRITION PRO-
12 GRAM FOR WOMEN, INFANTS, AND CHILDREN.—

13 (A) DEFINITION OF BREASTFEEDING
14 WOMAN.—Section 17(b) of the Child Nutrition
15 Act of 1966 (42 U.S.C. 1786(b)) is amended by
16 striking paragraph (1) and inserting the fol-
17 lowing:

18 “(1) BREASTFEEDING WOMAN.—The term
19 ‘breastfeeding woman’ means a woman who is not
20 more than 2 years postpartum and is breastfeeding
21 the infant of the woman.”.

22 (B) CERTIFICATION.—Section
23 17(d)(3)(A)(ii) of the Child Nutrition Act of
24 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amend-
25 ed—

1 (i) by striking the clause designation
 2 and heading and all that follows through
 3 “A State” and inserting the following:

4 “(ii) WOMEN.—

5 “(I) BREASTFEEDING WOMEN.—
 6 A State”;

7 (ii) in subclause (I) (as so des-
 8 ignated), by striking “1 year” and all that
 9 follows through “earlier” and inserting “2
 10 years postpartum”; and

11 (iii) by adding at the end the fol-
 12 lowing:

13 “(II) POSTPARTUM WOMEN.—A
 14 State may elect to certify a
 15 postpartum woman for a period of 2
 16 years.”.

17 (8) DEFINITIONS.—In this section:

18 (A) MATERNAL MORTALITY.—The term
 19 “maternal mortality” means death of a woman
 20 that occurs during pregnancy or within the one-
 21 year period following the end of such preg-
 22 nancy.

23 (B) SEVERE MATERNAL MORBIDITY.—The
 24 term “severe maternal morbidity” includes un-
 25 expected outcomes of labor and delivery that re-

1 sult in significant short-term or long-term con-
2 sequences to a woman's health.

3 (d) INCREASING EXCISE TAXES ON CIGARETTES AND
4 ESTABLISHING EXCISE TAX EQUITY AMONG ALL TO-
5 BACCO PRODUCT TAX RATES.—

6 (1) TAX PARITY FOR ROLL-YOUR-OWN TO-
7 BACCO.—Section 5701(g) of the Internal Revenue
8 Code of 1986 is amended by striking “\$24.78” and
9 inserting “\$49.56”.

10 (2) TAX PARITY FOR PIPE TOBACCO.—Section
11 5701(f) of the Internal Revenue Code of 1986 is
12 amended by striking “\$2.8311 cents” and inserting
13 “\$49.56”.

14 (3) TAX PARITY FOR SMOKELESS TOBACCO.—

15 (A) Section 5701(e) of the Internal Rev-
16 enue Code of 1986 is amended—

17 (i) in paragraph (1), by striking
18 “\$1.51” and inserting “\$26.84”;

19 (ii) in paragraph (2), by striking
20 “50.33 cents” and inserting “\$10.74”; and

21 (iii) by adding at the end the fol-
22 lowing:

23 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
24 SINGLE-USE UNITS.—On discrete single-use units,
25 \$100.66 per thousand.”.

1 (B) Section 5702(m) of such Code is
2 amended—

3 (i) in paragraph (1), by striking “or
4 chewing tobacco” and inserting “, chewing
5 tobacco, or discrete single-use unit”;

6 (ii) in paragraphs (2) and (3), by in-
7 sserting “that is not a discrete single-use
8 unit” before the period in each such para-
9 graph; and

10 (iii) by adding at the end the fol-
11 lowing:

12 “(4) DISCRETE SINGLE-USE UNIT.—The term
13 ‘discrete single-use unit’ means any product con-
14 taining tobacco that—

15 “(A) is not intended to be smoked; and

16 “(B) is in the form of a lozenge, tablet,
17 pill, pouch, dissolvable strip, or other discrete
18 single-use or single-dose unit.”.

19 (4) TAX PARITY FOR SMALL CIGARS.—Para-
20 graph (1) of section 5701(a) of the Internal Revenue
21 Code of 1986 is amended by striking “\$50.33” and
22 inserting “\$100.66”.

23 (5) TAX PARITY FOR LARGE CIGARS.—

24 (A) IN GENERAL.—Paragraph (2) of sec-
25 tion 5701(a) of the Internal Revenue Code of

1 1986 is amended by striking “52.75 percent”
2 and all that follows through the period and in-
3 serting the following: “\$49.56 per pound and a
4 proportionate tax at the like rate on all frac-
5 tional parts of a pound but not less than
6 10.066 cents per cigar.”.

7 (B) GUIDANCE.—The Secretary of the
8 Treasury, or the Secretary’s delegate, may issue
9 guidance regarding the appropriate method for
10 determining the weight of large cigars for pur-
11 poses of calculating the applicable tax under
12 section 5701(a)(2) of the Internal Revenue
13 Code of 1986.

14 (6) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO
15 AND CERTAIN PROCESSED TOBACCO.—Subsection (o)
16 of section 5702 of the Internal Revenue Code of
17 1986 is amended by inserting “, and includes proc-
18 essed tobacco that is removed for delivery or deliv-
19 ered to a person other than a person with a permit
20 provided under section 5713, but does not include
21 removals of processed tobacco for exportation” after
22 “wrappers thereof”.

23 (7) CLARIFYING TAX RATE FOR OTHER TO-
24 BACCO PRODUCTS.—

1 (A) IN GENERAL.—Section 5701 of the In-
2 ternal Revenue Code of 1986 is amended by
3 adding at the end the following new subsection:

4 “(i) OTHER TOBACCO PRODUCTS.—Any product not
5 otherwise described under this section that has been deter-
6 mined to be a tobacco product by the Food and Drug Ad-
7 ministration through its authorities under the Family
8 Smoking Prevention and Tobacco Control Act shall be
9 taxed at a level of tax equivalent to the tax rate for ciga-
10 rettes on an estimated per use basis as determined by the
11 Secretary.”.

12 (B) ESTABLISHING PER USE BASIS.—For
13 purposes of section 5701(i) of the Internal Rev-
14 enue Code of 1986, not later than 12 months
15 after the later of the date of the enactment of
16 this Act or the date that a product has been de-
17 termined to be a tobacco product by the Food
18 and Drug Administration, the Secretary of the
19 Treasury (or the Secretary of the Treasury’s
20 delegate) shall issue final regulations estab-
21 lishing the level of tax for such product that is
22 equivalent to the tax rate for cigarettes on an
23 estimated per use basis.

24 (8) CLARIFYING DEFINITION OF TOBACCO
25 PRODUCTS.—

1 (A) IN GENERAL.—Subsection (c) of sec-
2 tion 5702 of the Internal Revenue Code of 1986
3 is amended to read as follows:

4 “(c) TOBACCO PRODUCTS.—The term ‘tobacco prod-
5 ucts’ means—

6 “(1) cigars, cigarettes, smokeless tobacco, pipe
7 tobacco, and roll-your-own tobacco, and

8 “(2) any other product subject to tax pursuant
9 to section 5701(i).”.

10 (B) CONFORMING AMENDMENTS.—Sub-
11 section (d) of section 5702 of such Code is
12 amended by striking “cigars, cigarettes, smoke-
13 less tobacco, pipe tobacco, or roll-your-own to-
14 bacco” each place it appears and inserting “to-
15 bacco products”.

16 (9) INCREASING TAX ON CIGARETTES.—

17 (A) SMALL CIGARETTES.—Section
18 5701(b)(1) of such Code is amended by striking
19 “\$50.33” and inserting “\$100.66”.

20 (B) LARGE CIGARETTES.—Section
21 5701(b)(2) of such Code is amended by striking
22 “\$105.69” and inserting “\$211.38”.

23 (10) TAX RATES ADJUSTED FOR INFLATION.—
24 Section 5701 of such Code, as amended by sub-

1 section (g), is amended by adding at the end the fol-
2 lowing new subsection:

3 “(j) INFLATION ADJUSTMENT.—

4 “(1) IN GENERAL.—In the case of any calendar
5 year beginning after 2018, the dollar amounts pro-
6 vided under this chapter shall each be increased by
7 an amount equal to—

8 “(A) such dollar amount, multiplied by

9 “(B) the cost-of-living adjustment deter-
10 mined under section 1(f)(3) for the calendar
11 year, determined by substituting ‘calendar year
12 2017’ for ‘calendar year 2016’ in subparagraph
13 (A)(ii) thereof.

14 “(2) ROUNDING.—If any amount as adjusted
15 under paragraph (1) is not a multiple of \$0.01, such
16 amount shall be rounded to the next highest multiple
17 of \$0.01.”.

18 (11) FLOOR STOCKS TAXES.—

19 (A) IMPOSITION OF TAX.—On tobacco
20 products manufactured in or imported into the
21 United States which are removed before any tax
22 increase date and held on such date for sale by
23 any person, there is hereby imposed a tax in an
24 amount equal to the excess of—

1 (i) the tax which would be imposed
2 under section 5701 of the Internal Rev-
3 enue Code of 1986 on the article if the ar-
4 ticle had been removed on such date, over

5 (ii) the prior tax (if any) imposed
6 under section 5701 of such Code on such
7 article.

8 (B) CREDIT AGAINST TAX.—Each person
9 shall be allowed as a credit against the taxes
10 imposed by paragraph (1) an amount equal to
11 \$500. Such credit shall not exceed the amount
12 of taxes imposed by paragraph (1) on such date
13 for which such person is liable.

14 (C) LIABILITY FOR TAX AND METHOD OF
15 PAYMENT.—

16 (i) LIABILITY FOR TAX.—A person
17 holding tobacco products on any tax in-
18 crease date to which any tax imposed by
19 paragraph (1) applies shall be liable for
20 such tax.

21 (ii) METHOD OF PAYMENT.—The tax
22 imposed by paragraph (1) shall be paid in
23 such manner as the Secretary shall pre-
24 scribe by regulations.

1 (iii) TIME FOR PAYMENT.—The tax
2 imposed by paragraph (1) shall be paid on
3 or before the date that is 120 days after
4 the effective date of the tax rate increase.

5 (D) ARTICLES IN FOREIGN TRADE
6 ZONES.—Notwithstanding the Act of June 18,
7 1934 (commonly known as the Foreign Trade
8 Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.),
9 or any other provision of law, any article which
10 is located in a foreign trade zone on any tax in-
11 crease date shall be subject to the tax imposed
12 by paragraph (1) if—

13 (i) internal revenue taxes have been
14 determined, or customs duties liquidated,
15 with respect to such article before such
16 date pursuant to a request made under the
17 1st proviso of section 3(a) of such Act; or

18 (ii) such article is held on such date
19 under the supervision of an officer of the
20 United States Customs and Border Protec-
21 tion of the Department of Homeland Secu-
22 rity pursuant to the 2d proviso of such sec-
23 tion 3(a).

24 (E) DEFINITIONS.—For purposes of this
25 subsection—

1 (i) IN GENERAL.—Any term used in
2 this subsection which is also used in sec-
3 tion 5702 of such Code shall have the
4 same meaning as such term has in such
5 section.

6 (ii) TAX INCREASE DATE.—The term
7 “tax increase date” means the effective
8 date of any increase in any tobacco prod-
9 uct excise tax rate pursuant to the amend-
10 ments made by this section (other than
11 subsection (j) thereof).

12 (iii) SECRETARY.—The term “Sec-
13 retary” means the Secretary of the Treas-
14 ury or the Secretary’s delegate.

15 (F) CONTROLLED GROUPS.—Rules similar
16 to the rules of section 5061(e)(3) of such Code
17 shall apply for purposes of this subsection.

18 (G) OTHER LAWS APPLICABLE.—All provi-
19 sions of law, including penalties, applicable with
20 respect to the taxes imposed by section 5701 of
21 such Code shall, insofar as applicable and not
22 inconsistent with the provisions of this sub-
23 section, apply to the floor stocks taxes imposed
24 by paragraph (1), to the same extent as if such
25 taxes were imposed by such section 5701. The

1 Secretary may treat any person who bore the
2 ultimate burden of the tax imposed by para-
3 graph (1) as the person to whom a credit or re-
4 fund under such provisions may be allowed or
5 made.

6 (12) EFFECTIVE DATES.—

7 (A) IN GENERAL.—Except as provided in
8 paragraphs (2) through (4), the amendments
9 made by this section shall apply to articles re-
10 moved (as defined in section 5702(j) of the In-
11 ternal Revenue Code of 1986) after the last day
12 of the month which includes the date of the en-
13 actment of this Act.

14 (B) DISCRETE SINGLE-USE UNITS AND
15 PROCESSED TOBACCO.—The amendments made
16 by subsections (c)(1)(C), (c)(2), and (f) shall
17 apply to articles removed (as defined in section
18 5702(j) of the Internal Revenue Code of 1986)
19 after the date that is 6 months after the date
20 of the enactment of this Act.

21 (C) LARGE CIGARS.—The amendments
22 made by subsection (e) shall apply to articles
23 removed after December 31, 2021.

24 (D) OTHER TOBACCO PRODUCTS.—The
25 amendments made by subsection (g)(1) shall

1 apply to products removed after the last day of
2 the month which includes the date that the Sec-
3 retary of the Treasury (or the Secretary of the
4 Treasury’s delegate) issues final regulations es-
5 tablishing the level of tax for such product.

6 **SEC. 506. RURAL MATERNAL AND OBSTETRIC MODERNIZA-**
7 **TION OF SERVICES.**

8 (a) SHORT TITLE.—This section may be cited as the
9 “Rural Maternal and Obstetric Modernization of Services
10 Act” or the “Rural MOMS Act”.

11 (b) IMPROVING RURAL MATERNAL AND OBSTETRIC
12 CARE DATA.—

13 (1) MATERNAL MORTALITY AND MORBIDITY AC-
14 TIVITIES.—Section 301 of the Public Health Service
15 Act (42 U.S.C. 241) is amended—

16 (A) by redesignating subsections (e)
17 through (h) as subsections (f) through (i), re-
18 spectively; and

19 (B) by inserting after subsection (d), the
20 following:

21 “(e) The Secretary, acting through the Director of
22 the Centers for Disease Control and Prevention, shall ex-
23 pand, intensify, and coordinate the activities of the Cen-
24 ters for Disease Control and Prevention with respect to
25 maternal mortality and morbidity.”.

1 (2) OFFICE OF WOMEN’S HEALTH.—Section
2 310A(b)(1) of the Public Health Service Act (42
3 U.S.C. 242s(b)(1)) is amended by striking “and
4 sociocultural contexts” and inserting “sociocultural
5 (including race, ethnicity, language, class, and in-
6 come) contexts, including among Indians (as defined
7 in section 4 of the Indian Health Care Improvement
8 Act), and geographic contexts,” after “biological,”.

9 (3) SAFE MOTHERHOOD.—Section 317K(b)(2)
10 of the Public Health Service Act (42 U.S.C. 247b-
11 12(b)(2)) is amended—

12 (A) in subparagraph (L), by striking
13 “and” at the end;

14 (B) by redesignating subparagraph (M) as
15 subparagraph (N); and

16 (C) by inserting after subparagraph (L),
17 the following:

18 “(M) an examination of the relationship
19 between maternal health services in rural areas
20 and outcomes in delivery and postpartum care;
21 and”.

22 (4) OFFICE OF RESEARCH ON WOMEN’S
23 HEALTH.—Section 486 of the Public Health Service
24 Act (42 U.S.C. 287d) is amended—

25 (A) in subsection (b)—

1 (i) by redesignating paragraphs (4)
2 through (9) as paragraphs (5) through
3 (10), respectively;

4 (ii) by inserting after paragraph (3)
5 the following:

6 “(4) carry out paragraphs (1) and (2) with re-
7 spect to pregnancy, with priority given to deaths re-
8 lated to pregnancy;” and

9 (iii) in paragraph (5) (as so redesi-
10 gnated), by striking “through (3)” and in-
11 serting “through (4)”;

12 (B) in subsection (d)(4)(A)(iv), by insert-
13 ing “, including maternal mortality and other
14 maternal morbidity outcomes” before the semi-
15 colon.

16 (c) RURAL OBSTETRIC NETWORK GRANTS.—The
17 Public Health Service Act is amended by inserting after
18 section 317L–1 (42 U.S.C. 247b–13a) the following:

19 **“SEC. 317L–2. RURAL OBSTETRIC NETWORK GRANTS.**

20 “(a) IN GENERAL.—For the purpose of enabling the
21 Secretary (through grants, contracts, or otherwise), acting
22 through the Administrator of the Health Resources and
23 Services Administration, to establish collaborative im-
24 provement and innovation networks (referred to in this
25 section as ‘rural obstetric networks’) to improve outcomes

1 in birth and maternal morbidity and mortality, there is
2 appropriated to the Secretary, out of any money in the
3 Treasury not otherwise appropriated, \$3,000,000 for each
4 of fiscal years 2021 through 2025. Such amounts shall
5 remain available until expended.

6 “(b) USE OF FUNDS.—Amounts appropriated under
7 subsection (a) shall be used for the establishment of col-
8 laborative improvement and innovation networks to im-
9 prove maternal health in rural areas by improving out-
10 comes in birth and maternal morbidity and mortality.
11 Rural obstetric networks established in accordance with
12 this section shall—

13 “(1) assist pregnant women and other individ-
14 uals in rural areas in connecting with prenatal, labor
15 and birth, and postpartum care to improve outcomes
16 in birth and maternal mortality and morbidity;

17 “(2) identify successful prenatal, labor and
18 birth, and postpartum health delivery models for in-
19 dividuals in rural areas, including evidence-based
20 home visiting programs and successful, culturally
21 competent models with positive maternal health out-
22 comes that advance health equity;

23 “(3) develop a model for collaboration between
24 health facilities that have an obstetric health unit

1 and health facilities that do not have an obstetric
2 health unit;

3 “(4) provide training and guidance for health
4 facilities that do not have obstetric health units;

5 “(5) collaborate with academic institutions that
6 can provide regional expertise and research on ac-
7 cess, outcomes, needs assessments, and other identi-
8 fied data; and

9 “(6) measure and address inequities in birth
10 outcomes among rural residents, with an emphasis
11 on Black residents and residents who are Indians
12 (as defined in section 4 of the Indian Health Care
13 Improvement Act).

14 “(c) REQUIREMENTS FOR ESTABLISHMENT.—Not
15 later than 6 months after the date of enactment of this
16 section, the Secretary shall establish rural obstetric health
17 networks in at least 5 regions.

18 “(d) DEFINITIONS.—In this section:

19 “(1) FRONTIER AREA.—The term ‘frontier
20 area’ means a frontier county, as defined in section
21 1886(d)(3)(E)(iii)(III) of the Social Security Act.

22 “(2) INDIAN; INDIAN TRIBE.—The terms ‘In-
23 dian’ and ‘Indian tribe’ have the meanings given
24 such terms in section 4 of the Indian Health Care
25 Improvement Act.

1 “(3) REGION.—The term ‘region’ means a
2 State, Indian tribe, rural area, or frontier area.

3 “(4) RURAL AREA.—The term ‘rural area’ has
4 the meaning given that term in section
5 1886(d)(2)(D) of the Social Security Act.

6 “(5) STATE.—The term ‘State’ has the mean-
7 ing given that term for purposes of title V of the So-
8 cial Security Act.”.

9 (d) TELEHEALTH NETWORK AND TELEHEALTH RE-
10 SOURCE CENTERS GRANT PROGRAMS.—Section 330I of
11 the Public Health Service Act (42 U.S.C. 254c-14) is
12 amended—

13 (1) in subsection (f)(3), by adding at the end
14 the following:

15 “(M) Providers of maternal care services,
16 including prenatal, labor and birth, and
17 postpartum care services, and entities operating
18 obstetric care units.”;

19 (2) in subsection (h)(1)(B), by striking “or pre-
20 natal” and inserting “or prenatal, labor and birth,
21 or postpartum”; and

22 (3) in subsection (j)(1)(B), by inserting “equip-
23 ment useful for caring for pregnant individuals, in-
24 cluding ultrasound machines and fetal monitoring
25 equipment, and other” before “equipment”.

1 (e) RURAL MATERNAL AND OBSTETRIC CARE TRAIN-
2 ING DEMONSTRATION.—Part D of title VII of the Public
3 Health Service Act is amended by inserting after section
4 760 (42 U.S.C. 294k) the following:

5 **“SEC. 760A. RURAL MATERNAL AND OBSTETRIC CARE**
6 **TRAINING DEMONSTRATION.**

7 “(a) IN GENERAL.—The Secretary shall establish a
8 training demonstration program to award to eligible enti-
9 ties—

10 “(1) grants to support training for physicians,
11 medical residents, and fellows (including physicians,
12 residents, and fellows in family medicine and obstet-
13 rics and gynecology) to practice maternal and ob-
14 stetric medicine in rural community-based settings;

15 “(2) grants to support training for licensed and
16 accredited nurse practitioners, physician assistants,
17 certified nurse midwives, certified midwives, certified
18 professional midwives, home visiting nurses, or non-
19 clinical professionals such as doulas and community
20 health workers, to provide maternal care services in
21 rural community-based settings; and

22 “(3) grants to—

23 “(A) support establishing, maintaining, or
24 improving academic units or programs that pro-
25 vide training for students or faculty, including

1 through clinical experiences and research, to
2 improve maternal care in rural areas; or

3 “(B) develop evidence-based practices or
4 recommendations for the design of the units or
5 programs described in subparagraph (A), in-
6 cluding curriculum content standards.

7 “(b) ACTIVITIES.—

8 “(1) TRAINING FOR PHYSICIANS, MEDICAL
9 RESIDENTS, AND FELLOWS.—A recipient of a grant
10 under subsection (a)(1)—

11 “(A) shall use the grant funds to plan, de-
12 velop, and operate a training program for the
13 physicians, medical residents, and fellows de-
14 scribed in subsection (a)(1) to provide maternal
15 and obstetric health care services in rural com-
16 munity-based settings; and

17 “(B) may use the grant funds to provide
18 additional support for the administration of the
19 program or to meet the costs of projects to es-
20 tablish, maintain, or improve faculty develop-
21 ment, or departments, divisions, or other units
22 necessary to implement such training.

23 “(2) TRAINING FOR OTHER PROVIDERS.—A re-
24 cipient of a grant under subsection (a)(2)—

1 “(A) shall use the grant funds to plan, de-
2 velop, or operate a training program for the in-
3 dividuals described in subsection (a)(2) to pro-
4 vide maternal health care services in rural, com-
5 munity-based settings; and

6 “(B) may use the grant funds to provide
7 additional support for the administration of the
8 program or to meet the costs of projects to es-
9 tablish, maintain, or improve faculty develop-
10 ment, or departments, divisions, or other units
11 necessary to implement such program.

12 “(3) ACADEMIC UNITS OR PROGRAMS.—A re-
13 cipient of a grant under subsection (a)(3) shall enter
14 into a partnership with organizations such as an
15 education accrediting organization (such as the Liai-
16 son Committee on Medical Education, the Accredita-
17 tion Council for Graduate Medical Education, the
18 Commission on Osteopathic College Accreditation,
19 the Accreditation Commission for Education in
20 Nursing, the Commission on Collegiate Nursing
21 Education, the Accreditation Commission for Mid-
22 wifery Education, or the Accreditation Review Com-
23 mission on Education for the Physician Assistant) to
24 carry out activities under subsection (a)(3).

1 “(4) TRAINING PROGRAM REQUIREMENTS.—

2 The recipient of a grant under subsection (a)(1) or
3 (a)(2) shall ensure that training programs carried
4 out under the grant include instruction on—

5 “(A) maternal mental health, including
6 perinatal depression and anxiety and
7 postpartum depression;

8 “(B) maternal substance use disorder;

9 “(C) social determinants of health that im-
10 pact individuals living in rural communities, in-
11 cluding poverty, social isolation, access to nutri-
12 tion, education, transportation, and housing;
13 and

14 “(D) implicit bias.

15 “(c) ELIGIBLE ENTITIES.—

16 “(1) TRAINING FOR PHYSICIANS, MEDICAL
17 RESIDENTS, AND FELLOWS.—To be eligible to re-
18 ceive a grant under subsection (a)(1), an entity
19 shall—

20 “(A) be a consortium consisting of—

21 “(i) at least one teaching health cen-
22 ter (as defined in section 749A(f)); or

23 “(ii) the sponsoring institution (or
24 parent institution of the sponsoring insti-
25 tution) of—

1 “(I) an obstetrics and gynecology
2 or family medicine residency program
3 that is accredited by the Accreditation
4 Council for Graduate Medical Edu-
5 cation (or the parent institution of
6 such a program); or

7 “(II) a fellowship in maternal or
8 obstetric medicine, as determined ap-
9 propriate by the Secretary; or

10 “(B) be an entity described in subpara-
11 graph (A)(ii) that provides opportunities for
12 medical residents or fellows to train in rural
13 community-based settings.

14 “(2) TRAINING FOR OTHER PROVIDERS.—To be
15 eligible to receive a grant under subsection (a)(2),
16 an entity shall be—

17 “(A) a teaching health center (as defined
18 in section 749A(f));

19 “(B) a federally qualified health center (as
20 defined in section 1905(l)(2)(B) of the Social
21 Security Act);

22 “(C) a community mental health center (as
23 defined in section 1861(ff)(3)(B) of the Social
24 Security Act);

1 “(D) a rural health clinic (as defined in
2 section 1861(aa) of the Social Security Act);

3 “(E) a freestanding birth center (as de-
4 fined in section 1905(l)(3) of the Social Secu-
5 rity Act);

6 “(F) a health center operated by—

7 “(i) the Indian Health Service, an In-
8 dian tribe, or a tribal organization (as such
9 terms are defined in section 4 of the In-
10 dian Health Care Improvement Act); or

11 “(ii) a Native Hawaiian Health Care
12 System (as defined in section 12 of the
13 Native Hawaiian Health Care Improve-
14 ment Act); or

15 “(G) an entity with a demonstrated record
16 of success in providing academic training for
17 nurse practitioners, physician assistants, cer-
18 tified nurse-midwives, certified midwives, cer-
19 tified professional midwives, home visiting
20 nurses, or non-clinical professionals, such as
21 doulas and community health workers.

22 “(3) ACADEMIC UNITS OR PROGRAMS.—To be
23 eligible to receive a grant under subsection (a)(3),
24 an entity shall be a school of medicine or osteopathic
25 medicine, a nursing school, a physician assistant

1 training program, an accredited public or nonprofit
2 private hospital, an accredited medical residency pro-
3 gram, a school accredited by the Midwifery Edu-
4 cation and Accreditation Council, or a public or pri-
5 vate nonprofit entity which the Secretary has deter-
6 mined is capable of carrying out activities supported
7 by such grant.

8 “(4) APPLICATION.—To be eligible to receive a
9 grant under subsection (a), an entity shall submit to
10 the Secretary an application at such time, in such
11 manner, and containing such information as the Sec-
12 retary may require, including an estimate of the
13 amount to be expended to conduct training activities
14 under the grant (including ancillary and administra-
15 tive costs).

16 “(d) DURATION.—Grants awarded under this section
17 shall be for a minimum of 5 years.

18 “(e) STUDY AND REPORT.—

19 “(1) STUDY.—

20 “(A) IN GENERAL.—The Secretary, acting
21 through the Administrator of the Health Re-
22 sources and Services Administration, shall con-
23 duct a study on the results of the demonstra-
24 tion program under this section.

1 “(B) DATA SUBMISSION.—Not later than
2 90 days after the completion of the first year
3 of the training program, and each subsequent
4 year for the duration of the grant, that the pro-
5 gram is in effect, each recipient of a grant
6 under subsection (a) shall submit to the Sec-
7 retary such data as the Secretary may require
8 for analysis for the report described in para-
9 graph (2).

10 “(2) REPORT TO CONGRESS.—Not later than 1
11 year after receipt of the data described in paragraph
12 (1)(B), the Secretary shall submit to Congress a re-
13 port that includes—

14 “(A) an analysis of the effect of the dem-
15 onstration program under this section on the
16 quality, quantity, and distribution of maternal,
17 including prenatal, labor and birth, and
18 postpartum care services and the demographics
19 of the recipients of those services;

20 “(B) an analysis of maternal and infant
21 health outcomes (including quality of care, mor-
22 bidity, and mortality) before and after imple-
23 mentation of the program in the communities
24 served by entities participating in the dem-
25 onstration; and

1 “(C) recommendations on whether the
2 demonstration program under this section
3 should be expanded.

4 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section,
6 \$5,000,000 for each of fiscal years 2021 through 2025.”.

7 (f) GAO REPORT.—Not later than 1 year after the
8 date of enactment of this Act, the Comptroller General
9 of the United States shall submit to the appropriate com-
10 mittees of Congress a report on the maternal, including
11 prenatal, labor and birth, and postpartum, care in rural
12 areas. Such report shall include the following:

13 (1) The location of gaps in maternal and ob-
14 stetric clinicians and health professionals, including
15 non-clinical professionals such as doulas and com-
16 munity health workers.

17 (2) The location of gaps in facilities able to pro-
18 vide maternal, including prenatal, labor and birth,
19 and postpartum, care in rural areas, including care
20 for high-risk pregnancies.

21 (3) The gaps in data on maternal mortality and
22 recommendations to standardize the format on col-
23 lecting data related to maternal mortality and mor-
24 bidity.

1 (4) The gaps in maternal health by race and
2 ethnicity in rural communities, with a focus on ra-
3 cial inequities for Black residents and among Indian
4 Tribes and residents who are Indian (as such terms
5 are defined in section 4 of the Indian Health Care
6 Improvement Act).

7 (5) A list of specific activities that the Sec-
8 retary of Health and Human Services plans to con-
9 duct on maternal, including prenatal, labor and
10 birth, and postpartum, care.

11 (6) A plan for completing such activities.

12 (7) An explanation of Federal agency involve-
13 ment and coordination needed to conduct such ac-
14 tivities.

15 (8) A budget for conducting such activities.

16 (9) Other information that the Comptroller
17 General determines appropriate.

18 **SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN**
19 **UNEXPECTED INFANT DEATH AND SUDDEN**
20 **UNEXPLAINED DEATH IN CHILDHOOD.**

21 (a) ESTABLISHMENT.—The Secretary of Health and
22 Human Services, acting through the Administrator of the
23 Health Resources and Services Administration and in con-
24 sultation with the Director of the Centers for Disease Con-
25 trol and Prevention and the Director of the National Insti-

1 tutes of Health (in this section referred to as the “Sec-
2 retary”), shall establish and implement a culturally and
3 linguistically competent public health awareness and edu-
4 cation campaign to provide information that is focused on
5 decreasing the risk factors for sudden unexpected infant
6 death and sudden unexplained death in childhood, includ-
7 ing educating individuals about safe sleep environments,
8 sleep positions, and reducing exposure to smoking during
9 pregnancy and after birth.

10 (b) TARGETED POPULATIONS.—The campaign under
11 subsection (a) shall be designed to reduce health dispari-
12 ties through the targeting of populations with high rates
13 of sudden unexpected infant death and sudden unex-
14 plained death in childhood.

15 (c) CONSULTATION.—In establishing and imple-
16 menting the campaign under subsection (a), the Secretary
17 shall consult with national organizations representing
18 health care providers, including nurses and physicians,
19 parents, child care providers, children’s advocacy and safe-
20 ty organizations, maternal and child health programs, nu-
21 trition professionals focusing on women, infants, and chil-
22 dren, and other individuals and groups determined nec-
23 essary by the Secretary for such establishment and imple-
24 mentation.

25 (d) GRANTS.—

1 (1) IN GENERAL.—In carrying out the cam-
2 paign under subsection (a), the Secretary shall
3 award grants to national organizations, State and
4 local health departments, and community-based or-
5 ganizations for the conduct of education and out-
6 reach programs for nurses, parents, child care pro-
7 viders, public health agencies, and community orga-
8 nizations.

9 (2) APPLICATION.—To be eligible to receive a
10 grant under paragraph (1), an entity shall submit to
11 the Secretary an application at such time, in such
12 manner, and containing such information as the Sec-
13 retary may require.

14 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to carry out this section
16 such sums as may be necessary for each of fiscal years
17 2021 through 2025.

18 **SEC. 508. REDUCING UNINTENDED TEENAGE PREG-**
19 **NANCIES.**

20 Title III of the Public Health Service Act (42 U.S.C.
21 241 et seq.) is amended by adding at the end the fol-
22 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(f) of the
13 Social Security Act (as in effect on the day before the date
14 of the enactment of this part) are hereby transferred and
15 made available to the Secretary to carry out this section.
16 The amounts transferred and made available to carry out
17 this section shall remain available until expended.

18 “(i) DEFINITIONS.—In this section:

19 “(1) COMMUNITY ORGANIZATION.—The term
20 ‘community organization’ includes a State or local
21 health or education agency, public school, youth-fo-
22 cused organization that is faith-based and commu-
23 nity-based, juvenile justice entity, or other organiza-
24 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 2021 through 2025.

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 2021 through 2025.

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 contraceptives.

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 promotores, 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 contraceptives and an explanation
24 of the use, safety, efficacy, affordability, and
25 availability, including over-the-counter access,

1 of such contraceptives and options for access
2 without cost-sharing through insurance and
3 other programs; and

4 (B) be pilot tested for consumer com-
5 prehension, cultural and linguistic appropriate-
6 ness, and acceptance of the messages across
7 geographically, racially, ethnically, and linguis-
8 tically diverse populations.

9 (b) EMERGENCY CONTRACEPTION INFORMATION
10 PROGRAM FOR HEALTH CARE PROVIDERS.—

11 (1) IN GENERAL.—The Secretary, acting
12 through the Administrator of the Health Resources
13 and Services Administration and in consultation
14 with major medical and public health organizations,
15 shall develop and disseminate to health care pro-
16 viders, including pharmacists, information on emer-
17 gency contraceptives.

18 (2) INFORMATION.—The information dissemi-
19 nated under paragraph (1) shall include, at a min-
20 imum—

21 (A) information describing the use, safety,
22 efficacy, and availability of emergency contra-
23 ceptives, and options for access without cost-
24 sharing through insurance and other programs;

1 (B) a recommendation regarding the use of
2 such contraceptives; and

3 (C) information explaining how to obtain
4 copies of the information developed under sub-
5 section (a) for distribution to the patients of
6 the providers.

7 (c) DEFINITIONS.—In this section:

8 (1) HEALTH CARE PROVIDER.—The term
9 “health care provider” means an individual who is li-
10 censed or certified under State law to provide health
11 care services and who is operating within the scope
12 of such license. Such term shall include a phar-
13 macist.

14 (2) INSTITUTION OF HIGHER EDUCATION.—The
15 term “institution of higher education” has the same
16 meaning given such term in section 101(a) of the
17 Higher Education Act of 1965 (20 U.S.C. 1001(a)).

18 (3) SECRETARY.—The term “Secretary” means
19 the Secretary of Health and Human Services.

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 the fiscal years
23 2021 through 2025.

24 **SEC. 511. COMPREHENSIVE SEX EDUCATION PROGRAMS.**

25 (a) PURPOSES; FINDING; SENSE OF CONGRESS.—

1 (1) PURPOSES.—The purposes of this section
2 are to provide young people with comprehensive sex
3 education programs that—

4 (A) promote and uphold the rights of
5 young people to information in order to make
6 healthy decisions about their sexual health;

7 (B) provide the information and skills all
8 young people need to make informed, respon-
9 sible, and healthy decisions in order to become
10 sexually healthy adults and have healthy rela-
11 tionships;

12 (C) provide information about the preven-
13 tion of unintended pregnancy, sexually trans-
14 mitted infections, including HIV, dating vio-
15 lence, sexual assault, bullying, and harassment;
16 and

17 (D) provide resources and information on
18 topics ranging from gender stereotyping and
19 gender roles and stigma and socio-cultural in-
20 fluences surrounding sex and sexuality.

21 (2) FINDING ON REQUIRED RESOURCES.—In
22 order to provide the comprehensive sex education de-
23 scribed in paragraph (1), Congress finds that in-
24 creased resources are required for sex education pro-
25 grams that—

1 (A) substantially incorporate elements of
2 evidence-based programs or characteristics of
3 effective programs;

4 (B) cover a broad range of topics, includ-
5 ing medically accurate and complete informa-
6 tion that is age and developmentally appro-
7 priate about all the aspects of sex, sexual
8 health, and sexuality;

9 (C) are gender and gender identity-sen-
10 sitive, emphasizing the importance of equality
11 and the social environment for achieving sexual
12 and reproductive health and overall well-being;

13 (D) promote educational achievement, crit-
14 ical thinking, decision making, self-esteem, and
15 self-efficacy;

16 (E) help develop healthy attitudes and in-
17 sights necessary for understanding relationships
18 between oneself and others and society;

19 (F) foster leadership skills and community
20 engagement by—

21 (i) promoting principles of fairness,
22 human dignity, and respect; and

23 (ii) engaging young people as partners
24 in their communities; and

1 (G) are culturally and linguistically appro-
2 priate, reflecting the diverse circumstances and
3 realities of young people.

4 (3) SENSE OF CONGRESS.—It is the sense of
5 Congress that—

6 (A) federally funded sex education pro-
7 grams should aim to—

8 (i) provide information about a range
9 of human sexuality topics, including—

10 (I) human development, healthy
11 relationships, personal skills;

12 (II) sexual behavior including ab-
13 stinence;

14 (III) sexual health including pre-
15 venting unintended pregnancy;

16 (IV) sexually transmitted infec-
17 tions including HIV; and

18 (V) society and culture;

19 (ii) promote safe and healthy relation-
20 ships;

21 (iii) promote gender equity;

22 (iv) use, and be informed by, the best
23 scientific information available;

24 (v) be culturally appropriate and in-
25 clusive of youth with varying gender identi-

1 ties, gender expressions, and sexual ori-
2 entations;

3 (vi) be built on characteristics of ef-
4 fective programs;

5 (vii) expand the existing body of re-
6 search on comprehensive sex education
7 programs through program evaluation;

8 (viii) expand training programs for
9 teachers of comprehensive sex education;

10 (ix) build on programs funded under
11 section 513 of the Social Security Act (42
12 U.S.C. 713) and the Office of Adolescent
13 Health’s Teen Pregnancy Prevention Pro-
14 gram, funded under title II of the Consoli-
15 dated Appropriations Act, 2010 (Public
16 Law 111–117; 123 Stat. 3253), and on
17 programs supported through the Centers
18 for Disease Control and Prevention (CDC);
19 and

20 (x) promote and uphold the rights of
21 young people to information in order to
22 make healthy and autonomous decisions
23 about their sexual health; and

24 (B) no Federal funds should be used for
25 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 decision-making 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 decision making;
- 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) an Indian Tribe or Tribal organization,
23 as defined in section 4 of the Indian Self-Deter-
24 mination and Education Assistance Act (25
25 U.S.C. 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) decision making
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 title
21 shall include information about the potential effects of in-
22 travenous substance abuse.”.

23 (2) AMENDMENTS TO THE ELEMENTARY AND
24 SECONDARY EDUCATION ACT OF 1965.—Section 8526

1 of the Elementary and Secondary Education Act of
2 1965 (20 U.S.C. 7906) is amended—

3 (A) by striking paragraph (3);

4 (B) by redesignating paragraphs (4) and
5 (5) as paragraphs (3) and (4), respectively;

6 (C) in paragraph (3), as redesignated by
7 subparagraph (B), by inserting “or” after the
8 semicolon;

9 (D) in paragraph (4), as redesignated by
10 subparagraph (B), by striking “; or” and in-
11 serting a period; and

12 (E) by striking paragraph (6).

13 (i) DEFINITIONS.—In this section:

14 (1) ADOLESCENTS.—The term “adolescents”
15 means individuals who are ages 10 through 19 at
16 the time of commencement of participation in a pro-
17 gram supported under this section.

18 (2) AGE AND DEVELOPMENTALLY APPRO-
19 PRIATE.—The term “age and developmentally appro-
20 priate” means topics, messages, and teaching meth-
21 ods suitable to particular age, age group of children
22 and adolescents, or developmental levels, based on
23 cognitive, emotional, social, and behavioral capacity
24 of most students at that age level.

1 (3) APPROPRIATE COMMITTEES OF CON-
2 GRESS.—The term “appropriate committees of Con-
3 gress” means the Committee on Health, Education,
4 Labor, and Pensions of the Senate, the Committee
5 on Appropriations of the Senate, the Committee on
6 Energy and Commerce of the House of Representa-
7 tives, the Committee on Education and Labor of the
8 House of Representatives, and the Committee on
9 Appropriations of the House of Representatives.

10 (4) CHARACTERISTICS OF EFFECTIVE PRO-
11 GRAMS.—The term “characteristics of effective pro-
12 grams” means the aspects of evidence-based pro-
13 grams, including development, content, and imple-
14 mentation of such programs, that—

15 (A) have been shown to be effective in
16 terms of increasing knowledge, clarifying values
17 and attitudes, increasing skills, and impacting
18 upon behavior; and

19 (B) are widely recognized by leading med-
20 ical and public health agencies to be effective in
21 changing sexual behaviors that lead to sexually
22 transmitted infections, including HIV, unin-
23 tended pregnancy, and dating violence and sex-
24 ual assault among young people.

1 (5) COMPREHENSIVE SEX EDUCATION.—The
2 term “comprehensive sex education” means instruc-
3 tional part of a comprehensive school health edu-
4 cation approach which addresses the physical, men-
5 tal, emotional, and social dimensions of human sexu-
6 ality; designed to motivate and assist students to
7 maintain and improve their sexual health, prevent
8 disease and reduce sexual health-related risk behav-
9 iors; and enable and empower students to develop
10 and demonstrate age and developmentally appro-
11 priate sexuality and sexual health-related knowledge,
12 attitudes, skills, and practices.

13 (6) CONSENT.—The term “consent” means af-
14 firmative, conscious, and voluntary agreement to en-
15 gage in interpersonal, physical, or sexual activity.

16 (7) CULTURALLY APPROPRIATE.—The term
17 “culturally appropriate” means materials and in-
18 struction that respond to culturally diverse individ-
19 uals, families and communities in an inclusive, re-
20 spectful and effective manner; including materials
21 and instruction that are inclusive of race, ethnicity,
22 languages, cultural background, religion, sex, gender
23 identity, sexual orientation, and different abilities.

24 (8) EVIDENCE-BASED.—The term “evidence-
25 based”, when used with respect to sex education in-

1 struction, means a sex education program that has
2 been proven through rigorous evaluation to be effec-
3 tive in changing sexual behavior or incorporates ele-
4 ments of other programs that have been proven to
5 be effective in changing sexual behavior.

6 (9) GENDER EXPRESSION.—The term “gender
7 expression”, when used with respect to a sex edu-
8 cation program, means the expression of one’s gen-
9 der, such as through behavior, clothing, haircut, or
10 voice, and which may or may not conform to socially
11 defined behaviors and characteristics typically asso-
12 ciated with being either masculine or feminine.

13 (10) GENDER IDENTITY.—Except with respect
14 to subsection (f), the term “gender identity”, when
15 used with respect to a sex education program, means
16 the gender-related identity, appearance, mannerisms,
17 or other gender-related characteristics of an indi-
18 vidual, regardless of the individual’s designated sex
19 at birth including a person’s deeply held sense or
20 knowledge of their own gender; such as male, fe-
21 male, both or neither.

22 (11) INCLUSIVE.—The term “inclusive”, when
23 used with respect to a sex education program, means
24 curriculum that ensures that students from histori-

1 cally marginalized communities are reflected in
2 classroom materials and lessons.

3 (12) INSTITUTION OF HIGHER EDUCATION.—

4 The term “institution of higher education” has the
5 meaning given the term in section 101 of the Higher
6 Education Act of 1965 (20 U.S.C. 1001).

7 (13) MEDICALLY ACCURATE AND COMPLETE.—

8 The term “medically accurate and complete”, when
9 used with respect to a sex education program, means
10 that—

11 (A) the information provided through the
12 program is verified or supported by the weight
13 of research conducted in compliance with ac-
14 cepted scientific methods and is published in
15 peer-reviewed journals, where applicable; or

16 (B)(i) the program contains information
17 that leading professional organizations and
18 agencies with relevant expertise in the field rec-
19 ognize as accurate, objective, and complete; and

20 (ii) the program does not withhold infor-
21 mation about the effectiveness and benefits of
22 correct and consistent use of condoms and
23 other contraceptives.

24 (14) SECRETARY.—The term “Secretary”
25 means the Secretary of Health and Human Services.

1 (15) SEXUAL DEVELOPMENT.—The term “sex-
2 ual development” means the lifelong process of phys-
3 ical, behavioral, cognitive, and emotional growth and
4 change as it relates to an individual’s sexuality and
5 sexual maturation, including puberty, identity devel-
6 opment, socio-cultural influences, and sexual behav-
7 iors.

8 (16) SEXUAL ORIENTATION.—Except with re-
9 spect to subsection (f), the term “sexual orienta-
10 tion”, when used with respect to a sex education
11 program, means an individual’s attraction, including
12 physical or emotional, to the same or different gen-
13 der.

14 (17) YOUNG PEOPLE.—The term “young peo-
15 ple” means individuals who are ages 10 through 24
16 at the time of commencement of participation in a
17 program supported under this section.

18 (j) FUNDING.—

19 (1) APPROPRIATION.—For the purpose of car-
20 rying out this section, there is appropriated
21 \$75,000,000 for each of fiscal years 2021 through
22 2026. Amounts appropriated under this subsection
23 shall remain available until expended.

24 (2) RESERVATIONS OF FUNDS.—

1 (A) The Secretary shall reserve 50 percent
2 of the amount appropriated under paragraph
3 (1) for the purposes of awarding grants for
4 comprehensive sex education for adolescents
5 under subsection (c).

6 (B) The Secretary shall reserve 25 percent
7 of the amount appropriated under paragraph
8 (1) for the purposes of awarding grants for
9 comprehensive sex education at institutes of
10 higher education under subsection (d).

11 (C) The Secretary shall reserve 20 percent
12 of the amount appropriated under paragraph
13 (1) for the purposes of awarding grants for pre-
14 service and in-service teacher training under
15 subsection (e).

16 (D) The Secretary shall reserve 2 percent
17 of the amount appropriated under paragraph
18 (1) for the purpose of carrying out the impact
19 evaluation and reporting required under sub-
20 section (a).

21 (3) SECRETARIAL RESPONSIBILITIES.—The
22 Secretary shall reserve 3 percent of the amount ap-
23 propriated under paragraph (1) for each fiscal year
24 for expenditures by the Secretary to provide, directly
25 or through a competitive grant process, research,

1 training, and technical assistance, including dissemi-
2 nation of research and information regarding effec-
3 tive and promising practices, providing consultation
4 and resources, and developing resources and mate-
5 rials to support the activities of recipients of grants.
6 In carrying out such functions, the Secretary shall
7 collaborate with a variety of entities that have exper-
8 tise in adolescent sexual health development, edu-
9 cation, and promotion.

10 (4) REPROGRAMMING OF ABSTINENCE ONLY
11 UNTIL MARRIAGE PROGRAM FUNDING.—The unobli-
12 gated balance of funds made available to carry out
13 section 510 of the Social Security Act (42 U.S.C.
14 710) (as in effect on the day before the date of en-
15 actment of this Act) are hereby transferred and shall
16 be used by the Secretary to carry out this section.
17 The amounts transferred and made available to
18 carry out this section shall remain available until ex-
19 pended.

20 (5) REPEAL OF ABSTINENCE ONLY UNTIL MAR-
21 RIAGE PROGRAM.—Section 510 of the Social Secu-
22 rity Act (42 U.S.C. 710) is repealed.

23 **SEC. 512. COMPASSIONATE ASSISTANCE FOR RAPE EMER-**
24 **GENCIES.**

25 (a) MEDICARE.—

1 (1) LIMITATION ON PAYMENT.—Section
2 1866(a)(1) of the Social Security Act (42 U.S.C.
3 1395cc(a)(1)) is amended—

4 (A) by moving the indentation of subpara-
5 graph (W) 2 ems to the left;

6 (B) in subparagraph (X)—

7 (i) by moving the indentation 2 ems
8 to the left; and

9 (ii) by striking “and” at the end;

10 (C) in subparagraph (Y), by striking the
11 period at the end and inserting “; and”; and

12 (D) by inserting after subparagraph (Y)
13 the following new subparagraph:

14 “(Z) in the case of a hospital or critical access
15 hospital, to adopt and enforce a policy to ensure
16 compliance with the requirements of subsection (l)
17 and to meet the requirements of such subsection.”.

18 (2) ASSISTANCE TO VICTIMS.—Section 1866 of
19 the Social Security Act (42 U.S.C. 1395cc) is
20 amended by adding at the end the following new
21 subsection:

22 “(l) COMPASSIONATE ASSISTANCE FOR RAPE EMER-
23 GENCIES.—

24 “(1) IN GENERAL.—For purposes of section
25 1866(a)(1)(Z), a hospital meets the requirements of

1 this subsection if the hospital provides each of the
2 services described in paragraph (2) to each indi-
3 vidual, whether or not eligible for benefits under this
4 title or under any other form of health insurance,
5 who comes to the hospital on or after January 1,
6 2021, and—

7 “(A) who states to hospital personnel that
8 they are victims of sexual assault;

9 “(B) who is accompanied by an individual
10 who states to hospital personnel that the indi-
11 vidual is a victim of sexual assault; or

12 “(C) whom hospital personnel, during the
13 course of treatment and care for the individual,
14 have reason to believe is a victim of sexual as-
15 sault.

16 “(2) REQUIRED SERVICES DESCRIBED.—For
17 purposes of paragraph (1), the services described in
18 this subparagraph are the following:

19 “(A) Provision of medically and factually
20 accurate and unbiased written and oral infor-
21 mation about emergency contraception that—

22 “(i) is written in clear and concise
23 language;

24 “(ii) is readily comprehensible;

1 “(iii) includes an explanation that
2 emergency contraceptives—

3 “(I) has been approved by the
4 Food and Drug Administration for in-
5 dividuals and is a safe and effective
6 way to prevent pregnancy after unpro-
7 tected intercourse or contraceptive
8 failure if taken in a timely manner;

9 “(II) is more effective the sooner
10 it is taken; and

11 “(III) does not cause an abortion
12 and cannot interrupt an established
13 pregnancy;

14 “(iv) meets such conditions regarding
15 the provision of such information in lan-
16 guages other than English as the Secretary
17 may establish; and

18 “(v) is provided without regard to the
19 ability of the individual or their family to
20 pay costs associated with the provision of
21 such information to the individual.

22 “(B) Immediate offer to provide emergency
23 contraception to the individual at the hospital
24 and, in the case that the individual accepts such
25 offer, immediate provision to the individual of

1 such contraception on the same day it is re-
2 quested without regard to the inability of the
3 individual or their family to pay costs associ-
4 ated with the offer and provision of such con-
5 traception.

6 “(C) Development and implementation of a
7 written policy to ensure that an individual is
8 present at the hospital, or on-call, who—

9 “(i) has authority to dispense or pre-
10 scribe emergency contraception, independ-
11 ently, or under a protocol prepared by a
12 physician for the administration of emer-
13 gency contraception at the hospital to a
14 victim of sexual assault; and

15 “(ii) is trained to comply with the re-
16 quirements of this section.

17 “(D) Provision of medically and factually
18 accurate and unbiased written and oral infor-
19 mation and counseling about post-exposure pro-
20 phylaxis (PEP) protocol for the prevention of
21 HIV.

22 “(E) Immediately offer to begin PEP to
23 the individual at the hospital except in cases
24 where the medical professional’s best judgement
25 is that further evaluation is required or that

1 such a regimen will be substantially detrimental
 2 to the individual’s health. Such provision shall
 3 be offered regardless of the individual’s ability
 4 to pay. Hospitals shall be responsible for ensur-
 5 ing adequate supply of PEP medications to pro-
 6 vide to patients.

7 “(3) HOSPITAL DEFINED.—For purposes of
 8 this paragraph, the term ‘hospital’ includes a critical
 9 access hospital, as defined in section
 10 1861(mm)(1).”.

11 (b) LIMITATION ON PAYMENT UNDER MEDICAID.—
 12 Section 1903(i) of the Social Security Act (42 U.S.C.
 13 1396b(i)) is amended by inserting after paragraph (8) the
 14 following new paragraph:

15 “(9) with respect to any amount expended for
 16 care or services furnished under the plan by a hos-
 17 pital on or after January 1, 2021, unless such hos-
 18 pital meets the requirements specified in section
 19 1866(l) for purposes of title XVIII;”.

20 **SEC. 513. ACCESS TO BIRTH CONTROL DUTIES OF PHAR-**
 21 **MACIES TO ENSURE PROVISION OF FDA-AP-**
 22 **PROVED CONTRACEPTION.**

23 Part B of title II of the Public Health Service Act
 24 (42 U.S.C. 238 et seq.) is amended by adding at the end
 25 the following:

1 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
2 **OF FDA-APPROVED CONTRACEPTION.**

3 “(a) IN GENERAL.—Subject to subsection (c), a
4 pharmacy that receives Food and Drug Administration-
5 approved drugs or devices in interstate commerce shall
6 maintain compliance with the following:

7 “(1) If a customer requests a contraceptive or
8 a medication related to a contraceptive, including
9 emergency contraception, that is in stock, the phar-
10 macy shall ensure that the contraceptive is provided
11 to the customer without delay.

12 “(2) If a customer requests a contraceptive or
13 a medication related to a contraceptive that is not
14 in stock and the pharmacy in the normal course of
15 business stocks contraception, the pharmacy shall
16 immediately inform the customer that the contracep-
17 tive is not in stock and without delay offer the cus-
18 tomer the following options:

19 “(A) If the customer prefers to obtain the
20 contraceptive or a medication related to a con-
21 traceptive through a referral or transfer, the
22 pharmacy shall—

23 “(i) locate a pharmacy of the cus-
24 tomer’s choice or the closest pharmacy
25 confirmed to have the contraceptive or a

1 medication related to a contraceptive in
2 stock; and

3 “(ii) refer the customer or transfer
4 the prescription to that pharmacy.

5 “(B) If the customer prefers for the phar-
6 macy to order the contraceptive or a medication
7 related to a contraceptive, the pharmacy shall
8 obtain the contraceptive or medication under
9 the pharmacy’s standard procedure for expe-
10 dited ordering of medication and notify the cus-
11 tomer when the contraceptive or medication ar-
12 rives.

13 “(3) The pharmacy shall ensure that—

14 “(A) the pharmacy does not operate an en-
15 vironment in which customers are intimidated,
16 threatened, or harassed in the delivery of serv-
17 ices relating to a request for contraception or a
18 medication related to a contraceptive;

19 “(B) the pharmacy’s employees do not
20 interfere with or obstruct the delivery of serv-
21 ices relating to a request for contraception or a
22 medication related to a contraceptive;

23 “(C) the pharmacy’s employees do not in-
24 tentiously misrepresent or deceive customers
25 about the availability of a contraceptive or a

1 medication related to a contraceptive, or the
2 mechanism of action of such contraceptive or
3 medication;

4 “(D) the pharmacy’s employees do not
5 breach medical confidentiality with respect to a
6 request for a contraceptive or a medication re-
7 lated to a contraceptive or threaten to breach
8 such confidentiality; or

9 “(E) the pharmacy’s employees do not
10 refuse to return a valid, lawful prescription for
11 a contraceptive or a medication related to a
12 contraceptive upon customer request.

13 “(b) CONTRACEPTIVES NOT ORDINARILY
14 STOCKED.—Nothing in subsection (a)(2) shall be con-
15 strued to require any pharmacy to comply with such sub-
16 section if the pharmacy does not ordinarily stock contra-
17 ceptives or a medication related to a contraceptive in the
18 normal course of business.

19 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
20 MACY PRACTICE.—This section does not prohibit a phar-
21 macy from refusing to provide a contraceptive or a medi-
22 cation related to a contraceptive to a customer in accord-
23 ance with any of the following:

24 “(1) If it is unlawful to dispense the contracep-
25 tive or a medication related to a contraceptive to the

1 customer without a valid, lawful prescription and no
2 such prescription is presented.

3 “(2) If the customer is unable to pay for the
4 contraceptive or the medication related to a contra-
5 ceptive.

6 “(3) If the employee of the pharmacy refuses to
7 provide the contraceptive or a medication related to
8 a contraceptive on the basis of a professional clinical
9 judgment.

10 “(d) RELATION TO OTHER LAW.—

11 “(1) RULE OF CONSTRUCTION.—Nothing in
12 this section shall be construed to invalidate or limit
13 rights, remedies, procedures, or legal standards
14 under title VII of the Civil Rights Act of 1964.

15 “(2) CERTAIN CLAIMS.—The Religious Free-
16 dom Restoration Act of 1993 shall not provide a
17 basis for a claim concerning, or a defense to a claim
18 under, this section, or provide a basis for challenging
19 the application or enforcement of this section.

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) MEDICATION RELATED TO A CONTRACEP-
7 TIVE.—The term ‘medication related to a contracep-
8 tive’ means any drug or device approved by the Food
9 and Drug Administration that a medical professional
10 determines necessary to use before or in conjunction
11 with a contraceptive.

12 “(4) PHARMACY.—The term ‘pharmacy’ means
13 an entity that—

14 “(A) is authorized by a State to engage in
15 the business of selling prescription drugs at re-
16 tail; and

17 “(B) employs one or more employees.

18 “(5) PRODUCT.—The term ‘product’ means a
19 Food and Drug Administration-approved drug or de-
20 vice.

21 “(6) PROFESSIONAL CLINICAL JUDGMENT.—
22 The term ‘professional clinical judgment’ means the
23 use of professional knowledge and skills to form a
24 clinical judgment, in accordance with prevailing
25 medical standards.

1 “(7) WITHOUT DELAY.—The term ‘without
2 delay’, with respect to a pharmacy providing, pro-
3 viding a referral for, or ordering contraception, or
4 transferring the prescription for contraception,
5 means within the usual and customary timeframe at
6 the pharmacy for providing, providing a referral for,
7 or ordering other products, or transferring the pre-
8 scription for other products, respectively.

9 “(h) EFFECTIVE DATE.—This section shall take ef-
10 fect on the 31st day after the date of the enactment of
11 this section, without regard to whether the Secretary has
12 issued any guidance or final rule regarding this section.”.

13 **SEC. 514. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
14 **WOMEN’S HEALTH.**

15 Section 229(b) of the Public Health Service Act (42
16 U.S.C. 237a(b)) is amended—

17 (1) in paragraph (6), at the end, by striking
18 “and”;

19 (2) in paragraph (7), at the end, by striking the
20 period and inserting a semicolon; and

21 (3) by adding at the end the following new
22 paragraph:

23 “(8) facilitate policymakers, health system lead-
24 ers and providers, consumers, and other stake-
25 holders in understanding optimal maternity care and

1 support for the provision of such care, including the
2 priorities of—

3 “(A) protecting, promoting, and supporting
4 the innate capacities of childbearing individuals
5 and their newborns for childbirth, breastfeed-
6 ing, and attachment;

7 “(B) using obstetric interventions only
8 when such interventions are supported by
9 strong, high-quality evidence, and minimizing
10 overuse of maternity practices that have been
11 shown to have benefit in limited situations and
12 that can expose women, infants, or both to risk
13 of harm if used routinely and indiscriminately,
14 including continuous electronic fetal monitoring,
15 labor induction, epidural analgesia, primary ce-
16 sarian section, and routine repeat cesarean
17 birth;

18 “(C) reliably incorporating noninvasive,
19 evidence-based practices that have documented
20 correlation with considerable improvement in
21 outcomes with no detrimental side effects, such
22 as smoking cessation programs in pregnancy
23 and proven models of group prenatal care that
24 integrate health assessment, education, and
25 support into a unified program and supporting

1 evidence-based breastfeeding promotion efforts
2 with respect for a breastfeeding individual’s
3 personal decision making;

4 “(D) a shared understanding of the quali-
5 fications of licensed providers of maternity care
6 and the best evidence about the safety, satisfac-
7 tion, outcomes, and costs of their care, and ap-
8 propriate deployment of such caregivers within
9 the maternity care workforce to address the
10 needs of childbearing individuals and newborns
11 and the growing shortage of maternity care-
12 givers;

13 “(E) a shared understanding of the results
14 of the best available research comparing hos-
15 pital, birth center, and planned home births, in-
16 cluding information about each setting’s safety,
17 satisfaction, outcomes, and costs;

18 “(F) high-quality, evidence-based child-
19 birth education that promotes a natural,
20 healthy, and safe approach to pregnancy, child-
21 birth, and early parenting; is taught by certified
22 educators, peer counselors, and health profes-
23 sionals; and promotes informed decision making
24 by childbearing individuals; and

1 “(G) developing measures that enable a
2 more robust, balanced set of standardized ma-
3 ternity care measures, including performance
4 and quality measures;”.

5 **SEC. 515. INTERAGENCY COORDINATING COMMITTEE ON**
6 **THE PROMOTION OF OPTIMAL MATERNITY**
7 **OUTCOMES.**

8 (a) IN GENERAL.—Part A of title II of the Public
9 Health Service Act (42 U.S.C. 202 et seq.) is amended
10 by adding at the end the following:

11 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON**
12 **THE PROMOTION OF OPTIMAL MATERNITY**
13 **OUTCOMES.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Deputy Assistant Secretary for Women’s Health under
16 section 229 and in collaboration with the Federal officials
17 specified in subsection (b), shall establish the Interagency
18 Coordinating Committee on the Promotion of Optimal Ma-
19 ternity Outcomes (referred to in this section as the
20 ‘ICCPOM’).

21 “(b) OTHER AGENCIES.—The officials specified in
22 this subsection are the Secretary of Labor, the Secretary
23 of Defense, the Secretary of Veterans Affairs, the Surgeon
24 General, the Director of the Centers for Disease Control
25 and Prevention, the Administrator of the Health Re-

1 sources and Services Administration, the Administrator of
2 the Centers for Medicare & Medicaid Services, the Direc-
3 tor of the Indian Health Service, the Administrator of the
4 Substance Abuse and Mental Health Services Administra-
5 tion, the Director of the National Institute of Child Health
6 and Human Development, the Director of the Agency for
7 Healthcare Research and Quality, the Assistant Secretary
8 for Children and Families, the Deputy Assistant Secretary
9 for Minority Health, the Director of the Office of Per-
10 sonnel Management, and such other Federal officials as
11 the Secretary of Health and Human Services determines
12 to be appropriate.

13 “(c) CHAIR.—The Deputy Assistant Secretary for
14 Women’s Health shall serve as the chair of the ICCPOM.

15 “(d) DUTIES.—The ICCPOM shall guide policy and
16 program development across the Federal Government with
17 respect to promotion of optimal maternity care, provided,
18 however, that nothing in this section shall be construed
19 as transferring regulatory or program authority from an
20 agency to the ICCPOM.

21 “(e) CONSULTATIONS.—The ICCPOM shall actively
22 seek the input of, and shall consult with, all appropriate
23 and interested stakeholders, including State health depart-
24 ments, public health research and interest groups, founda-
25 tions, childbearing individuals and their advocates, and

1 maternity care professional associations and organiza-
2 tions, reflecting racially, ethnically, demographically, and
3 geographically diverse communities.

4 “(f) ANNUAL REPORT.—

5 “(1) IN GENERAL.—The Secretary, on behalf of
6 the ICCPOM, shall annually submit to Congress a
7 report that summarizes—

8 “(A) all programs and policies of Federal
9 agencies (including the Medicare Program
10 under title XVIII of the Social Security Act and
11 the Medicaid program under title XIX of such
12 Act) designed to promote optimal maternity
13 care, focusing particularly on programs and
14 policies that support the adoption of evidence
15 based maternity care, as defined by timely, sci-
16 entifically sound systematic reviews;

17 “(B) all programs and policies of Federal
18 agencies (including the Medicare Program
19 under title XVIII of the Social Security Act and
20 the Medicaid program under title XIX of such
21 Act) designed to address the problems of mater-
22 nal mortality and morbidity, infant mortality,
23 prematurity, and low birth weight, including
24 such programs and policies designed to address

1 racial and ethnic disparities with respect to
2 each of such problems;

3 “(C) the extent of progress in reducing
4 maternal mortality and infant mortality, low
5 birth weight, and prematurity at State and na-
6 tional levels; and

7 “(D) such other information regarding op-
8 timal maternity care (such as quality and per-
9 formance measures) as the Secretary deter-
10 mines to be appropriate.

11 The information specified in subparagraph (C) shall
12 be included in each such report in a manner that
13 disaggregates such information by race, ethnicity,
14 and indigenous status in order to determine the ex-
15 tent of progress in reducing racial and ethnic dis-
16 parities and disparities related to indigenous status.

17 “(2) CERTAIN INFORMATION.—Each report
18 under paragraph (1) shall include information
19 (disaggregated by race, ethnicity, and indigenous
20 status, as applicable) on the following rates and
21 costs by State:

22 “(A) The rate of primary cesarean deliv-
23 eries and repeat cesarean deliveries.

24 “(B) The rate of vaginal births after cesar-
25 ean.

1 “(C) The rate of vaginal breech births.

2 “(D) The rate of induction of labor.

3 “(E) The rate of freestanding birth center
4 births.

5 “(F) The rate of planned and unplanned
6 home birth.

7 “(G) The rate of attended births by pro-
8 vider, including by an obstetrician-gynecologist,
9 family practice physician, obstetrician-gyne-
10 cologist physician assistant, certified nurse-mid-
11 wife, certified midwife, and certified profes-
12 sional midwife.

13 “(H) The cost of maternity care
14 disaggregated by place of birth and provider of
15 care, including—

16 “(i) uncomplicated vaginal birth;

17 “(ii) complicated vaginal birth;

18 “(iii) uncomplicated cesarean birth;

19 and

20 “(iv) complicated cesarean birth.

21 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated, in addition to amounts
23 authorized to be appropriated under section 229(e), to
24 carry out this section \$1,000,000 for each of the fiscal
25 years 2021 through 2025.”.

1 (b) CONFORMING AMENDMENTS.—

2 (1) INCLUSION AS DUTY OF HHS OFFICE ON
3 WOMEN’S HEALTH.—Section 229(b) of such Act (42
4 U.S.C. 237a(b)), as amended by section 514, is fur-
5 ther amended by adding at the end the following
6 new paragraph:

7 “(9) establish the Interagency Coordinating
8 Committee on the Promotion of Optimal Maternity
9 Outcomes in accordance with section 229A; and”.

10 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
11 tion 229(d) of such Act (42 U.S.C. 237a(d)) is
12 amended by inserting “(other than under subsection
13 (b)(9))” after “under this section”.

14 **SEC. 516. CONSUMER EDUCATION CAMPAIGN.**

15 Section 229(b) of the Public Health Service Act (42
16 U.S.C. 237a(b)), as amended by sections 514 and 515,
17 is further amended by adding at the end the following:

18 “(10) not later than one year after the date of
19 the enactment of the Health Equity and Account-
20 ability Act of 2020, develop and implement a 4-year
21 culturally and linguistically appropriate multimedia
22 consumer education campaign that is designed to
23 promote understanding and acceptance of evidence-
24 based maternity practices and models of care for op-
25 timal maternity outcomes among individuals of

1 childbearing ages and families of such individuals
2 and that—

3 “(A) highlights the importance of pro-
4 tecting, promoting, and supporting the innate
5 capacities of childbearing individuals and their
6 newborns for childbirth, breastfeeding, and at-
7 tachment;

8 “(B) promotes understanding of the impor-
9 tance of using obstetric interventions when
10 medically necessary and when supported by
11 strong, high-quality evidence;

12 “(C) highlights the widespread overuse of
13 maternity practices that have been shown to
14 have benefit when used appropriately in situa-
15 tions of medical necessity, but which can expose
16 pregnant individuals, infants, or both to risk of
17 harm if used routinely and indiscriminately, in-
18 cluding continuous fetal monitoring, labor in-
19 duction, epidural anesthesia, elective primary
20 cesarean section, and repeat cesarean delivery;

21 “(D) emphasizes the noninvasive maternity
22 practices that have strong proven correlation or
23 may be associated with considerable improve-
24 ment in outcomes with no detrimental side ef-
25 fects, and are significantly underused in the

1 United States, including smoking cessation pro-
2 grams in pregnancy, group model prenatal care,
3 continuous labor support, nonsupine positions
4 for birth, and external version to turn breech
5 babies at term;

6 “(E) educates consumers about the quali-
7 fications of licensed providers of maternity care
8 and the best evidence about their safety, satis-
9 faction, outcomes, and costs;

10 “(F) informs consumers about the best
11 available research comparing birth center
12 births, planned home births, and hospital
13 births, including information about each set-
14 ting’s safety, satisfaction, outcomes, and costs;

15 “(G) fosters participation in high-quality,
16 evidence-based childbirth education that pro-
17 motes a natural, healthy, and safe approach to
18 pregnancy, childbirth, and early parenting; is
19 taught by certified educators, peer counselors,
20 and health professionals; and promotes in-
21 formed decision making by childbearing individ-
22 uals; and

23 “(H) is pilot tested for consumer com-
24 prehension, cultural sensitivity, and acceptance
25 of the messages across geographically, racially,

1 ethnically, and linguistically diverse popu-
2 lations.”.

3 **SEC. 517. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
4 **VIEWS FOR CARE OF CHILDBEARING INDI-**
5 **VIDUALS AND NEWBORNS.**

6 (a) IN GENERAL.—Not later than one year after the
7 date of the enactment of this Act, the Secretary of Health
8 and Human Services, through the Agency for Healthcare
9 Research and Quality, shall—

10 (1) make publicly available an online biblio-
11 graphic database identifying systematic reviews, in-
12 cluding an explanation of the level and quality of
13 evidence, for care of childbearing individuals and
14 newborns; and

15 (2) initiate regular updates that incorporate
16 newly issued and updated systematic reviews.

17 (b) SOURCES.—To aim for a comprehensive inventory
18 of systematic reviews relevant to maternal and newborn
19 care, the database shall identify reviews from diverse
20 sources, including—

21 (1) scientific peer-reviewed journals;

22 (2) databases, including Cochrane Database of
23 Systematic Reviews, Clinical Evidence, and Data-
24 base of Abstracts of Reviews of Effects; and

1 (3) internet websites of agencies and organiza-
2 tions throughout the world that produce such sys-
3 tematic reviews.

4 (c) FEATURES.—The database shall—

5 (1) provide bibliographic citations for each
6 record within the database, and for each such cita-
7 tion include an explanation of the level and quality
8 of evidence;

9 (2) include abstracts, as available;

10 (3) provide reference to companion documents
11 as may exist for each review, such as evidence tables
12 and guidelines or consumer educational materials de-
13 veloped from the review;

14 (4) provide links to the source of the full review
15 and to any companion documents;

16 (5) provide links to the source of a previous
17 version or update of the review;

18 (6) be searchable by intervention or other topic
19 of the review, reported outcomes, author, title, and
20 source; and

21 (7) offer to users periodic electronic notification
22 of database updates relating to users' topics of inter-
23 est.

24 (d) OUTREACH.—Not later than the first date the
25 database is made publicly available and periodically there-

1 after, the Secretary of Health and Human Services shall
2 publicize the availability, features, and uses of the data-
3 base under this section to the stakeholders described in
4 subsection (e).

5 (e) CONSULTATION.—For purposes of developing the
6 database under this section and maintaining and updating
7 such database, the Secretary of Health and Human Serv-
8 ices shall convene and consult with an advisory committee
9 composed of relevant stakeholders, including—

10 (1) Federal Medicaid administrators and State
11 agencies administering State plans under title XIX
12 of the Social Security Act pursuant to section
13 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

14 (2) providers of maternity and newborn care
15 from both academic and community-based settings,
16 including obstetrician-gynecologists, family physi-
17 cians, certified nurse midwives, certified midwives,
18 certified professional midwives, physician assistants,
19 perinatal nurses, pediatricians, and nurse practi-
20 tioners;

21 (3) maternal-fetal medicine specialists;

22 (4) neonatologists;

23 (5) childbearing individuals and advocates for
24 such individuals, including childbirth educators cer-
25 tified by a nationally accredited program, rep-

1 resenting communities that are diverse in terms of
2 race, ethnicity, indigenous status, and geographic
3 area;

4 (6) employers and purchasers;

5 (7) health facility and system leaders, including
6 both hospital and birth center facilities;

7 (8) journalists; and

8 (9) bibliographic informatics specialists.

9 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
10 authorized to be appropriated \$2,500,000 for each of the
11 fiscal years 2021 through 2023 for the purpose of devel-
12 oping the database and such sums as may be necessary
13 for each subsequent fiscal year for updating the database
14 and providing outreach and notification to users, as de-
15 scribed in this section.

16 **SEC. 518. EXPANSION OF CDC PREVENTION RESEARCH**
17 **CENTERS PROGRAM TO INCLUDE CENTERS**
18 **ON OPTIMAL MATERNITY OUTCOMES.**

19 (a) IN GENERAL.—Not later than one year after the
20 date of the enactment of this Act, the Secretary of Health
21 and Human Services, shall support the establishment of
22 additional Prevention Research Centers under the Preven-
23 tion Research Center Program administered by the Cen-
24 ters for Disease Control and Prevention. Such additional

1 centers shall each be known as a Center for Excellence
2 on Optimal Maternity Outcomes.

3 (b) RESEARCH.—Each Center for Excellence on Opti-
4 mal Maternity Outcomes shall—

5 (1) conduct at least one focused program of re-
6 search to improve maternity outcomes, including the
7 reduction of cesarean birth rates, elective inductions,
8 prematurity rates, and low birth weight rates within
9 an underserved population that has a disproportion-
10 ately large burden of suboptimal maternity out-
11 comes, including maternal mortality and morbidity,
12 infant mortality, prematurity, or low birth weight,
13 which such program shall include developing per-
14 formance and quality measures for accountability;

15 (2) work with partners on special interest
16 projects, as specified by the Centers for Disease
17 Control and Prevention and other relevant agencies
18 within the Department of Health and Human Serv-
19 ices, and on projects funded by other sources; and

20 (3) involve a minimum of two distinct birth set-
21 ting models, such as—

22 (A) a hospital labor and delivery model
23 and freestanding birth center model; or

24 (B) a hospital labor and delivery model
25 and planned home birth model.

1 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
2 for Excellence on Optimal Maternity Outcomes shall in-
3 clude the following interdisciplinary providers of maternity
4 care:

5 (1) Obstetrician-gynecologists.

6 (2) At least two of the following providers:

7 (A) Family practice physicians.

8 (B) Nurse practitioners.

9 (C) Physician assistants.

10 (D) Certified professional midwives.

11 (d) SERVICES.—Research conducted by each Center
12 for Excellence on Optimal Maternity Outcomes shall in-
13 clude at least 2 (and preferably more) of the following sup-
14 portive provider services:

15 (1) Mental health.

16 (2) Doula labor support.

17 (3) Nutrition education.

18 (4) Childbirth education.

19 (5) Social work.

20 (6) Physical therapy or occupation therapy.

21 (7) Substance abuse services.

22 (8) Home visiting.

23 (e) COORDINATION.—The programs of research at
24 each of the Centers of Excellence on Optimal Maternity

1 Outcomes shall complement and not replicate the work of
2 the other.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section
5 \$2,000,000 for each of the fiscal years 2021 through
6 2025.

7 **SEC. 519. EXPANDING MODELS ALLOWED TO BE TESTED BY**
8 **CENTER FOR MEDICARE & MEDICAID INNO-**
9 **VATION TO INCLUDE MATERNITY CARE MOD-**
10 **ELS.**

11 Section 1115A(b)(2)(B) of the Social Security Act
12 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
13 end the following new clause:

14 “(xxviii) Promoting evidence-based
15 models of care that have been associated
16 with reductions in maternal and infant
17 health disparities, including incorporating
18 the use of doula and promotoras support
19 for pregnant and childbearing individuals
20 into evidence-based models of prenatal
21 care, labor and delivery, and postpartum
22 care, and supporting the appropriate use of
23 out-of-hospital birth models, including
24 births at home and in freestanding birth
25 centers.”.

1 **SEC. 520. DEVELOPMENT OF INTERPROFESSIONAL MATER-**
2 **NITY CARE EDUCATIONAL MODELS AND**
3 **TOOLS.**

4 (a) IN GENERAL.—Not later than 6 months after the
5 date of the enactment of this Act, the Secretary of Health
6 and Human Services, acting in conjunction with the Ad-
7 ministrator of Health Resources and Services Administra-
8 tion, shall convene, for a 1-year period, an Interprofes-
9 sional Maternity Provider Education Commission to dis-
10 cuss and make recommendations for—

11 (1) a consensus standard physiologic maternity
12 care curriculum that takes into account the core
13 competencies for basic midwifery practice such as
14 those developed by the American College of Nurse
15 Midwives and the North American Registry of Mid-
16 wives, and the educational objectives for physicians
17 practicing in obstetrics and gynecology as deter-
18 mined by the Council on Resident Education in Ob-
19 stetrics and Gynecology;

20 (2) suggestions for multidisciplinary use of the
21 consensus physiologic curriculum;

22 (3) strategies to integrate and coordinate edu-
23 cation across maternity care disciplines, including
24 recommendations to increase medical and midwifery
25 student exposure to out-of-hospital birth; and

1 (4) pilot demonstrations of interprofessional
2 educational models.

3 (b) PARTICIPANTS.—The Commission shall include
4 maternity care educators, curriculum developers, service
5 leaders, certification leaders, and accreditation leaders
6 from the various professions that provide maternity care
7 in the United States. Such professions shall include obste-
8 trician gynecologists, certified nurse midwives or certified
9 midwives, family practice physicians, nurse practitioners,
10 physician assistants, certified professional midwives, and
11 perinatal nurses. Additionally, the Commission shall in-
12 clude representation from maternity care consumer advo-
13 cates.

14 (c) CURRICULUM.—The consensus standard physio-
15 logic maternity care curriculum described in subsection
16 (a)(1) shall—

17 (1) have a public health focus with a foundation
18 in health promotion and disease prevention;

19 (2) foster physiologic childbearing and woman
20 and family centered care;

21 (3) integrate strategies to reduce maternal and
22 infant morbidity and mortality;

23 (4) incorporate recommendations to ensure re-
24 spectful, safe, and seamless consultation, referral,
25 transport, and transfer of care when necessary;

1 (5) include cultural sensitivity and strategies to
2 decrease disparities in maternity outcomes; and

3 (6) include implicit bias training.

4 (d) REPORT.—Not later than 6 months after the final
5 meeting of the Commission, the Secretary of Health and
6 Human Services shall—

7 (1) submit to Congress a report containing the
8 recommendations made by the Commission under
9 this section; and

10 (2) make such report publicly available.

11 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
12 authorized to be appropriated to carry out this section
13 \$1,000,000 for each of the fiscal years 2021 and 2022,
14 and such sums as are necessary for each of the fiscal years
15 2023 through 2025.

16 **SEC. 521. INCLUDING SERVICES FURNISHED BY CERTAIN**
17 **STUDENTS, INTERNS, AND RESIDENTS SU-**
18 **PERVISED BY CERTIFIED NURSE MIDWIVES**
19 **WITHIN INPATIENT HOSPITAL SERVICES**
20 **UNDER MEDICARE.**

21 (a) IN GENERAL.—Section 1861(b) of the Social Se-
22 curity Act (42 U.S.C. 1395x(b)) is amended—

23 (1) in paragraph (6), by striking “; or” at the
24 end and inserting “, or in the case of services in a
25 hospital or osteopathic hospital by a student midwife

1 or an intern or resident-in-training under a teaching
2 program previously described in this paragraph who
3 is in the field of obstetrics and gynecology, if such
4 student midwife, intern, or resident-in-training is su-
5 pervised by a certified nurse-midwife to the extent
6 permitted under applicable State law and as may be
7 authorized by the hospital;”;

8 (2) in paragraph (7), by striking the period at
9 the end and inserting “; or”; and

10 (3) by adding at the end the following new
11 paragraph:

12 “(8) a certified nurse-midwife where the hos-
13 pital has a teaching program approved as specified
14 in paragraph (6), if—

15 “(A) the hospital elects to receive any pay-
16 ment due under this title for reasonable costs of
17 such services; and

18 “(B) all certified nurse-midwives in such
19 hospital agree not to bill charges for profes-
20 sional services rendered in such hospital to indi-
21 viduals covered under the insurance program
22 established by this title.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 subsection (a) shall apply to services furnished on or after
25 the date of the enactment of this Act.

1 **SEC. 522. GRANTS TO PROFESSIONAL ORGANIZATIONS TO**
2 **INCREASE DIVERSITY IN MATERNAL, REPRO-**
3 **DUCTIVE, AND SEXUAL HEALTH PROFES-**
4 **SIONALS.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services, through the Administrator of the Health
7 Resources and Services Administration, shall carry out a
8 grant program under which the Secretary may make to
9 eligible organizations—

10 (1) for fiscal year 2021, planning grants de-
11 scribed in subsection (b); and

12 (2) for the subsequent 4-year period, implemen-
13 tation grants described in subsection (c).

14 (b) PLANNING GRANTS.—

15 (1) IN GENERAL.—Planning grants described in
16 this subsection are grants for the following purposes:

17 (A) To collect data and identify any work-
18 force disparities, with respect to a health pro-
19 fession, at each of the following areas along the
20 health professional continuum:

21 (i) Pipeline availability with respect to
22 students at the high school and college or
23 university levels considering and working
24 toward entrance in the profession, includ-
25 ing barriers triggered by criminal records.

1 (ii) Entrance into the training pro-
2 gram for the profession.

3 (iii) Graduation from such training
4 program.

5 (iv) Entrance into practice, including
6 barriers triggered by criminal records.

7 (v) Retention in practice for more
8 than a 5-year period.

9 (B) To develop one or more strategies to
10 address the workforce disparities within the
11 health profession, as identified under (and in
12 response to the findings pursuant to) subpara-
13 graph (A).

14 (2) APPLICATION.—To be eligible to receive a
15 grant under this subsection, an eligible health pro-
16 fessional organization shall submit to the Secretary
17 of Health and Human Services an application in
18 such form and manner and containing such informa-
19 tion as specified by the Secretary.

20 (3) AMOUNT.—Each grant awarded under this
21 subsection shall be for an amount not to exceed
22 \$300,000.

23 (4) REPORT.—Each recipient of a grant under
24 this subsection shall submit to the Secretary of
25 Health and Human Services a report containing—

1 (A) information on the extent and distribu-
2 tion of workforce disparities identified through
3 the grant; and

4 (B) reasonable objectives and strategies
5 developed to address such disparities within a
6 5-, 10-, and 25-year period.

7 (c) IMPLEMENTATION GRANTS.—

8 (1) IN GENERAL.—Implementation grants de-
9 scribed in this subsection are grants to implement
10 one or more of the strategies developed pursuant to
11 a planning grant awarded under subsection (b).

12 (2) APPLICATION.—To be eligible to receive a
13 grant under this subsection, an eligible health pro-
14 fessional organization shall submit to the Secretary
15 of Health and Human Services an application in
16 such form and manner as specified by the Secretary.
17 Each such application shall contain information on
18 the capability of the organization to carry out a
19 strategy described in paragraph (1), involvement of
20 partners or coalitions, plans for developing sustain-
21 ability of the efforts after the culmination of the
22 grant cycle, and any other information specified by
23 the Secretary.

24 (3) AMOUNT.—Each grant awarded under this
25 subsection shall be for an amount not to exceed

1 \$500,000 each year during the 4-year period of the
2 grant.

3 (4) REPORTS.—For each of the first 3 years for
4 which an eligible health professional organization is
5 awarded a grant under this subsection, the organiza-
6 tion shall submit to the Secretary of Health and
7 Human Services a report on the activities carried
8 out by such organization through the grant during
9 such year and objectives for the subsequent year.
10 For the fourth year for which an eligible health pro-
11 fessional organization is awarded a grant under this
12 subsection, the organization shall submit to the Sec-
13 retary a report that includes an analysis of all the
14 activities carried out by the organization through the
15 grant and a detailed plan for continuation of out-
16 reach efforts.

17 (d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZA-
18 TION DEFINED.—For purposes of this section, the term
19 “eligible health professional organization” means a profes-
20 sional organization representing obstetrician-gyne-
21 cologists, certified nurse midwives, certified midwives,
22 family practice physicians, nurse practitioners whose scope
23 of practice includes maternity or sexual and reproductive
24 health care, physician assistants whose scope of practice
25 includes obstetrical or sexual and reproductive health care,

1 or certified professional midwives, adolescent medicine
2 specialists, and pediatricians who provide sexual and re-
3 productive health care.

4 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
5 authorized to be appropriated to carry out this section
6 \$2,000,000 for fiscal year 2021 and \$3,000,000 for each
7 of the fiscal years 2022 through 2025.

8 **SEC. 523. INTERAGENCY UPDATE TO THE QUALITY FAMILY**
9 **PLANNING GUIDELINES.**

10 (a) IN GENERAL.—Not later than six months after
11 the date of enactment of this Act, the Director of the Cen-
12 ters for Disease Control and Prevention and the Office
13 of Population Affairs shall review and expand the 2014
14 Quality Family Planning Guidelines to address—

15 (1) health disparities; and

16 (2) the importance of patient-directed contra-
17 ceptive decision making.

18 (b) CONSULTATION.—In carrying out subsection (a),
19 the Director of the Centers for Disease Control and Pre-
20 vention and the Office of Population Affairs shall convene
21 a meeting, and solicit the views of, stakeholders including
22 experts on health disparities, experts on reproductive coer-
23 cion, representatives of provider organizations, patient ad-
24 vocates, reproductive justice organizations, organizations
25 that represent racial and ethnic minority communities, or-

1 ganizations that represent people with disabilities, organi-
 2 zations that represent LGBTQ persons, and organizations
 3 that represent people with limited English proficiency.

4 **SEC. 524. DISSEMINATION OF THE QUALITY FAMILY PLAN-**
 5 **NING GUIDELINES.**

6 (a) IN GENERAL.—Not later than six months after
 7 the date of enactment of this Act, the Secretary of Health
 8 and Human Services and the Director of the Centers for
 9 Disease Control and Prevention shall—

10 (1) develop a plan for outreach to publicly fund-
 11 ed health care providers, including federally qualified
 12 health centers and branches of the Indian Health
 13 Service, about the quality family planning guidelines
 14 referred to in section 523; and

15 (2) award grants to eligible entities to imple-
 16 ment these guidelines for all patients seeking family
 17 planning services.

18 (b) DEFINITION.—In this section, the term “eligible
 19 entity” means a publicly funded health care provider that
 20 serves persons of reproductive age.

21 **Subtitle B—Pregnancy Screening**

22 **SEC. 531. PREGNANCY INTENTION SCREENING INITIATIVE**
 23 **DEMONSTRATION PROGRAM.**

24 Part P of title III of the Public Health Service Act
 25 (42 U.S.C. 280g et seq.), as amended by section

1 505(c)(6), is further amended by adding at the end the
2 following:

3 **“SEC. 399V-8. PREGNANCY INTENTION SCREENING INITIA-**
4 **TIVE DEMONSTRATION PROGRAM.**

5 “(a) PROGRAM ESTABLISHMENT.—The Secretary,
6 acting through the Director of the Centers for Disease
7 Control and Prevention, shall establish a demonstration
8 program to facilitate the clinical adoption of pregnancy in-
9 tention screening initiatives by health care and social serv-
10 ices providers.

11 “(b) GRANTS.—The Secretary may carry out the
12 demonstration program through awarding grants to eligi-
13 ble entities to implement pregnancy intention screening
14 initiatives, collect data, and evaluate such initiatives.

15 “(c) ELIGIBLE ENTITIES.—

16 “(1) IN GENERAL.—An eligible entity under
17 this section is an entity described in paragraph (2)
18 that provides non-directive, comprehensive, medically
19 accurate information.

20 “(2) ENTITIES DESCRIBED.—For purposes of
21 paragraph (1), an entity described in this paragraph
22 is a community-based organization, voluntary health
23 organization, public health department, community
24 health center, or other interested public or private

1 primary, behavioral, or other health care or social
2 service provider or organization.

3 “(d) PREGNANCY INTENTION SCREENING INITIA-
4 TIVE.—For purposes of this section, the term ‘pregnancy
5 intention screening initiative’ means any initiative by an
6 eligible entity to routinely screen women with respect to
7 their pregnancy intentions and goals to either prevent un-
8 intended pregnancies or improve the likelihood of healthy
9 pregnancies, in order to better provide health care that
10 meets the contraceptive or pre-pregnancy needs and goals
11 of such women.

12 “(e) EVALUATION.—

13 “(1) IN GENERAL.—The Secretary, acting
14 through the Director of the Centers for Disease
15 Control and Prevention, shall, by grant or contract,
16 and after consultation as described in paragraph (2),
17 conduct an evaluation of the demonstration pro-
18 gram, with respect to pregnancy intention screening
19 initiatives, conducted under this section. Such eval-
20 uation shall include:

21 “(A) Assessment of the implementation of
22 pregnancy intention screening protocols among
23 a diverse group of patients and providers, in-
24 cluding collecting data on the experiences and

1 outcomes for diverse patient populations in a
2 variety of clinical settings.

3 “(B) Analysis of outcome measures that
4 will facilitate effective and widespread adoption
5 of such protocols by health care providers for
6 inquiring about and responding to pregnancy
7 goals of women with both contraceptive and
8 pre-pregnancy care.

9 “(C) Consideration of health disparities
10 among the population served.

11 “(D) Assessment of the equitable and vol-
12 untary application of such initiatives to minor-
13 ity and medically underserved communities.

14 “(E) Assessment of the training, capacity,
15 and ongoing technical assistance needed for
16 providers to effectively implement such preg-
17 nancy intention screening protocols.

18 “(F) Assessment of whether referral sys-
19 tems for selected protocols follow evidence-based
20 standards that ensure access to comprehensive
21 health services and appropriate follow-up care.

22 “(G) Measuring through rigorous methods
23 the effect of such initiatives on key health out-
24 comes.

1 “(2) CONSULTATION WITH INDEPENDENT, EX-
2 PERT ADVISORY PANEL.—In conducting the evalua-
3 tion under paragraph (1), the Director of the Cen-
4 ters for Disease Control and Prevention shall consult
5 with physicians, physician assistants, advanced prac-
6 tice registered nurses, nurse midwives, and other
7 health care providers who specialize in women’s
8 health, and other experts in public health, clinical
9 practice, program evaluation, and research.

10 “(3) REPORT.—Not later than one year after
11 the last day of the demonstration program under
12 this section, the Director of the Centers for Disease
13 Control and Prevention shall submit to Congress a
14 report on the results of the evaluation conducted
15 under paragraph (1) and shall make the report pub-
16 licly available.

17 “(f) FUNDING.—

18 “(1) AUTHORIZATION OF APPROPRIATIONS.—
19 To carry out this section, there is authorized to be
20 appropriated \$10,000,000 for each of fiscal years
21 2021 through 2025.

22 “(2) LIMITATION.—Not more than 20 percent
23 of funds appropriated to carry out this section pur-
24 suant to paragraph (1) for a fiscal year may be used

1 for purposes of the evaluation under subsection
2 (e).”.

3 **TITLE VI—MENTAL HEALTH**

4 **SEC. 601. MENTAL HEALTH FINDINGS.**

5 Congress finds the following:

6 (1) Despite the existence of effective treat-
7 ments, inequities lie in the availability, accessibility,
8 and quality of mental health services for racial and
9 ethnic minorities and people with disabilities.

10 (2) These inequities have powerful significance
11 for minority groups and for society as a whole.

12 (3) Racial and ethnic minorities and people
13 with disabilities bear a greater burden from unmet
14 mental health needs and thus suffer a greater loss
15 to their overall health and productivity.

16 (4) Improving community conditions and one’s
17 home environment, paired with high-quality, acces-
18 sible, and culturally tailored mental health services,
19 can reduce the likelihood, frequency, and intensity of
20 challenges to one’s mental health.

21 (5) The presence of strong social connections
22 and trust, opportunities to experience and share cul-
23 tural identity, safe gathering places, and economic
24 opportunity are community factors that benefit men-
25 tal health.

1 (6) The social, physical, and economic condi-
2 tions in communities can have tremendous influence
3 on daily stressors that shape mental health out-
4 comes.

5 (7) The foremost barriers include the cost of
6 care, societal stigma, and the fragmented organiza-
7 tion of services.

8 (8) People with disabilities who are racial or
9 ethnic minorities may have co-occurring mental
10 health conditions which, without proper accommoda-
11 tions and support, further stigmatize them and limit
12 their participation in society.

13 (9) African-American, Latinx, Asian American,
14 Pacific Islander, Native, and other people of color
15 have attitudes toward mental health challenges that
16 are another barrier to seeking mental health care.

17 (10) Mental illness retains considerable stigma
18 in many communities of color, including those of
19 Asian Americans and Pacific Islanders, and seeking
20 treatment is not always encouraged.

21 (11) Addressing mental health stigma and in-
22 creasing culturally appropriate treatment modalities
23 in communities will help to increase utilization of
24 mental health services for people who have trouble
25 functioning because of mental health challenges.

1 (12) There is a link between mental health di-
2 agnosis and the likelihood of an individual commit-
3 ting suicide.

4 (13) A comprehensive public health approach to
5 behavioral health fosters protective factors in racial
6 and ethnic communities that support mental health.

7 (14) Approaches to mental health and address-
8 ing trauma must keep in mind the historical and
9 cultural trauma that has impacted many commu-
10 nities of color.

11 (15) Treatment modalities must keep ap-
12 proaches of individual communities to mental health
13 in mind, including by considering—

14 (A) approaches to cultural healing prac-
15 tices; and

16 (B) the mental health professionals needed
17 for such practices, such as peer support special-
18 ists.

19 (16) Approaches to mental health and address-
20 ing trauma must keep in mind the concept of
21 intersectionality of individuals; that individuals may
22 have many inequities that shape the way they proc-
23 ess and experience everyday life.

1 **SEC. 602. COVERAGE OF MARRIAGE AND FAMILY THERA-**
2 **PIST SERVICES, MENTAL HEALTH COUN-**
3 **SELOR SERVICES, SUBSTANCE ABUSE COUN-**
4 **SELOR SERVICES, AND PEER SUPPORT SPE-**
5 **CIALIST SERVICES UNDER PART B OF THE**
6 **MEDICARE PROGRAM.**

7 (a) COVERAGE OF SERVICES.—

8 (1) IN GENERAL.—Section 1861(s)(2) of the
9 Social Security Act (42 U.S.C. 1395x(s)(2)), as
10 amended by section 431(c), is amended—

11 (A) in subparagraph (HH), by striking

12 “and” at the end;

13 (B) in subparagraph (II), by adding “and”

14 after the semicolon at the end; and

15 (C) by adding at the end the following new

16 subparagraph:

17 “(JJ) marriage and family therapist services

18 (as defined in subsection (nnn)(1)), mental health

19 counselor services (as defined in subsection

20 (nnn)(3)), substance abuse counselor services (as de-

21 fined in subsection (nnn)(5)), and peer support spe-

22 cialist services (as defined in subsection (nnn)(7));”.

23 (2) DEFINITIONS.—Section 1861 of the Social

24 Security Act (42 U.S.C. 1395x), as amended by sec-

25 tions 207(b)(1), 417(a), and 433(c), is amended by

26 adding at the end the following new subsection:

1 “Marriage and Family Therapist Services; Marriage and
2 Family Therapist; Mental Health Counselor Serv-
3 ices; Mental Health Counselor; Substance Abuse
4 Counselor Services; Substance Abuse Counselor;
5 Peer Support Specialist Services; Peer Support Spe-
6 cialist

7 “(nnn)(1) The term ‘marriage and family therapist
8 services’ means services performed by a marriage and
9 family therapist (as defined in paragraph (2)) for the diag-
10 nosis and treatment of mental illnesses, which the mar-
11 riage and family therapist is legally authorized to perform
12 under State law (or the State regulatory mechanism pro-
13 vided by State law) of the State in which such services
14 are performed, as would otherwise be covered if furnished
15 by a physician or as an incident to a physician’s profes-
16 sional service, but only if no facility or other provider
17 charges or is paid any amounts with respect to the fur-
18 nishing of such services.

19 “(2) The term ‘marriage and family therapist’ means
20 an individual who—

21 “(A) possesses a master’s or doctoral degree
22 that qualifies for licensure or certification as a mar-
23 riage and family therapist pursuant to State law, in-
24 cluding but not limited to, clinical social workers and
25 occupational therapists;

1 “(B) after obtaining such degree has performed
2 at least 2 years of clinical supervised experience in
3 marriage and family therapy; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of marriage and family therapists, is li-
7 censed or certified as a marriage and family thera-
8 pist in such State.

9 “(3) The term ‘mental health counselor services’
10 means services performed by a mental health counselor (as
11 defined in paragraph (4)) for the diagnosis and treatment
12 of mental illnesses that the mental health counselor is le-
13 gally authorized to perform under State law (or the State
14 regulatory mechanism provided by the State law) of the
15 State in which such services are performed, as would oth-
16 erwise be covered if furnished by a physician or as incident
17 to a physician’s professional service, but only if no facility
18 or other provider charges or is paid any amounts with re-
19 spect to the furnishing of such services.

20 “(4) The term ‘mental health counselor’ means an
21 individual who—

22 “(A) possesses a master’s or doctor’s degree in
23 mental health counseling or a related field, including
24 clinical social workers and occupational therapists;

1 “(B) after obtaining such a degree has per-
2 formed at least 2 years of supervised mental health
3 counselor practice; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of mental health counselors or professional
7 counselors, is licensed or certified as a mental health
8 counselor or professional counselor in such State.

9 “(5) The term ‘substance abuse counselor services’
10 means services performed by a substance abuse counselor
11 (as defined in paragraph (6)) for the diagnosis and treat-
12 ment of substance abuse and addiction that the substance
13 abuse counselor is legally authorized to perform under
14 State law (or the State regulatory mechanism provided by
15 the State law) of the State in which such services are per-
16 formed, as would otherwise be covered if furnished by a
17 physician or as incident to a physician’s professional serv-
18 ice, but only if no facility or other provider charges or is
19 paid any amounts with respect to the furnishing of such
20 services.

21 “(6) The term ‘substance abuse counselor’ means an
22 individual who—

23 “(A) has performed at least 2 years of super-
24 vised substance abuse counselor practice;

1 “(B) in the case of an individual performing
2 services in a State that provides for licensure or cer-
3 tification of substance abuse counselors or profes-
4 sional counselors, is licensed or certified as a sub-
5 stance abuse counselor or professional counselor in
6 such State; or

7 “(C) is a drug and alcohol counselor as defined
8 in section 40.281 of title 49, Code of Federal Regu-
9 lations.

10 “(7) The term ‘peer support specialist services’
11 means services performed by a peer support specialist (as
12 defined in paragraph (8)) for the well-being of individuals
13 needing mental health support that the peer support spe-
14 cialist is legally authorized to perform under State law (or
15 the State regulatory mechanism provided by the State
16 law) of the State in which such services are performed,
17 as would otherwise be covered if furnished by a physician
18 or as incident to a physician’s professional service, but
19 only if no facility or other provider charges or is paid any
20 amounts with respect to the furnishing of such services.

21 “(8) The term ‘peer support specialist’ means an in-
22 dividual who—

23 “(A) is an individual living in recovery with
24 mental illness, addiction, or systems involvement;

25 “(B) has skills learned in formal training;

1 “(C) uses assets-based framing in speaking
2 about mental health, recovery, and well-being; and

3 “(D) delivers services in behavioral health set-
4 tings to promote mind-body recovery and resil-
5 iency.”.

6 (3) PROVISION FOR PAYMENT UNDER PART
7 B.—Section 1832(a)(2)(B) of the Social Security
8 Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

9 (A) by striking “and” at the end of clause
10 (iv); and

11 (B) by adding at the end the following new
12 clause:

13 “(v) marriage and family therapist
14 services, mental health counselor services,
15 substance abuse counselor services, and
16 peer support specialist services; and”.

17 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
18 of the Social Security Act (42 U.S.C. 1395l(a)(1)),
19 as amended by section 431(c)(3), is amended—

20 (A) by striking “and” before “(DD)”;

21 (B) by inserting before the semicolon at
22 the end the following: “, and (EE) with respect
23 to marriage and family therapist services, men-
24 tal health counselor services, substance abuse
25 counselor services, and peer support specialist

1 services under section 1861(s)(2)(JJ), the
2 amounts paid shall be 80 percent of the lesser
3 of the actual charge for the services or 75 per-
4 cent of the amount determined for payment of
5 a psychologist under subparagraph (L)”.

6 (5) EXCLUSION OF MARRIAGE AND FAMILY
7 THERAPIST SERVICES, MENTAL HEALTH COUNSELOR
8 SERVICES, AND PEER SUPPORT SPECIALIST SERV-
9 ICES FROM SKILLED NURSING FACILITY PROSPEC-
10 TIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii)
11 of the Social Security Act (42 U.S.C.
12 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
13 riage and family therapist services (as defined in
14 section 1861(nnn)(1)), mental health counselor serv-
15 ices (as defined in section 1861(nnn)(3)), and peer
16 support specialist services (as defined in section
17 1861(nnn)(7))” after “qualified psychologist serv-
18 ices,”.

19 (6) INCLUSION OF MARRIAGE AND FAMILY
20 THERAPISTS, MENTAL HEALTH COUNSELORS, AND
21 SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS
22 FOR ASSIGNMENT OF CLAIMS.—Section
23 1842(b)(18)(C) of the Social Security Act (42
24 U.S.C. 1395u(b)(18)(C)) is amended by adding at
25 the end the following new clauses:

1 “(vii) A marriage and family therapist (as de-
2 fined in section 1861(nnn)(2)).

3 “(viii) A mental health counselor (as defined in
4 section 1861(nnn)(4)).

5 “(ix) A substance abuse counselor (as defined
6 in section 1861(nnn)(6)).

7 “(x) A peer support specialist (as defined in
8 section 1861(nnn)(8)).”.

9 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
10 ICES PROVIDED IN CERTAIN SETTINGS.—

11 (1) RURAL HEALTH CLINICS AND FEDERALLY
12 QUALIFIED HEALTH CENTERS.—Section
13 1861(aa)(1)(B) of the Social Security Act (42
14 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
15 by a clinical social worker (as defined in subsection
16 (hh)(1)),” and inserting “, by a clinical social worker
17 (as defined in subsection (hh)(1)), by a marriage
18 and family therapist (as defined in subsection
19 (nnn)(2)), or by a mental health counselor (as de-
20 fined in subsection (nnn)(4)), or by a substance
21 abuse counselor (as defined in section 1861
22 (nnn)(6)), or by a peer support specialist (as defined
23 in section 1861(nnn)(8)).”.

24 (2) HOSPICE PROGRAMS.—Section
25 1861(dd)(2)(B)(i)(III) of the Social Security Act (42

1 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by in-
2 sserting “or one marriage and family therapist (as
3 defined in subsection (nnn)(2))” after “social work-
4 er”.

5 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
6 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR
7 POSTHOSPITAL SERVICES.—Section 1861(ee)(2)(G) of
8 the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is
9 amended by inserting “marriage and family therapist (as
10 defined in subsection (nnn)(2)),” after “social worker,”.

11 (d) EFFECTIVE DATE.—The amendments made by
12 this section shall apply with respect to services furnished
13 on or after January 1, 2021.

14 **SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION**
15 **PROGRAM.**

16 Part D of title V of the Public Health Service Act
17 (42 U.S.C. 290dd et seq.) is amended by adding at the
18 end the following:

19 **“SEC. 553. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
20 **PROVISION OF BEHAVIORAL HEALTH CARE**
21 **IN PRIMARY CARE SETTINGS.**

22 “(a) GRANTS.—The Secretary, acting through the
23 Assistant Secretary for Mental Health and Substance Use,
24 shall award grants to eligible entities for the purpose of

1 establishing interprofessional health care teams that pro-
2 vide behavioral health care.

3 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
4 a grant under this section, an entity shall be a Federally
5 qualified health center (as defined in section 1861(aa) of
6 the Social Security Act), rural health clinic, women’s
7 health clinic, or behavioral health program (including any
8 such program operated by a community-based organiza-
9 tion) serving a high proportion of individuals from racial
10 and ethnic minority groups (as defined in section
11 1707(g)).

12 “(c) LOAN FORGIVENESS.—To encourage qualified
13 allied health professionals to enter the mental health field,
14 an eligible entity receiving a grant under this section shall
15 agree to use not less than \$10,000 of the grant funds on
16 a loan forgiveness program for practitioners who commit
17 to working in the mental health field for a period of 2
18 years.

19 “(d) SCIENTIFICALLY AND CULTURALLY BASED.—
20 Integrated health care funded through this section shall
21 be scientifically and culturally based, taking into consider-
22 ation the results of the most recent peer-reviewed research
23 available.

24 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
25 carry out this section, there is authorized to be appro-

1 priated \$20,000,000 for each of fiscal years 2021 through
2 2025.”.

3 **SEC. 604. ADDRESSING RACIAL AND ETHNIC MENTAL**
4 **HEALTH DISPARITIES RESEARCH GAPS.**

5 (a) IN GENERAL.—Not later than 6 months after the
6 date of the enactment of this Act, the Director of the Na-
7 tional Institute on Minority Health and Health Disparities
8 shall enter into an arrangement with the National Acad-
9 emy of Sciences to carry out the activities under sub-
10 section (b), or, if the National Academy of Sciences de-
11 clines to enter into such an arrangement, the Director of
12 the National Institute on Minority Health and Health Dis-
13 parities, in cooperation with the Agency for Healthcare
14 Research and Quality, shall carry out the activities under
15 subsection (b).

16 (b) ACTIVITIES.—The applicable entity under sub-
17 section (a) shall—

18 (1) conduct a study with respect to mental
19 health disparities in racial and ethnic minority
20 groups (as defined in section 1707(g) of the Public
21 Health Service Act (42 U.S.C. 300u–6(g))); and

22 (2) submit to Congress a report on the results
23 of such study, including—

1 (A) a compilation of information on the dy-
2 namics of mental health outcomes in such racial
3 and ethnic minority groups;

4 (B) the degree of the co-occurrence of
5 mental conditions with other disabilities in such
6 racial and ethnic groups, including physical dis-
7 abilities, mental disabilities, and mental dis-
8 orders or mental health conditions which co-
9 occur with one another;

10 (C) a compilation of information on the
11 impact of exposure to community violence, com-
12 munity trauma, adverse childhood experiences,
13 weather extremes worsened by climate change
14 (such as heat waves, hurricanes, and wildfires),
15 substance use, and other psychological traumas,
16 on mental disorders in such racial and minority
17 groups, stratified by household income level;

18 (D) a compilation of information on the
19 impact of the intersectionality of transgender
20 individuals in racial and ethnic minority groups;
21 and

22 (E) a description of how protective factors
23 contrast and compare among different commu-
24 nities of color, identifying cultural strengths.

1 **SEC. 605. HEALTH PROFESSIONS COMPETENCIES TO AD-**
2 **DRESS RACIAL AND ETHNIC MENTAL HEALTH**
3 **DISPARITIES.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services, acting through the Assistant Secretary
6 for Mental Health and Substance Use, shall award grants
7 to qualified national organizations for the purposes of—

8 (1) developing, and disseminating to health pro-
9 fessional educational programs curricula or core
10 competencies addressing mental health inequities
11 among racial and ethnic minority groups for use in
12 the training of students in the professions of social
13 work, psychology, psychiatry, marriage and family
14 therapy, mental health counseling, peer support, and
15 substance abuse counseling; and

16 (2) certifying community health workers and
17 peer wellness specialists with respect to such cur-
18 ricula and core competencies and integrating and ex-
19 panding the use of such workers and specialists into
20 health care and community-based settings to address
21 mental health disparities among racial and ethnic
22 minority groups.

23 (b) CURRICULA; CORE COMPETENCIES.—Organiza-
24 tions receiving funds under subsection (a) may use the
25 funds to engage in the following activities related to the

1 development and dissemination of curricula or core com-
2 petencies described in subsection (a)(1):

3 (1) Formation of committees or working groups
4 comprised of experts from accredited health profes-
5 sions schools to identify core competencies relating
6 to mental health disparities among racial and ethnic
7 minority groups.

8 (2) Planning of workshops in national fora to
9 allow for public input, including input from commu-
10 nities of color with lived experience, into the edu-
11 cational needs associated with mental health dispari-
12 ties among racial and ethnic minority groups.

13 (3) Dissemination and promotion of the use of
14 curricula or core competencies in undergraduate and
15 graduate health professions training programs na-
16 tionwide.

17 (4) Establishing external stakeholder advisory
18 boards to provide meaningful input into policy and
19 program development and best practices to reduce
20 mental health inequities among racial and ethnic
21 groups, including participation from communities of
22 color with lived experience of the impacts of mental
23 health disparities.

24 (c) DEFINITIONS.—In this section:

1 (1) QUALIFIED NATIONAL ORGANIZATION.—The
2 term “qualified national organization” means a na-
3 tional organization that focuses on the education of
4 students in programs of social work, occupational
5 therapy, psychology, psychiatry, and marriage and
6 family therapy.

7 (2) RACIAL AND ETHNIC MINORITY GROUP.—
8 The term “racial and ethnic minority group” has the
9 meaning given to such term in section 1707(g) of
10 the Public Health Service Act (42 U.S.C. 300u-
11 6(g)).

12 (d) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2021 through 2025.

16 **SEC. 606. GEOACCESS STUDY.**

17 The Assistant Secretary for Mental Health and Sub-
18 stance Use shall—

19 (1) conduct a study to—

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

23 (B) assess the preparedness of speciality
24 mental health providers to deliver culturally and

1 linguistically appropriate, affordable, and acces-
2 sible services; and

3 (2) submit a report to Congress on the results
4 of such study.

5 **SEC. 607. ASIAN AMERICAN, NATIVE HAWAIIAN, PACIFIC IS-**
6 **LANDER, AND HISPANIC AND LATINO BEHAV-**
7 **IORAL AND MENTAL HEALTH OUTREACH AND**
8 **EDUCATION STRATEGIES.**

9 Part D of title V of the Public Health Service Act
10 (42 U.S.C. 290dd et seq.), as amended by section 603,
11 is further amended by adding at the end the following new
12 section:

13 **“SEC. 554. BEHAVIORAL AND MENTAL HEALTH OUTREACH**
14 **AND EDUCATION STRATEGIES.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Assistant Secretary for Mental Health and Substance
17 Use, shall, in coordination with advocacy and behavioral
18 and mental health organizations serving populations of
19 Asian American, Native Hawaiian, Pacific Islander, and
20 Hispanic and Latino individuals or communities, develop
21 and implement an outreach and education strategy to pro-
22 mote behavioral and mental health, clarify that behavioral
23 and mental health conditions are treatable and that rea-
24 sonable accommodations are required under section 504
25 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and

1 titles II and III of the Americans with Disabilities Act
2 of 1990 (42 U.S.C. 12131 et seq.), and reduce stigma as-
3 sociated with mental health conditions and substance
4 abuse among the Asian American, Native Hawaiian, Pa-
5 cific Islander, and Hispanic and Latino populations. Such
6 strategy shall—

7 “(1) be designed to—

8 “(A) meet the diverse cultural and lan-
9 guage needs of the various Asian American,
10 Native Hawaiian, Pacific Islander, and His-
11 panic and Latino populations; and

12 “(B) ensure such strategies are develop-
13 mentally (with respect to the beneficiary’s rel-
14 ative age and experience) and age appropriate,
15 as well as cognitively accessible to persons with
16 cognitive disabilities;

17 “(2) increase awareness of symptoms of mental
18 illnesses common among such populations, taking
19 into account differences within subgroups (such as
20 gender, gender identity, age, sexual orientation, dis-
21 ability, and ethnicity) of such populations;

22 “(3) provide information on evidence-based, cul-
23 turally and linguistically appropriate and adapted
24 interventions and treatments;

1 “(4) ensure full participation of, and engage,
2 both consumers and community members in the de-
3 velopment and implementation of materials; and

4 “(5) seek to broaden the perspective among
5 both individuals in such communities and stake-
6 holders serving such communities to use a com-
7 prehensive public health approach to promoting be-
8 havioral health that addresses a holistic view of
9 health by focusing on the intersection between be-
10 havioral and physical health.

11 “(b) REPORTS.—Beginning not later than 1 year
12 after the date of the enactment of this section and annu-
13 ally thereafter, the Secretary, acting through the Assistant
14 Secretary, shall submit to Congress, and make publicly
15 available, a report on the extent to which the strategy de-
16 veloped and implemented under subsection (a) increased
17 behavioral and mental health outcomes associated with
18 mental health conditions and substance abuse among
19 Asian American, Native Hawaiian, Pacific Islander, and
20 Hispanic and Latino populations.

21 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section
23 \$300,000 for fiscal year 2021.”.

24 **SEC. 608. MENTAL HEALTH IN SCHOOLS.**

25 (a) PURPOSE.—It is the purpose of this section to—

1 (1) revise, increase funding for, and expand the
2 scope of the Project AWARE State Educational
3 Agency Grant Program carried out by the Secretary
4 of Health and Human Services, in order to provide
5 access to more comprehensive school-based mental
6 health services and supports;

7 (2) provide for comprehensive staff development
8 for school and community service personnel working
9 in the school;

10 (3) provide for comprehensive training to im-
11 prove health and academic outcomes for children
12 with, or at risk for, mental health conditions, for
13 parents or guardians, siblings, and other family
14 members of such children, and for concerned mem-
15 bers of the community;

16 (4) provide for comprehensive, universal, evi-
17 dence-based screening to identify children and ado-
18 lescents with potential mental health conditions or
19 unmet emotional health needs;

20 (5) recognize best practices for the delivery of
21 mental health care in school-based settings, includ-
22 ing school-based health centers;

23 (6) provide for comprehensive training for par-
24 ents or guardians, siblings, other family members,
25 and concerned members of the community on behalf

1 of children and adolescents experiencing mental
2 health trauma, disorder, or disability; and

3 (7) establish formal working relationships be-
4 tween health, human service, and educational enti-
5 ties that support the mental and emotional health of
6 children and adolescents in the school setting.

7 (b) TECHNICAL AMENDMENTS.—The second part G
8 (relating to services provided through religious organiza-
9 tions) of title V of the Public Health Service Act (42
10 U.S.C. 290kk et seq.) is amended—

11 (1) by redesignating such part as part J; and

12 (2) by redesignating sections 581 through 584
13 as sections 596 through 596C, respectively.

14 (c) SCHOOL-BASED MENTAL HEALTH AND CHIL-
15 DREN AND VIOLENCE.—Section 581 of the Public Health
16 Service Act (42 U.S.C. 290hh) (relating to children and
17 violence) is amended to read as follows:

18 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN**
19 **AND ADOLESCENTS.**

20 “(a) IN GENERAL.—The Secretary, in consultation
21 with the Secretary of Education, shall, through grants,
22 contracts, or cooperative agreements awarded to eligible
23 entities described in subsection (c), provide comprehensive
24 school-based mental health services and supports to assist
25 children in local communities and schools (including

1 schools funded by the Bureau of Indian Education) deal-
2 ing with traumatic experiences, grief, bereavement, risk of
3 suicide, and violence. Such services and supports shall
4 be—

5 “(1) developmentally, linguistically, and cul-
6 turally appropriate;

7 “(2) trauma-informed; and

8 “(3) incorporate positive behavioral interven-
9 tions and supports.

10 “(b) ACTIVITIES.—Grants, contracts, or cooperative
11 agreements awarded under subsection (a), shall, as appro-
12 priate, be used for—

13 “(1) implementation of school and community-
14 based mental health programs that—

15 “(A) build awareness of individual trauma
16 and the intergenerational, continuum of impacts
17 of trauma on populations;

18 “(B) train appropriate staff to identify,
19 and screen for, signs of trauma exposure, men-
20 tal health disorders, or risk of suicide; and

21 “(C) incorporate positive behavioral inter-
22 ventions, family engagement, student treatment,
23 and multigenerational supports to foster the
24 health and development of children, prevent

1 mental health disorders, and ameliorate the im-
2 pact of trauma;

3 “(2) technical assistance to local communities
4 with respect to the development of programs de-
5 scribed in paragraph (1);

6 “(3) facilitating community partnerships among
7 families, students, law enforcement agencies, edu-
8 cation agencies, mental health and substance use
9 disorder service systems, family-based mental health
10 service systems, child welfare agencies, health care
11 providers (including primary care physicians, mental
12 health professionals, and other professionals who
13 specialize in children’s mental health such as child
14 and adolescent psychiatrists), institutions of higher
15 education, faith-based programs, trauma networks,
16 and other community-based systems to address child
17 and adolescent trauma, mental health issues, and vi-
18 olence; and

19 “(4) establishing and promoting best practices
20 that are either evidence- or culturally-based for chil-
21 dren and adolescents to share their experiences of
22 individual and community trauma, including their
23 exposure to violence, with trusted adults.

24 “(c) REQUIREMENTS.—

1 “(1) IN GENERAL.—To be eligible for a grant,
2 contract, or cooperative agreement under subsection
3 (a), an entity shall be a partnership that includes—

4 “(A) a State educational agency, as de-
5 fined in section 8101 of the Elementary and
6 Secondary Education Act of 1965, in coordina-
7 tion with one or more local educational agen-
8 cies, as defined in section 8101 of the Elemen-
9 tary and Secondary Education Act of 1965, or
10 a consortium of any entities described in sub-
11 paragraph (B), (C), (D), or (E) of section
12 8101(30) of such Act; and

13 “(B) at least 1 community-based mental
14 health provider, including a public or private
15 mental health entity, health care entity, family-
16 based mental health entity, trauma network, or
17 other community-based entity, as determined by
18 the Secretary (and which may include addi-
19 tional entities such as a human services agency,
20 law enforcement or juvenile justice entity, child
21 welfare agency, an institution of higher edu-
22 cation, or another entity, as determined by the
23 Secretary).

24 “(2) COMPLIANCE WITH HIPAA.—Any patient
25 records developed by covered entities through activi-

1 ties under the grant shall meet the regulations pro-
2 mulgated under section 264(c) of the Health Insur-
3 ance Portability and Accountability Act of 1996.

4 “(3) COMPLIANCE WITH FERPA.—Section 444
5 of the General Education Provisions Act (commonly
6 known as the ‘Family Educational Rights and Pri-
7 vacy Act of 1974’) shall apply to any entity that is
8 a member of the partnership in the same manner
9 that such section applies to an educational agency or
10 institution (as that term is defined in such section).

11 “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary
12 shall ensure that grants, contracts, or cooperative agree-
13 ments under subsection (a) will be distributed equitably
14 among the regions of the country and among urban and
15 rural areas.

16 “(e) DURATION OF AWARDS.—With respect to a
17 grant, contract, or cooperative agreement under sub-
18 section (a), the period during which payments under such
19 an award will be made to the recipient shall be 5 years,
20 with options for renewal.

21 “(f) EVALUATION AND MEASURES OF OUTCOMES.—

22 “(1) DEVELOPMENT OF PROCESS.—The Assist-
23 ant Secretary shall develop a fiscally appropriate
24 process for evaluating activities carried out under
25 this section. Such process shall include—

1 “(A) the development of guidelines for the
2 submission of program data by grant, contract,
3 or cooperative agreement recipients;

4 “(B) the development of measures of out-
5 comes (in accordance with paragraph (2)) to be
6 applied by such recipients in evaluating pro-
7 grams carried out under this section; and

8 “(C) the submission of annual reports by
9 such recipients concerning the effectiveness of
10 programs carried out under this section.

11 “(2) MEASURES OF OUTCOMES.—The Assistant
12 Secretary shall develop measures of outcomes to be
13 applied by recipients of assistance under this section
14 to evaluate the effectiveness of programs carried out
15 under this section, including outcomes related to the
16 student, family, and local educational systems sup-
17 ported by this Act.

18 “(3) SUBMISSION OF ANNUAL DATA.—An eligi-
19 ble entity described in subsection (c) that receives a
20 grant, contract, or cooperative agreement under this
21 section shall annually submit to the Assistant Sec-
22 retary a report that includes data to evaluate the
23 success of the program carried out by the entity
24 based on whether such program is achieving the pur-
25 poses of the program. Such reports shall utilize the

1 measures of outcomes under paragraph (2) in a rea-
2 sonable manner to demonstrate the progress of the
3 program in achieving such purposes.

4 “(4) EVALUATION BY ASSISTANT SECRETARY.—
5 Based on the data submitted under paragraph (3),
6 the Assistant Secretary shall annually submit to
7 Congress a report concerning the results and effec-
8 tiveness of the programs carried out with assistance
9 received under this section.

10 “(5) LIMITATION.—An eligible entity shall use
11 not more than 20 percent of amounts received under
12 a grant under this section to carry out evaluation
13 activities under this subsection.

14 “(g) INFORMATION AND EDUCATION.—The Sec-
15 retary shall disseminate best practices based on the find-
16 ings of the knowledge development and application under
17 this section.

18 “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF
19 APPROPRIATIONS.—

20 “(1) AMOUNT OF GRANTS.—A grant under this
21 section shall be in an amount that is not more than
22 \$2,000,000 for each of the first 5 fiscal years fol-
23 lowing the date of enactment of this section. The
24 Secretary shall determine the amount of each such

1 grant based on the population of children up to age
2 21 of the area to be served under the grant.

3 “(2) AUTHORIZATION OF APPROPRIATIONS.—
4 There is authorized to be appropriated to carry out
5 this section, \$130,000,000 for each of fiscal years
6 2021 through 2024.”.

7 (d) CONFORMING AMENDMENT.—Part G of title V
8 of the Public Health Service Act (42 U.S.C. 290hh et
9 seq.), as amended by this section, is further amended by
10 striking the part heading and inserting the following:

11 **“PART G—SCHOOL-BASED MENTAL HEALTH”.**
12 **SEC. 609. BUILDING AN EFFECTIVE WORKFORCE IN MEN-**
13 **TAL HEALTH.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services, in coordination with the Assistant Sec-
16 retary for Mental Health and Substance Use, the Adminis-
17 trator of the Health Resources and Services Administra-
18 tion, and the Secretary of Labor, shall, in coordination
19 with advocacy and behavioral and mental health organiza-
20 tions serving people of color—

21 (1) develop, strengthen, and implement strate-
22 gies to bolster career pathways for mental health
23 professionals; and

24 (2) identify the breadth of settings where men-
25 tal and behavioral health care can take place.

1 (b) CONTENTS.—Strategies under subsection (a)
2 shall include—

3 (1) the variety of settings where mental health
4 professionals are needed, including community-based
5 organizations, women’s centers, shelters, organiza-
6 tions focused on youth development, workforce agen-
7 cies, job placement and development centers, emer-
8 gency rooms, the special supplemental nutrition pro-
9 gram for women, infants, and children under section
10 17 of the Child Nutrition Act of 1966 (42 U.S.C.
11 1786), food banks, legal aid, and benefit issuers as
12 defined in section 3 of the Food and Nutrition Act
13 of 2008 (7 U.S.C. 2012);

14 (2) defining career pathways in mental and be-
15 havioral health, to help communities understand the
16 variety of careers in mental and behavioral health
17 that are available;

18 (3) building career pathways in mental and be-
19 havioral health as part of the curriculum at the
20 postsecondary education level;

21 (4) providing accessible training and certifi-
22 cation pathways for lay health workers such as com-
23 munity health workers and other peer support indi-
24 viduals to ensure that careers pay a living wage;

1 (5) creating incentives for students in the fields
2 of occupational therapy, social work, medicine, and
3 nursing to learn more about mental health, and to
4 include a mental health rotation as a part of the
5 health professional curricula;

6 (6) including training and education for teach-
7 ers about the basics of section 504 of the Rehabilita-
8 tion Act of 1973 (29 U.S.C. 794) and individualized
9 education programs (as defined in section 614(d) of
10 the Individuals with Disabilities Education Act (20
11 U.S.C. 1414(d)));

12 (7) researching, developing, and implementing
13 programs for mental and behavioral health profes-
14 sionals to prevent burnout; and

15 (8) finding better and increased avenues to en-
16 sure equity by providing better loan forgiveness pro-
17 grams, including a focus area within the National
18 Health Service Corps focused on community trauma.

19 **SEC. 610. MENTAL HEALTH AT THE BORDER.**

20 (a) **SHORT TITLE.**—This section may be cited as the
21 “Immigrants’ Mental Health Act of 2020”.

22 (b) **DEFINITIONS.**—In this section:

23 (1) **FORWARD OPERATING BASE.**—The term
24 “forward operating base” means a permanent facil-
25 ity established by U.S. Customs and Border Protec-

1 tion in forward or remote locations, and designated
2 as such by U.S. Customs and Border Protection.

3 (2) U.S. CUSTOMS AND BORDER PROTECTION
4 FACILITY.—The term “U.S. Customs and Border
5 Protection facility” means any of the following facili-
6 ties at which migrants are typically detained on be-
7 half of U.S. Customs and Border Protection:

8 (A) U.S. Border Patrol stations.

9 (B) Ports of entry.

10 (C) Checkpoints.

11 (D) Forward operating bases.

12 (E) Secondary inspection areas.

13 (F) Short-term custody facilities.

14 (c) TRAINING FOR CERTAIN CBP PERSONNEL IN
15 MENTAL HEALTH ISSUES.—

16 (1) TRAINING TO IDENTIFY RISK FACTORS AND
17 WARNING SIGNS IN IMMIGRANTS AND REFUGEES.—

18 (A) IN GENERAL.—The Commissioner of
19 U.S. Customs and Border Protection, in con-
20 sultation with the Assistant Secretary for Men-
21 tal Health and Substance Use, the Adminis-
22 trator of the Health Resources and Services Ad-
23 ministration, and nongovernmental experts in
24 the delivery of health care in humanitarian cri-
25 ses and in the delivery of health care to chil-

1 dren, shall develop and implement a training
2 curriculum for U.S. Customs and Border Pro-
3 tection agents and officers assigned to U.S.
4 Customs and Border Protection facilities to en-
5 able such agents and officers to identify the
6 risk factors and warning signs in immigrants
7 and refugees of mental health issues relating to
8 trauma.

9 (B) REQUIREMENTS.—The training cur-
10 riculum described in subparagraph (A) shall—

11 (i) apply to all U.S. Customs and
12 Border Protection agents and officers
13 working at U.S. Customs and Border Pro-
14 tection facilities;

15 (ii) provide for crisis intervention
16 using a trauma-informed approach; and

17 (iii) provide for mental health
18 screenings for immigrants and refugees ar-
19 riving at the border in their preferred lan-
20 guage or with appropriate language assist-
21 ance.

22 (2) TRAINING TO ADDRESS MENTAL HEALTH
23 AND WELLNESS OF CBP AGENTS AND OFFICERS.—

24 (A) IN GENERAL.—The Commissioner of
25 U.S. Customs and Border Protection, in con-

1 sultation with the Assistant Secretary for Men-
2 tal Health and Substance Use, the Adminis-
3 trator of the Health Resources and Services Ad-
4 ministration, and nongovernmental experts in
5 the delivery of mental health care, shall develop
6 and implement a training curriculum for U.S.
7 Customs and Border Protection agents and offi-
8 cers assigned to U.S. Customs and Border Pro-
9 tection facilities to address the mental health
10 and wellness of individuals working at such fa-
11 cilities.

12 (B) REQUIREMENTS.—The training cur-
13 riculum described in subparagraph (A) shall be
14 designed to help U.S. Customs and Border Pro-
15 tection agents and officers working at U.S.
16 Customs and Border Protection facilities—

17 (i) to better manage their own stress
18 and the stress of their coworkers; and

19 (ii) to be more aware of the psycho-
20 logical pressures experienced during their
21 jobs.

22 (3) ANNUAL REVIEW OF TRAINING.—Beginning
23 with respect to fiscal year 2022, the Assistant Sec-
24 retary for Mental Health and Substance Use shall—

1 (A) conduct an annual review of the train-
2 ing implemented pursuant to paragraphs (1)
3 and (2); and

4 (B) submit the results of each such review,
5 including any recommendations for improve-
6 ment of such training, to—

7 (i) the Commissioner of U.S. Customs
8 and Border Protection;

9 (ii) the Committee on Appropriations
10 of the Senate;

11 (iii) the Committee on Health, Edu-
12 cation, Labor, and Pensions of the Senate;

13 (iv) the Committee on Homeland Se-
14 curity and Governmental Affairs of the
15 Senate;

16 (v) the Committee on Appropriations
17 of the House of Representatives;

18 (vi) the Committee on Energy and
19 Commerce of the House of Representa-
20 tives;

21 (vii) the Committee on Homeland Se-
22 curity of the House of Representatives;
23 and

24 (viii) the Committee on the Judiciary
25 of the House of Representatives.

1 (4) AUTHORIZATION OF APPROPRIATIONS.—

2 There is authorized to be appropriated, to carry out
3 this subsection—

4 (A) for fiscal year 2021, \$50,000 to de-
5 velop the training required under paragraphs
6 (1) and (2); and

7 (B) for each of the fiscal years 2022
8 through 2026—

9 (i) \$20,000 to implement the training
10 required under paragraphs (1) and (2);
11 and

12 (ii) such sums as may be necessary to
13 review and make recommendations for
14 such training pursuant to paragraph (3).

15 (d) STAFFING BORDER FACILITIES AND DETENTION
16 CENTERS.—

17 (1) IN GENERAL.—The Commissioner of U.S.
18 Customs and Border Protection shall adequately
19 evaluate the mental health needs of immigrants, ref-
20 ugees, border patrol agents, and staff by assigning
21 not fewer than 1 qualified mental or behavioral
22 health expert to each U.S. Customs and Border Pro-
23 tection facility.

1 (2) QUALIFICATIONS.—A mental or behavioral
2 health expert is qualified for an assignment de-
3 scribed in paragraph (1) if the expert—

4 (A) is bilingual;

5 (B) is well-versed in culturally appropriate
6 and trauma-informed interventions; and

7 (C) has particular expertise in child or ad-
8 olescent mental health or family mental health.

9 (3) AUTHORIZATION OF APPROPRIATIONS.—

10 There is authorized to be appropriated \$3,000,000
11 for each of the fiscal years 2021 through 2025 to
12 carry out this subsection.

13 (e) PROHIBITION AGAINST SHARING DEPARTMENT
14 OF HEALTH AND HUMAN SERVICES MENTAL HEALTH IN-
15 FORMATION FOR ASYLUM DETERMINATIONS, IMMIGRA-
16 TION HEARINGS, OR DEPORTATION PROCEEDINGS.—The
17 officers, employees, and agents of the Department of
18 Health and Human Services, including the Office of Ref-
19 ugee Resettlement, may not share with the Department
20 of Homeland Security, and the officers, employees, and
21 agents of the Department of Homeland Security may not
22 request or receive from the Department of Health and
23 Human Services, for the purposes of an asylum deter-
24 mination, immigration hearing, or deportation proceeding,
25 any information or record that—

- 1 (1) concerns the mental health of an alien; and
2 (2) was obtained or produced by a mental or
3 behavioral health professional while the alien was in
4 a shelter or otherwise in the custody of the Federal
5 Government.

6 **TITLE VII—ADDRESSING HIGH**
7 **IMPACT MINORITY DISEASES**

8 **Subtitle A—Cancer**

9 **SEC. 701. LUNG CANCER MORTALITY REDUCTION.**

10 (a) **SHORT TITLE.**—This section may be cited as the
11 “Lung Cancer Mortality Reduction Act of 2020”.

12 (b) **FINDINGS.**—Congress makes the following find-
13 ings:

14 (1) Lung cancer is the leading cause of cancer
15 death for both men and women, accounting for 25
16 percent of all cancer deaths.

17 (2) Lung cancer kills more people annually
18 than breast cancer, prostate cancer, colon cancer,
19 liver cancer, melanoma, and kidney cancer combined.

20 (3) Since the National Cancer Act of 1971
21 (Public Law 92–218; 85 Stat. 778), coordinated and
22 comprehensive research has raised the 5-year sur-
23 vival rates for breast cancer to 90 percent, for pros-
24 tate cancer to 99 percent, and for colon cancer to
25 64 percent.

1 (4) The 5-year survival rate for lung cancer is
2 still only 18 percent, and a similar coordinated and
3 comprehensive research effort is required to achieve
4 increases in lung cancer survivability rates.

5 (5) Sixty percent of lung cancer cases are now
6 diagnosed in nonsmokers or former smokers.

7 (6) Two-thirds of nonsmokers diagnosed with
8 lung cancer are women.

9 (7) Certain minority populations, such as Afri-
10 can-American males, have disproportionately high
11 rates of lung cancer incidence and mortality, despite
12 their smoking rate being similar to other racial
13 groups.

14 (8) Members of the Baby Boomer Generation
15 are entering their 60s, the most common age at
16 which people develop lung cancer.

17 (9) Tobacco addiction and exposure to other
18 lung cancer carcinogens such as Agent Orange and
19 other herbicides and battlefield emissions are serious
20 problems among military personnel and war vet-
21 erans.

22 (10) Significant and rapid improvements in
23 lung cancer mortality can be expected through great-
24 er use and access to lung cancer screening tests for
25 at-risk individuals.

1 (11) Recent research has shown that screening
2 with low-dose computed tomography scan reduced
3 lung cancer death mortality by 20 percent for those
4 with a high risk of lung cancer through early detec-
5 tion. The Centers for Medicare & Medicaid Services
6 supports annual lung cancer screening for high-risk
7 patients with low-dose computed tomography.

8 (12) Additional strategies are necessary to fur-
9 ther enhance the existing tests and therapies avail-
10 able to diagnose and treat lung cancer in the future.

11 (13) The August 2001 Report of the Lung
12 Cancer Progress Review Group of the National Can-
13 cer Institute stated that funding for lung cancer re-
14 search was “far below the levels characterized for
15 other common malignancies and far out of propor-
16 tion to its massive health impact”.

17 (14) The Report of the Lung Cancer Progress
18 Review Group identified as its “highest priority” the
19 creation of integrated, multidisciplinary, multi-insti-
20 tutional research consortia organized around the
21 problem of lung cancer rather than around specific
22 research disciplines.

23 (15) The United States must enhance its re-
24 sponse to the issues raised in the Report of the
25 Lung Cancer Progress Review Group, and this can

1 be accomplished through the establishment of a co-
2 ordinated effort designed to reduce the lung cancer
3 mortality rate by 50 percent by 2020 and targeted
4 funding to support this coordinated effort.

5 (c) SENSE OF CONGRESS CONCERNING INVESTMENT
6 IN LUNG CANCER RESEARCH.—It is the sense of the Con-
7 gress that—

8 (1) lung cancer mortality reduction should be
9 made a national public health priority; and

10 (2) a comprehensive mortality reduction pro-
11 gram coordinated by the Secretary of Health and
12 Human Services is justified and necessary to ade-
13 quately address and reduce lung cancer mortality.

14 (d) LUNG CANCER MORTALITY REDUCTION PRO-
15 GRAM.—

16 (1) IN GENERAL.—Subpart 1 of part C of title
17 IV of the Public Health Service Act (42 U.S.C. 285
18 et seq.) is amended by adding at the end the fol-
19 lowing:

20 **“SEC. 417H. LUNG CANCER MORTALITY REDUCTION PRO-**
21 **GRAM.**

22 “(a) IN GENERAL.—Not later than 6 months after
23 the date of the enactment of the Health Equity and Ac-
24 countability Act of 2020, the Secretary, in consultation
25 with the Secretary of Defense, the Secretary of Veterans

1 Affairs, the Director of the National Institutes of Health,
2 the Director of the Centers for Disease Control and Pre-
3 vention, the Commissioner of Food and Drugs, the Admin-
4 istrator of the Centers for Medicare & Medicaid Services,
5 the Director of the National Institute on Minority Health
6 and Health Disparities, and other members of the Lung
7 Cancer Advisory Board established under section 701 of
8 the Health Equity and Accountability Act of 2020, shall
9 implement a comprehensive program, to be known as the
10 Lung Cancer Mortality Reduction Program, to achieve a
11 reduction of at least 25 percent in the mortality rate of
12 lung cancer by 2020.

13 “(b) REQUIREMENTS.—The Program shall include at
14 least the following:

15 “(1) With respect to the National Institutes of
16 Health—

17 “(A) a strategic review and prioritization
18 by the National Cancer Institute of research
19 grants to achieve the goal of the Lung Cancer
20 Mortality Reduction Program in reducing lung
21 cancer mortality;

22 “(B) the provision of funds to enable the
23 Airway Biology and Disease Branch of the Na-
24 tional Heart, Lung, and Blood Institute to ex-
25 pand its research programs to include pre-

1 dispositions to lung cancer, the interrelationship
2 between lung cancer and other pulmonary and
3 cardiac disease, and the diagnosis and treat-
4 ment of those interrelationships;

5 “(C) the provision of funds to enable the
6 National Institute of Biomedical Imaging and
7 Bioengineering to expedite the development of
8 computer-assisted diagnostic, surgical, treat-
9 ment, and drug-testing innovations to reduce
10 lung cancer mortality, such as through expan-
11 sion of the Institute’s Quantum Grant Program
12 and Image-Guided Interventions programs; and

13 “(D) the provision of funds to enable the
14 National Institute of Environmental Health
15 Sciences to implement research programs rel-
16 ative to the lung cancer incidence.

17 “(2) With respect to the Food and Drug Ad-
18 ministration—

19 “(A) activities under section 529B of the
20 Federal Food, Drug, and Cosmetic Act; and

21 “(B) activities under section 561 of the
22 Federal Food, Drug, and Cosmetic Act to ex-
23 pand access to investigational drugs and devices
24 for the diagnosis, monitoring, or treatment of
25 lung cancer.

1 “(3) With respect to the Centers for Disease
2 Control and Prevention, the establishment of an
3 early disease research and management program
4 under section 1511.

5 “(4) With respect to the Agency for Healthcare
6 Research and Quality, the conduct of a biannual re-
7 view of lung cancer screening, diagnostic, and treat-
8 ment protocols, and the issuance of updated guide-
9 lines.

10 “(5) The promotion (including education) of
11 lung cancer screening within minority and rural pop-
12 ulations and the study of the effectiveness of efforts
13 to increase such screening.

14 “(6) The cooperation and coordination of all
15 minority and health disparity programs within the
16 Department of Health and Human Services to en-
17 sure that all aspects of the Lung Cancer Mortality
18 Reduction Program under this section adequately
19 address the burden of lung cancer on minority and
20 rural populations.

21 “(7) The cooperation and coordination of all to-
22 bacco control and cessation programs within agen-
23 cies of the Department of Health and Human Serv-
24 ices to achieve the goals of the Lung Cancer Mor-
25 tality Reduction Program under this section with

1 particular emphasis on the coordination of drug and
2 other cessation treatments with early detection pro-
3 tocols.”.

4 (2) FEDERAL FOOD, DRUG, AND COSMETIC
5 ACT.—Subchapter B of chapter V of the Federal
6 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
7 seq.) is amended by adding at the end the following:

8 **“SEC. 529B. DRUGS RELATING TO LUNG CANCER.**

9 “(a) IN GENERAL.—The provisions of this sub-
10 chapter shall apply to a drug described in subsection (b)
11 to the same extent and in the same manner as such provi-
12 sions apply to a drug for a rare disease or condition.

13 “(b) QUALIFIED DRUGS.—A drug described in this
14 subsection is—

15 “(1) a chemoprevention drug for precancerous
16 conditions of the lung;

17 “(2) a drug for targeted therapeutic treat-
18 ments, including any vaccine, for lung cancer; or

19 “(3) a drug to curtail or prevent nicotine addic-
20 tion.

21 “(c) BOARD.—The Board established under section
22 701 of the Health Equity and Accountability Act of 2020
23 shall monitor the program implemented under this sec-
24 tion.”.

1 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
2 tion 561(e) of the Federal Food, Drug, and Cos-
3 metic Act (21 U.S.C. 360bbb(e)) is amended by in-
4 serting before the period the following: “and shall
5 include expanding access to drugs under section
6 529B, with substantial consideration being given to
7 whether the totality of information available to the
8 Secretary regarding the safety and effectiveness of
9 an investigational drug, as compared to the risk of
10 morbidity and death from the disease, indicates that
11 a patient may obtain more benefit than risk if treat-
12 ed with the drug”.

13 (4) CDC.—Title XV of the Public Health Serv-
14 ice Act (42 U.S.C. 300k et seq.) is amended by add-
15 ing at the end the following:

16 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
17 **PROGRAM.**

18 “The Secretary shall establish and implement an
19 early disease research and management program targeted
20 at the high incidence and mortality rates of lung cancer
21 among minority and low-income populations.”.

22 (e) DEPARTMENT OF DEFENSE AND THE DEPART-
23 MENT OF VETERANS AFFAIRS.—The Secretary of Defense
24 and the Secretary of Veterans Affairs, each in coordina-

1 tion with the Secretary of Health and Human Services,
2 shall engage—

3 (1) in the implementation within the Depart-
4 ment of Defense and the Department of Veterans
5 Affairs of an early detection and disease manage-
6 ment research program for military personnel and
7 veterans whose smoking history and exposure to car-
8 cinogens during active duty service has increased
9 their risk for lung cancer; and

10 (2) in the implementation of coordinated care
11 programs for military personnel and veterans diag-
12 nosed with lung cancer.

13 (f) LUNG CANCER ADVISORY BOARD.—

14 (1) IN GENERAL.—The Secretary of Health and
15 Human Services shall convene a Lung Cancer Advi-
16 sory Board (referred to in this section as the
17 “Board”)—

18 (A) to monitor the programs established
19 under this section (and the amendments made
20 by this section); and

21 (B) to provide annual reports to the Con-
22 gress concerning benchmarks, expenditures,
23 lung cancer statistics, and the public health im-
24 pact of such programs.

1 (2) COMPOSITION.—The Board shall be com-
2 prised of—

3 (A) the Secretary of Health and Human
4 Services;

5 (B) the Secretary of Defense;

6 (C) the Secretary of Veterans Affairs; and

7 (D) 2 representatives each from the fields
8 of clinical medicine focused on lung cancer,
9 lung cancer research, imaging, drug develop-
10 ment, and lung cancer advocacy, to be ap-
11 pointed by the Secretary of Health and Human
12 Services.

13 (g) AUTHORIZATION OF APPROPRIATIONS.—

14 (1) IN GENERAL.—To carry out this section
15 (and the amendments made by this section), there
16 are authorized to be appropriated \$75,000,000 for
17 fiscal year 2021 and such sums as may be necessary
18 for each of fiscal years 2022 through 2025.

19 (2) LUNG CANCER MORTALITY REDUCTION PRO-
20 GRAM.—The amounts appropriated under paragraph
21 (1) shall be allocated as follows:

22 (A) \$25,000,000 for fiscal year 2021, and
23 such sums as may be necessary for each of fis-
24 cal years 2022 through 2025, for the activities
25 described in section 417H(b)(1)(B) of the Pub-

1 lic Health Service Act, as added by subsection
2 (d);

3 (B) \$25,000,000 for fiscal year 2021, and
4 such sums as may be necessary for each of fis-
5 cal years 2022 through 2025, for the activities
6 described in section 417H(b)(1)(C) of the Pub-
7 lic Health Service Act;

8 (C) \$10,000,000 for fiscal year 2021, and
9 such sums as may be necessary for each of fis-
10 cal years 2022 through 2025, for the activities
11 described in section 417H(b)(1)(D) of the Pub-
12 lic Health Service Act; and

13 (D) \$15,000,000 for fiscal year 2021, and
14 such sums as may be necessary for each of fis-
15 cal years 2022 through 2025, for the activities
16 described in section 417H(b)(3) of the Public
17 Health Service Act.

18 **SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUT-**
19 **REACH, SCREENING, TESTING, ACCESS, AND**
20 **TREATMENT EFFECTIVENESS.**

21 (a) **SHORT TITLE.**—This section may be cited as the
22 “Prostate Research, Outreach, Screening, Testing, Access,
23 and Treatment Effectiveness Act of 2020” or the “PROS-
24 TATE Act”.

1 (b) FINDINGS.—Congress makes the following find-
2 ings:

3 (1) Prostate cancer is the second leading cause
4 of cancer death among men.

5 (2) In 2020, an estimated 191,930 individuals
6 in the United States will be diagnosed with prostate
7 cancer and approximately 33,330 will die from the
8 disease.

9 (3) Roughly 2,000,000 to 3,000,000 people in
10 the United States are living with a diagnosis of pros-
11 tate cancer and its consequences.

12 (4) Although prostate cancer generally affects
13 older individuals, younger men are also at risk for
14 the disease, and when prostate cancer appears in
15 early middle age, it frequently takes on a more ag-
16 gressive form.

17 (5) There are significant racial and ethnic dis-
18 parities that demand attention, for example, African
19 Americans have prostate cancer mortality rates that
20 are more than double those in the White population.

21 (6) Underserved rural populations have higher
22 rates of mortality compared to their urban counter-
23 parts, and innovative and cost-efficient methods to
24 improve rural access to high-quality care should take

1 advantage of advances in telehealth to diagnose and
2 treat prostate cancer when appropriate.

3 (7) Certain populations of veterans may have
4 nearly twice the incidence of prostate cancer as the
5 general population of the United States.

6 (8) Urologists may constitute the specialists
7 who diagnose and treat the vast majority of prostate
8 cancer patients.

9 (9) Although much basic and translational re-
10 search has been completed and much is currently
11 known, there are still many unanswered questions,
12 such as the extent to which known disparities are at-
13 tributable to disease etiology, access to care, or edu-
14 cation and awareness in the community.

15 (10) Causes of prostate cancer are not known.
16 There is not good information regarding how to dif-
17 ferentiate accurately, early on, between aggressive
18 and indolent forms of the disease. As a result, there
19 is significant overtreatment in prostate cancer.
20 There are no treatments that can durably arrest
21 growth or cure prostate cancer once it has metasta-
22 sized.

23 (11) A significant proportion of cases may be
24 clinically indolent and “overdiagnosed”, resulting in
25 significant overtreatment. More accurate tests will

1 allow men and their families to face less physical,
2 psychological, financial, and emotional trauma, and
3 billions of dollars could be saved in private and pub-
4 lic health care systems.

5 (12) Prostate cancer research and health care
6 programs across Federal agencies should be coordi-
7 nated to improve accountability and actively encour-
8 age the translation of research into practice and to
9 identify and implement best practices in order to
10 foster an integrated and consistent focus on effective
11 prevention, diagnosis, and treatment of the disease.

12 (c) PROSTATE CANCER COORDINATION AND EDU-
13 CATION.—

14 (1) INTERAGENCY PROSTATE CANCER COORDI-
15 NATION AND EDUCATION TASK FORCE.—Not later
16 than 180 days after the date of the enactment of
17 this Act, the Secretary of Veterans Affairs, in co-
18 operation with the Secretary of Defense and the Sec-
19 retary of Health and Human Services, shall estab-
20 lish an Interagency Prostate Cancer Coordination
21 and Education Task Force (in this section referred
22 to as the “Prostate Cancer Task Force”).

23 (2) DUTIES.—The Prostate Cancer Task Force
24 shall—

1 (A) develop a summary of advances in
2 prostate cancer research supported or con-
3 ducted by Federal agencies relevant to the diag-
4 nosis, prevention, and treatment of prostate
5 cancer, including psychosocial impairments re-
6 lated to prostate cancer treatment, and compile
7 a list of best practices that warrant broader
8 adoption in health care programs;

9 (B) consider establishing, and advocating
10 for, a guidance to enable physicians to allow
11 screening of men who are age 74 or older, on
12 a case-by-case basis, taking into account quality
13 of life and family history of prostate cancer;

14 (C) share and coordinate information on
15 research and health care program activities by
16 the Federal Government, including activities re-
17 lated to—

18 (i) determining how to improve re-
19 search and health care programs, including
20 psychosocial impairments related to pros-
21 tate cancer treatment;

22 (ii) identifying any gaps in the overall
23 research inventory and in health care pro-
24 grams;

1 (iii) identifying opportunities to pro-
2 mote translation of research into practice;
3 and

4 (iv) maximizing the effects of Federal
5 Government efforts by identifying opportu-
6 nities for collaboration and leveraging of
7 resources in research and health care pro-
8 grams that serve individuals who are sus-
9 ceptible to or diagnosed with prostate can-
10 cer;

11 (D) develop a comprehensive interagency
12 strategy and advise relevant Federal agencies in
13 the solicitation of proposals for collaborative,
14 multidisciplinary research and health care pro-
15 grams, including proposals to evaluate factors
16 that may be related to the etiology of prostate
17 cancer, that would—

18 (i) result in innovative approaches to
19 study emerging scientific opportunities or
20 eliminate knowledge gaps in research to
21 improve the prostate cancer research port-
22 folio of the Federal Government; and

23 (ii) outline key research questions,
24 methodologies, and knowledge gaps;

1 (E) develop a coordinated message related
2 to screening and treatment for prostate cancer
3 to be reflected in educational and beneficiary
4 materials for Federal health programs as such
5 documents are updated; and

6 (F) not later than 2 years after the date
7 of the establishment of the Prostate Cancer
8 Task Force, submit to the expert advisory pan-
9 els appointed under paragraph (4) to be re-
10 viewed and returned within 30 days, and then
11 within 90 days submitted to Congress, rec-
12 ommendations—

13 (i) regarding any appropriate changes
14 to research and health care programs, in-
15 cluding recommendations to improve the
16 research portfolio of the Department of
17 Veterans Affairs, the Department of De-
18 fense, the National Institutes of Health,
19 and other Federal agencies to ensure that
20 scientifically based strategic planning is
21 implemented in support of research and
22 health care program priorities;

23 (ii) designed to ensure that the re-
24 search and health care programs and ac-
25 tivities of the Department of Veterans Af-

1 fairs, the Department of Defense, the De-
2 partment of Health and Human Services,
3 and other Federal agencies are free of un-
4 necessary duplication;

5 (iii) regarding public participation in
6 decisions relating to prostate cancer re-
7 search and health care programs to in-
8 crease the involvement of patient advo-
9 cates, community organizations, and med-
10 ical associations representing a broad geo-
11 graphical area;

12 (iv) on how to best disseminate infor-
13 mation on prostate cancer research and
14 progress achieved by health care programs;

15 (v) about how to expand partnerships
16 between public entities, including Federal
17 agencies, and private entities to encourage
18 collaborative, cross-cutting research and
19 health care delivery;

20 (vi) assessing any cost savings and ef-
21 ficiencies realized through the efforts iden-
22 tified and supported in this subsection and
23 recommending expansion of those efforts
24 that have proved most promising while also

1 ensuring against any conflicts in directives
2 in law;

3 (vii) identifying key priority action
4 items from among the recommendations;
5 and

6 (viii) with respect to the level of fund-
7 ing needed by each agency to implement
8 the recommendations contained in the re-
9 port.

10 (3) MEMBERS OF THE PROSTATE CANCER TASK
11 FORCE.—The Prostate Cancer Task Force shall be
12 comprised of representatives from such Federal
13 agencies, as the head of each such applicable agency
14 determines necessary, so as to coordinate a uniform
15 message relating to prostate cancer screening and
16 treatment where appropriate, including representa-
17 tives of the following:

18 (A) The Department of Veterans Affairs,
19 including representatives of each relevant pro-
20 gram area of the Department of Veterans Af-
21 fairs.

22 (B) The Prostate Cancer Research Pro-
23 gram of the Congressionally Directed Medical
24 Research Program of the Department of De-
25 fense.

1 (C) The Department of Health and
2 Human Services, including, at a minimum, rep-
3 resentatives of each of the following:

4 (i) The National Institutes of Health.

5 (ii) National research institutes and
6 centers, including the National Cancer In-
7 stitute, the National Institute of Allergy
8 and Infectious Diseases, and the Office of
9 Minority Health.

10 (iii) The Centers for Medicare & Med-
11 icaid Services.

12 (iv) The Food and Drug Administra-
13 tion.

14 (v) The Centers for Disease Control
15 and Prevention.

16 (vi) The Agency for Healthcare Re-
17 search and Quality.

18 (vii) The Health Resources and Serv-
19 ices Administration.

20 (4) APPOINTING EXPERT ADVISORY PANELS.—

21 The Prostate Cancer Task Force shall appoint ex-
22 pert advisory panels, as the task force determines
23 appropriate, to provide input and concurrence from
24 individuals and organizations from the medical,
25 prostate cancer patient and advocate, research, and

1 delivery communities with expertise in prostate can-
2 cer diagnosis, treatment, and research, including
3 practicing urologists, primary care providers, and
4 others, and individuals with expertise in education
5 and outreach to underserved populations affected by
6 prostate cancer.

7 (5) MEETINGS.—The Prostate Cancer Task
8 Force shall convene not less frequently than twice
9 each year, or more frequently as the Secretary of
10 Veterans Affairs determines to be appropriate.

11 (6) FEDERAL ADVISORY COMMITTEE ACT.—The
12 Federal Advisory Committee Act (5 U.S.C. App.)
13 shall apply to the Prostate Cancer Task Force.

14 (7) SUNSET DATE.—The Prostate Cancer Task
15 Force shall terminate on September 30, 2025.

16 (d) PROSTATE CANCER RESEARCH.—

17 (1) RESEARCH COORDINATION PROGRAM.—

18 (A) IN GENERAL.—The Secretary of Vet-
19 erans Affairs, in coordination with the Sec-
20 retary of Defense and the Secretary of Health
21 and Human Services, shall establish and carry
22 out a program to coordinate and intensify pros-
23 tate cancer research.

24 (B) ELEMENTS.—The program established
25 under subparagraph (A) shall—

1 (i) develop advances in diagnostic and
2 prognostic methods and tests, including
3 biomarkers and an improved prostate can-
4 cer screening blood test, including improve-
5 ments or alternatives to the prostate spe-
6 cific antigen test and additional tests to
7 distinguish indolent from aggressive dis-
8 ease;

9 (ii) develop better understanding of
10 the etiology of the disease (including an
11 analysis of lifestyle factors proven to be in-
12 volved in higher rates of prostate cancer,
13 such as obesity and diet, and in different
14 ethnic, racial, and socioeconomic groups,
15 such as the African-American, Latino or
16 Hispanic, and American Indian popu-
17 lations and men with a family history of
18 prostate cancer) to improve prevention ef-
19 forts;

20 (iii) expand basic research into pros-
21 tate cancer, including studies of funda-
22 mental molecular and cellular mechanisms;

23 (iv) identify and provide clinical test-
24 ing of novel agents for the prevention and
25 treatment of prostate cancer;

1 (v) establish clinical registries for
2 prostate cancer;

3 (vi) use the National Institute of Bio-
4 medical Imaging and Bioengineering and
5 the National Cancer Institute for assess-
6 ment of appropriate imaging modalities;
7 and

8 (vii) address such other matters relat-
9 ing to prostate cancer research as may be
10 identified by the Federal agencies partici-
11 pating in the program under this sub-
12 section.

13 (C) UNDERSERVED MINORITY GRANT PRO-
14 GRAM.—In carrying out the program estab-
15 lished under subparagraph (A), the Secretary
16 shall—

17 (i) award grants to eligible entities to
18 carry out components of the research out-
19 lined in subparagraph (B);

20 (ii) integrate and build upon existing
21 knowledge gained from comparative effec-
22 tiveness research; and

23 (iii) recognize and address—

24 (I) the racial and ethnic dispari-
25 ties in the incidence and mortality

1 rates of prostate cancer and men with
2 a family history of prostate cancer;

3 (II) any barriers in access to care
4 and participation in clinical trials that
5 are specific to racial, ethnic, and other
6 underserved minorities and men with
7 a family history of prostate cancer;

8 (III) outreach and educational ef-
9 forts to raise awareness among the
10 populations described in subclause
11 (II); and

12 (IV) appropriate access and utili-
13 zation of imaging modalities.

14 (2) PROSTATE CANCER ADVISORY BOARD.—

15 (A) IN GENERAL.—There is established in
16 the Office of the Chief Scientist of the Food
17 and Drug Administration a Prostate Cancer
18 Scientific Advisory Board.

19 (B) DUTIES.—The board established under
20 subparagraph (A) shall be responsible for accel-
21 erating real-time sharing of the latest research
22 data and accelerating movement of new medi-
23 cines to patients.

24 (e) TELEHEALTH AND RURAL ACCESS PILOT
25 PROJECTS.—

1 (1) ESTABLISHMENT OF PILOT PROJECTS.—

2 (A) IN GENERAL.—The Secretary of Vet-
3 erans Affairs, in cooperation with the Secretary
4 of Defense and the Secretary of Health and
5 Human Services (referred to in this subsection
6 collectively as the “Secretaries”) shall establish
7 4-year telehealth pilot projects for the purpose
8 of analyzing the clinical outcomes and cost-ef-
9 fectiveness associated with telehealth services in
10 a variety of geographic areas that contain high
11 proportions of medically underserved popu-
12 lations, including African Americans, Latinos or
13 Hispanics, American Indians or Alaska Natives,
14 and those in rural areas.

15 (B) EFFICIENT AND EFFECTIVE CARE.—
16 Pilot projects established under subparagraph
17 (A) shall promote efficient use of specialist care
18 through better coordination of primary care and
19 physician extender teams in underserved areas
20 and more effectively employ tumor boards to
21 better counsel patients.

22 (2) ELIGIBLE ENTITIES.—

23 (A) IN GENERAL.—The Secretaries shall
24 select eligible entities to participate in the pilot
25 projects established under this subsection.

1 (B) PRIORITY.—In selecting eligible enti-
2 ties to participate in the pilot projects under
3 this subsection, the Secretaries shall give pri-
4 ority to entities located in medically under-
5 served areas, particularly those that include Af-
6 rican Americans, Latinos and Hispanics, and
7 facilities of the Indian Health Service, including
8 facilities operated by the Indian Health Service,
9 tribally operated facilities, and Urban Indian
10 Clinics, and those in rural areas.

11 (3) EVALUATION.—The Secretaries shall,
12 through the pilot projects, evaluate—

13 (A) the effective and economic delivery of
14 care in diagnosing and treating prostate cancer
15 with the use of telehealth services in medically
16 underserved and Tribal areas including collabo-
17 rative uses of health professionals and integra-
18 tion of the range of telehealth and other tech-
19 nologies;

20 (B) the effectiveness of improving the ca-
21 pacity of nonmedical providers and nonspecial-
22 ized medical providers to provide health services
23 for prostate cancer in medically underserved
24 and Tribal areas, including the exploration of
25 innovative medical home models with collabora-

1 tion between urologists, other relevant medical
2 specialists, including oncologists, radiologists,
3 and primary care teams, and coordination of
4 care through the efficient use of primary care
5 teams and physician extenders; and

6 (C) the effectiveness of using telehealth
7 services to provide prostate cancer treatment in
8 medically underserved areas, including the use
9 of tumor boards to facilitate better patient
10 counseling.

11 (4) REPORT.—Not later than 1 year after the
12 completion of the pilot projects under this sub-
13 section, the Secretaries shall submit to Congress a
14 report describing the outcomes of such pilot projects,
15 including any cost savings and efficiencies realized,
16 and providing recommendations, if any, for expand-
17 ing the use of telehealth services.

18 (f) EDUCATION AND AWARENESS.—

19 (1) CAMPAIGN.—

20 (A) IN GENERAL.—The Secretary of Vet-
21 erans Affairs shall develop a national education
22 campaign for prostate cancer.

23 (B) ELEMENTS.—The campaign developed
24 under subparagraph (A) shall involve the use of
25 written educational materials and public service

1 announcements consistent with the findings of
2 the Prostate Cancer Task Force under sub-
3 section (c) that are intended to encourage men
4 to seek prostate cancer screening when appro-
5 priate.

6 (2) RACIAL DISPARITIES AND THE POPULATION
7 OF MEN WITH A FAMILY HISTORY OF PROSTATE
8 CANCER.—In developing the campaign under para-
9 graph (1), the Secretary shall ensure that edu-
10 cational materials and public service announcements
11 used in the campaign are more readily available in
12 communities experiencing racial disparities in the in-
13 cidence and mortality rates of prostate cancer and to
14 men of any race classification with a family history
15 of prostate cancer.

16 (3) GRANTS.—In carrying out the campaign
17 under this subsection, the Secretary shall award
18 grants to nonprofit private entities to enable such
19 entities to test alternative outreach and education
20 strategies.

21 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated to carry out this section for
23 the period of fiscal years 2021 through 2025 an amount
24 equal to the amount of savings for the Federal Govern-

1 ment projected to be achieved over such period by imple-
2 mentation of this section.

3 **SEC. 703. PROSTATE RESEARCH, IMAGING, AND MEN'S EDU-**
4 **CATION (PRIME).**

5 (a) SHORT TITLE.—This section may be cited as the
6 “Prostate Research, Imaging, and Men’s Education Act
7 of 2020” or the “PRIME Act of 2020”.

8 (b) FINDINGS.—Congress makes the following find-
9 ings:

10 (1) Prostate cancer has reached epidemic pro-
11 portions, particularly among African-American men,
12 and strikes and kills men in numbers comparable to
13 the number of women who lose their lives from
14 breast cancer.

15 (2) Life-saving breakthroughs in screening, di-
16 agnosis, and treatment of breast cancer resulted
17 from the development of advanced imaging tech-
18 nologies led by the Federal Government.

19 (3) Men should have accurate and affordable
20 prostate cancer screening exams and minimally
21 invasive treatment tools, similar to what women have
22 for breast cancer.

23 (4) While it is important for men to take ad-
24 vantage of current prostate cancer screening tech-
25 niques, a recent NCI-funded study demonstrated

1 that the most common available methods of detect-
2 ing prostate cancer (PSA blood test and physical
3 exams) are not foolproof, causing numerous false
4 alarms and false reassurances.

5 (5) The absence of advanced imaging tech-
6 nologies for prostate cancer causes the lack of accu-
7 rate information critical for clinical decisions, result-
8 ing in missed cancers and lost lives, as well as un-
9 necessary and costly medical procedures, with re-
10 lated complications.

11 (6) With prostate imaging tools, men and their
12 families would face less physical, psychological, fi-
13 nancial, and emotional trauma and billions of dollars
14 could be saved in private and public health care sys-
15 tems.

16 (c) RESEARCH AND DEVELOPMENT OF PROSTATE
17 CANCER IMAGING TECHNOLOGIES.—

18 (1) EXPANSION OF RESEARCH.—The Secretary
19 of Health and Human Services (referred to in this
20 section as the “Secretary”), acting through the Di-
21 rector of the National Institutes of Health and the
22 Administrator of the Health Resources and Services
23 Administration, and in consultation with the Sec-
24 retary of Defense, shall carry out a program to ex-
25 pand and intensify research to develop innovative

1 advanced imaging technologies for prostate cancer
2 detection, diagnosis, and treatment comparable to
3 state-of-the-art mammography technologies.

4 (2) EARLY STAGE RESEARCH.—In imple-
5 menting the program under paragraph (1), the Sec-
6 retary, acting through the Administrator of the
7 Health Resources and Services Administration, shall
8 carry out a grant program to encourage the early
9 stages of research in prostate imaging to develop
10 and implement new ideas, proof of concepts, and
11 pilot studies for high-risk technologic innovation in
12 prostate cancer imaging that would have a high po-
13 tential impact for improving patient care, including
14 individualized care, quality of life, and cost-effective-
15 ness.

16 (3) LARGE SCALE LATER STAGE RESEARCH.—
17 In implementing the program under paragraph (1),
18 the Secretary, acting through the Director of the
19 National Institutes of Health, shall utilize the Na-
20 tional Institute of Biomedical Imaging and Bio-
21 engineering and the National Cancer Institute for
22 advanced stages of research in prostate imaging, in-
23 cluding technology development and clinical trials for
24 projects determined by the Secretary to have dem-

1 onstrated promising preliminary results and proof of
2 concept.

3 (4) INTERDISCIPLINARY PRIVATE-PUBLIC PART-
4 NERSHIPS.—In developing the program under para-
5 graph (1), the Secretary, acting through the Admin-
6 istrator of the Health Resources and Services Ad-
7 ministration, shall establish interdisciplinary private-
8 public partnerships to develop and implement re-
9 search strategies for expedited innovation in imaging
10 and image-guided treatment and to conduct such re-
11 search.

12 (5) RACIAL DISPARITIES.—In developing the
13 program under paragraph (1), the Secretary shall
14 recognize and address—

15 (A) the racial disparities in the incidences
16 of prostate cancer and mortality rates with re-
17 spect to such disease; and

18 (B) any barriers in access to care and par-
19 ticipation in clinical trials that are specific to
20 racial minorities.

21 (6) AUTHORIZATION OF APPROPRIATIONS.—

22 (A) IN GENERAL.—Subject to subpara-
23 graph (B), there is authorized to be appro-
24 priated to carry out this section, \$100,000,000
25 for each of the fiscal years 2021 through 2025.

1 (B) SPECIFIC ALLOCATIONS.—Of the
2 amount authorized to be appropriated under
3 subparagraph (A) for each of the fiscal years
4 described in such subparagraph—

5 (i) no less than 10 percent may be ap-
6 propriated to carry out the grant program
7 under paragraph (2); and

8 (ii) no more than 1 percent may be
9 appropriated to carry out paragraph (4).

10 (d) PUBLIC AWARENESS AND EDUCATION CAM-
11 PAIGN.—

12 (1) NATIONAL CAMPAIGN.—The Secretary shall
13 carry out a national campaign to increase the aware-
14 ness and knowledge of individuals in the United
15 States with respect to the need for prostate cancer
16 screening and for improved detection technologies.

17 (2) REQUIREMENTS.—The national campaign
18 conducted under this subsection shall include—

19 (A) roles for the Health Resources Services
20 Administration, the Office of Minority Health
21 of the Department of Health and Human Serv-
22 ices, the Centers for Disease Control and Pre-
23 vention, and the Office of Minority Health and
24 Health Equity of the Centers for Disease Con-
25 trol and Prevention; and

1 (B) the development and distribution of
2 written educational materials, and the develop-
3 ment and placing of public service announce-
4 ments, that are intended to encourage men to
5 seek prostate cancer screening and to create
6 awareness of the need for improved imaging
7 technologies for prostate cancer screening and
8 diagnosis, including in vitro blood testing and
9 imaging technologies.

10 (3) RACIAL DISPARITIES.—In developing the
11 national campaign under paragraph (1), the Sec-
12 retary shall recognize and address—

13 (A) the racial disparities in the incidences
14 of prostate cancer and mortality rates with re-
15 spect to such disease; and

16 (B) any barriers in access to care and par-
17 ticipation in clinical trials that are specific to
18 racial minorities.

19 (4) GRANTS.—The Secretary shall establish a
20 program to award grants to nonprofit private enti-
21 ties to enable such entities to test alternative out-
22 reach and education strategies to increase the
23 awareness and knowledge of individuals in the
24 United States with respect to the need for prostate
25 cancer screening and improved imaging technologies.

1 (5) AUTHORIZATION OF APPROPRIATIONS.—

2 There is authorized to be appropriated to carry out
3 this section, \$10,000,000 for each of fiscal years
4 2021 through 2025.

5 (e) IMPROVING PROSTATE CANCER SCREENING
6 BLOOD TESTS.—

7 (1) IN GENERAL.—The Secretary, in coordina-
8 tion with the Secretary of Defense, shall carry out
9 research to develop an improved prostate cancer
10 screening blood test using in-vitro detection.

11 (2) AUTHORIZATION OF APPROPRIATIONS.—

12 There is authorized to be appropriated to carry out
13 this section, \$20,000,000 for each of fiscal years
14 2021 through 2025.

15 (f) REPORTING AND COMPLIANCE.—

16 (1) REPORT AND STRATEGY.—Not later than
17 12 months after the date of the enactment of this
18 Act, the Secretary shall submit to Congress a report
19 that details the strategy of the Secretary for imple-
20 menting the requirements of this section and the
21 status of such efforts.

22 (2) FULL COMPLIANCE.—Not later than 36
23 months after the date of the enactment of this Act,
24 and annually thereafter, the Secretary shall submit
25 to Congress a report that—

1 (A) describes the research and development
2 and public awareness and education campaigns
3 funded under this section;

4 (B) provides evidence that projects involv-
5 ing high-risk, high impact technologic innova-
6 tion, proof of concept, and pilot studies are
7 prioritized;

8 (C) provides evidence that the Secretary
9 recognizes and addresses any barriers in access
10 to care and participation in clinical trials that
11 are specific to racial minorities in the imple-
12 mentation of this section;

13 (D) contains assurances that all the other
14 provisions of this section are fully implemented;
15 and

16 (E) certifies compliance with the provisions
17 of this section, or in the case of a Federal agen-
18 cy that has not complied with any of such pro-
19 visions, an explanation as to such failure to
20 comply.

21 **SEC. 704. PROSTATE CANCER DETECTION RESEARCH AND**
22 **EDUCATION.**

23 (a) **SHORT TITLE.**—This section may be cited as the
24 “Prostate Cancer Detection Research and Education
25 Act”.

1 (b) PLAN TO DEVELOP AND VALIDATE A TEST OR
2 TESTS FOR PROSTATE CANCER.—

3 (1) IN GENERAL.—The Secretary of Health and
4 Human Services (referred to in this section as the
5 “Secretary”), acting through the Director of the Na-
6 tional Institutes of Health, shall establish an advi-
7 sory council on prostate cancer (referred to in this
8 section as the “advisory council”) to draft a plan for
9 the development and validation of an accurate test
10 or tests, such as biomarkers or imaging, to detect
11 and diagnose prostate cancer.

12 (2) ADVISORY COUNCIL.—

13 (A) MEMBERSHIP.—

14 (i) FEDERAL MEMBERS.—The advi-
15 sory council shall be comprised of the fol-
16 lowing experts:

17 (I) A designee of the Centers for
18 Disease Control and Prevention.

19 (II) A designee of the Centers for
20 Medicare & Medicaid Services.

21 (III) A designee of the Office of
22 the Director of the National Cancer
23 Institute.

24 (IV) A designee of the Director
25 of the Department of Defense Con-

1 gressionally Directed Medical Re-
2 search Programs.

3 (V) A designee of the Director of
4 the National Institute of Biomedical
5 Imaging and Bioengineering.

6 (VI) A designee of the Director
7 of the National Institute of General
8 Medical Sciences.

9 (VII) A designee of the Director
10 of the National Institute on Minority
11 Health and Health Disparities.

12 (VIII) A designee of the Office of
13 the Director of the National Institutes
14 of Health.

15 (IX) A designee of the Food and
16 Drug Administration.

17 (X) A designee of the Agency for
18 Healthcare Research and Quality.

19 (XI) A designee of the Director
20 of the Telemedicine and Advanced
21 Technology Research Center of the
22 Department of Defense.

23 (ii) NON-FEDERAL MEMBERS.—In ad-
24 dition to the members described in clause
25 (i), the advisory council shall include 8 ex-

1 pert members from outside the Federal
2 Government to be appointed by the Sec-
3 retary, which shall include—

4 (I) 2 prostate cancer patient ad-
5 vocates;

6 (II) 2 health care providers with
7 a range of expertise and experience in
8 prostate cancer; and

9 (III) 4 leading researchers with
10 prostate cancer-related expertise in a
11 range of clinical disciplines.

12 (B) MEETINGS.—The advisory council
13 shall meet quarterly and such meetings shall be
14 open to the public.

15 (C) ADVICE.—The advisory council shall
16 advise the Secretary, or the Secretary’s des-
17 ignee.

18 (D) ANNUAL REPORT.—Not later than 1
19 year after the date of enactment of this Act, the
20 advisory council shall provide to the Secretary,
21 or the Secretary’s designee, and Congress—

22 (i) an initial evaluation of all federally
23 funded efforts in prostate cancer research
24 relating to the development and validation

1 of an accurate test or tests to detect and
2 diagnose prostate cancer;

3 (ii) a plan for the development and
4 validation of a reliable test or tests for the
5 detection and accurate diagnosis of pros-
6 tate cancer; and

7 (iii) a set of standards for prostate
8 cancer screening, developed in coordination
9 with the United States Preventive Services
10 Task Force, to ensure that any tools for
11 screening, detection, and diagnosis devel-
12 oped in accordance with the plan under
13 clause (ii) will meet the requirements of
14 the Task Force for recommendation as a
15 proven preventive or diagnostic service.

16 (E) TERMINATION.—The advisory council
17 shall terminate on December 31, 2024.

18 (3) FUNDING.—Notwithstanding any other pro-
19 vision of law, the Secretary may make available
20 \$1,000,000, from any unobligated amounts appro-
21 priated to the National Institutes of Health, for each
22 of fiscal years 2021 through 2025 to carry out this
23 subsection.

24 (c) COORDINATION AND INTENSIFICATION OF PROS-
25 TATE CANCER RESEARCH.—

1 (1) IN GENERAL.—The Director of the National
2 Institutes of Health, in consultation with the Sec-
3 retary of Defense, shall coordinate and intensify re-
4 search in accordance with the plan provided under
5 subsection (b)(2)(D)(ii), with particular attention
6 provided to leveraging existing research to develop
7 and validate a test or tests, such as biomarkers or
8 imaging, to detect and accurately diagnose prostate
9 cancer in order to improve quality of life for millions
10 of individuals in the United States, and decrease
11 health care system costs.

12 (2) FUNDING.—Notwithstanding any other pro-
13 vision of law, the Secretary may make available
14 \$30,000,000, from any unobligated amounts appro-
15 priated to the National Institutes of Health, for each
16 of fiscal years 2022 through 2026 to carry out this
17 subsection.

18 (d) PUBLIC AWARENESS AND EDUCATION CAM-
19 PAIGN.—

20 (1) NATIONAL CAMPAIGN.—The Secretary, in
21 coordination with the Director of the National Insti-
22 tutes of Health and the Director of the Centers for
23 Disease Control and Prevention, shall carry out a
24 national campaign to increase the awareness and
25 knowledge of prostate cancer.

1 (2) REQUIREMENTS.—The national campaign
2 conducted under paragraph (1) shall include—

3 (A) roles for the National Cancer Institute,
4 the National Institute on Minority Health and
5 Health Disparities, the Office of Minority
6 Health of the Department of Health and
7 Human Services, and the Office of Minority
8 Health and Health Equity of the Centers for
9 Disease Control and Prevention; and

10 (B) the development and distribution of
11 written educational materials, and the develop-
12 ment and placing of public service announce-
13 ments, that are intended to encourage men to
14 seek prostate cancer screening when symptoms
15 are present, when they have a family history of
16 prostate cancer, or if they belong to a high-risk
17 population.

18 (3) RACIAL DISPARITIES.—In developing the
19 national campaign under paragraph (1), the Sec-
20 retary shall recognize and address—

21 (A) the racial disparities in the incidences
22 of prostate cancer and mortality rates with re-
23 spect to such disease; and

1 (B) any barriers in access to patient care
2 and participation in clinical trials that are spe-
3 cific to racial minorities.

4 (4) GRANTS.—The Secretary shall establish a
5 program to award grants to nonprofit private enti-
6 ties to enable such entities to test alternative out-
7 reach and education strategies to increase the
8 awareness and knowledge of individuals in the
9 United States with respect to prostate cancer.

10 (5) AUTHORIZATION OF APPROPRIATIONS.—
11 There is authorized to be appropriated to carry out
12 this subsection, \$5,000,000 for each of fiscal years
13 2021 through 2025.

14 **SEC. 705. NATIONAL PROSTATE CANCER COUNCIL.**

15 (a) SHORT TITLE.—This section may be cited as the
16 “National Prostate Cancer Plan Act”.

17 (b) NATIONAL PROSTATE CANCER COUNCIL.—

18 (1) ESTABLISHMENT.—There is established in
19 the Office of the Secretary of Health and Human
20 Services (referred to in this section as the “Sec-
21 retary”) the National Prostate Cancer Council on
22 Screening, Early Detection, Assessment, and Moni-
23 toring of Prostate Cancer (referred to in this section
24 as the “Council”).

1 (2) PURPOSE OF THE COUNCIL.—The Council
2 shall—

3 (A) develop and implement a national stra-
4 tegic plan for the accelerated creation, advance-
5 ment, and testing of diagnostic tools to improve
6 screening, early detection, assessment, and
7 monitoring of prostate cancer, including—

8 (i) early detection of aggressive pros-
9 tate cancer to save lives;

10 (ii) monitoring of tumor response to
11 treatment, including recurrence and pro-
12 gression; and

13 (iii) accurate assessment and surveil-
14 lance of indolent disease to reduce unnec-
15 essary biopsies and treatment;

16 (B) provide information and coordination
17 of prostate cancer research and services across
18 all Federal agencies;

19 (C) review diagnostic tools and their over-
20 all effectiveness at screening, detecting, assess-
21 ing, and monitoring of prostate cancer;

22 (D) evaluate all programs in prostate can-
23 cer that are in existence on the date of enact-
24 ment of this Act, including Federal budget re-

1 quests and approvals and public-private part-
2 nerships;

3 (E) submit an annual report to the Sec-
4 retary and Congress on the creation and imple-
5 mentation of the national strategic plan under
6 subparagraph (A); and

7 (F) ensure the inclusion of men at high-
8 risk for prostate cancer, including men from
9 minority ethnic and racial populations and men
10 who are least likely to receive care, in clinical,
11 research, and service efforts, with the purpose
12 of decreasing health disparities.

13 (3) MEMBERSHIP.—

14 (A) FEDERAL MEMBERS.—The Council
15 shall be led by the Secretary or designee and
16 comprised of the following experts:

17 (i) Two representatives of the Na-
18 tional Institutes of Health, including 1 rep-
19 resentative of the National Institute of
20 Biomedical Imaging and Bioengineering
21 and 1 representative of the National Can-
22 cer Institute.

23 (ii) A representative of the Centers
24 for Disease Control and Prevention.

1 (iii) A representative of the Centers
2 for Medicare & Medicaid Services.

3 (iv) A designee of the Director of the
4 Department of Defense Congressionally
5 Directed Medical Research Programs.

6 (v) A designee of the Director of the
7 Office of Minority Health.

8 (vi) A representative of the Food and
9 Drug Administration.

10 (vii) A representative of the Agency
11 for Healthcare Research and Quality.

12 (B) NON-FEDERAL MEMBERS.—In addi-
13 tion to the members described in subparagraph
14 (A), the Council shall include 14 expert mem-
15 bers from outside the Federal Government,
16 which shall include—

17 (i) 6 prostate cancer patient advo-
18 cates, including—

19 (I) 2 patient-survivors;

20 (II) 2 caregivers of prostate can-
21 cer patients; and

22 (III) 2 representatives from na-
23 tional prostate cancer disease organi-
24 zations that fund research or have
25 demonstrated experience in providing

1 assistance to patients, families, and
2 medical professionals, including infor-
3 mation on health care options, edu-
4 cation, and referral; and

5 (ii) 8 health care stakeholders with
6 specific expertise in prostate cancer re-
7 search in the critical areas of clinical ex-
8 pertise, including medical oncology, radi-
9 ology, radiation oncology, urology, and pa-
10 thology.

11 (4) MEETINGS.—The Council shall meet quar-
12 terly and meetings shall be open to the public.

13 (5) ADVICE.—The Council shall advise the Sec-
14 retary, or the Secretary’s designee.

15 (6) ANNUAL REPORT.—The Council shall sub-
16 mit annual reports, beginning not later than 1 year
17 after the date of enactment of this Act, to the Sec-
18 retary or the Secretary’s designee and to Congress.

19 The annual report shall include—

20 (A) in the first year—

21 (i) an evaluation of all federally fund-
22 ed efforts in prostate cancer research and
23 gaps relating to the development and vali-
24 dation of diagnostic tools for prostate can-
25 cer; and

1 (ii) recommendations for priority ac-
2 tions to expand, eliminate, coordinate, or
3 condense programs based on the perform-
4 ance, mission, and purpose of the pro-
5 grams; and

6 (B) annually thereafter for 5 years—

7 (i) an outline for the development and
8 implementation of a national research plan
9 for creation and validation of accurate di-
10 agnostic tools to improve prostate cancer
11 care in accordance with paragraph (1);

12 (ii) roles for the National Cancer In-
13 stitute, National Institute on Minority
14 Health and Health Disparities, and the Of-
15 fice of Minority Health of the Department
16 of Health and Human Services;

17 (iii) an analysis of the disparities in
18 the incidence and mortality rates of pros-
19 tate cancer in men at high risk of the dis-
20 ease, including individuals with family his-
21 tory, increasing age, or African-American
22 heritage; and

23 (iv) a review of the progress towards
24 the realization of the proposed strategic
25 plan.

1 (7) TERMINATION.—The Council shall termi-
2 nate on December 31, 2025.

3 **SEC. 706. IMPROVED MEDICAID COVERAGE FOR CERTAIN**
4 **BREAST AND CERVICAL CANCER PATIENTS**
5 **IN THE TERRITORIES.**

6 (a) ELIMINATION OF FUNDING LIMITATIONS.—Sec-
7 tion 1108(g)(4) of the Social Security Act (42 U.S.C.
8 1308(g)(4)) is amended—

9 (1) by striking “paragraphs (1), (2), (3), and
10 (4) of”; and

11 (2) by adding at the end the following: “With
12 respect to fiscal years beginning with fiscal year
13 2021, 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 this subsection) to Puer-
18 to Rico, the Virgin Islands, Guam, the Northern
19 Mariana Islands, or American Samoa for such fiscal
20 year.”.

21 (b) APPLICATION OF ENHANCED FMAP FOR HIGH-
22 EST STATE.—Section 1905(b) of such Act (42 U.S.C.
23 1396d(b)) is amended by adding at the end the following:
24 “Notwithstanding the first sentence of this subsection,
25 with respect to medical assistance described in clause (4)

1 of such sentence that is furnished in Puerto Rico, the Vir-
2 gin Islands, Guam, the Northern Mariana Islands, or
3 American Samoa in a fiscal year, the Federal medical as-
4 sistance percentage is equal to the highest such percentage
5 applied under such clause for such fiscal year for any of
6 the 50 States or the District of Columbia that provides
7 such medical assistance for any portion of such fiscal
8 year.”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to payment for medical assistance
11 for items and services furnished on or after October 1,
12 2021.

13 **SEC. 707. CANCER PREVENTION AND TREATMENT DEM-**
14 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
15 **NORITIES.**

16 (a) DEMONSTRATION.—

17 (1) IN GENERAL.—The Secretary of Health and
18 Human Services (referred to in this section as the
19 “Secretary”) shall conduct demonstration projects
20 for the purpose of developing models and evaluating
21 methods that—

22 (A) improve the quality of items and serv-
23 ices provided to target individuals in order to
24 facilitate reduced disparities in early detection
25 and treatment of cancer;

1 (B) improve clinical outcomes, satisfaction,
2 quality of life, appropriate use of items and
3 services covered under the Medicare program
4 under title XVIII of the Social Security Act (42
5 U.S.C. 1395 et seq.), and referral patterns with
6 respect to target individuals with cancer;

7 (C) eliminate disparities in the rate of pre-
8 ventive cancer screening measures, such as Pap
9 smears, prostate cancer screenings, colon cancer
10 screenings, breast cancer screenings, and com-
11 puted tomography scans, for lung cancer among
12 target individuals;

13 (D) promote collaboration with community-
14 based organizations to ensure cultural com-
15 petency of health care professionals and lin-
16 guistic access for target individuals who are
17 persons with limited English proficiency; and

18 (E) encourage the incorporation of commu-
19 nity health workers to increase the efficiency
20 and appropriateness of cancer screening pro-
21 grams.

22 (2) COMMUNITY HEALTH WORKER DEFINED.—

23 In this section, the term “community health worker”
24 includes a community health advocate, a lay health
25 worker, a community health representative, a peer

1 health promoter, a community health outreach work-
2 er, and a promotore de salud, who promotes health
3 or nutrition within the community in which the indi-
4 vidual resides.

5 (3) TARGET INDIVIDUAL DEFINED.—In this
6 section, the term “target individual” means an indi-
7 vidual of a racial and ethnic minority group, as de-
8 fined in section 1707(g)(1) of the Public Health
9 Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-
10 tled to benefits under part A, and enrolled under
11 part B, of title XVIII of the Social Security Act.

12 (b) PROGRAM DESIGN.—

13 (1) INITIAL DESIGN.—Not later than 1 year
14 after the date of the enactment of this Act, the Sec-
15 retary shall evaluate best practices in the private
16 sector, community programs, and academic research
17 of methods that reduce disparities among individuals
18 of racial and ethnic minority groups in the preven-
19 tion and treatment of cancer and shall design the
20 demonstration projects based on such evaluation.

21 (2) NUMBER AND PROJECT AREAS.—Not later
22 than 2 years after the date of the enactment of this
23 Act, the Secretary shall implement at least 9 dem-
24 onstration projects, including the following:

1 (A) Two projects, each of which shall tar-
2 get different ethnic subpopulations, for each of
3 the 4 following major racial and ethnic minority
4 groups:

5 (i) American Indians and Alaska Na-
6 tives, Eskimos, and Aleuts.

7 (ii) Asian Americans.

8 (iii) Blacks and African Americans.

9 (iv) Latinos and Hispanics.

10 (v) Native Hawaiians and other Pa-
11 cific Islanders.

12 (B) One project within the Pacific Islands
13 or United States insular areas.

14 (C) At least one project in a rural area.

15 (D) At least one project in an inner-city
16 area.

17 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
18 TION OF DEMONSTRATION PROJECT RESULTS.—The
19 Secretary shall continue the existing demonstration
20 projects and may expand the number of demonstra-
21 tion projects if the initial report under subsection (c)
22 contains an evaluation that demonstration
23 projects—

1 (A) reduce expenditures under the Medi-
2 care program under title XVIII of the Social
3 Security Act (42 U.S.C. 1395 et seq.); or

4 (B) do not increase expenditures under
5 such Medicare program and reduce racial and
6 ethnic health disparities in the quality of health
7 care services provided to target individuals and
8 increase satisfaction of Medicare beneficiaries
9 and health care providers.

10 (c) REPORT TO CONGRESS.—

11 (1) IN GENERAL.—Not later than 2 years after
12 the date the Secretary implements the initial dem-
13 onstration projects, and biannually thereafter, the
14 Secretary shall submit to Congress a report regard-
15 ing the demonstration projects.

16 (2) CONTENT OF REPORT.—Each report under
17 paragraph (1) shall include the following:

18 (A) A description of the demonstration
19 projects.

20 (B) An evaluation of—

21 (i) the cost-effectiveness of the dem-
22 onstration projects;

23 (ii) the quality of the health care serv-
24 ices provided to target individuals under
25 the demonstration projects; and

1 (iii) beneficiary and health care pro-
2 vider satisfaction under the demonstration
3 projects.

4 (C) Any other information regarding the
5 demonstration projects that the Secretary de-
6 termines to be appropriate.

7 (d) WAIVER AUTHORITY.—The Secretary shall waive
8 compliance with the requirements of title XVIII of the So-
9 cial Security Act (42 U.S.C. 1395 et seq.) to such extent
10 and for such period as the Secretary determines is nec-
11 essary to conduct demonstration projects.

12 **SEC. 708. REDUCING CANCER DISPARITIES WITHIN MEDI-**
13 **CARE.**

14 (a) DEVELOPMENT OF MEASURES OF DISPARITIES
15 IN QUALITY OF CANCER CARE.—

16 (1) DEVELOPMENT OF MEASURES.—The Sec-
17 retary of Health and Human Services (in this sec-
18 tion referred to as the “Secretary”) shall enter into
19 an agreement with an entity that specializes in de-
20 veloping quality measures for cancer care under
21 which the entity shall develop a uniform set of meas-
22 ures to evaluate disparities in the quality of cancer
23 care and annually update such set of measures.

24 (2) MEASURES TO BE INCLUDED.—Such set of
25 measures shall include, with respect to the treatment

1 of cancer, measures of patient outcomes, the process
2 for delivering medical care related to such treat-
3 ment, patient counseling and engagement in deci-
4 sion-making, patient experience of care, resource
5 use, and practice capabilities, such as care coordina-
6 tion.

7 (b) ESTABLISHMENT OF REPORTING PROCESS.—

8 (1) IN GENERAL.—The Secretary shall establish
9 a reporting process that requires and provides for a
10 method for health care providers specified under
11 paragraph (2) to submit to the Secretary and make
12 public data on the performance of such providers
13 during each reporting period through use of the
14 measures developed pursuant to subsection (a). Such
15 data shall be submitted in a form and manner and
16 at a time specified by the Secretary.

17 (2) SPECIFICATION OF PROVIDERS TO REPORT
18 ON MEASURES.—The Secretary shall specify the
19 classes of Medicare providers of services and sup-
20 pliers, including hospitals, cancer centers, physi-
21 cians, primary care providers, and specialty pro-
22 viders, that will be required under such process to
23 publicly report on the measures specified under sub-
24 section (a).

1 (3) ASSESSMENT OF CHANGES.—Under such
2 reporting process, the Secretary shall establish a for-
3 mat that assesses changes in both the absolute and
4 relative disparities in cancer care over time. These
5 measures shall be presented in an easily comprehen-
6 sible format, such as those presented in the final
7 publications relating to Healthy People 2010 or the
8 National Healthcare Disparities Report.

9 (4) INITIAL IMPLEMENTATION.—The Secretary
10 shall implement the reporting process under this
11 subsection for reporting periods beginning not later
12 than 6 months after the date that measures are first
13 established under subsection (a).

14 **SEC. 709. CANCER CLINICAL TRIALS.**

15 (a) SHORT TITLE.—This section may be cited as the
16 “Henrietta Lacks Enhancing Cancer Research Act of
17 2020”.

18 (b) FINDINGS.—Congress finds as follows:

19 (1) Only a small percent of patients participate
20 in cancer clinical trials, even though most express an
21 interest in clinical research. There are several obsta-
22 cles that restrict individuals from participating in-
23 cluding lack of available local trials, restrictive eligi-
24 bility criteria, transportation to trial sites, taking
25 time off from work, and potentially increased med-

1 ical and nonmedical costs. Ultimately, about 1 in 5
2 cancer clinical trials fail because of lack of patient
3 enrollment.

4 (2) Groups that are generally underrepresented
5 in clinical trials include racial and ethnic minorities
6 and older, rural, and lower-income individuals.

7 (3) Henrietta Lacks, an African-American
8 woman, was diagnosed with cervical cancer at the
9 age of 31, and despite receiving painful radium
10 treatments, passed away on October 4, 1951.

11 (4) Medical researchers took samples of Hen-
12 rietta Lacks' tumor during her treatment and the
13 HeLa cell line from her tumor proved remarkably
14 resilient.

15 (5) HeLa cells were the first immortal line of
16 human cells. Henrietta Lacks' cells were unique,
17 growing by the millions, commercialized and distrib-
18 uted worldwide to researchers, resulting in advances
19 in medicine.

20 (6) Henrietta Lacks' prolific cells continue to
21 grow and contribute to remarkable advances in med-
22 icine, including the development of the polio vaccine,
23 as well as drugs for treating the effects of cancer,
24 HIV/AIDS, hemophilia, leukemia, and Parkinson's
25 disease. These cells have been used in research that

1 has contributed to our understanding of the effects
2 of radiation and zero gravity on human cells. These
3 immortal cells have informed research on chromo-
4 somal conditions, cancer, gene mapping, and preci-
5 sion medicine.

6 (7) Henrietta Lacks and her immortal cells
7 have made a significant contribution to global
8 health, scientific research, quality of life, and patient
9 rights.

10 (8) For more than 20 years, the advances made
11 possible by Henrietta Lacks' cells were without her
12 or her family's consent, and the revenues they gen-
13 erated were not known to or shared with her family.

14 (9) Henrietta Lacks and her family's experience
15 is fundamental to modern and future bioethics poli-
16 cies and informed consent laws that benefit patients
17 nationwide by building patient trust; promoting eth-
18 ical research that benefits all individuals, including
19 traditionally underrepresented populations; and pro-
20 tecting research participants.

21 (c) GAO STUDY ON BARRIERS TO PARTICIPATION IN
22 FEDERALLY FUNDED CANCER CLINICAL TRIALS BY POP-
23 ULATIONS THAT HAVE BEEN TRADITIONALLY UNDER-
24 REPRESENTED IN SUCH TRIALS.—

1 (1) IN GENERAL.—Not later than 2 years after
2 the date of enactment of this Act, the Comptroller
3 General of the United States shall—

4 (A) complete a study that—

5 (i) reviews what actions Federal agen-
6 cies have taken to help to address barriers
7 to participation in federally funded cancer
8 clinical trials by populations that have
9 been traditionally underrepresented in such
10 trials, and identifies challenges, if any, in
11 implementing such actions; and

12 (ii) identifies additional actions that
13 can be taken by Federal agencies to ad-
14 dress barriers to participation in federally
15 funded cancer clinical trials by populations
16 that have been traditionally underrep-
17 resented in such trials; and

18 (B) submit a report to the Congress on the
19 results of such study, including recommenda-
20 tions on potential changes in practices and poli-
21 cies to improve participation in such trials by
22 such populations.

23 (2) INCLUSION OF CLINICAL TRIALS.—The
24 study under paragraph (1)(A) shall include review of
25 cancer clinical trials that are largely funded by Fed-

1 eral agencies, including the National Institutes of
2 Health, the Department of Defense, the Department
3 of Veterans Affairs, the Agency for Healthcare Re-
4 search and Quality, the Food and Drug Administra-
5 tion, and such other Federal agencies as the Comp-
6 troller General of the United States may identify.

7 **Subtitle B—Viral Hepatitis and**
8 **Liver Cancer Control and Pre-**
9 **vention**

10 **SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL**
11 **AND PREVENTION.**

12 (a) **SHORT TITLE.**—This subtitle may be cited as the
13 “Viral Hepatitis and Liver Cancer Control and Prevention
14 Act of 2020”.

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

16 (1) In the United States, nearly 5,000,000 per-
17 sons are living with the hepatitis B virus (referred
18 to in this section as “HBV”) or the hepatitis C virus
19 (referred to in this section as “HCV”).

20 (2) In the United States, chronic HBV and
21 HCV are the most common causes of liver cancer,
22 the second deadliest and fastest growing cancer in
23 this country. Such viruses are the most common
24 cause of chronic liver disease, liver cirrhosis, and the
25 most common indications for liver transplantation.

1 At least 21,000 deaths per year in the United States
2 can be attributed to chronic HBV and HCV. Chron-
3 ic HCV is also a leading cause of death in Ameri-
4 cans living with HIV/AIDS; many of those living
5 with HIV/AIDS are coinfecting with chronic HBV,
6 chronic HCV, or both.

7 (3) According to the Centers for Disease Con-
8 trol and Prevention (referred to in this section as
9 the “CDC”), approximately 2 percent of the popu-
10 lation of the United States is living with chronic
11 HBV, chronic HCV, or both. The CDC has recog-
12 nized HCV as the Nation’s most common chronic
13 bloodborne virus infection and HBV as the deadliest
14 vaccine-preventable disease.

15 (4) HBV is transmitted through contact with
16 infectious blood, semen, or other bodily fluids and is
17 100 times more infectious than HIV. HCV is trans-
18 mitted by contact with infectious blood, particularly
19 through percutaneous exposures (such as puncture
20 through the skin).

21 (5) The CDC estimates that in 2016, more
22 than 41,000 people in the United States were newly
23 infected with HCV and nearly 21,000 people in the
24 United States were newly infected with HBV. These
25 estimates could be much higher due to many rea-

1 sons, including lack of screening education and
2 awareness, and perceived marginalization of the pop-
3 ulations at risk.

4 (6) In 2012, CDC released new guidelines rec-
5 ommending every person born between 1945 and
6 1965 receive a one-time test for HCV. Among the
7 estimated 102,000,000 (1,600,000 chronically HCV-
8 infected) eligible for screening, birth-cohort screen-
9 ing leads to 84,000 fewer cases of decompensated
10 cirrhosis, 46,000 fewer cases of hepatocellular car-
11 cinoma, 10,000 fewer liver transplants, and 78,000
12 fewer HCV-related deaths gained versus risk-based
13 screening.

14 (7) In 2013, the United States Preventive Serv-
15 ices Task Force (referred to in this section as the
16 “USPSTF”) issued a Grade B rating for screening
17 for HCV infection in persons at high risk for infec-
18 tion and adults born between 1945 and 1965. In
19 2014, the USPSTF issued a Grade B for screening
20 for HBV in persons at high-risk of hepatitis B infec-
21 tion. In 2009, the USPSTF issued a Grade A for
22 screening pregnant women for HBV during their
23 first prenatal visit, and in 2019, reaffirmed this
24 grade.

1 (8) There were 59 outbreaks (24 of HBV and
2 36 of HCV, including one of both HBV and HCV)
3 reported to CDC for investigation from 2008
4 through 2016 related to health care-associated infec-
5 tion of HBV and HCV, 56 of which occurred in non-
6 hospital settings. There were more than 115,983 pa-
7 tients potentially exposed to one of the viruses.

8 (9) Chronic HBV and chronic HCV usually do
9 not cause symptoms early in the course of the dis-
10 ease, but after many years of a clinically “silent”
11 phase, CDC estimates show more than 33 percent of
12 infected individuals will develop cirrhosis, end-stage
13 liver disease, or liver cancer. Since most individuals
14 with chronic HBV, HCV, or both are unaware of
15 their infection, they do not know to take precautions
16 to prevent the spread of their infection and can un-
17 knowingly exacerbate their own disease progression.

18 (10) HBV and HCV disproportionately affect
19 certain populations in the United States. Although
20 representing only about 6 percent of the population,
21 Asian Americans and Pacific Islanders account for
22 half of all chronic HBV cases in the United States.
23 Baby Boomers (those born between 1945 and 1965)
24 account for approximately 75 percent of domestic
25 chronic HCV cases. In addition, African Americans,

1 Latinos, and American Indian and Native Alaskans
2 are among the groups which have disproportionately
3 high rates of HBV or HCV infections in the United
4 States.

5 (11) For both chronic HBV and chronic HCV,
6 behavioral changes and appropriate medical care can
7 slow disease progression if diagnosis is made early.
8 Early diagnosis, which is determined through simple
9 blood tests, can reduce the risk of transmission and
10 disease progression through education and vaccina-
11 tion of household members and other susceptible
12 persons at risk.

13 (12) Advancements have led to the development
14 of improved diagnostic tests for viral hepatitis.
15 These tests, including rapid, point of care testing
16 and others in development, can facilitate testing, no-
17 tification of results and post-test counseling, and re-
18 ferral to care at the time of the testing visit. In par-
19 ticular, these tests are also advantageous because
20 they can be used simultaneously with HIV rapid
21 testing for persons at risk for both HCV and HIV
22 infections.

23 (13) For those chronically infected with HBV
24 or HCV, regular monitoring can lead to the early de-
25 tection of liver cancer at a stage where a cure is still

1 possible. Liver cancer is the second deadliest cancer
2 in the United States; however, liver cancer has re-
3 ceived little funding for research, prevention, or
4 treatment.

5 (14) Treatment for chronic HCV can eradicate
6 the disease in approximately 90 percent of those cur-
7 rently treated. While there is no cure for chronic
8 HBV, available treatments can effectively suppress
9 viral replication in the overwhelming majority of
10 those treated, thereby reducing the risk of trans-
11 mission and progression to liver scarring or liver
12 cancer.

13 (15) To combat the viral hepatitis epidemic in
14 the United States, in February 2017, the Depart-
15 ment of Health and Human Services released its
16 “National Viral Hepatitis Action Plan 2017–2020”
17 (referred to in this section as the “HHS Action
18 Plan”). In March 2017, the National Academies of
19 Sciences, Engineering, and Medicine released a re-
20 port entitled, “A National Strategy for the Elimini-
21 tion of Hepatitis B and C: Phase Two Report”
22 (referred to in this section as the “NAS report”),
23 recommending specific actions to eliminate viral hep-
24 atitis as public health problems in the United States
25 by 2030.

1 (16) The annual health care costs attributable
2 to HBV and HCV in the United States are signifi-
3 cant. For HBV, it is estimated to be approximately
4 \$2,500,000,000 (\$2,000 per infected person). In
5 2000, the lifetime cost of HBV—before the avail-
6 ability of most current therapies—was approximately
7 \$80,000 per chronically infected person, totaling
8 more than \$100,000,000,000. For HCV, medical
9 costs for patients are expected to increase from
10 \$30,000,000,000 in 2009 to over \$85,000,000,000
11 in 2024. Avoiding these costs by screening and diag-
12 nosing individuals earlier—and connecting them to
13 appropriate treatment and care, will save lives and
14 critical health care dollars. Currently, without a
15 comprehensive screening, testing, and diagnosis pro-
16 gram, most patients are diagnosed too late when
17 they need a liver transplant costing at least
18 \$314,000 for uncomplicated cases or when they have
19 liver cancer or end-stage liver disease which costs
20 \$30,980 to \$110,576 per hospital admission. As
21 health care costs continue to grow, it is critical that
22 the Federal Government invests in effective mecha-
23 nisms to avoid documented cost drivers.

24 (17) According to the NAS report in 2010,
25 chronic HBV and HCV infections cause substantial

1 morbidity and mortality despite being preventable
2 and treatable. Deficiencies in the implementation of
3 established guidelines for the prevention, diagnosis,
4 and medical management of chronic HBV and HCV
5 infections perpetuate personal and economic bur-
6 dens. Existing grants are not sufficient for the scale
7 of the health burden presented by HBV and HCV.

8 (18) Screening and testing for HBV and HCV
9 is aligned with the goal of Healthy People 2020 to
10 increase immunization rates and reduce preventable
11 infectious diseases. Awareness of disease and access
12 to prevention and treatment remain essential compo-
13 nents for reducing infectious disease transmission.

14 (19) Federal support is necessary to increase
15 knowledge and awareness of HBV and HCV and to
16 assist State and local prevention and control efforts
17 in reducing the morbidity and mortality of these
18 epidemics.

19 (20) The Centers for Disease Control and Pre-
20 vention reported a 233 percent increase in hepatitis
21 C cases from 2010 to 2016, stemming from the
22 opioid, heroin, and overdose epidemics affecting com-
23 munities nationwide. From 2014 to 2015, the num-
24 ber of reported cases of acute hepatitis B infection
25 in the United States rose for the first time since

1 2006, increasing by 20.7 percent, which is also
2 largely attributable to the opioid epidemic.

3 (21) The Secretary of Health and Human Serv-
4 ices has the discretion to carry out this subtitle (in-
5 cluding the amendments made by this subtitle) di-
6 rectly and through whichever of the agencies of the
7 Public Health Service the Secretary determines to be
8 appropriate, which may (in the Secretary's discre-
9 tion) include the Centers for Disease Control and
10 Prevention, the Health Resources and Services Ad-
11 ministration, the Substance Abuse and Mental
12 Health Services Administration, the National Insti-
13 tutes of Health (including the National Institute on
14 Minority Health and Health Disparities), and other
15 agencies of such Service.

16 (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B
17 AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,
18 AND MEDICAL MANAGEMENT PLAN.—Title III of the
19 Public Health Service Act (42 U.S.C. 241 et seq.), as
20 amended by title V, is further amended—

21 (1) by striking section 317N (42 U.S.C. 247b–
22 15); and

23 (2) by adding after part W, as added by section
24 508, the following:

1 **“PART X—BIENNIAL ASSESSMENT OF HHS HEPA-**
2 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
3 **CATION, RESEARCH, AND MEDICAL MANAGE-**
4 **MENT PLAN**

5 **“SEC. 399PP. BIENNIAL UPDATE OF THE PLAN.**

6 “(a) IN GENERAL.—The Secretary shall conduct a bi-
7 ennial assessment of the Secretary’s plan for the preven-
8 tion, control, and medical management of, and education
9 and research relating to, hepatitis B and hepatitis C, for
10 the purposes of—

11 “(1) incorporating into such plan new knowl-
12 edge or observations relating to hepatitis B and hep-
13 atitis C (such as knowledge and observations that
14 may be derived from clinical, laboratory, and epide-
15 miological research and disease detection, preven-
16 tion, and surveillance outcomes);

17 “(2) addressing gaps in the coverage or effec-
18 tiveness of the plan; and

19 “(3) evaluating and, if appropriate, updating
20 recommendations, guidelines, or educational mate-
21 rials of the Centers for Disease Control and Preven-
22 tion or the National Institutes of Health for health
23 care providers or the public on viral hepatitis in
24 order to be consistent with the plan.

25 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
26 Not later than October 1 of the first even-numbered year

1 beginning after the date of the enactment of this part,
2 and October 1 of each even-numbered year thereafter, the
3 Secretary shall publish in the Federal Register a notice
4 of the results of the assessments conducted under para-
5 graph (1). Such notice shall include—

6 “(1) a description of any revisions to the plan
7 referred to in subsection (a) as a result of the as-
8 sessment;

9 “(2) an explanation of the basis for any such
10 revisions, including the ways in which such revisions
11 can reasonably be expected to further promote the
12 original goals and objectives of the plan; and

13 “(3) in the case of a determination by the Sec-
14 retary that the plan does not need revision, an expla-
15 nation of the basis for such determination.

16 **“SEC. 399PP-1. ELEMENTS OF PROGRAM.**

17 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
18 Secretary, acting through the Director of the Centers for
19 Disease Control and Prevention, the Administrator of the
20 Health Resources and Services Administration, and the
21 Assistant Secretary for Mental Health and Substance Use,
22 and in accordance with the plan referred to in section
23 399PP(a), shall implement programs to increase aware-
24 ness and enhance knowledge and understanding of hepa-
25 titis B and hepatitis C. Such programs shall include—

1 “(1) the conduct of culturally and linguistically
2 appropriate health education in primary and sec-
3 ondary schools, college campuses, public awareness
4 campaigns, and community outreach activities (espe-
5 cially to the ethnic communities with high rates of
6 chronic hepatitis B and chronic hepatitis C and
7 other high-risk groups) to promote public awareness
8 and knowledge about the value of hepatitis A and
9 hepatitis B immunization; risk factors, transmission,
10 and prevention of hepatitis B and hepatitis C; the
11 value of screening for the early detection of hepatitis
12 B and hepatitis C; and options available for the
13 treatment of chronic hepatitis B and chronic hepa-
14 titis C;

15 “(2) the promotion of immunization programs
16 that increase awareness and access to hepatitis A
17 and hepatitis B vaccines for susceptible adults and
18 children;

19 “(3) the training of health care professionals
20 regarding the importance of vaccinating individuals
21 infected with hepatitis C and individuals who are at
22 risk for hepatitis C infection against hepatitis A and
23 hepatitis B;

24 “(4) the training of health care professionals
25 regarding the importance of vaccinating individuals

1 chronically infected with hepatitis B and individuals
2 who are at risk for chronic hepatitis B infection
3 against the hepatitis A virus;

4 “(5) the training of health care professionals
5 and health educators to make them aware of the
6 high rates of chronic hepatitis B and chronic hepa-
7 titis C in certain adult ethnic populations, and the
8 importance of prevention, detection, and medical
9 management of hepatitis B and hepatitis C and of
10 liver cancer screening;

11 “(6) the development and distribution of health
12 education curricula (including information relating
13 to the special needs of individuals infected with or
14 at risk of hepatitis B and hepatitis C, such as the
15 importance of prevention and early intervention, reg-
16 ular monitoring, the recognition of psychosocial
17 needs, appropriate treatment, and liver cancer
18 screening) for individuals providing hepatitis B and
19 hepatitis C counseling; and

20 “(7) support for the implementation of the cur-
21 ricula described in paragraph (6) by State and local
22 public health agencies.

23 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
24 PROGRAMS.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Director of the Centers for Disease
3 Control and Prevention, shall support the integra-
4 tion of activities described in paragraph (3) into ex-
5 isting clinical and public health programs at State,
6 local, territorial, and Tribal levels (including commu-
7 nity health clinics, programs for the prevention and
8 treatment of HIV/AIDS, sexually transmitted infec-
9 tions, and substance abuse, and programs for indi-
10 viduals in correctional settings).

11 “(2) COORDINATION OF DEVELOPMENT OF
12 FEDERAL SCREENING GUIDELINES.—

13 “(A) REFERENCES.—For purposes of this
14 subsection, the term ‘CDC Director’ means the
15 Director of the Centers for Disease Control and
16 Prevention, and the term ‘AHRQ Director’
17 means the Director of the Agency for
18 Healthcare Research and Quality.

19 “(B) AGENCY FOR HEALTHCARE RE-
20 SEARCH AND QUALITY.—Due to the rapidly
21 evolving standard of care associated with diag-
22 nosing and treating viral hepatitis infection, the
23 AHRQ Director shall convene the Preventive
24 Services Task Force under section 915(a) to re-

1 view its recommendation for screening for HBV
2 and HCV infection every 3 years.

3 “(3) ACTIVITIES.—

4 “(A) VOLUNTARY TESTING PROGRAMS.—

5 “(i) IN GENERAL.—The Secretary
6 shall establish a mechanism by which to
7 support and promote the development of
8 State, local, territorial, and tribal vol-
9 untary hepatitis B and hepatitis C testing
10 programs to screen the high-prevalence
11 populations to aid in the early identifica-
12 tion of chronically infected individuals.

13 “(ii) CONFIDENTIALITY OF THE TEST
14 RESULTS.—The Secretary shall prohibit
15 the use of the results of a hepatitis B or
16 hepatitis C test conducted by a testing pro-
17 gram developed or supported under this
18 subparagraph for any of the following:

19 “(I) Issues relating to health in-
20 surance.

21 “(II) To screen or determine
22 suitability for employment.

23 “(III) To discharge a person
24 from employment.

1 “(B) COUNSELING REGARDING VIRAL HEP-
2 ATITIS.—The Secretary shall support State,
3 local, territorial, and tribal programs in a wide
4 variety of settings, including those providing
5 primary and specialty health care services in
6 nonprofit private and public sectors, to—

7 “(i) provide individuals with ongoing
8 risk factors for hepatitis B and hepatitis C
9 infection with client-centered education
10 and counseling which concentrates on—

11 “(I) promoting testing of individ-
12 uals that have been exposed to their
13 blood, family members, and their sex-
14 ual partners; and

15 “(II) changing behaviors that
16 place individuals at risk for infection;

17 “(ii) provide individuals chronically in-
18 fected with hepatitis B or hepatitis C with
19 education, health information, and coun-
20 seling to reduce their risk of—

21 “(I) dying from end-stage liver
22 disease and liver cancer; and

23 “(II) transmitting viral hepatitis
24 to others; and

1 “(iii) provide women chronically in-
2 fected with hepatitis B or hepatitis C who
3 are pregnant or of childbearing age with
4 culturally and linguistically appropriate
5 health information, such as how to prevent
6 hepatitis B perinatal infection, and to al-
7 leviate fears associated with pregnancy or
8 raising a family.

9 “(C) IMMUNIZATION.—The Secretary shall
10 support State, local, territorial, and tribal ef-
11 forts to expand the current vaccination pro-
12 grams to protect every child in the Nation and
13 all susceptible adults, particularly those infected
14 with hepatitis C and high-prevalence ethnic
15 populations and other high-risk groups, from
16 the risks of acute and chronic hepatitis B infec-
17 tion by—

18 “(i) ensuring continued funding for
19 hepatitis B vaccination for all children 18
20 years of age or younger through the Vac-
21 cines for Children program;

22 “(ii) ensuring that the recommenda-
23 tions of the Advisory Committee on Immu-
24 nization Practices of the Centers for Dis-
25 ease Control and Prevention are followed

1 regarding the birth dose of hepatitis B vac-
2 cinations for newborns;

3 “(iii) requiring proof of hepatitis B
4 vaccination for entry into public or private
5 daycare, preschool, elementary school, sec-
6 ondary school, and institutions of higher
7 education;

8 “(iv) expanding the availability of
9 hepatitis B vaccination for all adults to
10 protect them from becoming acutely or
11 chronically infected, including ethnic and
12 other populations with high prevalence
13 rates of chronic hepatitis B infection;

14 “(v) expanding the availability of hep-
15 atitis B vaccination for all adults, particu-
16 larly those of reproductive age (women and
17 men less than 45 years of age), to protect
18 them from the risk of hepatitis B infection;

19 “(vi) ensuring the vaccination of indi-
20 viduals infected, or at risk for infection,
21 with hepatitis C against hepatitis A, hepa-
22 titis B, and other infectious diseases, as
23 appropriate, for which such individuals
24 may be at increased risk; and

1 “(vii) ensuring the vaccination of indi-
2 viduals infected, or at risk for infection,
3 with hepatitis B against hepatitis A virus
4 and other infectious diseases, as appro-
5 priate, for which such individuals may be
6 at increased risk.

7 “(D) MEDICAL REFERRAL.—The Secretary
8 shall support State, local, territorial, and tribal
9 programs that support—

10 “(i) referral of persons chronically in-
11 fected with hepatitis B or hepatitis C—

12 “(I) for medical evaluation to de-
13 termine the appropriateness for
14 antiviral treatment to reduce the risk
15 of progression to cirrhosis and liver
16 cancer; and

17 “(II) for ongoing medical man-
18 agement including regular monitoring
19 of liver function and screening for
20 liver cancer; and

21 “(ii) referral of persons infected with
22 acute or chronic hepatitis B infection or
23 acute or chronic hepatitis C infection for
24 drug and alcohol abuse treatment where
25 appropriate.

1 “(4) INCREASED SUPPORT FOR ADULT VIRAL
2 HEPATITIS PREVENTION COORDINATORS.—The Sec-
3 retary, acting through the CDC Director, shall pro-
4 vide increased support to adult viral hepatitis pre-
5 vention coordinators in State, local, territorial, and
6 tribal health departments in order to enhance the
7 additional management, networking, and technical
8 expertise needed to ensure successful integration of
9 hepatitis B and hepatitis C prevention and control
10 activities into existing public health programs.

11 “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

12 “(1) IN GENERAL.—The Secretary, acting
13 through the Director of the Centers for Disease
14 Control and Prevention, shall support the establish-
15 ment and maintenance of a national chronic and
16 acute hepatitis B and hepatitis C surveillance pro-
17 gram, in order to identify—

18 “(A) trends in the incidence of acute and
19 chronic hepatitis B and acute and chronic hepa-
20 titis C;

21 “(B) trends in the prevalence of acute and
22 chronic hepatitis B and acute and chronic hepa-
23 titis C infection among groups that may be dis-
24 proportionately affected; and

1 “(C) trends in liver cancer and end-stage
2 liver disease incidence and deaths, caused by
3 chronic hepatitis B and chronic hepatitis C in
4 the high-risk ethnic populations.

5 “(2) SEROPREVALENCE AND LIVER CANCER
6 STUDIES.—The Secretary, acting through the Direc-
7 tor of the Centers for Disease Control and Preven-
8 tion, shall prepare a report outlining the population-
9 based seroprevalence studies currently underway, fu-
10 ture planned studies, the criteria involved in deter-
11 mining which seroprevalence studies to conduct,
12 defer, or suspend, and the scope of those studies, the
13 economic and clinical impact of hepatitis B and hep-
14 atitis C, and the impact of chronic hepatitis B and
15 chronic hepatitis C infections on the quality of life.
16 Not later than one year after the date of the enact-
17 ment of this part, the Secretary shall submit the re-
18 port to the Committee on Health, Education, Labor,
19 and Pensions of the Senate and the Committee on
20 Energy and Commerce of the House of Representa-
21 tives.

22 “(3) CONFIDENTIALITY.—The Secretary shall
23 not disclose any individually identifiable information
24 identified under paragraph (1) or derived through
25 studies under paragraph (2).

1 “(d) RESEARCH.—The Secretary, acting through the
2 Director of the Centers for Disease Control and Preven-
3 tion, the Director of the National Cancer Institute, and
4 the Director of the National Institutes of Health, shall—

5 “(1) conduct epidemiologic and community-
6 based research to develop, implement, and evaluate
7 best practices for hepatitis B and hepatitis C pre-
8 vention especially in the ethnic populations with high
9 rates of chronic hepatitis B and chronic hepatitis C
10 and other high-risk groups;

11 “(2) conduct research on hepatitis B and hepa-
12 titis C natural history, pathophysiology, improved
13 treatments and prevention (such as the hepatitis C
14 vaccine), and noninvasive tests that help to predict
15 the risk of progression to liver cirrhosis and liver
16 cancer;

17 “(3) conduct research that will lead to better
18 noninvasive or blood tests to screen for liver cancer,
19 and more effective treatments of liver cancer caused
20 by chronic hepatitis B and chronic hepatitis C; and

21 “(4) conduct research comparing the effective-
22 ness of screening, diagnostic, management, and
23 treatment approaches for chronic hepatitis B, chron-
24 ic hepatitis C, and liver cancer in the affected com-
25 munities.

1 “(e) **UNDERSERVED AND DISPROPORTIONATELY AF-**
2 **FFECTED POPULATIONS.**—In carrying out this section, the
3 Secretary shall provide expanded support for individuals
4 with limited access to health education, testing, and health
5 care services and groups that may be disproportionately
6 affected by hepatitis B and hepatitis C.

7 “(f) **EVALUATION OF PROGRAM.**—The Secretary
8 shall develop benchmarks for evaluating the effectiveness
9 of the programs and activities conducted under this sec-
10 tion and make determinations as to whether such bench-
11 marks have been achieved.

12 **“SEC. 399PP-2. GRANTS.**

13 “(a) **IN GENERAL.**—The Secretary may award grants
14 to, or enter into contracts or cooperative agreements with,
15 States, political subdivisions of States, territories, Indian
16 tribes, or nonprofit entities that have special expertise re-
17 lating to hepatitis B, hepatitis C, or both, to carry out
18 activities under this part.

19 “(b) **APPLICATION.**—To be eligible for a grant, con-
20 tract, or cooperative agreement under subsection (a), an
21 entity shall prepare and submit to the Secretary an appli-
22 cation at such time, in such manner, and containing such
23 information as the Secretary may require.

1 **“SEC. 399PP-3. AUTHORIZATION OF APPROPRIATIONS.**

2 “There are authorized to be appropriated to carry out
3 this part \$90,000,000 for fiscal year 2021, \$90,000,000
4 for fiscal year 2022, \$110,000,000 for fiscal year 2023,
5 \$130,000,000 for fiscal year 2024, and \$150,000,000 for
6 fiscal year 2025.”.

7 **Subtitle C—Acquired Bone Marrow**
8 **Failure Diseases**

9 **SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

10 (a) **SHORT TITLE.**—This subtitle may be cited as the
11 “Bone Marrow Failure Disease Research and Treatment
12 Act of 2020”.

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

14 (1) Between 20,000 and 30,000 people in the
15 United States are diagnosed each year with
16 myelodysplastic syndromes, aplastic anemia, parox-
17 ysmal nocturnal hemoglobinuria, and other acquired
18 bone marrow failure diseases.

19 (2) Acquired bone marrow failure diseases have
20 a debilitating and often fatal impact on those diag-
21 nosed with these diseases.

22 (3) While some treatments for acquired bone
23 marrow failure diseases can prolong and improve the
24 quality of patients’ lives, there is no single cure for
25 these diseases.

1 (4) The prevalence of acquired bone marrow
2 failure diseases in the United States will continue to
3 grow as the general public ages.

4 (5) Evidence exists suggesting that acquired
5 bone marrow failure diseases occur more often in
6 minority populations, particularly in Asian-American
7 and Latino or Hispanic populations.

8 (6) The National Heart, Lung, and Blood Insti-
9 tute and the National Cancer Institute have con-
10 ducted important research into the causes of and
11 treatments for acquired bone marrow failure dis-
12 eases.

13 (7) The National Marrow Donor Program Reg-
14 istry has made significant contributions to the fight
15 against bone marrow failure diseases by connecting
16 millions of potential marrow donors with individuals
17 and families suffering from these conditions.

18 (8) Despite these advances, a more comprehen-
19 sive Federal strategic effort among numerous Fed-
20 eral agencies is needed to discover a cure for ac-
21 quired bone marrow failure disorders.

22 (9) Greater Federal surveillance of acquired
23 bone marrow failure diseases is needed to gain a bet-
24 ter understanding of the causes of acquired bone
25 marrow failure diseases.

1 retary shall take into consideration the recommenda-
2 tions of the Advisory Committee on Acquired Bone
3 Marrow Failure Diseases established under sub-
4 section (b).

5 “(3) PURPOSES OF REGISTRY.—The National
6 Acquired Bone Marrow Failure Disease Registry
7 shall—

8 “(A) identify the incidence and prevalence
9 of acquired bone marrow failure diseases in the
10 United States;

11 “(B) be used to collect and store data on
12 acquired bone marrow failure diseases, includ-
13 ing data concerning—

14 “(i) the age, race or ethnicity, general
15 geographic location, sex, and family history
16 of individuals who are diagnosed with ac-
17 quired bone marrow failure diseases, and
18 any other characteristics of such individ-
19 uals determined appropriate by the Sec-
20 retary;

21 “(ii) the genetic and environmental
22 factors that may be associated with devel-
23 oping acquired bone marrow failure dis-
24 eases;

1 “(iii) treatment approaches for deal-
2 ing with acquired bone marrow failure dis-
3 eases;

4 “(iv) outcomes for individuals treated
5 for acquired bone marrow failure diseases,
6 including outcomes for recipients of stem
7 cell therapeutic products as contained in
8 the database established pursuant to sec-
9 tion 379A; and

10 “(v) any other factors pertaining to
11 acquired bone marrow failure diseases de-
12 termined appropriate by the Secretary; and
13 “(C) be made available—

14 “(i) to the general public; and

15 “(ii) to researchers to facilitate fur-
16 ther research into the causes of, and treat-
17 ments for, acquired bone marrow failure
18 diseases in accordance with standard prac-
19 tices of the Centers for Disease Control
20 and Prevention.

21 “(b) ADVISORY COMMITTEE.—

22 “(1) ESTABLISHMENT.—Not later than 6
23 months after the date of the enactment of this sec-
24 tion, the Secretary, acting through the Director of
25 the Centers for Disease Control and Prevention,

1 shall establish an advisory committee, to be known
2 as the Advisory Committee on Acquired Bone Mar-
3 row Failure Diseases.

4 “(2) MEMBERS.—The members of the Advisory
5 Committee on Acquired Bone Marrow Failure Dis-
6 eases shall be appointed by the Secretary, acting
7 through the Director of the Centers for Disease
8 Control and Prevention, and shall include at least
9 one representative from each of the following:

10 “(A) A national patient advocacy organiza-
11 tion with experience advocating on behalf of pa-
12 tients suffering from acquired bone marrow
13 failure diseases.

14 “(B) The National Institutes of Health, in-
15 cluding at least one representative from each
16 of—

17 “(i) the National Cancer Institute;

18 “(ii) the National Heart, Lung, and
19 Blood Institute; and

20 “(iii) the Office of Rare Diseases.

21 “(C) The Centers for Disease Control and
22 Prevention.

23 “(D) Clinicians with experience in—

24 “(i) diagnosing or treating acquired
25 bone marrow failure diseases; or

1 “(ii) medical data registries.

2 “(E) Epidemiologists who have experience
3 with data registries.

4 “(F) Publicly or privately funded research-
5 ers who have experience researching acquired
6 bone marrow failure diseases.

7 “(G) The entity operating the C.W. Bill
8 Young Cell Transplantation Program estab-
9 lished pursuant to section 379 and the entity
10 operating the C.W. Bill Young Cell Transplan-
11 tation Program Outcomes Database.

12 “(3) RESPONSIBILITIES.—The Advisory Com-
13 mittee on Acquired Bone Marrow Failure Diseases
14 shall provide recommendations to the Secretary on
15 the establishment and maintenance of the National
16 Acquired Bone Marrow Failure Disease Registry, in-
17 cluding recommendations on the collection, mainte-
18 nance, and dissemination of data.

19 “(4) PUBLIC AVAILABILITY.—The Secretary
20 shall make the recommendations of the Advisory
21 Committee on Acquired Bone Marrow Failure Dis-
22 ease publicly available.

23 “(c) GRANTS.—The Secretary, acting through the
24 Director of the Centers for Disease Control and Preven-
25 tion, may award grants to, and enter into contracts and

1 cooperative agreements with, public or private nonprofit
2 entities for the management of, as well as the collection,
3 analysis, and reporting of data to be included in, the Na-
4 tional Acquired Bone Marrow Failure Disease Registry.

5 “(d) DEFINITION.—In this section, the term ‘ac-
6 quired bone marrow failure disease’ means—

7 “(1) myelodysplastic syndromes;

8 “(2) aplastic anemia;

9 “(3) paroxysmal nocturnal hemoglobinuria;

10 “(4) pure red cell aplasia;

11 “(5) acute myeloid leukemia that has pro-
12 gressed from myelodysplastic syndromes; or

13 “(6) large granular lymphocytic leukemia.

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section
16 \$3,000,000 for each of fiscal years 2021 through 2025.”.

17 (d) PILOT STUDIES THROUGH THE AGENCY FOR
18 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

19 (1) PILOT STUDIES.—The Secretary of Health
20 and Human Services, acting through the Director of
21 the Agency for Toxic Substances and Disease Reg-
22 istry, shall conduct pilot studies to determine which
23 environmental factors, including exposure to toxins,
24 may cause acquired bone marrow failure diseases.

1 (2) COLLABORATION WITH THE RADIATION IN-
2 JURY TREATMENT NETWORK.—In carrying out the
3 directives of this section, the Secretary may collabo-
4 rate with the Radiation Injury Treatment Network
5 of the C.W. Bill Young Cell Transplantation Pro-
6 gram established pursuant to section 379 of the
7 Public Health Service Act (42 U.S.C. 274k) to—

8 (A) augment data for the pilot studies au-
9 thorized by this section;

10 (B) access technical assistance that may be
11 provided by the Radiation Injury Treatment
12 Network; or

13 (C) perform joint research projects.

14 (3) AUTHORIZATION OF APPROPRIATIONS.—
15 There is authorized to be appropriated to carry out
16 this section \$1,000,000 for each of fiscal years 2021
17 through 2025.

18 (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
19 BONE MARROW FAILURE DISEASES.—Title XVII of the
20 Public Health Service Act (42 U.S.C. 300u et seq.) is
21 amended by inserting after section 1707A the following:

22 **“SEC. 1707B. MINORITY-FOCUSED PROGRAMS ON AC-**
23 **QUIRED BONE MARROW FAILURE DISEASE.**

24 **“(a) INFORMATION AND REFERRAL SERVICES.—**

1 “(1) IN GENERAL.—Not later than 6 months
2 after the date of the enactment of this section, the
3 Secretary, acting through the Deputy Assistant Sec-
4 retary for Minority Health, shall establish and co-
5 ordinate outreach and informational programs tar-
6 geted to minority populations affected by acquired
7 bone marrow failure diseases.

8 “(2) PROGRAM REQUIREMENTS.—Minority-fo-
9 cused outreach and informational programs author-
10 ized by this section at the National Minority Health
11 Resource Center supported under section 1707(b)(8)
12 (including by means of the Center’s website, through
13 appropriate locations such as the Center’s knowledge
14 center, and through appropriate programs such as
15 the Center’s resource persons network) and through
16 minority health consultants located at each Depart-
17 ment of Health and Human Services regional of-
18 fice—

19 “(A) shall make information about treat-
20 ment options and clinical trials for acquired
21 bone marrow failure diseases publicly available;
22 and

23 “(B) shall provide referral services for
24 treatment options and clinical trials.

1 “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
2 ISLANDER OUTREACH.—

3 “(1) IN GENERAL.—The Secretary, acting
4 through the Deputy Assistant Secretary for Minority
5 Health, shall undertake a coordinated outreach ef-
6 fort to connect Hispanic, Asian-American, and Pa-
7 cific Islander communities with comprehensive serv-
8 ices focused on treatment of, and information about,
9 acquired bone marrow failure diseases.

10 “(2) COLLABORATION.—In carrying out this
11 subsection, the Secretary may collaborate with public
12 health agencies, nonprofit organizations, community
13 groups, and online entities to disseminate informa-
14 tion about treatment options and clinical trials for
15 acquired bone marrow failure diseases.

16 “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

17 “(1) IN GENERAL.—Not later than 6 months
18 after the date of the enactment of this section, the
19 Secretary, acting through the Deputy Assistant Sec-
20 retary for Minority Health, shall award grants to, or
21 enter into cooperative agreements with, entities to
22 perform research on acquired bone marrow failure
23 diseases.

24 “(2) REQUIREMENT.—Grants and cooperative
25 agreements authorized by this subsection shall be

1 awarded or entered into on a competitive, peer-re-
2 viewed basis.

3 “(3) SCOPE OF RESEARCH.—Research funded
4 under this section shall examine factors affecting the
5 incidence of acquired bone marrow failure diseases
6 in minority populations.

7 “(d) DEFINITION.—In this section, the term ‘ac-
8 quired bone marrow failure disease’ has the meaning given
9 to such term in section 317W(d).

10 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section
12 \$2,000,000 for each of fiscal years 2021 through 2025.”.

13 (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-
14 QUIRED BONE MARROW FAILURE DISEASES.—

15 (1) GRANTS.—The Secretary of Health and
16 Human Services, acting through the Director of the
17 Agency for Healthcare Research and Quality, shall
18 award grants to entities to improve diagnostic prac-
19 tices and quality of care with respect to patients
20 with acquired bone marrow failure diseases.

21 (2) AUTHORIZATION OF APPROPRIATIONS.—
22 There is authorized to be appropriated to carry out
23 this section \$2,000,000 for each of fiscal years 2021
24 through 2025.

1 (g) DEFINITION.—In this section, the term “acquired
2 bone marrow failure disease” has the meaning given such
3 term in section 317W(d) of the Public Health Service Act,
4 as added by subsection (c).

5 **Subtitle D—Cardiovascular Dis-**
6 **ease, Chronic Disease, Obesity,**
7 **and Other Disease Issues**

8 **SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MI-**
9 **NORITY PATIENTS.**

10 (a) IN GENERAL.—The Secretary, acting through the
11 Director of the Agency for Healthcare Research and Qual-
12 ity, shall convene a series of meetings to develop guidelines
13 for disease screening for minority patient populations that
14 have a higher than average risk for many chronic diseases
15 and cancers.

16 (b) PARTICIPANTS.—In convening meetings under
17 subsection (a), the Secretary shall ensure that meeting
18 participants include representatives of—

19 (1) professional societies and associations;

20 (2) minority health organizations;

21 (3) health care researchers and providers, in-
22 cluding those with expertise in minority health;

23 (4) Federal health agencies, including the Of-
24 fice of Minority Health, the National Institute on

1 Minority Health and Health Disparities, and the
2 National Institutes of Health; and

3 (5) other experts as the Secretary determines
4 appropriate.

5 (c) DISEASES.—Screening guidelines for minority
6 populations shall be developed as appropriate under sub-
7 section (a) for—

8 (1) hypertension;

9 (2) hypercholesterolemia;

10 (3) diabetes;

11 (4) cardiovascular disease;

12 (5) cancers, including breast, prostate, colon,
13 cervical, and lung cancer;

14 (6) other pulmonary problems including sleep
15 apnea;

16 (7) asthma;

17 (8) kidney diseases;

18 (9) eye diseases and disorders, including glau-
19 coma;

20 (10) HIV/AIDS and sexually transmitted infec-
21 tions;

22 (11) uterine fibroids;

23 (12) autoimmune disease;

24 (13) mental health conditions;

1 (14) dental health conditions and oral diseases,
2 including oral cancer;

3 (15) environmental and related health illnesses
4 and conditions;

5 (16) sickle cell disease and sickle cell trait;

6 (17) violence and injury prevention and control;

7 (18) genetic and related conditions;

8 (19) heart disease and stroke;

9 (20) tuberculosis;

10 (21) chronic obstructive pulmonary disease;

11 (22) musculoskeletal diseases, arthritis, and
12 obesity; and

13 (23) other diseases determined appropriate by
14 the Secretary.

15 (d) DISSEMINATION.—Not later than 2 years after
16 the date of enactment of this Act, the Secretary shall pub-
17 lish and disseminate to health care provider organizations
18 the guidelines developed under subsection (a).

19 (e) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2021 through 2025.

23 **SEC. 732. CDC WISEWOMAN SCREENING PROGRAM.**

24 Section 1509 of the Public Health Service Act (42
25 U.S.C. 300n–4a) is amended—

1 (1) in subsection (a)—

2 (A) by striking the heading and inserting
3 “IN GENERAL.—”; and

4 (B) in the matter preceding paragraph (1),
5 by striking “may make grants” and all that fol-
6 lows through “purpose” and inserting the fol-
7 lowing: “may make grants to such States for
8 the purpose”; and

9 (2) in subsection (d)(1), by striking “there are
10 authorized” and all that follows through the period
11 and inserting “there are authorized to be appro-
12 priated \$23,000,000 for fiscal year 2021,
13 \$25,300,000 for fiscal year 2022, \$27,800,000 for
14 fiscal year 2023, \$30,800,000 for fiscal year 2024,
15 and \$34,000,000 for fiscal year 2025.”.

16 **SEC. 733. REPORT ON CARDIOVASCULAR CARE FOR WOMEN**
17 **AND MINORITIES.**

18 Part P of title III of the Public Health Service Act
19 (42 U.S.C. 280g et seq.), as amended by section 531, is
20 further amended by adding at the end the following:

21 **“SEC. 399V-9. REPORT ON CARDIOVASCULAR CARE FOR**
22 **WOMEN AND MINORITIES.**

23 “Not later than September 30, 2021, and annually
24 thereafter, the Secretary shall prepare and submit to Con-
25 gress a report on the quality of and access to care for

1 women and minorities with heart disease, stroke, and
2 other cardiovascular diseases. The report shall contain rec-
3 ommendations for eliminating disparities in, and improv-
4 ing the treatment of, heart disease, stroke, and other car-
5 diovascular diseases in women, racial and ethnic minori-
6 ties, those for whom English is not their primary lan-
7 guage, and individuals with disabilities.”.

8 **SEC. 734. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
9 **SATION SERVICES IN MEDICAID AND PRI-**
10 **VATE HEALTH INSURANCE.**

11 (a) REQUIRING MEDICAID COVERAGE OF COUN-
12 SELING AND PHARMACOTHERAPY FOR CESSATION OF TO-
13 BACCO USE.—Section 1905 of the Social Security Act (42
14 U.S.C. 1396d) is amended—

15 (1) in subsection (a)(4)(D), by striking “by
16 pregnant women”; and

17 (2) in subsection (bb)—

18 (A) by striking “by pregnant women” each
19 place it appears;

20 (B) in paragraph (1), in the matter before
21 subparagraph (A), by inserting “by individuals”
22 before “who use tobacco”; and

23 (C) in paragraph (2)(A), by striking “with
24 respect to pregnant women”.

1 (b) EXCEPTION FROM OPTIONAL RESTRICTION
2 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
3 Section 1927(d)(2)(F) of the Social Security Act (42
4 U.S.C. 1396r–8(d)(2)(F)) is amended—

5 (1) by striking “, in the case of pregnant
6 women”; and

7 (2) by striking “under the over-the-counter
8 monograph process”.

9 (c) STATE MONITORING AND PROMOTING OF COM-
10 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
11 MEDICAID.—Section 1902(a) of the Social Security Act
12 (42 U.S.C. 1396a(a)), as amended by section
13 433(d)(2)(A), is amended—

14 (1) by striking “and” at the end of paragraph
15 (86);

16 (2) by striking the period at the end of para-
17 graph (87) and inserting “; and”; and

18 (3) by inserting after paragraph (87) the fol-
19 lowing new paragraph:

20 “(88) provide for the State to monitor and pro-
21 mote the use of comprehensive tobacco cessation
22 services under the State plan, including conducting
23 an outreach campaign to increase awareness of, and
24 the benefits of using, such services among—

1 “(A) individuals entitled to medical assist-
2 ance under the State plan who use tobacco
3 products; and

4 “(B) clinicians and others who provide
5 services to individuals entitled to medical assist-
6 ance under the State plan.”.

7 (d) FEDERAL REIMBURSEMENT FOR MEDICAID OUT-
8 REACH CAMPAIGN TO INCREASE AWARENESS.—Section
9 1903(a) of the Social Security Act (42 U.S.C. 1396b(a))
10 is amended—

11 (1) by striking the period at the end of para-
12 graph (7) and inserting “; plus”; and

13 (2) by inserting after paragraph (7) the fol-
14 lowing new paragraph:

15 “(8) an amount equal to 90 percent of the
16 sums expended during each quarter which are attrib-
17 utable to the development, implementation, and eval-
18 uation of an outreach campaign to—

19 “(A) increase awareness of comprehensive
20 tobacco cessation services covered in the State
21 plan among—

22 “(i) individuals who are likely to be el-
23 igible for medical assistance under the
24 State plan; and

1 “(ii) clinicians and others who provide
2 services to individuals who are likely to be
3 eligible for medical assistance under the
4 State plan; and

5 “(B) increase awareness of the benefits of
6 using comprehensive tobacco cessation services
7 covered in the State plan among—

8 “(i) individuals who are likely to be el-
9 igible for medical assistance under the
10 State plan; and

11 “(ii) clinicians and others who provide
12 services to individuals who are likely to be
13 eligible for medical assistance under the
14 State plan about the benefits of using com-
15 prehensive tobacco cessation services.”.

16 (e) REMOVAL OF COST SHARING FOR COUNSELING
17 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
18 USE UNDER MEDICAID.—

19 (1) GENERAL COST SHARING LIMITATIONS.—
20 Section 1916 of the Social Security Act (42 U.S.C.
21 1396o) is amended—

22 (A) in subsections (a)(2)(B) and (b)(2)(B),
23 by striking “and counseling and
24 pharmacotherapy for cessation of tobacco use
25 by pregnant women (as defined in section

1 1905(bb)) and covered outpatient drugs (as de-
2 fined in subsection (k)(2) of section 1927 and
3 including nonprescription drugs described in
4 subsection (d)(2) of such section) that are pre-
5 scribed for purposes of promoting, and when
6 used to promote, tobacco cessation by pregnant
7 women in accordance with the Guideline re-
8 ferred to in section 1905(bb)(2)(A)” each place
9 it appears; and

10 (B) in each of subsections (a)(2)(B) and
11 (b)(2)(B) by inserting “and counseling and
12 pharmacotherapy for cessation of tobacco use
13 (as defined in section 1905d(bb)) and covered
14 outpatient drugs (as defined in subsection
15 (k)(2) of section 1927 and including non-
16 prescription drugs described in subsection
17 (d)(2) of such section) that are prescribed for
18 purposes of promoting, and when used to pro-
19 mote, tobacco cessation in accordance with the
20 Guideline referred to in section
21 1905(bb)(2)(A)” after “(or at the option of the
22 State, any services furnished to pregnant
23 women”.

1 (2) APPLICATION TO ALTERNATIVE COST SHAR-
2 ING.—Section 1916A(b)(3)(B) of such Act (42
3 U.S.C. 1396o–1(b)(3)(B)) is amended—

4 (A) in clause (iii), by striking “, and coun-
5 seling and pharmacotherapy for cessation of to-
6 bacco use by pregnant women (as defined in
7 section 1905(bb))”; and

8 (B) by adding at the end the following:

9 “(xii) Counseling and
10 pharmacotherapy for cessation of tobacco
11 use (as defined in section 1905(bb)) and
12 covered outpatient drugs (as defined in
13 subsection (k)(2) of section 1927 and in-
14 cluding nonprescription drugs described in
15 subsection (d)(2) of such section) that are
16 prescribed for purposes of promoting, and
17 when used to promote, tobacco cessation in
18 accordance with the Guideline referred to
19 in section 1905(bb)(2)(A).”.

20 (f) NO PRIOR AUTHORIZATION FOR TOBACCO CES-
21 SATION DRUGS UNDER MEDICAID.—Section 1927(d) of
22 the Social Security Act (42 U.S.C. 1396r–8) is amended—

23 (1) by striking in paragraph (1)(A) “A State”
24 and inserting “Except as otherwise provided in para-
25 graph (6), a State”;

1 (2) by redesignating paragraphs (6) and (7) as
2 paragraphs (7) and (8), respectively; and

3 (3) by inserting after paragraph (5) the fol-
4 lowing:

5 “(6) NO PRIOR AUTHORIZATION PROGRAMS FOR
6 TOBACCO CESSATION DRUGS.—A State plan under
7 this title shall not require, as a condition of coverage
8 or payment for a covered outpatient drug for which
9 Federal financial participation is available in accord-
10 ance with this section, the approval of an agent
11 when used to promote smoking cessation, including
12 agents approved by the Food and Drug Administra-
13 tion for the purposes of promoting, and when used
14 to promote, tobacco cessation.”.

15 (g) COMPREHENSIVE COVERAGE OF TOBACCO CES-
16 SATION COVERAGE IN PRIVATE HEALTH INSURANCE.—
17 Section 2713 of the Public Health Service Act (42 U.S.C.
18 300gg–13) is amended by adding at the end the following:

19 “(d) NO PRIOR AUTHORIZATION.—A group health
20 plan and a health insurance issuer offering group or indi-
21 vidual health insurance coverage shall not impose any
22 prior authorization requirement for tobacco cessation
23 counseling and pharmacotherapy that has in effect a rat-
24 ing of ‘A’ or ‘B’ in the current recommendations of the
25 United States Preventive Services Task Force.”.

1 (h) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to items and services furnished on
3 or after January 1, 2021.

4 **SEC. 735. CLINICAL RESEARCH FUNDING FOR ORAL**
5 **HEALTH.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall expand and intensify the conduct
8 and support of the research activities of the National In-
9 stitutes of Health and the National Institute of Dental
10 and Craniofacial Research to improve the oral health of
11 the population through the prevention and management
12 of oral diseases and conditions.

13 (b) INCLUDED RESEARCH ACTIVITIES.—Research
14 activities under subsection (a) shall include—

15 (1) comparative effectiveness research and clin-
16 ical disease management research addressing early
17 childhood caries and oral cancer; and

18 (2) awarding of grants and contracts to support
19 the training and development of health services re-
20 searchers, comparative effectiveness researchers, and
21 clinical researchers whose research improves the oral
22 health of the population.

1 **SEC. 736. PARTICIPATION BY MEDICAID BENEFICIARIES IN**
2 **APPROVED CLINICAL TRIALS.**

3 (a) IN GENERAL.—Title XIX of the Social Security
4 Act (42 U.S.C. 1396 et seq.) is amended by adding at
5 the end the following new section:

6 **“SEC. 1947. PARTICIPATION IN AN APPROVED CLINICAL**
7 **TRIAL.**

8 “(a) COVERAGE OF ROUTINE PATIENT COSTS ASSO-
9 CIATED WITH APPROVED CLINICAL TRIALS.—

10 “(1) INCLUSION.—Subject to paragraph (2),
11 routine patient costs shall include all items and serv-
12 ices consistent with the medical assistance provided
13 under the State plan that would otherwise be pro-
14 vided to the individual under such State plan if such
15 individual was not enrolled in an approved clinical
16 trial, including any items or services related to the
17 prevention, detection, and treatment of any medical
18 complications that arise as a result of participation
19 in the approved clinical trial.

20 “(2) EXCLUSION.—For purposes of paragraph
21 (1), routine patient costs does not include—

22 “(A) the investigational item, device, or
23 service itself;

24 “(B) items and services that are provided
25 solely to satisfy data collection and analysis

1 needs and that are not used in the direct clin-
2 ical management of the patient; or

3 “(C) a service that is clearly inconsistent
4 with widely accepted and established standards
5 of care for a particular diagnosis.

6 “(3) INFORMATION CONCERNING CLINICAL
7 TRIALS.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (B), the Secretary, in consultation with
10 relevant stakeholders, shall develop a single
11 standardized electronic form for use by the indi-
12 vidual or the referring health care provider to
13 submit to the State agency administering the
14 State plan in order to verify that the clinical
15 trial meets the conditions established for an ap-
16 proved clinical trial (as defined in subsection
17 (c)).

18 “(B) EXCLUDED INFORMATION.—For pur-
19 poses of subparagraph (A) or any such request
20 by the State agency for information regarding
21 a clinical trial, an individual or referring health
22 care provider shall not be required to submit—

23 “(i) the clinical protocol document for
24 the clinical trial; or

1 “(ii) subject to subparagraph (C), any
2 additional information other than such in-
3 formation as is required pursuant to the
4 form described in subparagraph (A).

5 “(C) OPTIONAL INFORMATION.—For pur-
6 poses of subparagraphs (A) and (B)(ii), the
7 form may include a requirement that the refer-
8 ring health care provider attest that the indi-
9 vidual is eligible to participate in the clinical
10 trial pursuant to the trial protocol and that in-
11 dividual participation in such trial would be ap-
12 propriate.

13 “(D) REVIEW OF INFORMATION.—

14 “(i) IN GENERAL.—A State plan
15 under this title shall establish a process for
16 timely review by the State agency of the
17 form and information submitted pursuant
18 to subparagraph (A) and, not later than
19 48 hours after receipt of such form, con-
20 firmation that the information provided in
21 such form satisfies the requirements estab-
22 lished under such subparagraph, with such
23 process to include establishment and oper-
24 ation of a 24-hour, toll-free telephone num-

1 ber and email address to provide for expedited communication.

2
3 “(ii) FAILURE TO RESPOND.—If an
4 individual or the referring health care provider does not receive a response or request for additional information from the
5 State agency following the 48-hour period
6 described in clause (i), the information
7 provided in the form may be presumed to
8 satisfy the requirements established under
9 this paragraph.
10
11

12 “(b) ENCOURAGEMENT OF PARTICIPATION IN APPROVED CLINICAL TRIALS.—

13
14 “(1) REASONABLY ACCESSIBLE PROVIDER.—
15 For purposes of participation in an approved clinical
16 trial by an individual eligible for medical assistance
17 under this title, the State agency administering the
18 State plan shall make reasonable efforts to ensure
19 that the individual is provided with access to a provider who is—
20

21 “(A) participating in the approved clinical
22 trial;

23 “(B) located not more than 25 miles from
24 the residence of the individual (or, if no such

1 provider is available, as close as possible to the
2 residence of the individual); and

3 “(C) a participating provider under the
4 State plan or has been deemed to be a partici-
5 pating provider under the State plan for pur-
6 poses of providing medical assistance to the in-
7 dividual during their participation in the ap-
8 proved clinical trial.

9 “(2) INFORMATIONAL MATERIALS.—The State
10 agency administering the plan approved under this
11 title shall develop informational materials and pro-
12 grams to encourage participating providers to make
13 appropriate referrals to physicians and other appro-
14 priate health care professionals who can provide in-
15 dividuals with access to approved clinical trials.

16 “(c) DEFINITION OF APPROVED CLINICAL TRIAL.—
17 The term ‘approved clinical trial’ has the same meaning
18 as provided under subsection (d) of the section 2709 of
19 the Public Health Service Act that relates to coverage for
20 individuals participating in approved clinical trials.”

21 (b) CONFORMING AMENDMENT.—Section 1902(a) of
22 the Social Security Act (42 U.S.C. 1396a(a)), as amended
23 by section 734(c), is amended—

24 (1) by striking “and” at the end of paragraph
25 (87);

1 (2) by striking the period at the end of para-
2 graph (88) and inserting “; and”; and

3 (3) by inserting after paragraph (88) the fol-
4 lowing new paragraph:

5 “(89) provide that participation in an approved
6 clinical trial and coverage of routine patient costs
7 associated with such trial for an individual eligible
8 for medical assistance under this title is conducted
9 in accordance with the requirements under section
10 1947.”.

11 (c) EFFECTIVE DATE.—

12 (1) IN GENERAL.—Except as provided in para-
13 graph (2), the amendments made by this section
14 shall apply to calendar quarters beginning on or
15 after October 1, 2021.

16 (2) DELAY PERMITTED FOR STATE PLAN
17 AMENDMENT.—In the case of a State plan for med-
18 ical assistance under title XIX of the Social Security
19 Act (42 U.S.C. 1396 et seq.) which the Secretary of
20 Health and Human Services determines requires
21 State legislation (other than legislation appro-
22 priating funds) in order for the plan to meet the ad-
23 ditional requirements imposed by the amendments
24 made by this section, the State plan shall not be re-
25 garded as failing to comply with the requirements of

1 such title solely on the basis of its failure to meet
2 these additional requirements before the first day of
3 the first calendar quarter beginning after the close
4 of the first regular session of the State legislature
5 that begins after the date of enactment of this Act.
6 For purposes of the previous sentence, in the case
7 of a State that has a 2-year legislative session, each
8 year of such session shall be deemed to be a sepa-
9 rate regular session of the State legislature.

10 **SEC. 737. GUIDE ON EVIDENCE-BASED STRATEGIES FOR**
11 **PUBLIC HEALTH DEPARTMENT OBESITY PRE-**
12 **VENTION PROGRAMS.**

13 (a) DEVELOPMENT AND DISSEMINATION OF AN EVI-
14 DENCE-BASED STRATEGIES GUIDE.—The Secretary of
15 Health and Human Services (referred to in this section
16 as the “Secretary”), acting through the Director of the
17 Centers for Disease Control and Prevention, not later than
18 2 years after the date of enactment of this Act, shall—

19 (1) develop a guide on evidence-based strategies
20 for State, territorial, and local health departments to
21 use to build and maintain effective obesity preven-
22 tion and reduction programs, and, in consultation
23 with stakeholders that have expertise in Tribal
24 health, a guide on such evidence-based strategies
25 with respect to Indian Tribes and Tribal organiza-

1 tions for such Indian Tribes and Tribal organiza-
2 tions to use for such purpose, both of which guides
3 shall—

4 (A) describe an integrated program struc-
5 ture for implementing interventions proven to
6 be effective in preventing and reducing the inci-
7 dence of obesity; and

8 (B) recommend—

9 (i) optimal resources, including staff-
10 ing and infrastructure, for promoting nu-
11 trition and obesity prevention and reduc-
12 tion; and

13 (ii) strategies for effective obesity pre-
14 vention programs for State and local
15 health departments, Indian Tribes, and
16 Tribal organizations, including strategies
17 related to—

18 (I) the application of evidence-
19 based and evidence-informed practices
20 to prevent and reduce obesity rates;

21 (II) the development, implemen-
22 tation, and evaluation of obesity pre-
23 vention and reduction strategies for
24 specific communities and populations;

1 (III) demonstrated knowledge of
2 obesity prevention practices that re-
3 duce associated preventable diseases,
4 health conditions, death, and health
5 care costs;

6 (IV) best practices for the coordi-
7 nation of efforts to prevent and re-
8 duce obesity and related chronic dis-
9 eases;

10 (V) addressing the underlying
11 risk factors and social determinants of
12 health that impact obesity rates; and

13 (VI) interdisciplinary coordina-
14 tion between relevant public health of-
15 ficials specializing in fields such as
16 nutrition, physical activity, epidemi-
17 ology, communications, and policy im-
18 plementation, and collaboration be-
19 tween public health officials and com-
20 munity-based organizations; and

21 (2) disseminate the guides and current re-
22 search, evidence-based practices, tools, and edu-
23 cational materials related to obesity prevention, con-
24 sistent with the guides, to State and local health de-
25 partments, Indian Tribes, and Tribal organizations.

1 (b) TECHNICAL ASSISTANCE.—The Secretary, acting
2 through the Director of the Centers for Disease Control
3 and Prevention, shall provide technical assistance to State
4 and local health departments, Indian Tribes, and Tribal
5 organizations to support such health departments in im-
6 plementing the guides developed under subsection (a)(1).

7 (c) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—In
8 this section, the terms “Indian Tribe” and “Tribal organi-
9 zation” have the meanings given the terms “Indian tribe”
10 and “tribal organization”, respectively, in section 4 of the
11 Indian Self-Determination and Education Assistance Act
12 (25 U.S.C. 5304).

13 **Subtitle E—HIV/AIDS**

14 **SEC. 741. STATEMENT OF POLICY.**

15 It is the policy of the United States to achieve an
16 AIDS-free generation, and to—

17 (1) expand access to lifesaving antiretroviral
18 therapy for people living with HIV and immediately
19 link people to continuous and coordinated high-quality
20 care when they learn they are living with HIV;

21 (2) expand targeted efforts to prevent HIV in-
22 fection using a combination of effective, evidence-
23 based approaches, including routine HIV screening,
24 and universal access to HIV prevention tools in com-

1 communities disproportionately impacted by HIV, par-
2 ticularly communities of color;

3 (3) ensure laws, policies, and regulations do not
4 impede access to prevention, treatment, and care for
5 people living with HIV or disproportionately im-
6 pacted by HIV;

7 (4) accelerate research for more efficacious HIV
8 prevention and treatments tools, a cure, and a vac-
9 cine; and

10 (5) respect the human rights and dignity of
11 persons living with HIV.

12 **SEC. 742. FINDINGS.**

13 The Congress finds the following:

14 (1) Over 1,100,000 people are estimated to be
15 living with HIV in the United States according to
16 the Centers for Disease Control and Prevention, 14
17 percent of whom are unaware they are living with
18 HIV.

19 (2) Annually there are about 37,600 new HIV
20 infections and 15,800 deaths in people with an HIV
21 diagnosis in 50 States and 6 dependent areas of the
22 United States.

23 (3) The Centers for Disease Control and Pre-
24 vention estimates that, in 2017, there were approxi-
25 mately 38,700 people newly diagnosed with HIV.

1 The estimated number of annual new HIV infections
2 declined 9 percent from 2010 to 2016. However, the
3 number of new infections is increasing among cer-
4 tain populations, such as Latino gay and bisexual
5 men, where annual infections increase 21 percent.

6 (4) HIV disproportionately affects certain popu-
7 lations in the United States. Though African Ameri-
8 cans represent approximately 12 percent of the pop-
9 ulation, African Americans account for almost half
10 (42 percent) of all people living with HIV in the
11 United States. African-American men who have sex
12 with men account for 26 percent of all new HIV in-
13 fections and have remained stable from 2010 to
14 2016.

15 (5) Disparities continue to exist among Latinos
16 and Hispanics; in 2017, Latinos and Hispanics
17 made up 18 percent of the United States population
18 and 26 percent of new infections.

19 (6) Though the rate of new infections among
20 American Indians and Alaska Natives (referred to in
21 this section as “AI/AN”) is proportional to their
22 population size, from 2010 to 2016, the annual
23 number of HIV diagnoses increased 46 percent
24 among AI/AN overall and 81 percent among AI/AN
25 gay and bisexual men.

1 (7) Asian Americans account for about 2 per-
2 cent of new HIV infections, but in 2013, 22 percent
3 were undiagnosed, the highest rate of undiagnosed
4 HIV among any race or ethnicity. Between 2010
5 and 2016, the number of Asians receiving an HIV
6 diagnosis increased by 42 percent.

7 (8) The latest data from the Centers for Dis-
8 ease Control and Prevention indicates that new in-
9 fections among women declined 21 percent between
10 2010 and 2016.

11 (9) The history of HIV shows that culturally
12 relevant and gender-responsive supportive services,
13 including psychosocial support, treatment literacy,
14 case management, and transportation are necessary
15 strategies to reach and engage women and girls in
16 medical care.

17 (10) Among the 3,000,000 HIV testing events
18 reported to the Centers for Disease Control and Pre-
19 vention in 2017, the percentage of transgender peo-
20 ple who received a new HIV diagnosis was 3 times
21 the national average. A 2019 systematic review and
22 meta-analysis found that an estimated 14 percent of
23 transgender women have HIV. By race/ethnicity, an
24 estimated 44 percent of Black/African-American
25 transgender women, 26 percent of Hispanic/Latina

1 transgender women, and 7 percent of White
2 transgender women have HIV. The limited data
3 available on transgender individuals point to a dis-
4 proportionate burden of HIV infection.

5 (11) Stigma and discrimination contribute to
6 such disparities.

7 (12) The Centers for Disease Control and Pre-
8 vention has determined that increasing the propor-
9 tion of people who know their HIV status is an es-
10 sential component of comprehensive HIV treatment
11 and prevention efforts and that early diagnosis is
12 critical in order for people with HIV to receive life-
13 extending therapy. Additionally, the Centers for Dis-
14 ease Control and Prevention recommend routine
15 HIV screening in health care settings for all patients
16 aged 13 to 64, regardless of risk.

17 (13) In 1998, Congress created the National
18 Minority AIDS Initiative to provide technical assist-
19 ance, build capacity, and strengthen outreach efforts
20 among local institutions and community-based orga-
21 nizations that serve racial and ethnic minorities liv-
22 ing with or vulnerable to HIV.

23 (14) To combat the HIV epidemic in the United
24 States, the National HIV/AIDS Strategy (referred
25 to in this section as “NHAS”) provides a framework

1 of increasing access to care, reducing new infections,
2 and eliminating HIV-related health disparities. The
3 vision of NHAS is “The United States will become
4 a place where new HIV infections are rare and when
5 they do occur, every person, regardless of age, gen-
6 der, race/ethnicity, gender identity, or socioeconomic
7 circumstance, will have unfettered access to high
8 quality, life-extending care, free from stigma and
9 discrimination.”.

10 (15) In January 2019, the Department of
11 Health and Human Services began implementing the
12 initiative “Ending the HIV Epidemic: A Plan for
13 America”. The initiative seeks to reduce the number
14 of new HIV infections in the United States by 75
15 percent by 2025, and then by at least 90 percent by
16 2030, for an estimated 250,000 total HIV infection
17 averted.

18 (16) At present, many States and United
19 States territories have criminal statutes based on
20 “exposure” to HIV. Most of these laws were adopted
21 before the availability of effective antiretroviral
22 treatment for HIV/AIDS.

23 (17) Research shows that stable housing leads
24 to better health outcomes for those living with HIV.
25 Inadequate or unstable housing is not only a barrier

1 to effective treatment, but also increases the likeli-
2 hood of engaging in risky behaviors leading to HIV
3 infection. Insecure housing puts people with HIV/
4 AIDS at risk of premature death from exposure to
5 other diseases, poor nutrition, and lack of medical
6 care.

7 (18) Due to advances in treatment, many peo-
8 ple living with HIV today are living healthy lives and
9 have the ability and desire to fully participate in all
10 aspects of community life, including employment.
11 Research associates being employed with tremendous
12 economic, social, and health benefits for many people
13 living with HIV.

14 (19) The common benefits associated with em-
15 ployment include income, autonomy, productivity,
16 and status within society, daily structure, making a
17 contribution to one's community, and increased skills
18 and self-esteem. Research also indicates that many
19 people with disabilities, including people living with
20 HIV, report perceiving themselves as being less dis-
21 abled or not disabled at all, when working. Further-
22 more, some studies link working with better physical
23 and mental health outcomes for people living with
24 HIV when compared to those who are not working.
25 Preliminary data also suggest that transitioning to

1 employment is associated with reduced HIV-related
2 health risk behavior for many people.

3 (20) In July 2012, the Food and Drug Admin-
4 istration approved the first drug to be used as pre-
5 exposure prophylaxis (PrEP). PrEP reduces the risk
6 of HIV infection in HIV-negative individuals. Stud-
7 ies have shown that PrEP reduces HIV transmission
8 from sex by about 99 percent when taken consist-
9 ently. Despite increases in PrEP uptake, PrEP use
10 remains low among gay and bisexual men of color.
11 The Centers for Disease Control and Prevention
12 found that uptake was lower among African-Amer-
13 ican (26 percent) and Latino (30 percent) men com-
14 pared with White men (42 percent). Similarly, PrEP
15 awareness was lower among African-American (86
16 percent) and Latino (87 percent) men compared
17 with White men (95 percent). While clinical research
18 on transgender populations and PrEP is currently
19 limited, the Centers for Disease Control and Preven-
20 tion recommends PrEP use in transgender popu-
21 lations. In September 2019, the Food and Drug Ad-
22 ministration approved the second drug to be used as
23 PrEP.

24 (21) Syringe service programs have been associ-
25 ated with lowered HIV infections, lower hepatitis C

1 infections, and increased linkage to substance use
2 treatment.

3 (22) There is now conclusive scientific evidence
4 that a person living with HIV who is on
5 antiretroviral therapy and is durably virally sup-
6 pressed (defined as having a consistent viral load of
7 less than 200 copies/ml) does not sexually transmit
8 HIV. The conclusive evidence about the highly effec-
9 tive preventative benefits of antiretroviral therapy
10 provides an unprecedented opportunity to improve
11 the lives of people living with HIV, improve treat-
12 ment uptake and adherence, and advocate for ex-
13 panded access to treatment and care.

14 **SEC. 743. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
15 **ANCE PROGRAM TREATMENTS.**

16 Section 2623 of the Public Health Service Act (42
17 U.S.C. 300ff–31b) is amended by adding at the end the
18 following:

19 “(c) **ADDITIONAL FUNDING FOR AIDS DRUG AS-**
20 **SISTANCE PROGRAM TREATMENTS.**—In addition to
21 amounts otherwise authorized to be appropriated for car-
22 rying out this subpart, there are authorized to be appro-
23 priated such sums as may be necessary to carry out sec-
24 tions 2612(b)(3)(B) and 2616 for each of fiscal years
25 2021 through 2024.”.

1 **SEC. 744. ENHANCING THE NATIONAL HIV SURVEILLANCE**
2 **SYSTEM.**

3 (a) GRANTS.—The Secretary of Health and Human
4 Services, acting through the Director of the Centers for
5 Disease Control and Prevention, shall make grants to
6 States to support integration of public health surveillance
7 systems into all electronic health records in order to allow
8 rapid communications between the clinical setting and
9 health departments, by means that include—

10 (1) providing technical assistance and policy
11 guidance to State and local health departments, clin-
12 ical providers, and other agencies serving individuals
13 with HIV to improve the interoperability of data sys-
14 tems relevant to monitoring HIV care and sup-
15 portive services;

16 (2) capturing longitudinal data pertaining to
17 the initiation and ongoing prescription or dispensing
18 of antiretroviral therapy for individuals diagnosed
19 with HIV (such as through pharmacy-based report-
20 ing);

21 (3) obtaining information—

22 (A) on a voluntary basis, on sexual orienta-
23 tion and gender identity; and

24 (B) on sources of coverage (or the lack of
25 coverage) for medical treatment (including cov-
26 erage through the Medicaid program, the Medi-

1 care program, the program under title XXVI of
2 the Public Health Service Act (42 U.S.C.
3 300ff–11 et seq.); commonly referred to as the
4 “Ryan White HIV/AIDS Program”), other pub-
5 lic funding, private insurance, and health main-
6 tenance organizations); and

7 (4) obtaining and using current geographic
8 markers of residence (such as current address, zip
9 code, partial zip code, and census block).

10 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
11 rying out this section, the Secretary of Health and Human
12 Services shall ensure that appropriate privacy and security
13 safeguards are met to prevent unauthorized disclosure of
14 protected health information and compliance with the
15 HIPAA privacy and security law (as defined in section
16 3009 of the Public Health Service Act (42 U.S.C. 300jj–
17 19)) and other relevant laws and regulations.

18 (c) PROHIBITION AGAINST IMPROPER USE OF
19 DATA.—No grant under this section may be used to allow
20 or facilitate the collection or use of surveillance or clinical
21 data or records—

22 (1) for punitive measures of any kind, civil or
23 criminal, against the subject of such data or records;
24 or

1 (2) for imposing any requirement or restriction
2 with respect to an individual without the individual's
3 written consent.

4 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out this section, there are authorized to be appropriated
6 such sums as may be necessary for each of fiscal years
7 2021 through 2024.

8 **SEC. 745. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
9 **LINKAGE TO AND RETENTION IN APPRO-**
10 **PRIATE CARE.**

11 (a) STRATEGIES.—The Secretary of Health and
12 Human Services, in collaboration with the Director of the
13 Centers for Disease Control and Prevention, the Assistant
14 Secretary for Mental Health and Substance Use, the Di-
15 rector of the Office of AIDS Research, the Administrator
16 of the Health Resources and Services Administration, and
17 the Administrator of the Centers for Medicare & Medicaid
18 Services, shall—

19 (1) identify evidence-based strategies most ef-
20 fective at addressing the multifaceted issues that im-
21 pede disease status awareness and linkage to and re-
22 tention in appropriate care, taking into consideration
23 health care systems issues, clinic and provider
24 issues, and individual psychosocial, environmental,
25 and other contextual factors;

1 (2) support the wide-scale implementation of
2 the evidence-based strategies identified pursuant to
3 paragraph (1), including through incorporating such
4 strategies into health care coverage supported by the
5 Medicaid program under title XIX of the Social Se-
6 curity Act (42 U.S.C. 1396 et seq.), the program
7 under title XXVI of the Public Health Service Act
8 (42 U.S.C. 300ff–11 et seq.; commonly referred to
9 as the “Ryan White HIV/AIDS Program”), and
10 health plans purchased through an American Health
11 Benefit Exchange established pursuant to section
12 1311 of the Patient Protection and Affordable Care
13 Act (42 U.S.C. 18031); and

14 (3) not later than 1 year after the date of the
15 enactment of this Act, submit a report to the Con-
16 gress on the status of activities under paragraphs
17 (1) and (2).

18 (b) 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 2021
21 through 2024.

1 **SEC. 746. IMPROVING ENTRY INTO AND RETENTION IN**
2 **CARE AND ANTIRETROVIRAL ADHERENCE**
3 **FOR PERSONS WITH HIV.**

4 (a) SENSE OF CONGRESS.—It is the sense of Con-
5 gress that AIDS research has led to scientific advance-
6 ments that have—

7 (1) saved the lives of millions of people living
8 with HIV;

9 (2) prevented millions from new diagnoses; and

10 (3) had broad benefits that extend far beyond
11 helping people at risk for or living with HIV.

12 (b) IN GENERAL.—The Secretary of Health and
13 Human Services, acting through the Director of the Na-
14 tional Institutes of Health, shall expand, intensify, and co-
15 ordinate operational and translational research and other
16 activities of the National Institutes of Health regarding
17 methods—

18 (1) to increase adoption of evidence-based ad-
19 herence strategies within HIV care and treatment
20 programs;

21 (2) to increase HIV testing and case detection
22 rates;

23 (3) to reduce HIV-related health disparities;

24 (4) to ensure that research to improve adher-
25 ence to HIV care and treatment programs address
26 the unique concerns of women;

1 (5) to integrate HIV prevention and care serv-
2 ices with mental health and substance use preven-
3 tion and treatment delivery systems;

4 (6) to increase knowledge on the implementa-
5 tion of preexposure prophylaxis (referred to in this
6 section as “PrEP”), including with respect to—

7 (A) who can benefit most from PrEP;

8 (B) how to provide PrEP safely and effi-
9 ciently;

10 (C) how to integrate PrEP with other es-
11 sential prevention methods such as condoms;
12 and

13 (D) how to ensure high levels of adherence;
14 and

15 (7) to increase knowledge of “undetectable and
16 untransmittable”, when a person living with HIV
17 who is on antiretroviral therapy and is durably
18 virally suppressed (defined as having a consistent
19 viral load of less than 200 copies/ml) cannot sexually
20 transmit HIV.

21 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
22 out this section, there are authorized to be appropriated
23 such sums as may be necessary for fiscal years 2021
24 through 2024.

1 **SEC. 747. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
2 **ETHNIC MINORITY COMMUNITIES.**

3 (a) IN GENERAL.—For the purpose of reducing new
4 HIV diagnoses in racial and ethnic minority communities,
5 the Secretary of Health and Human Services, acting
6 through the Deputy Assistant Secretary for Minority
7 Health, may make grants to public health agencies and
8 faith-based organizations to conduct—

9 (1) outreach activities related to HIV preven-
10 tion and testing activities;

11 (2) HIV prevention activities; and

12 (3) HIV testing activities.

13 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
14 out this section, there are authorized to be appropriated
15 such sums as may be necessary for fiscal years 2021
16 through 2024.

17 **SEC. 748. MINORITY AIDS INITIATIVE.**

18 (a) EXPANDED FUNDING.—The Secretary of Health
19 and Human Services, in collaboration with the Deputy As-
20 sistant Secretary for Minority Health, the Director of the
21 Centers for Disease Control and Prevention, the Adminis-
22 trator of the Health Resources and Services Administra-
23 tion, and the Assistant Secretary for Mental Health and
24 Substance Use, shall provide funds and carry out activities
25 to expand the Minority AIDS Initiative.

1 (b) USE OF FUNDS.—The additional funds made
2 available under this section may be used, through the Mi-
3 nority AIDS Initiative, to support the following activities:

4 (1) Providing technical assistance and infra-
5 structure support to reduce HIV/AIDS in minority
6 populations.

7 (2) Increasing minority populations' access to
8 HIV prevention and care services.

9 (3) Building strong community programs and
10 partnerships to address HIV prevention and the
11 health care needs of specific racial and ethnic minor-
12 ity populations.

13 (c) PRIORITY INTERVENTIONS.—Within the racial
14 and ethnic minority populations referred to in subsection
15 (b), priority in conducting intervention services shall be
16 given to—

17 (1) men who have sex with men;

18 (2) youth;

19 (3) persons who engage in intravenous drug
20 abuse;

21 (4) women;

22 (5) homeless individuals; and

23 (6) individuals incarcerated or in the penal sys-
24 tem.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
2 rying out this section, there are authorized to be appro-
3 priated \$610,000,000 for fiscal year 2021 and such sums
4 as may be necessary for each of fiscal years 2022 through
5 2025.

6 **SEC. 749. HEALTH CARE PROFESSIONALS TREATING INDI-**
7 **VIDUALS WITH HIV.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services, acting through the Administrator of the
10 Health Resources and Services Administration, shall ex-
11 pand, intensify, and coordinate workforce initiatives of the
12 Health Resources and Services Administration to increase
13 the capacity of the health workforce focusing primarily on
14 HIV to meet the demand for culturally competent care,
15 and may award grants for any of the following:

16 (1) Development of curricula for training pri-
17 mary care providers in HIV/AIDS prevention and
18 care, including routine HIV testing.

19 (2) Support to expand access to culturally and
20 linguistically accessible benefits counselors, trained
21 peer navigators, and mental and behavioral health
22 professionals with expertise in HIV.

23 (3) Training health care professionals to pro-
24 vide care to individuals living with HIV.

1 (4) Development by grant recipients under title
2 XXVI of the Public Health Service Act (42 U.S.C.
3 300ff–11 et seq.; commonly referred to as the “Ryan
4 White HIV/AIDS Program”) and other persons, of
5 policies for providing culturally relevant and sen-
6 sitive treatment to individuals living with HIV, with
7 particular emphasis on treatment to racial and eth-
8 nic minorities, men who have sex with men, and
9 women, young people, and children living with HIV.

10 (5) Development and implementation of pro-
11 grams to increase the use of telehealth to respond to
12 HIV-specific health care needs in rural and minority
13 communities, with particular emphasis given to
14 medically underserved communities and insular
15 areas.

16 (6) Evaluating interdisciplinary medical pro-
17 vider care team models that promote high-quality
18 care, with particular emphasis on care to racial and
19 ethnic minorities.

20 (7) Training health care professionals to make
21 them aware of the high rates of chronic hepatitis B
22 and chronic hepatitis C in adult racial and ethnic
23 populations, and the importance of prevention, de-
24 tection, and medical management of hepatitis B and
25 hepatitis C and of liver cancer screening.

1 (8) Development of curricula for training pri-
 2 mary care providers that HIV and tuberculosis are
 3 significant mutual comorbidities, and that a patient
 4 who tests positive for one disease should be offered
 5 and encouraged to receive testing for the other.

6 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
 7 out this section, there are authorized to be appropriated
 8 such sums as may be necessary for fiscal years 2021
 9 through 2024.

10 **SEC. 750. HIV/AIDS PROVIDER LOAN REPAYMENT PRO-**
 11 **GRAM.**

12 (a) IN GENERAL.—The Secretary may enter into an
 13 agreement with any physician, nurse practitioner, or phy-
 14 sician assistant under which—

15 (1) the physician, nurse practitioner, or physi-
 16 cian assistant agrees to serve as a medical provider
 17 for a period of not less than 2 years—

18 (A) at a Ryan White-funded or title X-
 19 funded facility with a critical shortage of doc-
 20 tors (as determined by the Secretary); or

21 (B) in an area with a high incidence of
 22 HIV/AIDS; and

23 (2) the Secretary agrees to make payments in
 24 accordance with subsection (b) on the professional

1 education loans of the physician, nurse practitioner,
2 or physician assistant.

3 (b) MANNER OF PAYMENTS.—The payments de-
4 scribed in subsection (a) shall be made by the Secretary
5 as follows:

6 (1) Upon completion by the physician, nurse
7 practitioner, or physician assistant for whom the
8 payments are to be made of the first year of the
9 service specified in the agreement entered into with
10 the Secretary under subsection (a), the Secretary
11 shall pay 30 percent of the principal of and the in-
12 terest on the individual's professional education
13 loans.

14 (2) Upon completion by the physician, nurse
15 practitioner, or physician assistant of the second
16 year of such service, the Secretary shall pay another
17 30 percent of the principal of and the interest on
18 such loans.

19 (3) Upon completion by that individual of a
20 third year of such service, the Secretary shall pay
21 another 25 percent of the principal of and the inter-
22 est on such loans.

23 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
24 part III of part D of title III of the Public Health Service
25 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent

1 with this section, apply to the program carried out under
2 this section in the same manner and to the same extent
3 as such provisions apply to the National Health Service
4 Corps loan repayment program.

5 (d) REPORTS.—Not later than 18 months after the
6 date of the enactment of this Act, and annually thereafter,
7 the Secretary shall prepare and submit to Congress a re-
8 port describing the program carried out under this section,
9 including statements regarding the following:

10 (1) The number of physicians, nurse practi-
11 tioners, and physician assistants enrolled in the pro-
12 gram.

13 (2) The number and amount of loan repay-
14 ments.

15 (3) The placement location of loan repayment
16 recipients at facilities described in subsection (a)(1).

17 (4) The default rate and actions required.

18 (5) The amount of outstanding default funds.

19 (6) To the extent that it can be determined, the
20 reason for the default.

21 (7) The demographics of individuals partici-
22 pating in the program.

23 (8) An evaluation of the overall costs and bene-
24 fits of the program.

25 (e) DEFINITIONS.—In this section:

1 (1) 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 2021
23 through 2024.

1 **SEC. 751. DENTAL EDUCATION LOAN REPAYMENT PRO-**
2 **GRAM.**

3 (a) **IN GENERAL.**—The Secretary may enter into an
4 agreement with any dentist under which—

5 (1) the dentist agrees to serve as a dentist for
6 a period of not less than 2 years at a facility with
7 a critical shortage of dentists (as determined by the
8 Secretary) in an area with a high incidence of HIV/
9 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 2021 through 2024.

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 2021
4 through 2024.

5 **SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE**
6 **POPULATIONS.**

7 (a) IN GENERAL.—The Secretary shall submit to
8 Congress and the President an annual report on the im-
9 pact of HIV/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 on communities of color include the fol-
 2 lowing:

3 (1) National Black HIV/AIDS Awareness Day.

4 (2) National Latino AIDS Awareness Day.

5 (3) National Asian and Pacific Islander HIV/
 6 AIDS Awareness Day.

7 (4) National Native American HIV/AIDS
 8 Awareness Day.

9 (5) National Youth HIV/AIDS Awareness Day.

10 (b) CALL TO ACTION.—It is the sense of Congress
 11 that the President should call on members of communities
 12 of color—

13 (1) to become involved at the local community
 14 level in HIV testing, policy, and advocacy;

15 (2) to become aware, engaged, and empowered
 16 on the HIV epidemic within their communities; and

17 (3) to urge members of their communities to re-
 18 duce risk factors, practice safe sex and other preven-
 19 tive measures, be tested for HIV, and seek care
 20 when appropriate.

21 **SEC. 755. REVIEW OF ALL FEDERAL AND STATE LAWS,**
 22 **POLICIES, AND REGULATIONS REGARDING**
 23 **THE CRIMINAL PROSECUTION OF INDIVID-**
 24 **UALS FOR HIV-RELATED OFFENSES.**

25 (a) DEFINITIONS.—In this section:

1 (1) HIV.—The term “HIV” has the meaning
2 given to the term in section 2689 of the Public
3 Health Service Act (42 U.S.C. 300ff–88).

4 (2) STATE.—The term “State” includes the
5 District of Columbia, American Samoa, the Com-
6 monwealth of the Northern Mariana Islands, Guam,
7 Puerto Rico, and the United States Virgin Islands.

8 (b) SENSE OF CONGRESS REGARDING LAWS OR REG-
9 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV.—
10 It is the sense of Congress that Federal and State laws,
11 policies, and regulations regarding people living with
12 HIV—

13 (1) should not place unique or additional bur-
14 dens on such individuals solely as a result of their
15 HIV status; and

16 (2) should instead demonstrate a public health-
17 oriented, evidence-based, medically accurate, and
18 contemporary understanding of—

19 (A) the multiple factors that lead to HIV
20 transmission;

21 (B) the relative risk of HIV transmission
22 routes;

23 (C) the current health implications of liv-
24 ing with HIV;

1 (D) the associated benefits of treatment
2 and support services for people living with HIV;

3 (E) the impact of punitive HIV-specific
4 laws and policies on public health, on people liv-
5 ing with or affected by HIV, and on their fami-
6 lies and communities; and

7 (F) the current science on HIV prevention
8 and treatment, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP),
9 and viral suppression.
10

11 (c) REVIEW OF ALL FEDERAL AND STATE LAWS,
12 POLICIES, AND REGULATIONS REGARDING THE CRIMINAL
13 PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OF-
14 FENSES.—

15 (1) REVIEW OF FEDERAL AND STATE LAWS.—

16 (A) IN GENERAL.—Not later than 90 days
17 after the date of the enactment of this Act, the
18 Attorney General, the Secretary of Health and
19 Human Services, and the Secretary of Defense
20 acting jointly (in this paragraph and paragraph
21 (2) referred to as the “designated officials”)
22 shall initiate a national review of Federal and
23 State laws, policies, regulations, and judicial
24 precedents and decisions regarding criminal and
25 related civil commitment cases involving people

1 living with HIV, including in regards to the
2 Uniform Code of Military Justice.

3 (B) CONSULTATION.—In carrying out the
4 review under subparagraph (A), the designated
5 officials shall ensure diverse participation and
6 consultation from each State, including with—

7 (i) State attorneys general (or their
8 representatives);

9 (ii) State public health officials (or
10 their representatives);

11 (iii) State judicial and court system
12 officers, including judges, district attor-
13 neys, prosecutors, defense attorneys, law
14 enforcement, and correctional officers;

15 (iv) members of the United States
16 Armed Forces, including members of other
17 Federal services subject to the Uniform
18 Code of Military Justice;

19 (v) people living with HIV, particu-
20 larly those who have been subject to HIV-
21 related prosecution or who are from com-
22 munities whose members have been dis-
23 proportionately subject to HIV-specific ar-
24 rests and prosecutions;

1 (vi) legal advocacy and HIV service
2 organizations that work with people living
3 with HIV;

4 (vii) nongovernmental health organi-
5 zations that work on behalf of people living
6 with HIV; and

7 (viii) trade organizations or associa-
8 tions representing persons or entities de-
9 scribed in clauses (i) through (vii).

10 (C) RELATION TO OTHER REVIEWS.—In
11 carrying out the review under subparagraph
12 (A), the designated officials may utilize other
13 existing reviews of criminal and related civil
14 commitment cases involving people living with
15 HIV, including any such review conducted by
16 any Federal or State agency or any public
17 health, legal advocacy, or trade organization or
18 association if the designated officials determine
19 that such reviews were conducted in accordance
20 with the principles set forth in subsection (b).

21 (2) REPORT.—No later than 180 days after ini-
22 tiating the review required by paragraph (1), the At-
23 torney General shall transmit to Congress and make
24 publicly available a report containing the results of
25 the review, which includes the following:

1 (A) For each State and for the Uniform
2 Code of Military Justice, a summary of the rel-
3 evant laws, policies, regulations, and judicial
4 precedents and decisions regarding criminal
5 cases involving people living with HIV, includ-
6 ing, if applicable, the following:

7 (i) A determination of whether such
8 laws, policies, regulations, and judicial
9 precedents and decisions place any unique
10 or additional burdens upon people living
11 with HIV.

12 (ii) A determination of whether such
13 laws, policies, regulations, and judicial
14 precedents and decisions demonstrate a
15 public health-oriented, evidence-based,
16 medically accurate, and contemporary un-
17 derstanding of—

18 (I) the multiple factors that lead
19 to HIV transmission;

20 (II) the relative risk of HIV
21 transmission routes;

22 (III) the current health implica-
23 tions of living with HIV;

1 (IV) the associated benefits of
2 treatment and support services for
3 people living with HIV;

4 (V) the impact of punitive HIV-
5 specific laws and policies on public
6 health, on people living with or af-
7 fected by HIV, and on their families
8 and communities; and

9 (VI) the current science on HIV
10 prevention and treatment, including
11 pre-exposure prophylaxis (PrEP),
12 post-exposure prophylaxis (PEP), and
13 viral suppression.

14 (iii) An analysis of the public health
15 and legal implications of such laws, poli-
16 cies, regulations, and judicial precedents,
17 including an analysis of the consequences
18 of having a similar penal scheme applied to
19 comparable situations involving other com-
20 municable diseases.

21 (iv) An analysis of the proportionality
22 of punishments imposed under HIV-spe-
23 cific laws, policies, regulations, and judicial
24 precedents, taking into consideration pen-
25 alties attached to violation of State laws

1 against similar degrees of endangerment or
2 harm, such as driving while intoxicated or
3 transmission of other communicable dis-
4 eases, or more serious harms, such as ve-
5 hicular manslaughter offenses.

6 (B) An analysis of common elements
7 shared among State laws, policies, regulations,
8 and judicial precedents.

9 (C) A set of best practice recommendations
10 directed to State governments, including State
11 attorneys general, public health officials, and
12 judicial officers, in order to ensure that laws,
13 policies, regulations, and judicial precedents re-
14 garding people living with HIV are in accord-
15 ance with the principles set forth in subsection
16 (b).

17 (D) Recommendations for adjustments to
18 the Uniform Code of Military Justice, as may
19 be necessary, in order to ensure that laws, poli-
20 cies, regulations, and judicial precedents re-
21 garding people living with HIV are in accord-
22 ance with the principles set forth in subsection
23 (b).

24 (3) GUIDANCE.—Within 90 days of the release
25 of the report required by paragraph (2), the Attor-

1 ney General and the Secretary of Health and
2 Human Services, acting jointly, shall develop and
3 publicly release updated guidance for States based
4 on the set of best practice recommendations required
5 by paragraph (2)(C) in order to assist States dealing
6 with criminal and related civil commitment cases re-
7 garding people living with HIV.

8 (4) MONITORING AND EVALUATION SYSTEM.—

9 Within 60 days of the release of the guidance re-
10 quired by paragraph (3), the Attorney General and
11 the Secretary of Health and Human Services, acting
12 jointly, shall establish an integrated monitoring and
13 evaluation system which includes, where appropriate,
14 objective and quantifiable performance goals and in-
15 dicators to measure progress toward statewide im-
16 plementation in each State of the best practice rec-
17 ommendations required in paragraph (2)(C), includ-
18 ing to monitor, track, and evaluate the effectiveness
19 of assistance provided pursuant to subsection (d).

20 (5) ADJUSTMENTS TO FEDERAL LAWS, POLI-

21 CIES, OR REGULATIONS.—Within 90 days of the re-
22 lease of the report required by paragraph (2), the
23 Attorney General, the Secretary of Health and
24 Human Services, and the Secretary of Defense, act-
25 ing jointly, shall develop and transmit to the Presi-

1 dent and the Congress, and make publicly available,
2 such proposals as may be necessary to implement
3 adjustments to Federal laws, policies, or regulations,
4 including to the Uniform Code of Military Justice,
5 based on the recommendations required by para-
6 graph (2)(D), either through Executive order or
7 through changes to statutory law.

8 (6) AUTHORIZATION OF APPROPRIATIONS.—

9 (A) IN GENERAL.—There are authorized to
10 be appropriated such sums as may be necessary
11 for the purpose of carrying out this subsection.
12 Amounts authorized to be appropriated by the
13 preceding sentence are in addition to amounts
14 otherwise authorized to be appropriated for
15 such purpose.

16 (B) AVAILABILITY OF FUNDS.—Amounts
17 appropriated pursuant to the authorization of
18 appropriations in subparagraph (A) are author-
19 ized to remain available until expended.

20 (d) AUTHORIZATION TO PROVIDE GRANTS.—

21 (1) GRANTS BY ATTORNEY GENERAL.—

22 (A) IN GENERAL.—The Attorney General
23 may provide assistance to eligible State and
24 local entities and eligible nongovernmental orga-
25 nizations for the purpose of incorporating the

1 best practice recommendations developed under
2 subsection (c)(2)(C) within relevant State laws,
3 policies, regulations, and judicial decisions re-
4 garding people living with HIV.

5 (B) AUTHORIZED ACTIVITIES.—The assist-
6 ance authorized by subparagraph (A) may in-
7 clude—

8 (i) direct technical assistance to eligi-
9 ble State and local entities in order to de-
10 velop, disseminate, or implement State
11 laws, policies, regulations, or judicial deci-
12 sions that conform with the best practice
13 recommendations developed under sub-
14 section (c)(2)(C);

15 (ii) direct technical assistance to eligi-
16 ble nongovernmental organizations in order
17 to provide education and training, includ-
18 ing through classes, conferences, meetings,
19 and other educational activities, to eligible
20 State and local entities; and

21 (iii) subcontracting authority to allow
22 eligible State and local entities and eligible
23 nongovernmental organizations to seek
24 technical assistance from legal and public
25 health experts with a demonstrated under-

1 standing of the principles underlying the
2 best practice recommendations developed
3 under subsection (c)(2)(C).

4 (2) GRANTS BY SECRETARY OF HEALTH AND
5 HUMAN SERVICES.—

6 (A) IN GENERAL.—The Secretary of
7 Health and Human Services, acting through the
8 Director of the Centers for Disease Control and
9 Prevention, may provide assistance to State and
10 local public health departments and eligible
11 nongovernmental organizations for the purpose
12 of supporting eligible State and local entities to
13 incorporate the best practice recommendations
14 developed under subsection (c)(2)(C) within rel-
15 evant State laws, policies, regulations, and judi-
16 cial decisions regarding people living with HIV.

17 (B) AUTHORIZED ACTIVITIES.—The assist-
18 ance authorized by subparagraph (A) may in-
19 clude—

20 (i) direct technical assistance to State
21 and local public health departments in
22 order to support the development, dissemi-
23 nation, or implementation of State laws,
24 policies, regulations, or judicial decisions
25 that conform with the set of best practice

1 recommendations developed under sub-
2 section (c)(2)(C);

3 (ii) direct technical assistance to eligi-
4 ble nongovernmental organizations in order
5 to provide education and training, includ-
6 ing through classes, conferences, meetings,
7 and other educational activities, to State
8 and local public health departments; and

9 (iii) subcontracting authority to allow
10 State and local public health departments
11 and eligible nongovernmental organizations
12 to seek technical assistance from legal and
13 public health experts with a demonstrated
14 understanding of the principles underlying
15 the best practice recommendations devel-
16 oped under subsection (c)(2)(C).

17 (3) LIMITATION.—As a condition of receiving
18 assistance through this subsection, eligible State and
19 local entities, State and local public health depart-
20 ments, and eligible nongovernmental organizations
21 shall agree—

22 (A) not to place any unique or additional
23 burdens on people living with HIV solely as a
24 result of their HIV status; and

1 (B) that if the entity, department, or orga-
2 nization promulgates any laws, policies, regula-
3 tions, or judicial decisions regarding people liv-
4 ing with HIV, such actions shall demonstrate a
5 public health-oriented, evidence-based, medically
6 accurate, and contemporary understanding of—

7 (i) the multiple factors that lead to
8 HIV transmission;

9 (ii) the relative risk of HIV trans-
10 mission routes;

11 (iii) the current health implications of
12 living with HIV;

13 (iv) the associated benefits of treat-
14 ment and support services for people living
15 with HIV;

16 (v) the impact of punitive HIV-spe-
17 cific laws and policies on public health, on
18 people living with or affected by HIV, and
19 on their families and communities; and

20 (vi) the current science on HIV pre-
21 vention and treatment, including pre-expo-
22 sure prophylaxis (PrEP), post-exposure
23 prophylaxis (PEP), and viral suppression.

24 (4) REPORT.—No later than 1 year after the
25 date of the enactment of this Act, and annually

1 thereafter, the Attorney General and the Secretary
2 of Health and Human Services, acting jointly, shall
3 transmit to Congress and make publicly available a
4 report describing, for each State, the impact and ef-
5 fectiveness of the assistance provided through this
6 section. Each such report shall include—

7 (A) a detailed description of the progress
8 each State has made, if any, in implementing
9 the best practice recommendations developed
10 under subsection (c)(2)(C) as a result of the as-
11 sistance provided under this subsection, and
12 based on the performance goals and indicators
13 established as part of the monitoring and eval-
14 uation system in subsection (c)(4);

15 (B) a brief summary of any outreach ef-
16 forts undertaken during the prior year by the
17 Attorney General and the Secretary of Health
18 and Human Services to encourage States to
19 seek assistance under this subsection in order
20 to implement the best practice recommenda-
21 tions developed under subsection (c)(2)(C);

22 (C) a summary of how assistance provided
23 through this subsection is being utilized by eli-
24 gible State and local entities, State and local
25 public health departments, and eligible non-

1 governmental organizations and, if applicable,
2 any contractors, including with respect to non-
3 governmental organizations, the type of tech-
4 nical assistance provided, and an evaluation of
5 the impact of such assistance on eligible State
6 and local entities; and

7 (D) a summary and description of eligible
8 State and local entities, State and local public
9 health departments, and eligible nongovern-
10 mental organizations receiving assistance
11 through this subsection, including if applicable,
12 a summary and description of any contractors
13 selected to assist in implementing such assist-
14 ance.

15 (5) DEFINITIONS.—For the purposes of this
16 subsection:

17 (A) ELIGIBLE STATE AND LOCAL ENTI-
18 TIES.—The term “eligible State and local enti-
19 ties” means the relevant individuals, offices, or
20 organizations that directly participate in the de-
21 velopment, dissemination, or implementation of
22 State laws, policies, regulations, or judicial deci-
23 sions, including—

24 (i) State governments, including State
25 attorneys general, State departments of

1 justice, and State National Guards, or
2 their equivalents;

3 (ii) State judicial and court systems,
4 including trial courts, appellate courts,
5 State supreme courts and courts of appeal,
6 and State correctional facilities, or their
7 equivalents; and

8 (iii) local governments, including city
9 and county governments, district attorneys,
10 and local law enforcement departments, or
11 their equivalents.

12 (B) STATE AND LOCAL PUBLIC HEALTH
13 DEPARTMENTS.—The term “State and local
14 public health departments” means the fol-
15 lowing:

16 (i) State public health departments, or
17 their equivalents, including the chief officer
18 of such departments and infectious disease
19 and communicable disease specialists with-
20 in such departments.

21 (ii) Local public health departments,
22 or their equivalents, including city and
23 county public health departments, the chief
24 officer of such departments, and infectious

1 disease and communicable disease special-
2 ists within such departments.

3 (iii) Public health departments or offi-
4 cials, or their equivalents, within State or
5 local correctional facilities.

6 (iv) Public health departments or offi-
7 cials, or their equivalents, within State Na-
8 tional Guards.

9 (v) Any other recognized State or
10 local public health organization or entity
11 charged with carrying out official State or
12 local public health duties.

13 (C) ELIGIBLE NONGOVERNMENTAL ORGA-
14 NIZATIONS.—The term “eligible nongovern-
15 mental organizations” means the following:

16 (i) Nongovernmental organizations,
17 including trade organizations or associa-
18 tions that represent—

19 (I) State attorneys general, or
20 their equivalents;

21 (II) State public health officials,
22 or their equivalents;

23 (III) State judicial and court offi-
24 cers, including judges, district attor-
25 neys, prosecutors, defense attorneys,

- 1 law enforcement, and correctional offi-
2 cers;
- 3 (IV) State National Guards;
4 (V) people living with HIV;
5 (VI) legal advocacy and HIV
6 service organizations that work with
7 people living with HIV; and
- 8 (VII) nongovernmental health or-
9 ganizations that work on behalf of
10 people living with HIV.
- 11 (ii) Nongovernmental organizations,
12 including trade organizations or associa-
13 tions that demonstrate a public-health ori-
14 ented, evidence-based, medically accurate,
15 and contemporary understanding of—
- 16 (I) the multiple factors that lead
17 to HIV transmission;
- 18 (II) the relative risk of HIV
19 transmission routes;
- 20 (III) the current health implica-
21 tions of living with HIV;
- 22 (IV) the associated benefits of
23 treatment and support services for
24 people living with HIV;

1 (V) the impact of punitive HIV-
 2 specific laws and policies on public
 3 health, on people living with or af-
 4 fected by HIV, and on their families
 5 and communities; and

6 (VI) the current science on HIV
 7 prevention and treatment, including
 8 pre-exposure prophylaxis (PrEP),
 9 post-exposure prophylaxis (PEP), and
 10 viral suppression.

11 (6) AUTHORIZATION OF APPROPRIATIONS.—

12 (A) IN GENERAL.—In addition to amounts
 13 otherwise made available, there are authorized
 14 to be appropriated to the Attorney General and
 15 the Secretary of Health and Human Services
 16 such sums as may be necessary to carry out
 17 this subsection for each of the fiscal years 2021
 18 through 2024.

19 (B) AVAILABILITY OF FUNDS.—Amounts
 20 appropriated pursuant to the authorizations of
 21 appropriations in subparagraph (A) are author-
 22 ized to remain available until expended.

23 **SEC. 756. EXPANDING SUPPORT FOR CONDOMS IN PRIS-**
 24 **ONS.**

25 (a) DEFINITIONS.—In this section:

1 (1) COMMUNITY ORGANIZATION.—The term
2 “community organization” means a public health
3 care facility or a nonprofit organization that pro-
4 vides health- or STI-related services according to es-
5 tablished public health standards.

6 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
7 The term “comprehensive sexuality education”
8 means sexuality education—

9 (A) that includes information about absti-
10 nence and about the proper use and disposal of
11 sexual barrier protection devices; and

12 (B) that is—

13 (i) evidence-based;

14 (ii) medically accurate;

15 (iii) age and developmentally appro-
16 priate;

17 (iv) gender and identity sensitive;

18 (v) culturally and linguistically appro-
19 priate; and

20 (vi) structured to promote critical
21 thinking, self-esteem, respect for others,
22 and the development of healthy attitudes
23 and relationships.

24 (3) CORRECTIONAL FACILITY.—The term “cor-
25 rectional facility” means any prison, penitentiary,

1 adult detention facility, juvenile detention facility,
2 jail, or other facility to which individuals may be
3 sent after conviction of a crime or act of juvenile de-
4 linquency within the United States.

5 (4) INCARCERATED INDIVIDUAL.—The term
6 “incarcerated individual” means any individual who
7 is serving a sentence in a correctional facility after
8 conviction of a crime.

9 (5) SEXUAL BARRIER PROTECTION DEVICE.—
10 The term “sexual barrier protection device” means
11 any physical device approved by the Food and Drug
12 Administration that has not been tampered with and
13 which reduces the probability of STI transmission or
14 infection between sexual partners, including female
15 condoms, male condoms, and dental dams.

16 (6) SEXUALLY TRANSMITTED INFECTION.—The
17 term “sexually transmitted infection” or “STI”
18 means any disease or infection that is commonly
19 transmitted through sexual activity, including HIV,
20 gonorrhea, chlamydia, syphilis, genital herpes, viral
21 hepatitis, and human papillomavirus.

22 (7) STATE.—The term “State” includes the
23 District of Columbia, American Samoa, the Com-
24 monwealth of the Northern Mariana Islands, Guam,
25 Puerto Rico, and the United States Virgin Islands.

1 (b) AUTHORITY TO ALLOW COMMUNITY ORGANIZA-
2 TIONS TO PROVIDE STI COUNSELING, STI PREVENTION
3 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-
4 VICES IN FEDERAL CORRECTIONAL FACILITIES.—

5 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not
6 later than 30 days after the date of enactment of
7 this Act, the Attorney General shall direct the Direc-
8 tor of the Bureau of Prisons to allow community or-
9 ganizations to, in accordance with all relevant Fed-
10 eral laws and regulations that govern visitation in
11 correctional facilities—

12 (A) distribute sexual barrier protection de-
13 vices in Federal correctional facilities; and

14 (B) engage in STI counseling and STI pre-
15 vention education in Federal correctional facili-
16 ties.

17 (2) INFORMATION REQUIREMENT.—Any com-
18 munity organization permitted to distribute sexual
19 barrier protection devices under paragraph (1) shall
20 ensure that the individuals to whom the devices are
21 distributed are informed about the proper use and
22 disposal of sexual barrier protection devices in ac-
23 cordance with established public health practices.
24 Any community organization conducting STI coun-

1 seling or STI prevention education under paragraph
2 (1) shall offer comprehensive sexuality education.

3 (3) POSSESSION OF DEVICE PROTECTED.—A
4 Federal correctional facility may not, because of the
5 possession or use of a sexual barrier protection de-
6 vice—

7 (A) take adverse action against an incar-
8 cerated individual; or

9 (B) consider possession or use as evidence
10 of prohibited activity for the purpose of any
11 Federal correctional facility administrative pro-
12 ceeding.

13 (4) IMPLEMENTATION.—The Attorney General
14 and the Director of the Bureau of Prisons shall im-
15 plement this section according to established public
16 health practices in a manner that protects the
17 health, safety, and privacy of incarcerated individ-
18 uals and of correctional facility staff.

19 (c) SENSE OF CONGRESS REGARDING DISTRIBUTION
20 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
21 PRISON SYSTEMS.—It is the sense of the Congress that
22 States should allow for the legal distribution of sexual bar-
23 rier protection devices in State correctional facilities to re-
24 duce the prevalence and spread of STIs in those facilities.

1 (d) SURVEY OF AND REPORT ON CORRECTIONAL FA-
2 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
3 STIs.—

4 (1) SURVEY.—Not later than 180 days after
5 the date of enactment of this Act, and annually
6 thereafter for 5 years, the Attorney General, after
7 consulting with the Secretary of Health and Human
8 Services, State officials, and community organiza-
9 tions, shall, to the maximum extent practicable, con-
10 duct a survey of all Federal and State correctional
11 facilities, to determine the following:

12 (A) COUNSELING, TREATMENT, AND SUP-
13 PORTIVE SERVICES.—Whether the correctional
14 facility—

15 (i) requires incarcerated individuals to
16 participate in counseling, treatment, and
17 supportive services related to STIs; or

18 (ii) offers such programs to incarcer-
19 ated individuals.

20 (B) ACCESS TO SEXUAL BARRIER PROTEC-
21 TION DEVICES.—Whether incarcerated individ-
22 uals can—

23 (i) possess sexual barrier protection
24 devices;

- 1 (ii) purchase sexual barrier protection
2 devices;
- 3 (iii) purchase sexual barrier protection
4 devices at a reduced cost; or
- 5 (iv) obtain sexual barrier protection
6 devices without cost.

7 (C) INCIDENCE OF SEXUAL VIOLENCE.—
8 The incidence of sexual violence and assault
9 committed by incarcerated individuals and by
10 correctional facility staff.

11 (D) PREVENTION EDUCATION OFFERED.—
12 The type of prevention education, information,
13 or training offered to incarcerated individuals
14 and correctional facility staff regarding sexual
15 violence and the spread of STIs, including
16 whether such education, information, or train-
17 ing—

18 (i) constitutes comprehensive sexuality
19 education;

20 (ii) is compulsory for new incarcerated
21 individuals and for new staff; and

22 (iii) is offered on an ongoing basis.

23 (E) STI TESTING.—Whether the correc-
24 tional facility tests incarcerated individuals for

1 STIs or gives them the option to undergo such
2 testing—

- 3 (i) at intake;
- 4 (ii) on a regular basis; and
- 5 (iii) prior to release.

6 (F) STI TEST RESULTS.—The number of
7 incarcerated individuals who are tested for STIs
8 and the outcome of such tests at each correc-
9 tional facility, disaggregated to include results
10 for—

- 11 (i) the type of sexually transmitted in-
12 fection tested for;
- 13 (ii) the race and ethnicity of individ-
14 uals tested;
- 15 (iii) the age of individuals tested; and
- 16 (iv) the gender of individuals tested.

17 (G) PRERELEASE REFERRAL POLICY.—
18 Whether incarcerated individuals are informed
19 prior to release about STI-related services or
20 other health services in their communities, in-
21 cluding free and low-cost counseling and treat-
22 ment options.

23 (H) PRERELEASE REFERRALS MADE.—
24 The number of referrals to community-based
25 organizations or public health facilities offering

1 STI-related or other health services provided to
2 incarcerated individuals prior to release, and
3 the type of counseling or treatment for which
4 the referral was made.

5 (I) REINSTATEMENT OF MEDICAID BENE-
6 FITS.—Whether the correctional facility assists
7 incarcerated individuals that were enrolled in
8 the State Medicaid program prior to their in-
9 carceration, in reinstating their enrollment
10 upon release and whether such individuals re-
11 ceive referrals as provided by subparagraph (G)
12 to entities that accept the State Medicaid pro-
13 gram, including if applicable—

14 (i) the number of such individuals, in-
15 cluding those diagnosed with HIV, that
16 have been reinstated;

17 (ii) a list of obstacles to reinstating
18 enrollment or to making determinations of
19 eligibility for reinstatement, if any; and

20 (iii) the number of individuals denied
21 enrollment.

22 (J) OTHER ACTIONS TAKEN.—Whether the
23 correctional facility has taken any other action,
24 in conjunction with community organizations or

1 otherwise, to reduce the prevalence and spread
2 of STIs in that facility.

3 (2) PRIVACY.—In conducting the survey under
4 paragraph (1), the Attorney General shall not re-
5 quest or retain the identity of any individual who
6 has sought or been offered counseling, treatment,
7 testing, or prevention education information regard-
8 ing an STI (including information about sexual bar-
9 rier protection devices), or who has tested positive
10 for an STI.

11 (3) REPORT.—

12 (A) IN GENERAL.—The Attorney General
13 shall transmit to Congress and make publicly
14 available the results of the survey required
15 under paragraph (1), both for the United
16 States as a whole and disaggregated as to each
17 State and each correctional facility.

18 (B) DEADLINES.—To the maximum extent
19 possible, the Attorney General shall—

20 (i) issue the first report under sub-
21 paragraph (A) not later than 1 year after
22 the date of enactment of this Act; and

23 (ii) issue reports under subparagraph
24 (A) annually thereafter for 5 years.

25 (e) STRATEGY.—

1 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
2 Attorney General, in consultation with the Secretary
3 of Health and Human Services, State officials, and
4 community organizations, shall develop and imple-
5 ment a 5-year strategy to reduce the prevalence and
6 spread of STIs in Federal and State correctional fa-
7 cilities. To the maximum extent possible, the strat-
8 egy shall be developed, transmitted to Congress, and
9 made publicly available no later than 180 days after
10 the transmission of the first report required under
11 subsection (d)(3).

12 (2) CONTENTS OF STRATEGY.—The strategy
13 developed under paragraph (1) shall include the fol-
14 lowing:

15 (A) PREVENTION EDUCATION.—A plan for
16 improving prevention education, information,
17 and training offered to incarcerated individuals
18 and correctional facility staff, including infor-
19 mation and training on sexual violence and the
20 spread of STIs, and comprehensive sexuality
21 education.

22 (B) SEXUAL BARRIER PROTECTION DEVICE
23 ACCESS.—A plan for expanding access to sexual
24 barrier protection devices in correctional facili-
25 ties.

1 (C) SEXUAL VIOLENCE REDUCTION.—A
2 plan for reducing the incidence of sexual vio-
3 lence among incarcerated individuals and cor-
4 rectional facility staff, developed in consultation
5 with the National Prison Rape Elimination
6 Commission.

7 (D) COUNSELING AND SUPPORTIVE SERV-
8 ICES.—A plan for expanding access to coun-
9 seling and supportive services related to STIs in
10 correctional facilities.

11 (E) TESTING.—A plan for testing incarcer-
12 ated individuals for STIs during intake, during
13 regular health exams, and prior to release, and
14 that—

15 (i) is conducted in accordance with
16 guidelines established by the Centers for
17 Disease Control and Prevention;

18 (ii) includes pretest counseling;

19 (iii) requires that incarcerated individ-
20 uals are notified of their option to decline
21 testing at any time;

22 (iv) requires that incarcerated individ-
23 uals are confidentially notified of their test
24 results in a timely manner; and

1 (v) ensures that incarcerated individ-
2 uals testing positive for STIs receive post-
3 test counseling, care, treatment, and sup-
4 portive services.

5 (F) TREATMENT.—A plan for ensuring
6 that correctional facilities have the necessary
7 medicine and equipment to treat and monitor
8 STIs and for ensuring that incarcerated indi-
9 viduals living with or testing positive for STIs
10 receive and have access to care and treatment
11 services.

12 (G) STRATEGIES FOR DEMOGRAPHIC
13 GROUPS.—A plan for developing and imple-
14 menting culturally appropriate, sensitive, and
15 specific strategies to reduce the spread of STIs
16 among demographic groups heavily impacted by
17 STIs.

18 (H) LINKAGES WITH COMMUNITIES AND
19 FACILITIES.—A plan for establishing and
20 strengthening linkages to local communities and
21 health facilities that—

22 (i) provide counseling, testing, care,
23 and treatment services;

1 (ii) may receive individuals recently
2 released from incarceration who are living
3 with STIs; and

4 (iii) accept payment through the State
5 Medicaid program.

6 (I) ENROLLMENT IN STATE MEDICAID
7 PROGRAMS.—Plans to ensure that—

8 (i) incarcerated individuals who were
9 enrolled in their State Medicaid program
10 prior to incarceration in a correctional fa-
11 cility are automatically reenrolled in such
12 program upon their release; and

13 (ii) incarcerated individuals who were
14 not enrolled in their State Medicaid pro-
15 gram prior to incarceration, and who are
16 diagnosed with HIV while incarcerated in
17 a correctional facility, are automatically
18 enrolled in such program upon their re-
19 lease.

20 (J) OTHER PLANS.—Any other plans de-
21 veloped by the Attorney General for reducing
22 the spread of STIs or improving the quality of
23 health care in correctional facilities.

24 (K) MONITORING SYSTEM.—A monitoring
25 system that establishes performance goals re-

1 lated to reducing the prevalence and spread of
2 STIs in correctional facilities and which, where
3 feasible, expresses such goals in quantifiable
4 form.

5 (L) MONITORING SYSTEM PERFORMANCE
6 INDICATORS.—Performance indicators that
7 measure or assess the achievement of the per-
8 formance goals described in subparagraph (K).

9 (M) COST ESTIMATE.—A detailed estimate
10 of the funding necessary to implement the
11 strategy at the Federal and State levels for all
12 5 years, including the amount of funds required
13 by community organizations to implement the
14 parts of the strategy in which they take part.

15 (3) REPORT.—Not later than 1 year after the
16 date of the enactment of this Act, and annually
17 thereafter, the Attorney General shall transmit to
18 Congress and make publicly available an annual
19 progress report regarding the implementation and
20 effectiveness of the strategy described in paragraph
21 (1). The progress report shall include an evaluation
22 of the implementation of the strategy using the mon-
23 itoring system and performance indicators provided
24 for in subparagraphs (K) and (L) of paragraph (2).

25 (f) AUTHORIZATION OF APPROPRIATIONS.—

1 (1) IN GENERAL.—There are authorized to be
 2 appropriated such sums as may be necessary to
 3 carry out this section for each of fiscal years 2021
 4 through 2025.

5 (2) AVAILABILITY OF FUNDS.—Amounts made
 6 available under paragraph (1) are authorized to re-
 7 main available until expended.

8 **SEC. 757. AUTOMATIC REINSTATEMENT OR ENROLLMENT**
 9 **IN MEDICAID FOR PEOPLE WHO TEST POSI-**
 10 **TIVE FOR HIV BEFORE REENTERING COMMU-**
 11 **NITIES.**

12 (a) IN GENERAL.—Section 1902(e) of the Social Se-
 13 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
 14 the end the following:

15 “(16) ENROLLMENT OF EX-OFFENDERS.—

16 “(A) AUTOMATIC ENROLLMENT OR REIN-
 17 STATEMENT.—

18 “(i) IN GENERAL.—The State plan
 19 shall provide for the automatic enrollment
 20 or reinstatement of enrollment of an eligi-
 21 ble individual—

22 “(I) if such individual is sched-
 23 uled to be released from a public insti-
 24 tution due to the completion of sen-

1 tence, not less than 30 days prior to
2 the scheduled date of the release; and

3 “(II) if such individual is to be
4 released from a public institution on
5 parole or on probation, as soon as
6 possible after the date on which the
7 determination to release such indi-
8 vidual was made, and before the date
9 such individual is released.

10 “(ii) EXCEPTION.—If a State makes a
11 determination that an individual is not eli-
12 gible to be enrolled under the State plan—

13 “(I) on or before the date by
14 which the individual would be enrolled
15 under clause (i), such clause shall not
16 apply to such individual; or

17 “(II) after such date, the State
18 may terminate the enrollment of such
19 individual.

20 “(B) RELATIONSHIP OF ENROLLMENT TO
21 PAYMENT FOR SERVICES.—

22 “(i) IN GENERAL.—Subject to sub-
23 paragraph (A)(ii), an eligible individual
24 who is enrolled, or whose enrollment is re-
25 instated, under subparagraph (A) shall be

1 eligible for all services for which medical
2 assistance is provided under the State plan
3 after the date that the eligible individual is
4 released from the public institution.

5 “(ii) RELATIONSHIP TO PAYMENT
6 PROHIBITION FOR INMATES.—No provision
7 of this paragraph may be construed to per-
8 mit payment for care or services for which
9 payment is excluded under subdivision (A)
10 following paragraph (31) of section
11 1905(a).

12 “(C) TREATMENT OF CONTINUOUS ELIGI-
13 BILITY.—

14 “(i) SUSPENSION FOR INMATES.—Any
15 period of continuous eligibility under this
16 title shall be suspended on the date an in-
17 dividual enrolled under this title becomes
18 an inmate of a public institution (except as
19 a patient of a medical institution).

20 “(ii) DETERMINATION OF REMAINING
21 PERIOD.—Notwithstanding any changes to
22 State law related to continuous eligibility
23 during the time that an individual is an in-
24 mate of a public institution (except as a
25 patient of a medical institution), subject to

1 clause (iii), with respect to an eligible indi-
2 vidual who was subject to a suspension
3 under clause (i), on the date that such in-
4 dividual is released from a public institu-
5 tion the suspension of continuous eligibility
6 under such clause shall be lifted for a pe-
7 riod that is equal to the time remaining in
8 the period of continuous eligibility for such
9 individual on the date that such period was
10 suspended under such clause.

11 “(iii) EXCEPTION.—If a State makes
12 a determination that an individual is not
13 eligible to be enrolled under the State
14 plan—

15 “(I) on or before the date that
16 the suspension of continuous eligibility
17 is lifted under clause (ii), such clause
18 shall not apply to such individual; or

19 “(II) after such date, the State
20 may terminate the enrollment of such
21 individual.

22 “(D) AUTOMATIC ENROLLMENT OR REIN-
23 STATEMENT OF ENROLLMENT DEFINED.—For
24 purposes of this paragraph, the term ‘automatic
25 enrollment or reinstatement of enrollment’

1 means that the State determines eligibility for
2 medical assistance under the State plan without
3 a program application from, or on behalf of, the
4 eligible individual, but an individual can only be
5 automatically enrolled in the State Medicaid
6 plan if the individual affirmatively consents to
7 being enrolled through affirmation in writing,
8 by telephone, orally, through electronic signa-
9 ture, or through any other means specified by
10 the Secretary.

11 “(E) ELIGIBLE INDIVIDUAL DEFINED.—
12 For purposes of this paragraph, the term ‘eligi-
13 ble individual’ means an individual who is an
14 inmate of a public institution (except as a pa-
15 tient in a medical institution)—

16 “(i) who was enrolled under the State
17 plan for medical assistance immediately be-
18 fore becoming an inmate of such an insti-
19 tution; or

20 “(ii) who is diagnosed with human im-
21 munodeficiency virus.”.

22 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
23 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
24 ICAID BENEFITS.—

1 (1) IN GENERAL.—Subject to paragraph (3),
2 with respect to a State, for each of the first 4 cal-
3 endar quarters in which the State plan meets the re-
4 quirements of paragraph (16) of section 1902(e) of
5 the Social Security Act (42 U.S.C. 1396a(e)) (as
6 added by subsection (a)), the Federal matching pay-
7 ments (including payments based on the Federal
8 medical assistance percentage) made to such State
9 under section 1903 of the Social Security Act (42
10 U.S.C. 1396b) for the State expenditures described
11 in paragraph (2) shall be increased by 5 percentage
12 points.

13 (2) EXPENDITURES.—The expenditures de-
14 scribed in this paragraph are the following:

15 (A) Expenditures for which payment is
16 available under section 1903 of the Social Secu-
17 rity Act (42 U.S.C. 1396b) and which are at-
18 tributable to strengthening the State’s enroll-
19 ment and administrative resources for the pur-
20 pose of improving processes for enrolling (or re-
21 instating the enrollment of) eligible individuals
22 (as such term is defined in subparagraph (E) of
23 paragraph (16) of section 1902(e) of the Social
24 Security Act (42 U.S.C. 1396a(e)) (as amended
25 by subsection (a))).

1 (B) Expenditures for medical assistance
2 (as such term is defined in section 1905(a) of
3 the Social Security Act (42 U.S.C. 1396d(a)))
4 provided to such eligible individuals.

5 (3) REQUIREMENTS; LIMITATION.—

6 (A) REPORT.—A State is not eligible for
7 an increase in its Federal matching payments
8 under paragraph (1) unless the State agrees to
9 submit to the Secretary of Health and Human
10 Services, and make publicly available, a report
11 that contains the information required under
12 paragraph (4) by the end of the 1-year period
13 during which the State receives increased Fed-
14 eral matching payments in accordance with that
15 paragraph.

16 (B) MAINTENANCE OF ELIGIBILITY.—

17 (i) IN GENERAL.—Subject to clause
18 (ii), a State is not eligible for an increase
19 in its Federal matching payments under
20 paragraph (1) if eligibility standards,
21 methodologies, or procedures under its
22 State plan under title XIX of the Social
23 Security Act (42 U.S.C. 1396 et seq.), or
24 waiver of such a plan, are more restrictive
25 than the eligibility standards, methodolo-

1 gies, or procedures, respectively, under
2 such plan or waiver as in effect on the date
3 of enactment of this Act.

4 (ii) STATE REINSTATEMENT OF ELIGI-
5 BILITY PERMITTED.—A State that has re-
6 stricted eligibility standards, methodolo-
7 gies, or procedures under its State plan
8 under title XIX of the Social Security Act
9 (42 U.S.C. 1396 et seq.), or a waiver of
10 such plan, after the date of enactment of
11 this Act, is no longer ineligible under
12 clause (i) beginning with the first calendar
13 quarter in which the State has reinstated
14 eligibility standards, methodologies, or pro-
15 cedures that are no more restrictive than
16 the eligibility standards, methodologies, or
17 procedures, respectively, under such plan
18 (or waiver) as in effect on such date.

19 (C) LIMITATION OF MATCHING PAYMENTS
20 TO 100 PERCENT.—In no case shall an increase
21 in Federal matching payments under paragraph
22 (1) result in Federal matching payments that
23 exceed 100 percent of State expenditures.

1 (4) REQUIRED REPORT INFORMATION.—The in-
2 formation that is required in the report under para-
3 graph (3)(A) shall include—

4 (A) the results of an evaluation of the im-
5 pact of the implementation of the requirements
6 of paragraph (16) of section 1902(e) of the So-
7 cial Security Act (42 U.S.C. 1396a(e)) on im-
8 proving the State’s processes for enrolling indi-
9 viduals who are released from public institu-
10 tions under the State Medicaid plan;

11 (B) the number of individuals who were
12 automatically enrolled (or whose enrollment was
13 reinstated) under such paragraph during the 1-
14 year period during which the State received in-
15 creased payments under this subsection; and

16 (C) any other information that is required
17 by the Secretary of Health and Human Serv-
18 ices.

19 (c) EFFECTIVE DATE.—

20 (1) IN GENERAL.—Except as provided in para-
21 graph (2), the amendments made by subsection (a)
22 shall take effect 180 days after the date of the en-
23 actment of this Act.

24 (2) RULE FOR CHANGES REQUIRING STATE
25 LEGISLATION.—In the case of a State plan for med-

1 ical assistance under title XIX of the Social Security
2 Act (42 U.S.C. 1396 et seq.) which the Secretary of
3 Health and Human Services determines requires
4 State legislation (other than legislation appro-
5 priating funds) in order for the plan to meet the ad-
6 ditional requirement imposed by the amendments
7 made by subsection (a), the State plan shall not be
8 regarded as failing to comply with the requirements
9 of such title solely on the basis of its failure to meet
10 this additional requirement before the first day of
11 the first calendar quarter beginning after the close
12 of the first regular session of the State legislature
13 that begins after the date of the enactment of this
14 Act. For purposes of the previous sentence, in the
15 case of a State that has a 2-year legislative session,
16 each year of such session shall be deemed to be a
17 separate regular session of the State legislature.

18 **SEC. 758. STOP HIV IN PRISON.**

19 (a) **SHORT TITLE.**—This section may be cited as the
20 “Stop HIV in Prison Act”.

21 (b) **IN GENERAL.**—The Director of the Bureau of
22 Prisons (referred to in this section as the “Director”) shall
23 develop a comprehensive policy to provide HIV testing,
24 treatment, and prevention for inmates within the correc-
25 tional setting and upon reentry.

1 (c) PURPOSE.—The purposes of the policy required
2 to be developed under subsection (b) shall be as follows:

3 (1) To stop the spread of HIV among inmates.

4 (2) To protect prison guards and other per-
5 sonnel from HIV infection.

6 (3) To provide comprehensive medical treat-
7 ment to inmates who are living with HIV.

8 (4) To promote HIV awareness and prevention
9 among inmates.

10 (5) To encourage inmates to take personal re-
11 sponsibility for their health.

12 (6) To reduce the risk that inmates will trans-
13 mit HIV to other persons in the community fol-
14 lowing their release from prison.

15 (d) CONSULTATION.—The Director shall consult with
16 appropriate officials of the Department of Health and
17 Human Services, the Office of National Drug Control Pol-
18 icy, and the Centers for Disease Control and Prevention
19 regarding the development of the policy required under
20 subsection (b).

21 (e) TIME LIMIT.—Not later than 1 year after the
22 date of enactment of this Act, the Director shall draft ap-
23 propriate regulations to implement the policy required to
24 be developed under subsection (b).

1 (f) REQUIREMENTS FOR POLICY.—The policy re-
2 quired to be developed under subsection (b) shall provide
3 for the following:

4 (1) TESTING AND COUNSELING UPON IN-
5 TAKE.—

6 (A) Health care personnel shall provide
7 routine HIV testing to all inmates as a part of
8 a comprehensive medical examination imme-
9 diately following admission to a facility. Health
10 care personnel need not provide routine HIV
11 testing to an inmate who is transferred to a fa-
12 cility from another facility if the inmate's med-
13 ical records are transferred with the inmate and
14 indicate that the inmate has been tested pre-
15 viously.

16 (B) To all inmates admitted to a facility
17 prior to the effective date of this policy, health
18 care personnel shall provide routine HIV testing
19 within no more than 6 months. HIV testing for
20 these inmates may be performed in conjunction
21 with other health services provided to these in-
22 mates by health care personnel.

23 (C) All HIV tests under this paragraph
24 shall comply with the opt-out provision.

1 (2) PRE-TEST AND POST-TEST COUNSELING.—

2 Health care personnel shall provide confidential pre-
3 test and post-test counseling to all inmates who are
4 tested for HIV. Counseling may be included with
5 other general health counseling provided to inmates
6 by health care personnel.

7 (3) HIV PREVENTION EDUCATION.—

8 (A) Health care personnel shall improve
9 HIV awareness through frequent educational
10 programs for all inmates. HIV educational pro-
11 grams may be provided by community-based or-
12 ganizations, local health departments, and in-
13 mate peer educators.

14 (B) HIV educational materials shall be
15 made available to all inmates at orientation, at
16 health care clinics, at regular educational pro-
17 grams, and prior to release. Both written and
18 audiovisual materials shall be made available to
19 all inmates.

20 (C)(i) The HIV educational programs and
21 materials under this paragraph shall include in-
22 formation on—

23 (I) modes of transmission, including
24 transmission through tattooing, sexual con-
25 tact, and intravenous drug use;

- 1 (II) prevention methods;
2 (III) treatment; and
3 (IV) disease progression.

4 (ii) The programs and materials shall be
5 culturally sensitive, written or designed for low-
6 literacy levels, available in a variety of lan-
7 guages, and present scientifically accurate in-
8 formation in a clear and understandable man-
9 ner.

10 (4) HIV TESTING UPON REQUEST.—

11 (A) Health care personnel shall allow in-
12 mates to obtain HIV tests upon request once
13 per year or whenever an inmate has a reason to
14 believe the inmate may have been exposed to
15 HIV. Health care personnel shall, both orally
16 and in writing, inform inmates, during orienta-
17 tion and periodically throughout incarceration,
18 of their right to obtain HIV tests.

19 (B) Health care personnel shall encourage
20 inmates to request HIV tests if the inmate is
21 sexually active, has been raped, uses intra-
22 venous drugs, receives a tattoo, or if the inmate
23 is concerned that the inmate may have been ex-
24 posed to HIV.

1 (C) An inmate's request for an HIV test
2 shall not be considered an indication that the
3 inmate has put him/herself at risk of infection
4 and/or committed a violation of prison rules.

5 (5) HIV TESTING OF PREGNANT WOMAN.—

6 (A) Health care personnel shall provide
7 routine HIV testing to all inmates who become
8 pregnant.

9 (B) All HIV tests under this paragraph
10 shall comply with the opt-out provision.

11 (6) COMPREHENSIVE TREATMENT.—

12 (A) Health care personnel shall provide all
13 inmates who test positive for HIV—

14 (i) timely, comprehensive medical
15 treatment;

16 (ii) confidential counseling on man-
17 aging their medical condition and pre-
18 venting its transmission to other persons;
19 and

20 (iii) voluntary partner notification
21 services.

22 (B) Health care provided under this para-
23 graph shall be consistent with current Depart-
24 ment of Health and Human Services guidelines
25 and standard medical practice. Health care per-

1 sonnel shall discuss treatment options, the im-
2 portance of adherence to antiretroviral therapy,
3 and the side effects of medications with inmates
4 receiving treatment.

5 (C) Health care personnel and pharmacy
6 personnel shall ensure that the facility for-
7 mulary contains all Food and Drug Administra-
8 tion-approved medications necessary to provide
9 comprehensive treatment for inmates living with
10 HIV, and that the facility maintains adequate
11 supplies of such medications to meet inmates'
12 medical needs. Health care personnel and phar-
13 macy personnel shall also develop and imple-
14 ment automatic renewal systems for these medi-
15 cations to prevent interruptions in care.

16 (D) Correctional staff, health care per-
17 sonnel, and pharmacy personnel shall develop
18 and implement distribution procedures to en-
19 sure timely and confidential access to medica-
20 tions.

21 (7) PROTECTION OF CONFIDENTIALITY.—

22 (A) Health care personnel shall develop
23 and implement procedures to ensure the con-
24 fidentiality of inmate tests, diagnoses, and
25 treatment. Health care personnel and correc-

1 tional staff shall receive regular training on the
2 implementation of these procedures. Penalties
3 for violations of inmate confidentiality by health
4 care personnel or correctional staff shall be
5 specified and strictly enforced.

6 (B) HIV testing, counseling, and treat-
7 ment shall be provided in a confidential setting
8 where other routine health services are provided
9 and in a manner that allows the inmate to re-
10 quest and obtain these services as routine med-
11 ical services.

12 (8) TESTING, COUNSELING, AND REFERRAL
13 PRIOR TO REENTRY.—

14 (A) Health care personnel shall provide
15 routine HIV testing to all inmates not earlier
16 than 3 months prior to their release and re-
17 entry into the community. Inmates who are al-
18 ready known to be infected need not be tested
19 again. This requirement may be waived if an in-
20 mate's release occurs without sufficient notice
21 to the Bureau to allow health care personnel to
22 perform a routine HIV test and notify the in-
23 mate of the results.

24 (B) All HIV tests under this paragraph
25 shall comply with the opt-out provision.

1 (C) To all inmates who test positive for
2 HIV and all inmates who already are known to
3 have HIV, health care personnel shall provide—

4 (i) confidential prerelease counseling
5 on managing their medical condition in the
6 community, accessing appropriate treat-
7 ment and services in the community, and
8 preventing the transmission of their condi-
9 tion to family members and other persons
10 in the community;

11 (ii) referrals to appropriate health
12 care providers and social service agencies
13 in the community that meet the inmate's
14 individual needs, including voluntary part-
15 ner notification services and prevention
16 counseling services for people living with
17 HIV; and

18 (iii) a 30-day supply of any medically
19 necessary medications the inmate is cur-
20 rently receiving.

21 (9) OPT-OUT PROVISION.—Inmates shall have
22 the right to refuse routine HIV testing. Inmates
23 shall be informed both orally and in writing of this
24 right. Oral and written disclosure of this right may
25 be included with other general health information

1 and counseling provided to inmates by health care
2 personnel. If an inmate refuses a routine test for
3 HIV, health care personnel shall make a note of the
4 inmate's refusal in the inmate's confidential medical
5 records. However, the inmate's refusal shall not be
6 considered a violation of prison rules or result in dis-
7 disciplinary action. Any reference in this section to the
8 "opt-out provision" shall be deemed a reference to
9 the requirement of this paragraph.

10 (10) EXCLUSION OF TESTS PERFORMED UNDER
11 SECTION 4014(b) FROM THE DEFINITION OF ROU-
12 TINE HIV TESTING.—HIV testing of an inmate
13 under section 4014(b) of title 18, United States
14 Code, is not routine HIV testing for the purposes of
15 the opt-out provision. Health care personnel shall
16 document the reason for testing under section
17 4014(b) of title 18, United States Code, in the in-
18 mate's confidential medical records.

19 (11) TIMELY NOTIFICATION OF TEST RE-
20 SULTS.—Health care personnel shall provide timely
21 notification to inmates of the results of HIV tests.

22 (g) CHANGES IN EXISTING LAW.—

23 (1) SCREENING IN GENERAL.—Section 4014(a)
24 of title 18, United States Code, is amended—

1 (A) by striking “for a period of 6 months
2 or more”;

3 (B) by striking “, as appropriate,”; and

4 (C) by striking “if such individual is deter-
5 mined to be at risk for infection with such virus
6 in accordance with the guidelines issued by the
7 Bureau of Prisons relating to infectious disease
8 management” and inserting “unless the indi-
9 vidual declines. The Attorney General shall also
10 cause such individual to be so tested before re-
11 lease unless the individual declines.”.

12 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
13 CIVIL AND CRIMINAL PROCEEDINGS.—Section
14 4014(d) of title 18, United States Code, is amended
15 by inserting “or under the Stop HIV in Prison Act”
16 after “under this section”.

17 (3) SCREENING AS PART OF ROUTINE SCREEN-
18 ING.—Section 4014(e) of title 18, United States
19 Code, is amended by adding at the end the fol-
20 lowing: “Such rules shall also provide that the initial
21 test under this section be performed as part of the
22 routine health screening conducted at intake.”.

23 (h) REPORTING REQUIREMENTS.—

24 (1) REPORT ON HEPATITIS, LIVER, AND OTHER
25 DISEASES.—Not later than 1 year after the date of

1 enactment of this Act, the Director shall provide a
2 report to the Congress on the policies and proce-
3 dures of the Bureau of Prisons to provide testing,
4 treatment, and prevention education programs for
5 hepatitis, liver failure, and other liver-related dis-
6 eases transmitted through sexual activity, intra-
7 venous drug use, or other means. The Director shall
8 consult with appropriate officials of the Department
9 of Health and Human Services, the Office of Na-
10 tional Drug Control Policy, the Office of National
11 AIDS Policy, and the Centers for Disease Control
12 and Prevention regarding the development of this re-
13 port.

14 (2) ANNUAL REPORTS.—

15 (A) GENERALLY.—Not later than 2 years
16 after the date of enactment of this Act, and
17 then annually thereafter, the Director shall re-
18 port to Congress on the incidence among in-
19 mates of diseases transmitted through sexual
20 activity and intravenous drug use.

21 (B) MATTERS PERTAINING TO VARIOUS
22 DISEASES.—Each report under paragraph (1)
23 shall discuss—

24 (i) the incidence among inmates of
25 HIV, hepatitis, and other diseases trans-

1 mitted through sexual activity and intra-
2 venous drug use; and

3 (ii) updates on the testing, treatment,
4 and prevention education programs for
5 these diseases conducted by the Bureau of
6 Prisons.

7 (C) MATTERS PERTAINING TO HIV
8 ONLY.—Each report under paragraph (1) shall
9 also include—

10 (i) the number of inmates who tested
11 positive for HIV upon intake;

12 (ii) the number of inmates who tested
13 positive prior to reentry;

14 (iii) the number of inmates who were
15 not tested prior to reentry because they
16 were released without sufficient notice;

17 (iv) the number of inmates who opted-
18 out of taking the test;

19 (v) the number of inmates who were
20 tested under section 4014(b) of title 18,
21 United States Code; and

22 (vi) the number of inmates under
23 treatment for HIV.

24 (D) CONSULTATION.—The Director shall
25 consult with appropriate officials of the Depart-

1 ment of Health and Human Services, the Office
2 of National Drug Control Policy, and the Cen-
3 ters for Disease Control and Prevention regard-
4 ing the development of each report under para-
5 graph (1).

6 **SEC. 759. SUPPORT DATA SYSTEM REVIEW AND INDICA-**
7 **TORS FOR MONITORING HIV CARE.**

8 The Secretary of Health and Human Services, in col-
9 laboration with the Assistant Secretary for Health, the Di-
10 rector of the Office of Infectious Disease and HIV/AIDS
11 Policy, the Director of the Centers for Disease Control and
12 Prevention, the Assistant Secretary for Mental Health and
13 Substance Use, the Director of the Department of Hous-
14 ing and Urban Development, the Director of the Office
15 of AIDS Research, the Administrator of the Health Re-
16 sources and Services Administration, and the Adminis-
17 trator of the Centers for Medicare & Medicaid Services,
18 shall expand and coordinate efforts to align metrics across
19 agencies and modify Federal data systems, to—

20 (1) adopt the National Academy of Medicine’s
21 clinical HIV care indicators as the core metrics for
22 monitoring the quality of HIV care, mental health,
23 substance abuse, and supportive services;

24 (2) better enable assessment of the impact of
25 the National HIV/AIDS Strategy and the Patient

1 Protection and Affordable Care Act (Public Law
2 111–148) on improving HIV care and access to sup-
3 portive services for individuals with HIV;

4 (3) expand the demographic data elements to be
5 captured by Federal data systems relevant to HIV
6 care to permit calculation of the indicators for sub-
7 groups of the population of people with diagnosed
8 HIV infection, including—

9 (A) age;

10 (B) race;

11 (C) ethnicity;

12 (D) sex (assigned at birth);

13 (E) gender identity;

14 (F) sexual orientation;

15 (G) current geographic marker of resi-
16 dence;

17 (H) income or poverty level; and

18 (I) primary means of reimbursement for
19 medical services (including a State Medicaid
20 program, the Medicare program, the Ryan
21 White HIV/AIDS Program, private insurance,
22 health maintenance organizations, and no cov-
23 erage); and

24 (4) streamline data collection and systematically
25 review all existing reporting requirements for feder-

1 ally funded HIV programs to ensure that only essen-
2 tial data are collected.

3 **SEC. 760. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**
4 **ENDING THE HIV EPIDEMIC: A PLAN FOR**
5 **AMERICA.**

6 Title II of the Public Health Service Act (42 U.S.C.
7 202 et seq.) is amended by inserting after section 241 the
8 following:

9 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
10 **OF NATIONAL HIV/AIDS STRATEGY.**

11 “(a) TRANSFER AUTHORIZATION.—Of the discre-
12 tionary appropriations made available to the Department
13 of Health and Human Services for any fiscal year for pro-
14 grams and activities that, as determined by the Secretary,
15 pertain to HIV, the Secretary may transfer up to 1 per-
16 cent of such appropriations to the Office of the Assistant
17 Secretary for Health for implementation of the Ending the
18 HIV Epidemic: A Plan for America.

19 “(b) CONGRESSIONAL NOTIFICATION.—Not less than
20 30 days before making any transfer under this section,
21 the Secretary shall give notice of the transfer to the Con-
22 gress.

23 “(c) DEFINITIONS.—In this section, the term ‘End-
24 ing the HIV Epidemic: A Plan for America’ means the
25 initiative of the Department of Health and Human Serv-

1 ices that seeks to reduce the number of new HIV infec-
2 tions in the United States by 75 percent by 2025, and
3 then by at least 90 percent by 2030, for an estimated
4 250,000 total HIV infections averted.”.

5 **Subtitle F—Diabetes**

6 **SEC. 771. RESEARCH, TREATMENT, AND EDUCATION.**

7 Subpart 3 of part C of title IV of the Public Health
8 Service Act (42 U.S.C. 285c et seq.) is amended by adding
9 at the end the following new section:

10 **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

11 “(a) IN GENERAL.—The Director of NIH shall ex-
12 pand, intensify, and support ongoing research and other
13 activities with respect to prediabetes and diabetes, particu-
14 larly type 2, in minority populations.

15 “(b) RESEARCH.—

16 “(1) DESCRIPTION.—Research under subsection
17 (a) shall include investigation into—

18 “(A) the causes of diabetes, including so-
19 cioeconomic, geographic, clinical, environmental,
20 genetic, and other factors that may contribute
21 to increased rates of diabetes in minority popu-
22 lations; and

23 “(B) the causes of increased incidence of
24 diabetes complications in minority populations,

1 and possible interventions to decrease such inci-
2 dence.

3 “(2) INCLUSION OF MINORITY PARTICIPANTS.—

4 In conducting and supporting research described in
5 subsection (a), the Director of NIH shall seek to in-
6 clude minority participants as study subjects in clin-
7 ical trials.

8 “(c) REPORT; COMPREHENSIVE PLAN.—

9 “(1) IN GENERAL.—The Diabetes Mellitus
10 Interagency Coordinating Committee shall—

11 “(A) prepare and submit to the Congress,
12 not later than 6 months after the date of enact-
13 ment of this section, a report on Federal re-
14 search and public health activities with respect
15 to prediabetes and diabetes in minority popu-
16 lations; and

17 “(B) develop and submit to Congress, not
18 later than 1 year after the date of enactment of
19 this section, an effective and comprehensive
20 Federal plan (including all appropriate Federal
21 health programs) to address prediabetes and di-
22 abetes in minority populations.

23 “(2) CONTENTS.—The report under paragraph
24 (1)(A) shall at minimum address each of the fol-
25 lowing:

1 “(A) Research on diabetes and prediabetes
2 in minority populations, including such research
3 on—

4 “(i) genetic, behavioral, and environ-
5 mental factors; and

6 “(ii) prevention and complications
7 among individuals within these populations
8 who have already developed diabetes.

9 “(B) Surveillance and data collection on
10 diabetes and prediabetes in minority popu-
11 lations, including with respect to—

12 “(i) efforts to better determine the
13 prevalence of diabetes among Asian-Amer-
14 ican and Pacific Islander subgroups; and

15 “(ii) efforts to coordinate data collec-
16 tion on the American Indian population.

17 “(C) Community-based interventions to ad-
18 dress diabetes and prediabetes targeting minor-
19 ity populations, including—

20 “(i) the evidence base for such inter-
21 ventions;

22 “(ii) the cultural appropriateness of
23 such interventions; and

24 “(iii) efforts to educate the public on
25 the causes and consequences of diabetes.

1 “(D) Education and training programs for
2 health professionals (including community
3 health workers) on the prevention and manage-
4 ment of diabetes and its related complications
5 that is supported by the Health Resources and
6 Services Administration, including such pro-
7 grams supported by—

8 “(i) the National Health Service
9 Corps; or

10 “(ii) the community health centers
11 program under section 330.

12 “(d) EDUCATION.—The Director of NIH shall—

13 “(1) through the National Institute on Minority
14 Health and Health Disparities and the National Di-
15 abetes Education Program—

16 “(A) make grants to programs funded
17 under section 464z-4 for the purpose of estab-
18 lishing a mentoring program for health care
19 professionals to be more involved in weight
20 counseling, obesity research, and nutrition; and

21 “(B) provide for the participation of mi-
22 nority health professionals in diabetes-focused
23 research programs; and

24 “(2) make grants for programs to establish a
25 pipeline from high school to professional school that

1 will increase minority representation in diabetes-fo-
2 cused health fields by expanding Minority Access to
3 Research Careers program internships and men-
4 toring opportunities for recruitment.

5 “(e) DEFINITIONS.—For purposes of this section:

6 “(1) DIABETES MELLITUS INTERAGENCY CO-
7 ORDINATING COMMITTEE.—The ‘Diabetes Mellitus
8 Interagency Coordinating Committee’ means the Di-
9 abetes Mellitus Interagency Coordinating Committee
10 established under section 429.

11 “(2) MINORITY POPULATION.—The term ‘mi-
12 nority population’ means a racial and ethnic minor-
13 ity group, as defined in section 1707.”.

14 **SEC. 772. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

15 Part B of title III of the Public Health Service Act
16 (42 U.S.C. 243 et seq.), as amended by section 721, is
17 further amended by inserting after section 317W the fol-
18 lowing section:

19 **“SEC. 317X. DIABETES IN MINORITY POPULATIONS.**

20 “(a) RESEARCH AND OTHER ACTIVITIES.—

21 “(1) IN GENERAL.—The Secretary, acting
22 through the Director of the Centers for Disease
23 Control and Prevention, shall conduct and support
24 research and public health activities with respect to
25 diabetes in minority populations.

1 “(2) CERTAIN ACTIVITIES.—Activities under
2 paragraph (1) regarding diabetes in minority popu-
3 lations shall include the following:

4 “(A) Further enhancing the National
5 Health and Nutrition Examination Survey by
6 oversampling Asian Americans, Native Hawai-
7 ians, and Pacific Islanders in appropriate geo-
8 graphic areas to better determine the preva-
9 lence of diabetes in such populations as well as
10 to improve the data collection of diabetes pene-
11 tration disaggregated into major ethnic groups
12 within such populations. The Secretary shall en-
13 sure that any such oversampling does not re-
14 duce the oversampling of other minority popu-
15 lations including African-American and Latino
16 populations.

17 “(B) Through the Division of Diabetes
18 Translation—

19 “(i) providing for prevention research
20 to better understand how to influence
21 health care systems changes to improve
22 quality of care being delivered to such popu-
23 lations;

24 “(ii) carrying out model demonstra-
25 tion projects to design, implement, and

1 evaluate effective diabetes prevention and
2 control interventions for minority popu-
3 lations, including culturally appropriate
4 community-based interventions;

5 “(iii) developing and implementing a
6 strategic plan to reduce diabetes in minor-
7 ity populations through applied research to
8 reduce disparities and culturally and lin-
9 guistically appropriate community-based
10 interventions;

11 “(iv) supporting, through the national
12 diabetes prevention program under section
13 399V–3, diabetes prevention program sites
14 in underserved regions highly impacted by
15 diabetes; and

16 “(v) implementing, through the na-
17 tional diabetes prevention program under
18 section 399V–3, a demonstration program
19 developing new metrics measuring health
20 outcomes related to diabetes that can be
21 stratified by specific minority populations.

22 “(b) EDUCATION.—The Secretary, acting through
23 the Director of the Centers for Disease Control and Pre-
24 vention, shall direct the Division of Diabetes Translation
25 to conduct and support both programs to educate the pub-

1 lie on diabetes in minority populations and programs to
2 educate minority populations about the causes and effects
3 of diabetes.

4 “(c) DIABETES; HEALTH PROMOTION, PREVENTION
5 ACTIVITIES, AND ACCESS.—The Secretary, acting through
6 the Director of the Centers for Disease Control and Pre-
7 vention and the National Diabetes Education Program,
8 shall conduct and support programs to educate specific
9 minority populations through culturally appropriate and
10 linguistically appropriate information campaigns about
11 prevention of, and managing, diabetes.

12 “(d) DEFINITION.—For purposes of this section, the
13 term ‘minority population’ means a racial and ethnic mi-
14 nority group, as defined in section 1707.”.

15 **SEC. 773. PROGRAMS TO EDUCATE HEALTH PROVIDERS ON**
16 **THE CAUSES AND EFFECTS OF DIABETES IN**
17 **MINORITY POPULATIONS.**

18 Part P of title III of the Public Health Service Act
19 (42 U.S.C. 280g et seq.), as amended by section 733, is
20 further amended by adding at the end the following new
21 section:

1 **“SEC. 399V-10. PROGRAMS TO EDUCATE HEALTH PRO-**
2 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
3 **ABETES IN MINORITY POPULATIONS.**

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Director of the Health Resources and Services Admin-
6 istration, shall conduct and support programs described
7 in subsection (b) to educate health professionals on the
8 causes and effects of diabetes in minority populations.

9 “(b) PROGRAMS.—Programs described in this sub-
10 section, with respect to education on diabetes in minority
11 populations, shall include the following:

12 “(1) Giving priority, under the primary care
13 training and enhancement program under section
14 747—

15 “(A) to awarding grants to focus on or ad-
16 dress diabetes; and

17 “(B) to adding minority populations to the
18 list of vulnerable populations that should be
19 served by such grants.

20 “(2) Providing additional funds for the Health
21 Careers Opportunity Program, the Centers for Ex-
22 cellence, and the Minority Faculty Fellowship Pro-
23 gram to partner with the Office of Minority Health
24 under section 1707 and the National Institutes of
25 Health to strengthen programs for career opportuni-

1 ties focused on diabetes treatment and care within
 2 underserved regions highly impacted by diabetes.

3 “(3) Developing a diabetes focus within, and
 4 providing additional funds for, the National Health
 5 Service Corps scholarship program—

6 “(A) to place individuals in areas that are
 7 disproportionately affected by diabetes and to
 8 provide diabetes treatment and care in such
 9 areas; and

10 “(B) to provide such individuals continuing
 11 medical education specific to diabetes care.”.

12 **SEC. 774. RESEARCH, EDUCATION, AND OTHER ACTIVITIES**
 13 **REGARDING DIABETES IN AMERICAN INDIAN**
 14 **POPULATIONS.**

15 Part P of title III of the Public Health Service Act
 16 (42 U.S.C. 280g et seq.), as amended by section 773, is
 17 further amended by adding at the end the following sec-
 18 tion:

19 **“SEC. 399V-11. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
 20 **TIES REGARDING DIABETES IN AMERICAN IN-**
 21 **DIAN POPULATIONS.**

22 “In addition to activities under sections 317X, 399V-
 23 10, and 434B, the Secretary, acting through the Indian
 24 Health Service and in collaboration with other appropriate
 25 Federal agencies, shall—

1 “(1) conduct and support research and other
2 activities with respect to diabetes; and

3 “(2) coordinate the collection of data on clini-
4 cally and culturally appropriate diabetes treatment,
5 care, prevention, and services by health care profes-
6 sionals to the American Indian population.”.

7 **SEC. 775. UPDATED REPORT ON HEALTH DISPARITIES.**

8 The Secretary of Health and Human Services shall
9 seek to enter into an arrangement with the National Acad-
10 emy of Medicine under which the National Academy will—

11 (1) not later than 1 year after the date of en-
12 actment of this Act, submit to Congress an updated
13 version of the 2003 report entitled “Unequal Treat-
14 ment: Confronting Racial and Ethnic Disparities in
15 Health Care”; and

16 (2) in such updated version, address how racial
17 and ethnic health disparities have changed since the
18 publication of the original report.

19 **Subtitle G—Lung Disease**

20 **SEC. 776. EXPANSION OF THE NATIONAL ASTHMA EDU-
21 CATION AND PREVENTION PROGRAM.**

22 (a) FINDINGS.—Congress finds as follows:

23 (1) The prevalence of asthma has increased
24 since 1980 and affects more than 26,000,000 people
25 in the United States.

1 (2) Significant disparities in asthma morbidity
2 and mortality exist for both adults and children par-
3 ticularly for low-income and minority populations,
4 particularly African Americans and Puerto Ricans.

5 (3) African-American children are twice as like-
6 ly to have asthma as White children.

7 (4) In 2016, almost 4,500,000 non-Hispanic
8 African Americans reported having asthma. African
9 Americans with asthma are 3 times as likely to visit
10 the emergency department and twice as likely to get
11 hospitalized as White patients with asthma.

12 (5) Puerto Ricans are 3.4 times as likely to die
13 from asthma compared with all other Hispanic or
14 Latino groups. Overall Hispanic Americans are 30
15 percent more likely to be hospitalized for asthma
16 than non-Hispanic Whites.

17 (6) The majority of adults with asthma are
18 women.

19 (b) IN GENERAL.—Not later than 2 years after the
20 date of the enactment of this Act, the Secretary of Health
21 and Human Services shall convene a working group com-
22 prised of patient groups, nonprofit organizations, medical
23 societies, and other relevant governmental and nongovern-
24 mental entities, including those that participate in the Na-

1 tional Asthma Education and Prevention Program, to de-
2 velop a report to Congress that—

3 (1) catalogs, with respect to asthma prevention,
4 management, and surveillance—

5 (A) the activities of the Federal Govern-
6 ment, including identifying all Federal pro-
7 grams that carry out asthma-related activities,
8 as well as assessment of the progress of the
9 Federal Government and States, with respect to
10 achieving the goals of Healthy People 2020;
11 and

12 (B) the activities of other entities that par-
13 ticipate in the program, including nonprofit or-
14 ganizations, patient advocacy groups, and med-
15 ical societies; and

16 (2) makes recommendations for the future di-
17 rection of asthma activities, in consultation with re-
18 searchers from the National Institutes of Health and
19 other member bodies of the National Asthma Edu-
20 cation and Prevention Program who are qualified to
21 review and analyze data and evaluate interventions,
22 including—

23 (A) a description of how the Federal Gov-
24 ernment may better coordinate and improve its

1 response to asthma including identifying any
2 barriers that may exist;

3 (B) a description of how the Federal Gov-
4 ernment may continue, expand, and improve its
5 private-public partnerships with respect to asth-
6 ma including identifying any barriers that may
7 exist;

8 (C) identification of steps that may be
9 taken to reduce the—

10 (i) morbidity, mortality, and overall
11 prevalence of asthma;

12 (ii) financial burden of asthma on so-
13 ciety;

14 (iii) burden of asthma on dispropor-
15 tionately affected areas, particularly those
16 in medically underserved populations (as
17 defined in section 330(b)(3) of the Public
18 Health Service Act (42 U.S.C.
19 254b(b)(3))); and

20 (iv) burden of asthma as a chronic
21 disease;

22 (D) identification of programs and policies
23 that have achieved the steps described in sub-
24 paragraph (C), and steps that may be taken to

1 expand such programs and policies to benefit
2 larger populations; and

3 (E) recommendations for future research
4 and interventions.

5 (c) REPORT TO CONGRESS.—At the end of the 5-year
6 period following the submission of the report under this
7 section, the National Asthma Education and Prevention
8 Program shall evaluate the analyses and recommendations
9 under such report and determine whether a new report
10 to the Congress is necessary, and make appropriate rec-
11 ommendations to the Congress.

12 **SEC. 777. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
13 **FOR DISEASE CONTROL AND PREVENTION.**

14 Section 317I of the Public Health Service Act (42
15 U.S.C. 247b–10) is amended to read as follows:

16 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
17 **FOR DISEASE CONTROL AND PREVENTION.**

18 “(a) PROGRAM FOR PROVIDING INFORMATION AND
19 EDUCATION TO THE PUBLIC.—The Secretary, acting
20 through the Director of the Centers for Disease Control
21 and Prevention, shall collaborate with State and local
22 health departments to conduct activities, including the
23 provision of information and education to the public re-
24 garding asthma including—

1 “(1) deterring the harmful consequences of un-
2 controlled asthma; and

3 “(2) disseminating health education and infor-
4 mation regarding prevention of asthma episodes and
5 strategies for managing asthma.

6 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—

7 The Secretary, acting through the Director of the Centers
8 for Disease Control and Prevention, shall collaborate with
9 State and local health departments to develop State plans
10 incorporating public health responses to reduce the burden
11 of asthma, particularly regarding disproportionately af-
12 fected populations.

13 “(c) COMPILATION OF DATA.—The Secretary, acting
14 through the Director of the Centers for Disease Control
15 and Prevention, shall, in cooperation with State and local
16 public health officials—

17 “(1) conduct asthma surveillance activities to
18 collect data on the prevalence and severity of asth-
19 ma, the effectiveness of public health asthma inter-
20 ventions, and the quality of asthma management, in-
21 cluding—

22 “(A) collection of household data on the
23 local burden of asthma;

24 “(B) surveillance of health care facilities;
25 and

1 “(C) collection of data not containing indi-
2 vidually identifiable information from electronic
3 health records or other electronic communica-
4 tions;

5 “(2) compile and annually publish data regard-
6 ing the prevalence and incidence of childhood asth-
7 ma, the child mortality rate, and the number of hos-
8 pital admissions and emergency department visits by
9 children associated with asthma nationally and in
10 each State and at the county level by age, sex, race,
11 and ethnicity, as well as lifetime and current preva-
12 lence; and

13 “(3) compile and annually publish data regard-
14 ing the prevalence and incidence of adult asthma,
15 the adult mortality rate, and the number of hospital
16 admissions and emergency department visits by
17 adults associated with asthma nationally and in each
18 State and at the county level by age, sex, race, eth-
19 nicity, industry, and occupation, as well as lifetime
20 and current prevalence.

21 “(d) COORDINATION OF DATA COLLECTION.—The
22 Director of the Centers for Disease Control and Preven-
23 tion, in conjunction with State and local health depart-
24 ments, shall coordinate data collection activities under

1 paragraphs (2) and (3) of subsection (c) so as to maximize
2 comparability of results.

3 “(e) COLLABORATION.—The Centers for Disease
4 Control and Prevention are encouraged to collaborate with
5 national, State, and local nonprofit organizations to pro-
6 vide information and education about asthma, and to
7 strengthen such collaborations when possible.

8 “(f) ADDITIONAL FUNDING.—In addition to any
9 other authorization of appropriations that is available to
10 the Centers for Disease Control and Prevention for the
11 purpose of carrying out this section, there are authorized
12 to be appropriated to such Centers such sums as may be
13 necessary for each of fiscal years 2021 through 2025 for
14 the purpose of carrying out this section.”.

15 **SEC. 778. INFLUENZA AND PNEUMONIA VACCINATION CAM-**
16 **PAIGN.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services shall—

19 (1) enhance the annual campaign by the De-
20 partment of Health and Human Services to increase
21 the number of people vaccinated each year for influ-
22 enza and pneumonia; and

23 (2) include in such campaign the use of written
24 educational materials, public service announcements,

1 physician education, and any other means which the
2 Secretary deems effective.

3 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
4 out the annual campaign described in subsection (a), the
5 Secretary of Health and Human Services shall ensure
6 that—

7 (1) educational materials and public service an-
8 nouncements are readily and widely available in
9 communities experiencing disparities in the incidence
10 and mortality rates of influenza and pneumonia; and

11 (2) the campaign uses targeted, culturally ap-
12 propriate messages and messengers to reach under-
13 served communities.

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

18 **SEC. 779. CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

19 **ACTION PLAN.**

20 (a) FINDINGS.—Congress finds as follows:

21 (1) Chronic obstructive pulmonary disease (re-
22 ferred to in this subsection as “COPD”) refers to
23 chronic bronchitis and emphysema, incurable dis-
24 eases that make it difficult to exhale all the air from

1 one's lungs, and that can cause persistent coughing,
2 shortness of breath, and sputum.

3 (2) COPD exacerbations—episodes of acute dif-
4 ficulty breathing and moderate to severe fatigue—
5 are dangerous, and their treatment often requires
6 hospitalization.

7 (3) While smoking is the primary risk factor for
8 COPD, other risk factors include air pollution, occu-
9 pational exposures, heredity, a history of childhood
10 respiratory infections, and socioeconomic status.

11 (4) It is estimated that over 13,500,000 adults
12 in the United States have COPD.

13 (5) COPD is the third-leading cause of death in
14 the United States, claiming over 134,000 lives in
15 2010.

16 (6) Since 2000, deaths for women with COPD
17 have exceeded deaths in men.

18 (7) Although African Americans have a lower
19 prevalence of COPD in the United States, research-
20 ers have shown that African Americans may be
21 underdiagnosed. Furthermore, research has shown
22 that African Americans develop COPD with less cu-
23 mulative smoke exposure and at a younger age.

24 (b) IN GENERAL.—The Director of the Centers for
25 Disease Control and Prevention shall conduct, support,

1 and expand public health strategies, prevention, diagnosis,
2 surveillance, and public and professional awareness activi-
3 ties regarding chronic obstructive pulmonary disease.

4 (c) NATIONAL ACTION PLAN.—

5 (1) DEVELOPMENT.—Not later than 2 years
6 after the date of the enactment of this Act, the Di-
7 rector of the National Heart, Lung, and Blood Insti-
8 tute, in consultation with the Director of the Centers
9 for Disease Control and Prevention, shall develop a
10 national action plan to address chronic obstructive
11 pulmonary disease in the United States with partici-
12 pation from patients, caregivers, health profes-
13 sionals, patient advocacy organizations, researchers,
14 providers, public health professionals, and other
15 stakeholders.

16 (2) CONTENTS.—At a minimum, such plan
17 shall include recommendations for—

18 (A) public health interventions for the pur-
19 pose of implementation of the national plan;

20 (B) biomedical, health services, and public
21 health research on chronic obstructive pul-
22 monary disease; and

23 (C) inclusion of chronic obstructive pul-
24 monary disease in the health data collections of
25 all Federal agencies.

1 (3) CONSIDERATION.—In developing such plan,
2 the Director of the National Heart, Lung, and Blood
3 Institute shall consider the recommendations and
4 findings of the National Academy of Medicine in the
5 report entitled “A Nationwide Framework for Sur-
6 veillance of Cardiovascular and Chronic Lung Dis-
7 eases” (July 22, 2011).

8 (d) CHRONIC DISEASE PREVENTION PROGRAMS.—
9 The Director of the National Heart, Lung, and Blood In-
10 stitute shall carry out the following:

11 (1) Conduct public education and awareness ac-
12 tivities with patient and professional organizations
13 to stimulate earlier diagnosis and improve patient
14 outcomes from treatment of chronic obstructive pul-
15 monary disease. To the extent known and relevant,
16 such public education and awareness activities shall
17 reflect differences in chronic obstructive pulmonary
18 disease by cause (tobacco, environmental, occupa-
19 tional, biological, and genetic) and include a focus
20 on outreach to undiagnosed and, as appropriate, mi-
21 nority populations.

22 (2) Supplement and expand upon the activities
23 of the National Heart, Lung, and Blood Institute by
24 making grants to nonprofit organizations, State and
25 local jurisdictions, and Indian tribes for the purpose

1 of reducing the burden of chronic obstructive pul-
2 monary disease, especially in disproportionately im-
3 pacted communities, through public health interven-
4 tions and related activities.

5 (3) Coordinate with the Centers for Disease
6 Control and Prevention, the Indian Health Service,
7 the Health Resources and Services Administration,
8 and the Department of Veterans Affairs to develop
9 pilot programs to demonstrate best practices for the
10 diagnosis and management of chronic obstructive
11 pulmonary disease.

12 (4) Develop improved techniques and identify
13 best practices, in coordination with the Secretary of
14 Veterans Affairs, for assisting chronic obstructive
15 pulmonary disease patients to successfully stop
16 smoking, including identification of subpopulations
17 with different needs. Initiatives under this para-
18 graph may include research to determine whether
19 successful smoking cessation strategies are different
20 for chronic obstructive pulmonary disease patients
21 compared to such strategies for patients with other
22 chronic diseases.

23 (e) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
24 PROGRAMS.—The Director of the Centers for Disease
25 Control and Prevention shall—

1 (1) support research into the environmental and
2 occupational causes and biological mechanisms that
3 contribute to chronic obstructive pulmonary disease;
4 and

5 (2) develop and disseminate public health inter-
6 ventions that will lessen the impact of environmental
7 and occupational causes of chronic obstructive pul-
8 monary disease.

9 (f) DATA COLLECTION.—Not later than 180 days
10 after the enactment of this Act, the Director of the Na-
11 tional Heart, Lung, and Blood Institute and the Director
12 of the Centers for Disease Control and Prevention, acting
13 jointly, shall assess the depth and quality of information
14 on chronic obstructive pulmonary disease that is collected
15 in surveys and population studies conducted by the Cen-
16 ters for Disease Control and Prevention, including wheth-
17 er there are additional opportunities for information to be
18 collected in the National Health and Nutrition Examina-
19 tion Survey, the National Health Interview Survey, and
20 the Behavioral Risk Factors Surveillance System surveys.
21 The Director of the National Heart, Lung, and Blood In-
22 stitute shall include the results of such assessment in the
23 national action plan under subsection (c).

24 (g) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section

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

3 **Subtitle H—Tuberculosis**

4 **SEC. 781. ELIMINATION OF ALL FORMS OF TUBERCULOSIS.**

5 (a) SHORT TITLE.—This subtitle may be cited as the
6 “End Tuberculosis Act”.

7 (b) FINDINGS.—Congress makes the following find-
8 ings:

9 (1) In the United States, 9,025 people were di-
10 agnosed with tuberculosis (referred to in this section
11 as “TB”) in 2018.

12 (2) Disparities in TB exist and significantly im-
13 pact minority communities in the United States. The
14 Centers for Disease Control and Prevention (re-
15 ferred to in this section as “CDC”) finds that 70
16 percent of people diagnosed with TB in 2018 self-
17 identified as racial and ethnic minorities.

18 (3) African Americans comprised 20 percent of
19 people diagnosed with TB during 2018. The popu-
20 lation-adjusted rate of TB among African Americans
21 is 1.7 times higher than the national total, and 8.0
22 times higher than among Whites.

23 (4) Asian Americans, Native Hawaiians, and
24 other Pacific Islanders comprised 37 percent of peo-
25 ple diagnosed with TB during 2018. The population-

1 adjusted rate of TB among Asian Americans is 6.2
2 times higher than the national total, and 31 times
3 higher than among Whites. The population-adjusted
4 rate of TB among Native Hawaiians and other Pa-
5 cific Islanders is 4.8 times higher than the national
6 total, and 23.2 times higher than among Whites.

7 (5) Hispanics and Latinos comprised 26 per-
8 cent of people diagnosed with TB during 2018. The
9 population-adjusted rate of TB among Hispanics
10 and Latinos is 1.6 times higher than the national
11 total, and 8.0 times higher than among Whites.

12 (6) TB is both preventable and curable, but the
13 current rate of decline of TB in the United States
14 remains too slow to achieve TB elimination in this
15 century.

16 (7) TB is transmitted through the air when a
17 person who has TB disease in their lungs coughs or
18 sneezes. People who are in close proximity to the
19 person with TB can breathe in the TB bacteria, and
20 the bacteria will initially settle in their lungs. With-
21 out proper and timely diagnosis and access to treat-
22 ment, the TB bacteria may grow and spread to
23 other parts of their body.

24 (8) As many as 13,000,000 people in the
25 United States may have latent TB Infection (re-

1 ferred to in this section as “LTBI”). People with
2 LTBI have TB bacteria in their bodies, but their
3 immune system is containing the bacteria, and they
4 are not sick, nor do they have any current risk of
5 spreading TB to others. LTBI can activate into in-
6 fectious, life-threatening TB if not treated. Modeling
7 has shown that eliminating TB is not possible with-
8 out addressing LTBI.

9 (9) Comorbidities associated with TB include
10 cancer, diabetes mellitus, and HIV. People with
11 these medical conditions and compromised immune
12 systems are more likely to develop active TB disease
13 and to have worse outcomes from TB.

14 (10) Forms of active TB that do not show drug
15 resistance are classified as drug-susceptible TB (re-
16 ferred to in this section as “DS-TB”). Drug-resist-
17 ant TB (referred to in this section as “DR-TB”) is
18 a rising threat to the public health of the United
19 States. DR-TB that exhibits resistance to two or
20 more first-line drugs is referred to as multi-drug re-
21 sistant TB (referred to in this section as “MDR-
22 TB”). MDR-TB that also is resistant to at least
23 one injectable second-line medication and at least
24 one fluoroquinolone is classified as extensively drug-

1 resistant TB (referred to in this section as “XDR-
2 TB”).

3 (11) Approximately 97 people in the United
4 States were diagnosed with MDR-TB in 2018. One
5 person was diagnosed with XDR-TB in the same
6 year.

7 (12) In the United States, \$480,000,000 was
8 spent in 2018 to treat TB; direct treatment costs
9 average \$19,000 to treat a patient with DS-TB,
10 \$175,000 to treat a patient with MDR-TB, and
11 \$544,000 to treat a patient with XDR-TB. When
12 factoring in productivity losses during treatment,
13 DS-TB averages \$46,000, MDR-TB averages
14 \$294,000 and XDR-TB averages \$694,000. Treat-
15 ment is often difficult, with daily complex multi-pill
16 regimens and injections, with side-effects ranging
17 from hearing and vision loss to mental health issues.

18 (13) Recognizing the public health, economic
19 and societal costs to the threat of MDR-TB, the
20 National Action Plan to Combat MDR-TB was de-
21 veloped by the White House to provide the United
22 States with a comprehensive three-pronged strategy
23 to address MDR-TB by strengthening domestic ca-
24 pacity to combat MDR-TB; improve international
25 capacity and cooperation to combat MDR-TB; accel-

1 erate basic and applied research and development
2 for new therapies, diagnostics and prevention strate-
3 gies to combat MDR-TB.

4 (14) Additional Federal support is necessary to
5 expand TB control efforts in case finding and treat-
6 ment to address LTBI in a national prevention ini-
7 tiative. Key policy and research breakthroughs in-
8 crease the success of a TB prevention initiative: the
9 U.S. Preventative Services Task Force recommenda-
10 tion’s “B” rating, screening for LTBI among high-
11 risk adults as a covered service increases the likeli-
12 hood that impacted racial and ethnic minority
13 groups can get tested for TB; a new, shorter course
14 treatment regimen reduces the length of treatment
15 for LTBI from every day for 6 to 9 months to one
16 dose per week for 12 weeks, increasing likelihood of
17 treatment completion; and the use of blood-based di-
18 agnostic tests, Interferon-gamma release assays or
19 IGRAs, increases ability to detect LTBI among pa-
20 tients in affected communities.

21 (15) The right to health, and the right to
22 science as a necessary human right to help achieve
23 the right to health, is enshrined in Articles 25 and
24 27 of the Universal Declaration of Human Rights.
25 These fundamental human rights cannot be achieved

1 when anyone lacks access to TB prevention or treat-
2 ment, and when the benefits of scientific innovation
3 are not extended to people with all forms of TB.

4 **SEC. 782. ADDITIONAL FUNDING FOR STATES IN COM-**
5 **BATING AND ELIMINATING TUBERCULOSIS.**

6 Section 317E(h) of the Public Health Act (42 U.S.C.
7 247b–6(h)) is amended by adding at the end the following:

8 “(3) ADDITIONAL FUNDING FOR STATES IN
9 COMBATING AND ELIMINATING TUBERCULOSIS.—In
10 addition to amounts otherwise authorized to be ap-
11 propriated to carry out this section, there are au-
12 thorized to be appropriated such sums as may be
13 necessary to carry out this section for each of fiscal
14 years 2020 through 2021.”.

15 **SEC. 783. STRENGTHENING CLINICAL RESEARCH FUNDING**
16 **FOR TUBERCULOSIS.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services shall expand and intensify support for
19 current and prospective research activities of the National
20 Institutes of Health, the Biomedical Advanced Research
21 and Development Authority, and the Centers for Disease
22 Control and Prevention Division of Tuberculosis Elimini-
23 nation to develop new therapeutics, diagnostics, vaccines,
24 and other prevention modalities in addressing all forms
25 of tuberculosis (referred to in this section as “TB”).

1 (b) INCLUDED RESEARCH ACTIVITIES.—Research
2 activities under subsection (a) shall include—

3 (1) research and development, and pathways to
4 approval, for novel, safe drugs and drug regimens
5 for the treatment of TB, including in adolescent and
6 pediatric populations and in pregnant and lactating
7 women;

8 (2) research to develop rapid diagnostic tests
9 for all forms of TB, including diagnostics that can
10 be used for pediatric populations and people living
11 with HIV, diagnostics that can detect extra pul-
12 monary TB and drug resistance, and diagnostics
13 that can be used at the point of care;

14 (3) research to advance basic knowledge of the
15 pathogenesis of TB and its major comorbidities, in-
16 cluding HIV and diabetes mellitus;

17 (4) research to improve knowledge and under-
18 standings of the role of latency in TB and the fac-
19 tors that increase the risk of latent TB infection
20 progressing to active, symptomatic TB disease;

21 (5) awarding grants and contracts to specifi-
22 cally develop new and needed vaccines to address
23 TB;

24 (6) awarding grants and contracts to support
25 the training and development of clinical researchers

1 whose research improves the landscape of tools to
2 combat TB; and

3 (7) awarding grants and contracts to support
4 capacity-building and develop clinical trial site infra-
5 structure in the United States and in TB endemic
6 countries to support the aforementioned research ac-
7 tivities.

8 **Subtitle I—Osteoarthritis and** 9 **Musculoskeletal Diseases**

10 **SEC. 785. FINDINGS.**

11 Congress finds as follows:

12 (1) Eighty percent of African-American women
13 and nearly 74 percent of Hispanic men are either
14 overweight or obese, speeding the onset and progres-
15 sion of arthritis.

16 (2) Arthritis affects 46,000,000 people in the
17 United States, and that number will rise to
18 67,000,000 by the year 2030.

19 (3) Twenty-seven million people in the United
20 States suffer from osteoarthritis, the most common
21 form of arthritis, making it the leading cause of dis-
22 ability in the United States. Osteoarthritis is some-
23 times referred to as degenerative joint disease.

24 (4) Obesity accelerates the onset of arthritis: 70
25 percent of obese adults with mild osteoarthritis of

1 the knee at age 60 will develop advanced end-stage
2 disease by age 80. In contrast, just 43 percent of
3 non-obese adults will have end-stage disease over the
4 same time period.

5 (5) Arthritis affects 1 in 5 people in the United
6 States and is the single greatest cause of chronic
7 pain and disability in the United States.

8 (6) Women, African Americans, and Hispanics
9 have more severe arthritis and functional limitations.
10 These same individuals are more likely to be obese,
11 diabetic, and have higher incidence of heart dis-
12 ease—medical conditions that can be improved with
13 physical activity. Instead of moving, however, these
14 groups have an inactivity rate of 40 to 50 percent,
15 which continues to increase.

16 (7) Arthritis costs \$128,000,000,000 a year, in-
17 cluding \$81,000,000,000 in direct costs (medical)
18 and \$47,000,000,000 in indirect costs (lost earn-
19 ings). Each year, \$309,000,000,000 in direct and in-
20 direct costs is lost due to disparities in osteoarthritis
21 and musculoskeletal diseases.

22 (8) Obesity and other chronic health conditions
23 exacerbate the debilitating impact of arthritis, lead-
24 ing to inactivity, loss of independence, and a per-
25 petual cycle of comorbid chronic conditions.

1 (9) Sixty-one percent of arthritis sufferers are
2 women, and women represent 64 percent of an esti-
3 mated 43,000,000 annual visits to physicians' offices
4 and outpatient clinics where arthritis was the pri-
5 mary diagnosis. Women also represented 60 percent
6 of approximately 1,000,000 hospitalizations that oc-
7 curred in 2003 for which arthritis was the primary
8 diagnosis.

9 (10) Women ages 65 and older have up to 2½
10 times more disabilities than men of the same age.
11 Higher rates of obesity and arthritis among this
12 group explained up to 48 percent of the gender gap
13 in disability, above all other common chronic health
14 conditions.

15 (11) The primary indication for total knee
16 arthroplasty (referred to in this section as "TKA"),
17 also known as knee replacement, is relief of signifi-
18 cant, disabling pain caused by severe arthritis.

19 (12) Knee replacement is surgery for people
20 with severe knee damage. Knee replacement can re-
21 lieve pain and allow an individual to be more active.
22 The process for a total knee replacement involves
23 the surgeon removing damaged cartilage and bone
24 from the surface of the knee joint and replacing the
25 cartilage and bone with a man-made surface of

1 metal and plastic. In a partial knee replacement, the
2 surgeon only replaces part of the knee joint.

3 (13) Total hip replacement, also called total hip
4 arthroplasty (referred to in this section as “THA”),
5 is used if hip pain interferes with daily activities and
6 more conservative treatments have not helped. Ar-
7 thritis damage is the most common reason to need
8 hip replacement.

9 (14) The odds of a family practice physician
10 recommending TKA to a male patient with moderate
11 arthritis are twice that of a female patient, while the
12 odds of an orthopaedic surgeon recommending TKA
13 to a male patient with moderate arthritis are 22
14 times that of a female patient.

15 (15) African Americans with doctor-diagnosed
16 arthritis have a higher prevalence of severe pain at-
17 tributable to arthritis, compared with Whites (34.0
18 percent versus 22.6 percent). African Americans,
19 compared to Whites, report a higher proportion of
20 work limitations (39.5 percent versus 28.0 percent)
21 and a higher prevalence of arthritis-attributable
22 work limitation (6.6 percent versus 4.6 percent).

23 (16) Hispanics are 50 percent more likely than
24 non-Hispanic Whites to report needing assistance

1 with at least one instrumental activity of daily living
2 and to have difficulty walking.

3 (17) African Americans and Hispanics were 1.3
4 times more likely to have activity limitation, 1.6
5 times more likely to have work limitations, and 1.9
6 times more likely to have severe joint pain than
7 Whites.

8 (18) In 2003, the National Academy of Medi-
9 cine reported that the rates of TKA and THA
10 among African-American and Hispanic patients are
11 significantly lower than for Whites—even for those
12 with equitable health care coverage such as through
13 Medicare or the Department of Veterans Affairs.

14 (19) According to the Centers for Disease Con-
15 trol and Prevention, in 2000, African-American
16 Medicare enrollees were 37 percent less likely than
17 White Medicare enrollees to undergo total knee re-
18 placements. In 2006, the disparity increased to 39
19 percent.

20 (20) Even after adjusting for insurance and
21 health access, Hispanics and African Americans are
22 almost 50 percent less likely to undergo total knee
23 replacement than Whites.

1 **SEC. 786. OSTEOARTHRITIS AND OTHER MUSCULO-**
2 **SKELETAL HEALTH-RELATED ACTIVITIES OF**
3 **THE CENTERS FOR DISEASE CONTROL AND**
4 **PREVENTION.**

5 (a) EDUCATION AND AWARENESS ACTIVITIES.—The
6 Secretary of Health and Human Services, acting through
7 the Director of the Centers for Disease Control and Pre-
8 vention, shall direct the National Center for Chronic Dis-
9 ease Prevention and Health Promotion to conduct and ex-
10 pand the Health Community Program and Arthritis Pro-
11 gram to educate the public on—

12 (1) the causes of, preventive health actions for,
13 and effects of arthritis and other musculoskeletal
14 conditions in minority patient populations; and

15 (2) the effects of such conditions on other
16 comorbidities including obesity, hypertension, and
17 cardiovascular disease.

18 (b) PROGRAMS ON ARTHRITIS AND MUSCULO-
19 SKELETAL CONDITIONS.—Education and awareness pro-
20 grams of the Centers for Disease Control and Prevention
21 on arthritis and other musculoskeletal conditions in minor-
22 ity communities shall—

23 (1) be culturally and linguistically appropriate
24 to minority patients, targeting musculoskeletal
25 health promotion and prevention programs of each
26 major ethnic group, including—

- 1 (A) Native Americans and Alaska Natives;
2 (B) Asian Americans;
3 (C) African Americans and Blacks;
4 (D) Hispanic and Latino Americans; and
5 (E) Native Hawaiians and Pacific Island-
6 ers; and

7 (2) include public awareness campaigns directed
8 toward these patient populations that emphasize the
9 importance of musculoskeletal health, physical activ-
10 ity, diet and healthy lifestyle, and weight reduction
11 for overweight and obese patients.

12 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there are authorized to be appropriated
14 such sums as are necessary for fiscal year 2021 and each
15 subsequent fiscal year.

16 **SEC. 787. GRANTS FOR COMPREHENSIVE OSTEOARTHRITIS**
17 **AND MUSCULOSKELETAL DISEASE HEALTH**
18 **EDUCATION WITHIN HEALTH PROFESSIONS**
19 **SCHOOLS.**

20 (a) PROGRAM AUTHORIZED.—The Secretary of
21 Health and Human Services (in this section referred to
22 as the “Secretary”), in coordination with the Secretary of
23 Education, shall award grants, on a competitive basis, to
24 academic health science centers, health professions
25 schools, and institutions of higher education to enable

1 such centers, schools, and institutions to provide people
2 with comprehensive education on arthritis and musculo-
3 skeletal health, particularly—

4 (1) obesity-related musculoskeletal diseases;

5 (2) arthritis and osteoarthritis;

6 (3) arthritis and musculoskeletal health dispari-
7 ties; and

8 (4) the relationship between arthritis and mus-
9 culoskeletal diseases and metabolic activity, psycho-
10 logical health, and comorbidities such as diabetes,
11 cardiovascular disease, and hypertension.

12 (b) DURATION.—Grants awarded under this section
13 shall be for a period of 5 years.

14 (c) APPLICATIONS.—An academic health science cen-
15 ter, health professions school, or institution of higher edu-
16 cation seeking a grant under this section shall submit an
17 application to the Secretary at such time, in such manner,
18 and containing such information as the Secretary may re-
19 quire.

20 (d) PRIORITY.—In awarding grants under this sec-
21 tion, the Secretary shall give priority to an institution of
22 higher education that—

23 (1) has an enrollment of needy students, as de-
24 fined in section 318(b) of the Higher Education Act
25 of 1965 (20 U.S.C. 1059e(b));

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

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

5 (4) is an Alaska Native-serving institution, as
6 defined in section 317(b) of such Act (20 U.S.C.
7 1059d(b));

8 (5) is a Native Hawaiian-serving institution, as
9 defined in section 317(b) of such Act (20 U.S.C.
10 1059d(b));

11 (6) is a Predominately Black Institution, as de-
12 fined in section 318(b) of such Act (20 U.S.C.
13 1059e(b));

14 (7) is a Native American-serving, non-Tribal in-
15 stitution, as defined in section 319(b) of such Act
16 (20 U.S.C. 1059f(b));

17 (8) is an Asian American and Native American
18 Pacific Islander-serving institution, as defined in
19 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

20 (9) is a minority institution, as defined in sec-
21 tion 365 of such Act (20 U.S.C. 1067k), with an en-
22 rollment of needy students, as defined in section 312
23 of such Act (20 U.S.C. 1058).

24 (e) USES OF FUNDS.—An academic health science
25 center, health professions school, or institution of higher

1 education receiving a grant under this section may use
2 grant funds to integrate issues relating to comprehensive
3 arthritis and musculoskeletal health into the academic or
4 support sectors of the center, school, or institution in
5 order to reach a large number of students, by carrying
6 out 1 or more of the following activities:

7 (1) Developing educational content for issues
8 relating to comprehensive arthritis and musculo-
9 skeletal health education that will be incorporated
10 into first-year orientation or core courses.

11 (2) Creating innovative technology-based ap-
12 proaches to deliver arthritis and musculoskeletal
13 health education to students, faculty, and staff.

14 (3) Developing and employing peer-outreach
15 and education programs to generate discussion, edu-
16 cate, and raise awareness among students about
17 issues relating to arthritis and musculoskeletal
18 health disorders, and their relationship to diabetes,
19 hypertension, cardiovascular disease, psychological
20 health, and other comorbid conditions.

21 (f) REPORT TO CONGRESS.—

22 (1) IN GENERAL.—Not later than 1 year after
23 the date of the enactment of this Act, and annually
24 thereafter for a period of 5 years, the Secretary shall
25 prepare and submit to the appropriate committees of

1 Congress a report on the activities to provide health
 2 professions students with comprehensive arthritis
 3 and musculoskeletal health education funded under
 4 this section.

5 (2) REPORT ELEMENTS.—The report described
 6 in paragraph (1) shall include information about—

7 (A) the number of entities that are receiv-
 8 ing grant funds;

9 (B) the specific activities supported by
 10 grant funds;

11 (C) the number of students served by
 12 grant programs; and

13 (D) the status of program evaluations.

14 (g) DEFINITION OF INSTITUTION OF HIGHER EDU-
 15 CATION.—In this section, the term “institution of higher
 16 education” has the meaning given such term in section
 17 101(b) of the Higher Education Act of 1965 (20 U.S.C.
 18 1001(b)).

19 **Subtitle J—Sleep and Circadian** 20 **Rhythm Disorders**

21 **SEC. 791. SHORT TITLE; FINDINGS.**

22 (a) SHORT TITLE.—This subtitle may be cited as the
 23 “Sleep and Circadian Rhythm Disorders Health Dispari-
 24 ties Act”.

25 (b) FINDINGS.—Congress finds the following:

1 (1) Decrements in sleep health such as sleep
2 apnea, insufficient sleep time, and insomnia, affect
3 50,000,000 to 70,000,000 adults in the United
4 States. Twelve to eighteen million United States
5 adults have sleep apnea, a chronic disorder charac-
6 terized by one or more pauses in breathing which
7 can last from a few seconds to minutes. They may
8 occur 30 times or more an hour, disrupting sleep
9 and resulting in excessive daytime sleepiness and
10 loss in productivity.

11 (2) Seventy percent of high school students are
12 not getting enough sleep on school nights, while 33
13 percent of people in the United States get fewer
14 than 7 hours of sleep per night, and roughly 6,000
15 fatal motor vehicle crashes are caused by drowsy
16 drivers.

17 (3) Insufficient sleep and insomnia are more
18 prevalent in women. Women who are pregnant and
19 have sleep apnea are at an increased risk of cardio-
20 vascular complications during pregnancy. The im-
21 pact of disparities in sleep health is associated with
22 a growing number of health problems, including the
23 following:

24 (A) Hypertension.

25 (B) Cancer.

- 1 (C) Stroke.
- 2 (D) Cardiac arrhythmia.
- 3 (E) Chronic heart failure and heart dis-
4 ease.
- 5 (F) Diabetes.
- 6 (G) Cognitive functioning and behavior.
- 7 (H) Depression and bipolar disorder.
- 8 (I) Substance abuse.

9 (4) A sleep disparity exists in that poor sleep
10 quality is strongly associated with poverty and race.
11 Factors such as employment, education, and health
12 status, amongst others, significantly mediated this
13 effect only in poor subjects, suggesting a differential
14 vulnerability to these factors in poor relative to
15 nonpoor individuals in the context of sleep quality.

16 (5) African Americans sleep worse than Cauca-
17 sian Americans. African Americans take longer to
18 fall asleep, report poorer sleep quality, have more
19 light and less deep sleep, and nap more often and
20 longer.

21 (6) African Americans and individuals in lower
22 socioeconomic status groups may be at an increased
23 risk for sleep disturbances and associated health
24 consequences.

1 (7) Among young African Americans, the likeli-
2 hood of having sleep disordered breathing and exhib-
3 iting risk factors for poor sleep is twice that in
4 young Caucasians. Frequent snoring is more com-
5 mon among African-American and Hispanic women
6 and Hispanic men compared to non-Hispanic Cauca-
7 sians, independent of other factors including obesity.

8 (8) African Americans with sleep-disordered
9 breathing develop symptoms at a younger age than
10 Caucasians but appear less likely to be diagnosed
11 and treated in a timely manner. This delay may at
12 least in part be due to reduced access to care.

13 (9) Sleep loss contributes to increased risk for
14 chronic conditions such as obesity, diabetes, and hy-
15 pertension, all of which have increased prevalence in
16 underserved, underrepresented minorities. Racial
17 and ethnic disparities related to obesity may also
18 contribute to disparities in health outcomes related
19 to sleep-disordered breathing.

20 (10) Non-Caucasian adults report an insomnia
21 rate of 12.9 percent compared to only 6.6 percent
22 for Caucasians.

23 (11) African-American women have a higher in-
24 cidence of insomnia than African-American men,

1 perhaps related in part to higher risk for chronic
2 persisting symptoms.

3 **SEC. 792. SLEEP AND CIRCADIAN RHYTHM DISORDERS RE-**
4 **SEARCH ACTIVITIES OF THE NATIONAL IN-**
5 **STITUTES OF HEALTH.**

6 (a) IN GENERAL.—The Director of the National In-
7 stitutes of Health, acting through the Director of the Na-
8 tional Heart, Lung, and Blood Institute, shall—

9 (1) continue to expand research activities ad-
10 dressing sleep health disparities; and

11 (2) continue implementation of the NIH Sleep
12 Disorders Research Plan across all institutes and
13 centers of the National Institutes of Health to im-
14 prove treatment and prevention of sleep health dis-
15 parities.

16 (b) REQUIRED RESEARCH ACTIVITIES.—In con-
17 ducting or supporting research relating to sleep and circa-
18 dian rhythm, the Director of the National Heart, Lung,
19 and Blood Institute shall—

20 (1) advance epidemiology and clinical research
21 to achieve a more complete understanding of dispari-
22 ties in domains of sleep health and across population
23 subgroups for which cardiovascular and metabolic
24 health disparities exist, including—

25 (A) prevalence and severity of sleep apnea;

1 (B) habitual sleep duration;

2 (C) sleep timing and regularity; and

3 (D) insomnia;

4 (2) develop study designs and analytical ap-
5 proaches to explain and predict multilevel and life-
6 course determinants of sleep health and to elucidate
7 the sleep-related causes of cardiovascular and meta-
8 bolic health disparities across the age spectrum, in-
9 cluding such determinants and causes that are—

10 (A) environmental;

11 (B) biological or genetic;

12 (C) psychosocial;

13 (D) societal;

14 (E) political; or

15 (F) economic;

16 (3) determine the contribution of sleep impair-
17 ments such as sleep apnea, insufficient sleep dura-
18 tion, irregular sleep schedules, and insomnia to un-
19 explained disparities in cardiovascular and metabolic
20 risk and disease outcomes;

21 (4) develop study designs, data sampling and
22 collection tools, and analytical approaches to opti-
23 mize understanding of mediating and moderating
24 factors, and feedback mechanisms coupling sleep to
25 cardiovascular and metabolic health disparities;

1 (5) advance research to understand cultural
2 and linguistic barriers (on the person, provider, or
3 system level) to access to care, medical diagnosis,
4 and treatment of sleep disorders in diverse popu-
5 lation groups;

6 (6) develop and test multilevel interventions (in-
7 cluding sleep health education in diverse commu-
8 nities) to reduce disparities in sleep health that will
9 impact ability to improve disparities in cardio-
10 vascular and metabolic risk or disease;

11 (7) create opportunities to integrate sleep and
12 health disparity science by strategically utilizing re-
13 sources (existing or anticipated cohorts), exchanging
14 scientific data and ideas (cross-over into scientific
15 meetings), and develop multidisciplinary investi-
16 gator-initiated grant applications; and

17 (8) enhance the diversity and foster career de-
18 velopment of young investigators involved in sleep
19 and health disparities science.

20 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
21 out this section, there are authorized to be appropriated
22 such sums as may be necessary for fiscal year 2021 and
23 each subsequent fiscal year.

1 **SEC. 793. SLEEP AND CIRCADIAN RHYTHM HEALTH DIS-**
2 **PARITIES-RELATED ACTIVITIES OF THE CEN-**
3 **TERS FOR DISEASE CONTROL AND PREVEN-**
4 **TION.**

5 (a) IN GENERAL.—The Director of the Centers for
6 Disease Control and Prevention shall conduct, support,
7 and expand public health strategies and prevention, diag-
8 nosis, surveillance, and public and professional awareness
9 activities regarding sleep and circadian rhythm disorders.

10 (b) FINDINGS.—Congress finds as follows:

11 (1) Sleep disorders and sleep deficiency unre-
12 lated to a primary sleep disorder are underdiagnosed
13 and are increasingly detrimental to health status.

14 (2) The consequences to society include addi-
15 tional diseases, motor vehicle accidents, decreased
16 longevity, elevated direct medical costs, and indirect
17 costs related to work absenteeism and property dam-
18 age.

19 (c) REQUIRED SURVEILLANCE AND EDUCATION
20 AWARENESS ACTIVITIES.—In conducting or supporting
21 research relating to sleep and circadian rhythm disorders
22 surveillance and education awareness activities, the Direc-
23 tor of the Centers for Disease Control and Prevention
24 shall—

25 (1) ensure that such activities are culturally
26 and linguistically appropriate to minority patients,

1 targeting sleep and circadian rhythm health pro-
2 motion and prevention programs of each major eth-
3 nic group, including—

4 (A) Native Americans and Alaska Natives;

5 (B) Asian Americans;

6 (C) African Americans and Blacks;

7 (D) Hispanic and Latino-Americans; and

8 (E) Native Hawaiians and Pacific Island-
9 ers;

10 (2) collect and compile national and State sur-
11 veillance data on sleep disorders health disparities;

12 (3) continue to develop and implement new
13 sleep questions in public health surveillance systems
14 to increase public awareness of sleep health and
15 sleep disorders and their impact on health;

16 (4) publish monthly reports highlighting geo-
17 graphic, racial, and ethnic disparities in sleep health,
18 as well as relationships between insufficient sleep
19 and chronic disease, health risk behaviors, and other
20 outcomes as determined necessary by the Director;
21 and

22 (5) include public awareness campaigns that in-
23 form patient populations from major ethnic groups
24 about the prevalence of sleep and circadian rhythm

1 disorders and emphasize the importance of sleep
2 health.

3 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there are authorized to be appropriated
5 such sums as may be necessary for fiscal year 2021 and
6 each subsequent fiscal year.

7 **SEC. 794. GRANTS FOR COMPREHENSIVE SLEEP AND CIR-**
8 **CADIAN HEALTH EDUCATION WITHIN**
9 **HEALTH PROFESSIONS SCHOOLS.**

10 (a) PROGRAM AUTHORIZED.—The Secretary of
11 Health and Human Services (referred to in this section
12 as the “Secretary”), in coordination with the Secretary of
13 Education, shall award grants, on a competitive basis, to
14 academic health science centers, health professions
15 schools, and institutions of higher education to enable
16 such centers, schools, and institutions to provide people
17 with comprehensive education on sleep and circadian
18 health, particularly—

19 (1) poor sleep health;

20 (2) sleep disorders;

21 (3) sleep health disparities; and

22 (4) the relationship between sleep and circadian
23 health on metabolic activity, neurological activity,
24 comorbidities, and other diseases.

1 (b) DURATION.—Grants awarded under this section
2 shall be for a period of 5 years.

3 (c) APPLICATIONS.—An academic health science cen-
4 ter, health professions school, or institution of higher edu-
5 cation seeking a grant under this section shall submit an
6 application to the Secretary at such time, in such manner,
7 and containing such information as the Secretary may re-
8 quire.

9 (d) PRIORITY.—In awarding grants under this sec-
10 tion, the Secretary shall give priority to an institution of
11 higher education that—

12 (1) has an enrollment of needy students, as de-
13 fined in section 318(b) of the Higher Education Act
14 of 1965 (20 U.S.C. 1059e(b));

15 (2) is a Hispanic-serving institution, as defined
16 in section 502(a) of such Act (20 U.S.C. 1101a(a));

17 (3) is a Tribal College or University, as defined
18 in section 316(b) of such Act (20 U.S.C. 1059c(b));

19 (4) is an Alaska Native-serving institution, as
20 defined in section 317(b) of such Act (20 U.S.C.
21 1059d(b));

22 (5) is a Native Hawaiian-serving institution, as
23 defined in section 317(b) of such Act (20 U.S.C.
24 1059d(b));

1 (6) is a Predominately Black Institution, as de-
2 fined in section 318(b) of such Act (20 U.S.C.
3 1059e(b));

4 (7) is a Native American-serving, nontribal in-
5 stitution, as defined in section 319(b) of such Act
6 (20 U.S.C. 1059f(b));

7 (8) is an Asian American and Native American
8 Pacific Islander-serving institution, as defined in
9 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

10 (9) is a minority institution, as defined in sec-
11 tion 365 of such Act (20 U.S.C. 1067k), with an en-
12 rollment of needy students, as defined in section 312
13 of such Act (20 U.S.C. 1058).

14 (e) USES OF FUNDS.—An academic health science
15 center, health professions school, or institution of higher
16 education receiving a grant under this section may use the
17 grant funds to integrate issues relating to comprehensive
18 sleep and circadian health into the academic or support
19 sectors of the center, school, or institution, in order to
20 reach a large number of students, by carrying out 1 or
21 more of the following activities:

22 (1) Developing educational content for issues
23 relating to comprehensive sleep and circadian health
24 education that will be incorporated into first-year
25 orientation or core courses.

1 (2) Creating innovative technology-based ap-
2 proaches to deliver sleep health education to stu-
3 dents, faculty, and staff.

4 (3) Developing and employing peer-outreach
5 and education programs to generate discussion, edu-
6 cate, and raise awareness among students about
7 issues relating to poor quality sleep, sleep and circa-
8 dian disorders, and the role sleep health plays in
9 other diseases and comorbidities.

10 (f) REPORT TO CONGRESS.—

11 (1) IN GENERAL.—Not later than 1 year after
12 the date of the enactment of this Act, and annually
13 thereafter for a period of 5 years, the Secretary shall
14 prepare and submit to the appropriate committees of
15 Congress a report on the activities to provide health
16 professions students with comprehensive sleep and
17 circadian health education funded under this section.

18 (2) REPORT ELEMENTS.—The report described
19 in paragraph (1) shall include information about—

20 (A) the number of entities that are receiv-
21 ing grant funds;

22 (B) the specific activities supported by
23 grant funds;

24 (C) the number of students served by
25 grant programs; and

1 (D) the status of program evaluations.

2 (g) DEFINITION OF INSTITUTION OF HIGHER EDU-
3 CATION.—In this section, the term “institution of higher
4 education” has the meaning given such term in section
5 101(b) of the Higher Education Act of 1965 (20 U.S.C.
6 1001(b)).

7 **SEC. 795. REPORT ON IMPACT OF SLEEP AND CIRCADIAN**
8 **HEALTH DISORDERS IN VULNERABLE AND**
9 **RACIAL/ETHNIC POPULATIONS.**

10 (a) IN GENERAL.—Not later than 1 year after the
11 date of enactment of this Act, the Secretary of Health and
12 Human Services shall submit to Congress and the Presi-
13 dent a report on the impact of sleep and circadian health
14 disorders for racial and ethnic minority communities and
15 other vulnerable populations.

16 (b) CONTENTS.—The report under subsection (a)
17 shall include information on the—

18 (1) progress that has been made in reducing
19 the impact of sleep and circadian health disorders in
20 such communities and populations;

21 (2) opportunities that exist to make additional
22 progress in reducing the impact of sleep and circa-
23 dian health disorders in such communities and popu-
24 lations;

1 (3) challenges that may impede such additional
2 progress; and

3 (4) Federal funding necessary to achieve sub-
4 stantial reductions in sleep and circadian health dis-
5 orders in racial and ethnic minority communities.

6 **Subtitle K—Kidney Disease Re-**
7 **search, Surveillance, Preven-**
8 **tion, and Treatment**

9 **SEC. 797. KIDNEY DISEASE, RESEARCH, SURVEILLANCE,**
10 **PREVENTION, AND TREATMENT.**

11 (a) SHORT TITLE.—This section may be cited as the
12 “Kidney Disease Research, Surveillance, Prevention and
13 Treatment Improvement Act of 2020”.

14 (b) FINDINGS.—Congress makes the following find-
15 ings:

16 (1) Kidney diseases impact 37,000,000 individ-
17 uals in the United States.

18 (2) African Americans comprise just 13 percent
19 of the United States population, but 33 percent of
20 the United States dialysis patient population. Com-
21 pared to Caucasians, kidney failure prevalence is
22 about 3.7 times greater in African Americans, 1.4
23 times greater in Native Americans, and 1.5 times
24 greater in Asian Americans.

1 (3) Peritoneal dialysis and home hemodialysis
2 use is 40–50 percent lower among African Ameri-
3 cans and Hispanics.

4 (4) Every racial and ethnic minority group in
5 the United States is significantly less likely to be
6 treated with home dialysis than Whites, and demo-
7 graphic and clinical characteristics are insufficient to
8 explain this differential use.

9 (5) African Americans on dialysis, irrespective
10 of dialysis modality, and Hispanics undergoing PD
11 or in-center HD, are significantly less likely than
12 their White counterparts to receive a kidney trans-
13 plant.

14 (6) African Americans, Hispanics, and Asian
15 Americans are less likely to receive living donor kid-
16 ney transplants than Whites. Efforts to reduce dis-
17 parities in live donor kidney transplantation for Afri-
18 can-American, Hispanic, and Asian patients with
19 kidney failure have been unsuccessful.

20 (7) Medicare and Medicaid patients are less
21 likely to receive a preemptive transplant from a de-
22 ceased donor compared to private insurance patients
23 (5 percent and 11 percent versus 24 percent), and
24 Black and Hispanic patients are less likely to receive
25 a preemptive transplant from a deceased donor com-

1 pared with White patients even after changes to the
2 kidney allocation system (5 percent of Black patients
3 and 5 percent of Hispanic patients compared with
4 18 percent of White patients).

5 (8) Low-income populations are significantly
6 more likely to progress to kidney failure.

7 (9) Low socioeconomic status is associated with
8 increased incidence of chronic kidney disease, pro-
9 gression to kidney failure, inadequate dialysis treat-
10 ment, and reduced access to kidney transplantation.

11 (10) The 3 goals of Executive Order 13879 of
12 July 10, 2019 (84 Fed. Reg. 33817; relating to Ad-
13 vancing American Kidney Health), recognizes the
14 need for more transplants, better prevention and
15 education, and improved access to treatment modal-
16 ities.

17 **SEC. 798. KIDNEY DISEASE RESEARCH IN MINORITY POPU-**
18 **LATIONS.**

19 (a) IN GENERAL.—The Director of the National In-
20 stitutes of Health shall expand, intensify, and support on-
21 going research and other activities with respect to kidney
22 disease in minority populations.

23 (b) RESEARCH.—

24 (1) DESCRIPTION.—Research under subsection

25 (a) shall include investigation into—

1 (A) the causes of kidney disease, including
2 socioeconomic, geographic, clinical, environ-
3 mental, genetic, and other factors that may
4 contribute to increased rates of kidney disease
5 in minority populations; and

6 (B) the causes of increased incidence of
7 kidney disease complications in minority popu-
8 lations, and possible interventions to decrease
9 such incidence.

10 (2) INCLUSION OF MINORITY PARTICIPANTS.—

11 In conducting and supporting research described in
12 subsection (a), the Director of the National Insti-
13 tutes of Health shall seek to include minority par-
14 ticipants as study subjects in clinical trials.

15 (c) REPORT; COMPREHENSIVE PLAN.—

16 (1) IN GENERAL.—The Secretary of Health and
17 Human Services shall—

18 (A) prepare and submit to the Congress,
19 not later than 6 months after the date of enact-
20 ment of this section, a report on Federal re-
21 search and public health activities with respect
22 to kidney disease in minority populations; and

23 (B) develop and submit to Congress, not
24 later than 1 year after the date of enactment of
25 this section, an effective and comprehensive

1 Federal plan (including all appropriate Federal
2 health programs) to address kidney disease in
3 minority populations.

4 (2) CONTENTS.—The report under paragraph
5 (1)(A) shall at minimum address each of the fol-
6 lowing:

7 (A) Research on kidney disease in minority
8 populations, including such research on—

9 (i) genetic, behavioral, and environ-
10 mental factors; and

11 (ii) prevention and complications
12 among individuals within these populations
13 who have already developed kidney disease.

14 (B) Surveillance and data collection on
15 kidney disease in minority populations, includ-
16 ing with respect to—

17 (i) efforts to better determine the
18 prevalence of kidney disease among Asian-
19 American and Pacific Islander subgroups;
20 and

21 (ii) efforts to coordinate data collec-
22 tion on the American Indian population.

23 (C) Community-based interventions to ad-
24 dress kidney disease targeting minority popu-
25 lations, including—

1 (i) the evidence base for such inter-
2 ventions;

3 (ii) the cultural appropriateness of
4 such interventions; and

5 (iii) efforts to educate the public on
6 the causes and consequences of kidney dis-
7 ease.

8 (D) Education and training programs for
9 health professionals (including community
10 health workers) on the prevention and manage-
11 ment of kidney disease and its related complica-
12 tions that are supported by the Health Re-
13 sources and Services Administration, including
14 such programs supported by the Bureau of
15 Health Workforce, the Bureau of Primary
16 Health Care, and the Healthcare Systems Bu-
17 reau.

18 **SEC. 799. KIDNEY DISEASE ACTION PLAN.**

19 (a) IN GENERAL.—The Director of the Centers for
20 Disease Control and Prevention shall conduct, support,
21 and expand public health strategies, prevention, diagnosis,
22 surveillance, and public and professional awareness activi-
23 ties regarding kidney disease.

24 (b) NATIONAL ACTION PLAN.—

1 (1) DEVELOPMENT.—Not later than 2 years
2 after the date of the enactment of this Act, the Di-
3 rector of the National Institute of Diabetes and Di-
4 gestive and Kidney Diseases, in consultation with
5 the Director of the Centers for Disease Control and
6 Prevention, shall develop a national action plan to
7 address kidney disease in the United States with
8 participation from patients, caregivers, health pro-
9 fessionals, patient advocacy organizations, research-
10 ers, providers, public health professionals, and other
11 stakeholders.

12 (2) CONTENTS.—At a minimum, such plan
13 shall include recommendations for—

14 (A) public health interventions for the pur-
15 pose of implementation of the national plan;

16 (B) biomedical, health services, and public
17 health research on kidney disease; and

18 (C) inclusion of kidney disease in the
19 health data collections of all Federal agencies.

20 (c) KIDNEY DISEASE PREVENTION PROGRAMS.—The
21 Director of the National Institute of Diabetes and Diges-
22 tive and Kidney Diseases shall carry out the following:

23 (1) Conduct public education and awareness ac-
24 tivities with patient and professional organizations
25 to stimulate earlier diagnosis and improve patient

1 outcomes from treatment of kidney disease. To the
2 extent known and relevant, such public education
3 and awareness activities shall reflect differences in
4 kidney disease by cause (such as hypertension, dia-
5 betes, and polycystic kidney disease) and include a
6 focus on outreach to undiagnosed and, as appro-
7 priate, minority populations.

8 (2) Supplement and expand upon the activities
9 of the National Institute of Diabetes and Digestive
10 and Kidney Diseases by making grants to nonprofit
11 organizations, State and local jurisdictions, and In-
12 dian tribes for the purpose of reducing the burden
13 of kidney disease, especially in disproportionately im-
14 pacted communities, through public health interven-
15 tions and related activities.

16 (3) Coordinate with the Centers for Disease
17 Control and Prevention, the Indian Health Service,
18 the Health Resources and Services Administration,
19 and the Department of Veterans Affairs to develop
20 pilot programs to demonstrate best practices for the
21 diagnosis and management of kidney disease.

22 (4) Develop improved techniques and identify
23 best practices, in coordination with the Secretary of
24 Veterans Affairs, for assisting kidney disease pa-
25 tients.

1 (d) DATA COLLECTION.—Not later than 180 days
2 after the date of enactment of this Act, the Director of
3 the National Institute of Diabetes and Digestive and Kid-
4 ney Diseases and the Director of the Centers for Disease
5 Control and Prevention, acting jointly, shall assess the
6 depth and quality of information on kidney disease that
7 is collected in surveys and population studies conducted
8 by the Centers for Disease Control and Prevention, includ-
9 ing whether there are additional opportunities for informa-
10 tion to be collected in the National Health and Nutrition
11 Examination Survey, the National Health Interview Sur-
12 vey, and the Behavioral Risk Factor Surveillance System
13 surveys. The Director of the National Institute of Diabetes
14 and Digestive and Kidney Diseases shall include the re-
15 sults of such assessment in the national action plan under
16 subsection (b).

17 (e) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section
19 \$1,000,000 for fiscal year 2021, \$1,000,000 for fiscal year
20 2022, \$1,000,000 for fiscal year 2023, \$1,000,000 for fis-
21 cal year 2024, and \$1,000,000 for fiscal year 2025.

22 **SEC. 799A. HOME DIALYSIS AND INCREASING END-STAGE**
23 **RENAL DISEASE TREATMENT MODALITIES IN**
24 **MINORITY COMMUNITIES ACTION PLAN.**

25 (a) NATIONAL ACTION PLAN.—

1 (1) DEVELOPMENT.—Not later than 2 years
2 after the date of the enactment of this Act, the Di-
3 rector of the National Institute of Diabetes and Di-
4 gestive and Kidney Diseases, in consultation with
5 the Director of the Centers for Disease Control and
6 Prevention, shall develop a national action plan to
7 increase the number of home dialyzers and choice in
8 dialysis treatment modality in the United States
9 with participation from patients, caregivers, health
10 professionals, patient advocacy organizations, re-
11 searchers, providers, public health professionals, and
12 other stakeholders in minority communities.

13 (2) CONTENTS.—At a minimum, such plan
14 shall include recommendations for—

15 (A) public health officials for the purpose
16 of implementation of the national plan;

17 (B) biomedical, health services, and public
18 health research on home dialysis and modalities
19 in minority communities; and

20 (C) inclusion of dialysis location and mo-
21 dality in the health data collections of all Fed-
22 eral agencies.

23 (b) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section
25 \$1,000,000 for fiscal year 2021, \$1,000,000 for fiscal year

1 2022, \$1,000,000 for fiscal year 2023, \$1,000,000 for fis-
2 cal year 2024, and \$1,000,000 for fiscal year 2025.

3 **SEC. 799B. INCREASING KIDNEY TRANSPLANTS IN MINOR-**
4 **ITY POPULATIONS.**

5 (a) IN GENERAL.—The Director of the National In-
6 stitutes of Health shall expand, intensify, and support on-
7 going research and other activities with respect to kidney
8 transplants in minority populations.

9 (b) RESEARCH.—Research under subsection (a) shall
10 include investigation into—

11 (1) the causes of lower rates of kidney trans-
12 plants in minority populations, including socio-
13 economic, geographic, clinical, environmental, ge-
14 netic, and other factors that may contribute to lower
15 rates of kidney transplants in minority populations;
16 and

17 (2) possible interventions to increase kidney
18 transplants.

19 (c) REPORT; COMPREHENSIVE PLAN.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services shall—

22 (A) prepare and submit to the Congress,
23 not later than 6 months after the date of enact-
24 ment of this section, a report on Federal re-
25 search and public health activities with respect

1 to kidney transplants as a treatment for end-
2 stage renal disease in minority populations; and

3 (B) develop and submit to the Congress,
4 not later than 1 year after the date of enact-
5 ment of this section, an effective and com-
6 prehensive Federal plan (including all appro-
7 priate Federal health programs) to increase the
8 number of kidney transplants in minority popu-
9 lations.

10 (2) CONTENTS.—The report under paragraph
11 (1)(A) shall at a minimum address each of the fol-
12 lowing:

13 (A) Research on kidney transplants in mi-
14 nority populations, including such research on
15 financial, insurance coverage, genetic, behav-
16 ioral, and environmental factors.

17 (B) Surveillance and data collection on
18 kidney transplants in minority populations, in-
19 cluding with respect to—

20 (i) efforts to increase kidney trans-
21 plants among Asian-American and Pacific
22 Islander subgroups with end-stage renal
23 disease; and

24 (ii) efforts to increase kidney trans-
25 plants in the American Indian population.

1 (C) Community-based efforts to increase
2 kidney transplants targeting minority popu-
3 lations, including—

4 (i) the evidence base for such in-
5 creases;

6 (ii) the cultural appropriateness of
7 such increases; and

8 (iii) efforts to educate the public on
9 kidney transplants.

10 (D) Education and training programs for
11 health professionals (including community
12 health workers) on the kidney transplants that
13 are supported by the Health Resources and
14 Services Administration, including such pro-
15 grams supported by the Bureau of Health
16 Workforce, the Bureau of Primary Health Care,
17 and the Healthcare Systems Bureau.

18 **SEC. 799C. ENVIRONMENTAL AND OCCUPATIONAL HEALTH**
19 **PROGRAMS.**

20 The Director of the Centers for Disease Control and
21 Prevention shall—

22 (1) support research into the environmental and
23 occupational causes and biological mechanisms that
24 contribute to kidney disease; and

1 (2) develop and disseminate public health inter-
2 ventions that will lessen the impact of environmental
3 and occupational causes of kidney disease.

4 **SEC. 799D. UNDERSTANDING THE TREATMENT PATTERNS**
5 **ASSOCIATED WITH PROVIDING CARE AND**
6 **TREATMENT OF KIDNEY FAILURE IN MINOR-**
7 **ITY POPULATIONS.**

8 (a) **STUDY.**—The Secretary of Health and Human
9 Services (in this section referred to as the “Secretary”)
10 shall conduct a study on treatment patterns associated
11 with providing care, under the Medicare program under
12 title XVIII of the Social Security Act (42 U.S.C. 1395
13 et seq.), the Medicaid program under title XIX of such
14 Act (42 U.S.C. 1396 et seq.), and through private health
15 insurance, to minority populations that are disproportion-
16 ately affected by kidney failure.

17 (b) **REPORT.**—Not later than 1 year after the date
18 of the enactment of this Act, the Secretary shall submit
19 to Congress a report on the study conducted under sub-
20 section (a), together with such recommendations as the
21 Secretary determines to be appropriate.

22 **SEC. 799E. IMPROVING ACCESS IN UNDERSERVED AREAS.**

23 (a) **DEFINITION OF PRIMARY CARE SERVICES.**—Sec-
24 tion 331(a)(3)(D) of the Public Health Service Act (42

1 U.S.C. 254d(a)(3)(D)) is amended by inserting “renal di-
2 alysis,” after “dentistry,”.

3 (b) NATIONAL HEALTH SERVICE CORPS SCHOLAR-
4 SHIP PROGRAM.—Section 338A(a)(2) of the Public Health
5 Service Act (42 U.S.C. 254l(a)(2)) is amended by insert-
6 ing “, which may include nephrology health professionals”
7 before the period at the end.

8 (c) NATIONAL HEALTH SERVICE CORPS LOAN RE-
9 PAYMENT PROGRAM.—Section 338B(a)(2) of the Public
10 Health Service Act (42 U.S.C. 254l–1(a)(2)) is amended
11 by inserting “, which may include nephrology health pro-
12 fessionals” before the period at the end.

13 **TITLE VIII—HEALTH** 14 **INFORMATION TECHNOLOGY**

15 **SEC. 800. DEFINITIONS.**

16 In this title:

17 (1) CERTIFIED ELECTRONIC HEALTH RECORD
18 TECHNOLOGY.—The term “certified EHR tech-
19 nology” has the meaning given such term in section
20 3000 of the Public Health Service Act (42 U.S.C.
21 300jj).

22 (2) EHR.—The term “EHR” means an elec-
23 tronic health record.

24 (3) INTEROPERABILITY.—The term “interoper-
25 ability” has the meaning given such term in section

1 3000 of the Public Health Service Act (42 U.S.C.
2 300jj). Evaluation and measurement of interoper-
3 ability shall consider exchange of electronic health
4 information, usability of exchanged electronic health
5 information, effective application and use of the ex-
6 changed electronic health information, and impact
7 on outcomes of interoperability.

8 (4) ACCESS.—The term “access”, with respect
9 to health information, means access described in sec-
10 tion 164.524 of title 45, Code of Federal Regula-
11 tions (or any successor regulations).

12 (5) CERTIFIED ELECTRONIC HEALTH RECORD
13 TECHNOLOGY; EHR.—The terms “certified electronic
14 health record technology” and “EHR” include the
15 health information infrastructure for interoper-
16 ability, access, exchange, and use of electronic health
17 information required under title XXX of the Public
18 Health Service Act (42 U.S.C. 300jj et seq.), and
19 are not limited to electronic health records main-
20 tained by doctors.

1 **Subtitle A—Reducing Health**
2 **Disparities Through Health IT**

3 **SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR**
4 **PROMOTION OF HEALTH IT.**

5 The Secretary of Health and Human Services, acting
6 through the Administrator of the Health Resources and
7 Services Administration, shall expand and intensify the
8 programs and activities of the Administration (directly or
9 through grants or contracts) to provide technical assist-
10 ance and resources to health centers (as defined in section
11 330(a) of the Public Health Service Act (42 U.S.C.
12 254b(a))) to adopt and meaningfully use certified EHR
13 technology for the management of chronic diseases and
14 health conditions and reduction of health disparities.

15 **SEC. 802. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**
16 **CIAL AND ETHNIC MINORITY COMMUNITIES;**
17 **OUTREACH AND ADOPTION OF HEALTH IT IN**
18 **SUCH COMMUNITIES.**

19 (a) NATIONAL COORDINATOR FOR HEALTH INFOR-
20 MATION TECHNOLOGY.—

21 (1) IN GENERAL.—Not later than 18 months
22 after the date of enactment of this Act, the National
23 Coordinator for Health Information Technology (re-
24 ferred to in this section as the “National Coordi-
25 nator”) shall—

1 (A) conduct an evaluation of the level of
2 interoperability, access, use, and accessibility of
3 electronic health records in racial and ethnic
4 minority communities, focusing on whether pa-
5 tients in such communities have providers who
6 use electronic health records, and the degree to
7 which patients in such communities can access,
8 exchange, and use without special effort their
9 health information in those electronic health
10 records, and indicating whether such pro-
11 viders—

12 (i) are participating in the Medicare
13 program under title XVIII of the Social
14 Security Act (42 U.S.C. 1395 et seq.) or
15 a State plan under title XIX of such Act
16 (42 U.S.C. 1396 et seq.) (or a waiver of
17 such plan);

18 (ii) have received incentive payments
19 or incentive payment adjustments under
20 Medicare and Medicaid Electronic Health
21 Records Incentive Programs (as defined in
22 subsection (c)(2));

23 (iii) are MIPS eligible professionals,
24 as defined in paragraph (1)(C) of section
25 1848(q) of the Social Security Act (42

1 U.S.C. 1395w-4(q)), for purposes of the
2 Merit-Based Incentive Payment System
3 under such section; or

4 (iv) have been recruited by any of the
5 Health Information Technology Regional
6 Extension Centers established under sec-
7 tion 3012 of the Public Health Service Act
8 (42 U.S.C. 300jj-32); and

9 (B) publish the results of such evaluation
10 including the race and ethnicity of such pro-
11 viders and the populations served by such pro-
12 viders.

13 (2) CERTIFICATION CRITERION.—Not later
14 than 1 year after the date of enactment of this Act,
15 the National Coordinator shall—

16 (A) promulgate a certification criterion and
17 module of certified EHR technology that strati-
18 fies quality measures for purposes of the Merit-
19 Based Incentive Payment System by disparity
20 characteristics, including race, ethnicity, lan-
21 guage, gender, gender identity, sexual orienta-
22 tion, socio-economic status, and disability sta-
23 tus, as such characteristics are defined for pur-
24 poses of certified EHR technology; and

1 (B) report to the Centers for Medicare &
2 Medicaid Services the quality measures strati-
3 fied by race and at least 2 other disparity char-
4 acteristics.

5 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—
6 As soon as practicable after the date of enactment of this
7 Act, the Director of the National Center for Health Statis-
8 tics shall provide to Congress a more detailed analysis of
9 the data presented in National Center for Health Statis-
10 tics data brief entitled “Adoption of Certified Electronic
11 Health Record Systems and Electronic Information Shar-
12 ing in Physician Offices: United States, 2013 and 2014”
13 (NCHS Data Brief No. 236).

14 (c) CENTERS FOR MEDICARE & MEDICAID SERV-
15 ICES.—

16 (1) IN GENERAL.—As part of the process of
17 collecting information, with respect to a provider, at
18 registration and attestation for purposes of Medicare
19 and Medicaid Electronic Health Records Incentive
20 Programs (as defined in paragraph (2)) or the
21 Merit-Based Incentive Payment System under sec-
22 tion 1848(q) of the Social Security Act (42 U.S.C.
23 1395w-4(q)), the Secretary of Health and Human
24 Services shall collect the race and ethnicity of such
25 provider.

1 (2) MEDICARE AND MEDICAID ELECTRONIC
2 HEALTH RECORDS INCENTIVE PROGRAMS DE-
3 FINED.—For purposes of paragraph (1), the term
4 “Medicare and Medicaid Electronic Health Records
5 Incentive Programs” means the incentive programs
6 under section 1814(l)(3), subsections (a)(7) and (o)
7 of section 1848, subsections (l) and (m) of section
8 1853, subsections (b)(3)(B)(ix)(I) and (n) of section
9 1886, and subsections (a)(3)(F) and (t) of section
10 1903 of the Social Security Act (42 U.S.C.
11 1395f(l)(3), 1395w-4, 1395w-23, 1395ww, and
12 1396b).

13 (d) NATIONAL COORDINATOR’S ASSESSMENT OF IM-
14 PACT OF HIT.—Section 3001(e)(6)(C) of the Public
15 Health Service Act (42 U.S.C. 300jj-11(e)(6)(C)) is
16 amended—

17 (1) in the heading by inserting “, RACIAL AND
18 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
19 DISPARITIES”;

20 (2) by inserting “, in communities with a high
21 proportion of individuals from racial and ethnic mi-
22 nority groups (as defined in section 1707(g)), in-
23 cluding people with disabilities in these groups,”
24 after “communities with health disparities”;

1 (3) by striking “The National Coordinator” and
2 inserting the following:

3 “(i) IN GENERAL.—The National Co-
4 ordinator”; and

5 (4) by adding at the end the following:

6 “(ii) CRITERIA.—In any publication
7 under clause (i), the National Coordinator
8 shall include best practices for encouraging
9 partnerships between the Federal Govern-
10 ment, States, and private entities to ex-
11 pand outreach for and the adoption of cer-
12 tified EHR technology in communities with
13 a high proportion of individuals from racial
14 and ethnic minority groups (as so defined),
15 while also maintaining the accessibility re-
16 quirements of section 508 of the Rehabili-
17 tation Act of 1973 to encourage patient in-
18 volvement in patient health care. The Na-
19 tional Coordinator shall—

20 “(I) not later than 6 months
21 after the submission of the report re-
22 quired under section 822 of the
23 Health Equity and Accountability Act
24 of 2020, establish criteria for evalu-
25 ating the impact of health information

1 technology on communities with a
2 high proportion of individuals from
3 racial and ethnic minority groups (as
4 so defined) taking into account the
5 findings in such report; and

6 “(II) not later than 1 year after
7 the submission of such report, conduct
8 and publish the results of an evalua-
9 tion of such impact.”.

10 **SEC. 803. NONDISCRIMINATION AND HEALTH EQUITY IN**
11 **HEALTH INFORMATION TECHNOLOGY.**

12 (a) IN GENERAL.—Covered entities shall ensure that
13 electronic and information technology in their health pro-
14 grams or activities does not exclude individuals from par-
15 ticipation in, deny individuals the benefits of, or subject
16 individuals to discrimination under any health program or
17 activity on the basis of race, color, national origin, sex,
18 age, or disability.

19 (b) COVERED ENTITIES.—In this section, the term
20 “covered entity” means—

21 (1) an entity that operates a health program or
22 activity, any part of which receives Federal financial
23 assistance;

24 (2) an entity established under title I of the Pa-
25 tient Protection and Affordable Care Act (Public

1 Law 114–148) that administers a health program or
2 activity; or

3 (3) the Department of Health and Human
4 Services.

5 **SEC. 804. LANGUAGE ACCESS IN HEALTH INFORMATION**
6 **TECHNOLOGY.**

7 The National Coordinator shall—

8 (1) not later than 18 months after the date of
9 enactment of this Act, propose a rule for providing
10 access to patients, through certified EHR tech-
11 nology, to their personal health information in a
12 computable format, including using patient portals
13 or third-party applications (as described in section
14 3009(e) of the Public Health Service Act (42 U.S.C.
15 300jj–19(e))), in the 10 most common non-English
16 languages;

17 (2) hold a public hearing to identify best prac-
18 tices for carrying out paragraph (1); and

19 (3) not later than 6 months after the public
20 hearing under paragraph (2), promulgate a final
21 regulation with respect to paragraph (1).

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 2021
 9 through 2026”.

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) survey a cross-section of individuals in
10 medically underserved areas and report their opin-
11 ions about the various topics of study;

12 (3) examine the degree of interoperability
13 among health information technology and users of
14 health information technology in medically under-
15 served areas, including patients, providers, and com-
16 munity services;

17 (4) examine the impact of health information
18 technology on providing quality care and reducing
19 the cost of care to individuals in such areas, includ-
20 ing the impact of such technology on improved
21 health outcomes for individuals, including which
22 technology worked for which population and how it
23 improved health outcomes for that population;

1 (5) examine the impact of health information
2 technology on improving health care-related deci-
3 sions by both patients and providers in such areas;

4 (6) identify specific best practices for using
5 health information technology to foster the con-
6 sistent provision of physical accessibility and reason-
7 able policy accommodations in health care to individ-
8 uals with disabilities in such areas;

9 (7) assess the feasibility and costs associated
10 with the use of health information technology in
11 such areas;

12 (8) evaluate whether the adoption and use of
13 qualified electronic health records (as defined in sec-
14 tion 3000 of the Public Health Service Act (42
15 U.S.C. 300jj)) is effective in reducing health dispari-
16 ties, including analysis of clinical quality measures
17 reported by providers who are participating in the
18 Medicare program under title XVIII of the Social
19 Security Act (42 U.S.C. 1395 et seq.) or a State
20 plan under title XIX of such Act (42 U.S.C. 1396
21 et seq.) (or a waiver of such plan), pursuant to pro-
22 grams to encourage the adoption and use of certified
23 EHR technology;

24 (9) identify providers in medically underserved
25 areas that are not electing to adopt and use elec-

1 tronic health records and determine what barriers
2 are preventing those providers from adopting and
3 using such records; and

4 (10) examine urban and rural community
5 health systems and determine the impact that health
6 information technology may have on the capacity of
7 primary health providers in those systems.

8 (c) MEDICALLY UNDERSERVED AREA.—The term
9 “medically underserved area” means—

10 (1) a population that has been designated as a
11 medically underserved population under section
12 330(b)(3) of the Public Health Service Act (42
13 U.S.C. 254b(b)(3));

14 (2) an area that has been designated as a
15 health professional shortage area under section 332
16 of the Public Health Service Act (42 U.S.C. 254e);

17 (3) an area or population that has been des-
18 ignated as a medically underserved community under
19 section 799B of the Public Health Service Act (42
20 U.S.C. 295p); or

21 (4) another area or population that—

22 (A) experiences significant barriers to ac-
23 cessing quality health services; and

24 (B) has a high prevalence of diseases or
25 conditions described in title VII, with such dis-

1 eases or conditions having a disproportionate
2 impact on racial and ethnic minority groups (as
3 defined in section 1707(g) of the Public Health
4 Service Act (42 U.S.C. 300u-6(g))) or a sub-
5 group of people with disabilities who have spe-
6 cific functional impairments.

7 **SEC. 823. ASSESSMENT OF USE AND MISUSE OF DE-IDENTI-**
8 **FIED HEALTH DATA.**

9 (a) **IN GENERAL.**—Not later than 18 months after
10 the date of enactment of this Act, the Secretary of Health
11 and Human Services shall—

12 (1) enter into an agreement with the Office of
13 the National Coordinator to conduct a study, in con-
14 sultation with relevant stakeholders, on the impact
15 of digital health technology on medically underserved
16 areas (as described in section 822(c)); and

17 (2) submit a report to Congress describing the
18 results of such study, including any recommenda-
19 tions for legislative or administrative action.

20 (b) **STUDY.**—The study described in subsection
21 (a)(1) shall—

22 (1) examine the overall prevalence, and histor-
23 ical and existing practices and their respective preva-
24 lence, of use and misuse of de-identified protected
25 health information, as defined in section 160.103,

1 title 45, Code of Federal Regulations (or any suc-
2 cessor regulations), to discriminate against or ben-
3 efit medically underserved areas;

4 (2) identify best practices and tools to leverage
5 the benefits and prevent misuse of de-identified pro-
6 tected health information to discriminate against
7 medically underserved areas;

8 (3) examine the overall prevalence, and histor-
9 ical and existing practices and their respective preva-
10 lence, of use and misuse of de-identified personal
11 health information other than protected health infor-
12 mation, as defined in section 160.103, title 45, Code
13 of Federal Regulations (or any successor regula-
14 tions), to discriminate against or benefit medically
15 underserved areas; and

16 (4) identify best practices and tools to leverage
17 the benefits and prevent misuse of de-identified per-
18 sonal health information other than protected health
19 information to discriminate against medically under-
20 served areas.

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)); 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.

1 **TITLE IX—ACCOUNTABILITY**
2 **AND EVALUATION**

3 **SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL**
4 **ASSISTED HEALTH CARE SERVICES AND RE-**
5 **SEARCH PROGRAMS ON THE BASIS OF SEX**
6 **(INCLUDING SEX ORIENTATION, GENDER**
7 **IDENTITY, AND PREGNANCY, INCLUDING**
8 **TERMINATION OF PREGNANCY), RACE,**
9 **COLOR, NATIONAL ORIGIN, MARITAL STATUS,**
10 **FAMILIAL STATUS, SEXUAL ORIENTATION,**
11 **GENDER IDENTITY, OR DISABILITY STATUS.**

12 (a) IN GENERAL.—No person in the United States
13 shall, on the basis of sex (including sex orientation, gender
14 identity, and pregnancy, including termination of preg-
15 nancy), race, color, national origin, marital status, familial
16 status, sexual orientation, gender identity, or disability
17 status, be excluded from participation in, be denied the
18 benefits of, or be subjected to discrimination under any
19 health program or activity, including any health research
20 program or activity, receiving Federal financial assistance,
21 including credits, subsidies, or contracts of insurance or
22 any health program or activity that is administered by an
23 executive agency.

24 (b) DEFINITION.—In this section, the term “familial
25 status” means, with respect to one or more individuals—

1 (1) being domiciled with any individual related
 2 by blood or affinity whose close association with the
 3 individual is the equivalent of a family relationship;

4 (2) being in the process of securing legal cus-
 5 tody of any individual; or

6 (3) being pregnant.

7 **SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER**
 8 **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

9 A payment to a provider of services, physician, or
 10 other supplier under part B, C, or D of title XVIII of
 11 the Social Security Act shall be deemed a grant, and not
 12 a contract of insurance or guaranty, for the purposes of
 13 title VI of the Civil Rights Act of 1964.

14 **SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
 15 **THE DEPARTMENT OF HEALTH AND HUMAN**
 16 **SERVICES.**

17 Title XXXIV of the Public Health Service Act, as
 18 amended by titles I, II, and III of this Act, is further
 19 amended by inserting after subtitle C the following:

20 **“Subtitle D—Strengthening**
 21 **Accountability**

22 **“SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

23 “(a) IN GENERAL.—The Secretary shall establish
 24 within the Office for Civil Rights an Office of Health Dis-

1 parities, which shall be headed by a director to be ap-
2 pointed by the Secretary.

3 “(b) PURPOSE.—The Office of Health Disparities
4 shall ensure that the health programs, activities, and oper-
5 ations of health entities that receive Federal financial as-
6 sistance are in compliance with title VI of the Civil Rights
7 Act, including through the following activities:

8 “(1) The development and implementation of
9 an action plan to address racial and ethnic health
10 care disparities, which shall address concerns relat-
11 ing to the Office for Civil Rights as released by the
12 United States Commission on Civil Rights in the re-
13 port entitled ‘Health Care Challenge: Acknowledging
14 Disparity, Confronting Discrimination, and Ensuring
15 Equity’ (September 1999) in conjunction with
16 the reports by the National Academy of Sciences
17 (formerly known as the Institute of Medicine) enti-
18 tled ‘Unequal Treatment: Confronting Racial and
19 Ethnic Disparities in Health Care’, ‘Crossing the
20 Quality Chasm: A New Health System for the 21st
21 Century’, ‘In the Nation’s Compelling Interest: En-
22 suring Diversity in the Health Care Workforce’,
23 ‘The National Partnership for Action to End Health
24 Disparities’, and ‘The Health of Lesbian, Gay, Bi-
25 sexual, and Transgender People’, and other related

1 reports by the National Academy of Sciences. This
2 plan shall be publicly disclosed for review and com-
3 ment and the final plan shall address any comments
4 or concerns that are received by the Office.

5 “(2) Investigative and enforcement actions
6 against intentional discrimination and policies and
7 practices that have a disparate impact on minorities.

8 “(3) The review of racial, ethnic, gender iden-
9 tity, sexual orientation, sex, disability status, socio-
10 economic status, and primary language health data
11 collected by Federal health agencies to assess health
12 care disparities related to intentional discrimination
13 and policies and practices that have a disparate im-
14 pact on minorities. Such review shall include an as-
15 sessment of health disparities in communities with a
16 combination of these classes.

17 “(4) Outreach and education activities relating
18 to compliance with title VI of the Civil Rights Act.

19 “(5) The provision of technical assistance for
20 health entities to facilitate compliance with title VI
21 of the Civil Rights Act.

22 “(6) Coordination and oversight of activities of
23 the civil rights compliance offices established under
24 section 3442.

25 “(7) Ensuring—

1 “(A) at a minimum, compliance with the
2 most recent version of the Office of Manage-
3 ment and Budget statistical policy directive en-
4 titled ‘Standards for Maintaining, Collecting,
5 and Presenting Federal Data on Race and Eth-
6 nicity’; and

7 “(B) consideration of available data and
8 language standards such as—

9 “(i) the standards for collecting and
10 reporting data under section 3101; and

11 “(ii) the National Standards on Cul-
12 turally and Linguistically Appropriate
13 Services of the Office of Minority Health.

14 “(c) FUNDING AND STAFF.—The Secretary shall en-
15 sure the effectiveness of the Office of Health Disparities
16 by ensuring that the Office is provided with—

17 “(1) adequate funding to enable the Office to
18 carry out its duties under this section; and

19 “(2) staff with expertise in—

20 “(A) epidemiology;

21 “(B) statistics;

22 “(C) health quality assurance;

23 “(D) minority health and health dispari-
24 ties;

25 “(E) cultural and linguistic competency;

1 “(F) civil rights; and

2 “(G) social, behavioral, and economic de-
3 terminants of health.

4 “(d) REPORT.—Not later than December 31, 2021,
5 and annually thereafter, the Secretary, in collaboration
6 with the Director of the Office for Civil Rights and the
7 Deputy Assistant Secretary for Minority Health, shall
8 submit a report to the Committee on Health, Education,
9 Labor, and Pensions of the Senate and the Committee on
10 Energy and Commerce of the House of Representatives
11 that includes—

12 “(1) the number of cases filed, broken down by
13 category;

14 “(2) the number of cases investigated and
15 closed by the office;

16 “(3) the outcomes of cases investigated;

17 “(4) the staffing levels of the office including
18 staff credentials;

19 “(5) the number of other lingering and emerg-
20 ing cases in which civil rights inequities can be dem-
21 onstrated; and

22 “(6) the number of cases remaining open and
23 an explanation for their open status.

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

1 such sums as may be necessary for each of fiscal years
 2 2021 through 2026.

3 **“SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OF-**
 4 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**
 5 **HEALTH AND HUMAN SERVICES AGENCIES.**

6 “(a) IN GENERAL.—The Secretary shall establish
 7 civil rights compliance offices in each agency within the
 8 Department of Health and Human Services that admin-
 9 isters health programs.

10 “(b) PURPOSE OF OFFICES.—Each office established
 11 under subsection (a) shall ensure that recipients of Fed-
 12 eral financial assistance under Federal health programs
 13 administer programs, services, and activities in a manner
 14 that—

15 “(1) does not discriminate, either intentionally
 16 or in effect, on the basis of race, national origin, lan-
 17 guage, ethnicity, sex, age, disability, sexual orienta-
 18 tion, and gender identity; and

19 “(2) promotes the reduction and elimination of
 20 disparities in health and health care based on race,
 21 national origin, language, ethnicity, sex, age, dis-
 22 ability, sexual orientation, and gender identity.

23 “(c) POWERS AND DUTIES.—The offices established
 24 in subsection (a) shall have the following powers and du-
 25 ties:

1 “(1) The establishment of compliance and pro-
2 gram participation standards for recipients of Fed-
3 eral financial assistance under each program admin-
4 istered by the applicable agency, including the estab-
5 lishment of disparity reduction standards to encom-
6 pass disparities in health and health care related to
7 race, national origin, language, ethnicity, sex, age,
8 disability, sexual orientation, and gender identity.

9 “(2) The development and implementation of
10 program-specific guidelines that interpret and apply
11 Department of Health and Human Services guid-
12 ance under title VI of the Civil Rights Act of 1964
13 and section 1557 of the Patient Protection and Af-
14 fordable Care Act to each Federal health program
15 administered by the agency.

16 “(3) The development of a disparity-reduction
17 impact analysis methodology that shall be applied to
18 every rule issued by the agency and published as
19 part of the formal rulemaking process under sections
20 555, 556, and 557 of title 5, United States Code.

21 “(4) Oversight of data collection, analysis, and
22 publication requirements for all recipients of Federal
23 financial assistance under each Federal health pro-
24 gram administered by the agency; compliance with,
25 at a minimum, the most recent version of the Office

1 of Management and Budget statistical policy direc-
2 tive entitled ‘Standards for Maintaining, Collecting,
3 and Presenting Federal Data on Race and Eth-
4 nicity’; and consideration of available data and lan-
5 guage standards such as—

6 “(A) the standards for collecting and re-
7 porting data under section 3101; and

8 “(B) the National Standards on Culturally
9 and Linguistically Appropriate Services of the
10 Office of Minority Health.

11 “(5) The conduct of publicly available studies
12 regarding discrimination within Federal health pro-
13 grams administered by the agency as well as dis-
14 parity reduction initiatives by recipients of Federal
15 financial assistance under Federal health programs.

16 “(6) Annual reports to the Committee on
17 Health, Education, Labor, and Pensions and the
18 Committee on Finance of the Senate and the Com-
19 mittee on Energy and Commerce and the Committee
20 on Ways and Means of the House of Representatives
21 on the progress in reducing disparities in health and
22 health care through the Federal programs adminis-
23 tered by the agency.

24 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
25 IN THE DEPARTMENT OF JUSTICE.—

1 “(1) DEPARTMENT OF HEALTH AND HUMAN
2 SERVICES.—The Office for Civil Rights of the De-
3 partment of Health and Human Services shall pro-
4 vide standard-setting and compliance review inves-
5 tigation support services to the Civil Rights Compli-
6 ance Office for each agency described in subsection
7 (a), subject to paragraph (2).

8 “(2) DEPARTMENT OF JUSTICE.—The Office
9 for Civil Rights of the Department of Justice may,
10 as appropriate, institute formal proceedings when a
11 civil rights compliance office established under sub-
12 section (a) determines that a recipient of Federal fi-
13 nancial assistance is not in compliance with the dis-
14 parity reduction standards of the applicable agency.

15 “(e) DEFINITION.—In this section, the term ‘Federal
16 health programs’ mean programs—

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

20 “(2) under this Act that provide Federal finan-
21 cial assistance for health care, biomedical research,
22 health services research, and programs designed to
23 improve the public’s health, including health service
24 programs.”.

1 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

2 (a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3(a) of the Civil Rights Commission Act
3 of 1983 (42 U.S.C. 1975a(a)) is amended—
4

5 (1) in paragraph (1), by striking “and” at the
6 end;
7

8 (2) in paragraph (2), by striking the period at
9 the end and inserting “; and”; and

10 (3) by adding at the end the following:

11 “(3) shall, with respect to activities carried out
12 in health care and correctional facilities toward the
13 goal of eliminating health disparities between the
14 general population and members of minority groups
15 based on race or color, promote coordination of such
16 activities of—

17 “(A) the Office for Civil Rights within the
18 Office of Justice Programs of the Department
19 of Justice;

20 “(B) the Office of Justice Programs within
21 the Department of Justice;

22 “(C) the Office for Civil Rights within the
23 Department of Health and Human Services;
24 and

25 “(D) the Office of Minority Health within
26 the Department of Health and Human Services

1 (headed by the Deputy Assistant Secretary for
2 Minority Health).”.

3 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
4 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
5 1975c) is amended by striking the first sentence and in-
6 serting the following: “For the purpose of carrying out
7 this Act, there are authorized to be appropriated
8 \$30,000,000 for fiscal year 2021, and such sums as may
9 be necessary for each of the fiscal years 2022 through
10 2026.”.

11 **SEC. 905. SENSE OF CONGRESS CONCERNING FULL FUND-**
12 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
13 **AND ETHNIC HEALTH DISPARITIES.**

14 (a) FINDINGS.—Congress makes the following find-
15 ings:

16 (1) The health status of the population of the
17 United States is declining and the United States
18 currently ranks below most industrialized nations in
19 health status measured by longevity, sickness, and
20 mortality.

21 (2) Racial and ethnic minority populations tend
22 to have the poorest health status and face substan-
23 tial cultural, social, and economic barriers to obtain-
24 ing quality health care.

1 (3) Lesbian, gay, bisexual, transgender, queer,
2 and questioning populations experience significant
3 personal and structural barriers to obtaining high-
4 quality health care.

5 (4) Efforts to improve minority health have
6 been limited by inadequate resources (funding, staff-
7 ing, and stewardship) and lack of accountability.

8 (b) SENSE OF CONGRESS.—It is the sense of Con-
9 gress that—

10 (1) health disparities negatively impact out-
11 comes for health and human security of the Nation;

12 (2) reducing racial, ethnic, sexual, and gender
13 disparities in prevention and treatment are unique
14 civil and human rights challenges and, as such, Fed-
15 eral agencies and health care entities and systems
16 receiving Federal funds should be accountable for
17 their role in causing disparities and inequity;

18 (3) funding for the National Institute on Mi-
19 nority Health and Health Disparities, the Office of
20 Civil Rights in the Department of Health and
21 Human Services, the National Institute of Nursing
22 Research, and the Office of Minority Health should
23 be doubled by fiscal year 2022;

24 (4) adequate funding by fiscal year 2022, and
25 subsequent funding increases, should be provided for

1 health and human service professions training pro-
2 grams, the Racial and Ethnic Approaches to Com-
3 munity Health Initiative at the Centers for Disease
4 Control and Prevention, the Minority HIV/AIDS
5 Initiative, and the Excellence Centers to Eliminate
6 Ethnic/Racial Disparities Program at the Agency for
7 Healthcare Research and Quality;

8 (5) funding should be fully restored to the Ra-
9 cial and Ethnic Approaches to Community Health
10 Initiative at the Centers for Disease Control and
11 Prevention, which has been a successful program at
12 the community health level, and efforts should con-
13 tinue to place a strong emphasis on building commu-
14 nity capacity to secure financial resources and tech-
15 nical assistance to eliminate health disparities;

16 (6) adequate funding for fiscal year 2022 and
17 increased funding for future years should be pro-
18 vided for the Racial and Ethnic Approaches to Com-
19 munity Health Initiative's United States Risk Fac-
20 tor Survey to ensure adequate data collection to
21 track health disparities, and there should be appro-
22 priate avenues provided to disseminate findings to
23 the general public;

24 (7) current and newly created health disparity
25 elimination incentives, programs, agencies, and de-

1 partments under this Act (and the amendments
2 made by this Act) should receive adequate staffing
3 and funding by fiscal year 2022; and

4 (8) stewardship and accountability should be
5 provided to the Congress and the President for
6 measurable and sustainable progress toward health
7 disparity elimination.

8 **SEC. 906. GAO AND NIH REPORTS.**

9 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-
10 NIC DIVERSITY.—

11 (1) IN GENERAL.—The Comptroller General of
12 the United States shall conduct a study on the racial
13 and ethnic diversity among the following groups:

14 (A) All applicants for grants, contracts,
15 and cooperative agreements awarded by the Na-
16 tional Institutes of Health during the period be-
17 ginning on January 1, 2009, and ending De-
18 cember 31, 2019.

19 (B) All recipients of such grants, con-
20 tracts, and cooperative agreements during such
21 period.

22 (C) All members of the peer review panels
23 of such applicants and recipients, respectively.

24 (2) REPORT.—Not later than 6 months after
25 the date of the enactment of this Act, the Comp-

1 troller General shall complete the study under para-
2 graph (1) and submit to Congress a report con-
3 taining the results of such study.

4 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
5 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
6 DISPARITIES.—Not later than 6 months after the date of
7 the enactment of this Act, and biennially thereafter, the
8 Director of the National Institutes of Health, in collabora-
9 tion with the Director of the National Institute on Minor-
10 ity Health and Health Disparities, shall submit to Con-
11 gress a report that details and evaluates—

12 (1) the steps taken during the applicable report
13 period by the Director of the National Institutes of
14 Health to enforce the expanded planning, coordina-
15 tion, review, and evaluation authority provided the
16 National Institute on Minority Health and Health
17 Disparities under section 464z–3(h) of the Public
18 Health Service Act (42 U.S.C. 285(h)) over all mi-
19 nority health and health disparity research that is
20 conducted or supported by the Institutes and Cen-
21 ters at the National Institutes of Health; and

22 (2) the outcomes of such steps.

23 (c) GAO REPORT RELATED TO RECIPIENTS OF
24 PPACA FUNDING.—Not later than one year after the
25 date of the enactment of this Act and biennially thereafter

1 until 2024, the Comptroller General of the United States
2 shall submit to Congress a report that identifies—

3 (1) the racial and ethnic diversity of commu-
4 nity-based organizations that applied for Federal en-
5 rollment funding provided pursuant to the Patient
6 Protection and Affordable Care Act (Public Law
7 111–148) (including the amendments made by such
8 Act);

9 (2) the percentage of such organizations that
10 were awarded such funding; and

11 (3) the impact of such community-based organi-
12 zations’ enrollment efforts on the insurance status of
13 their communities.

14 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
15 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
16 PARITIES.—The Director of the National Institute on Mi-
17 nority Health and Health Disparities shall prepare an an-
18 nual report on the activities carried out or to be carried
19 out by such institute, and shall submit each such report
20 to the Committee on Health, Education, Labor, and Pen-
21 sions of the Senate, the Committee on Energy and Com-
22 merce of the House of Representatives, the Secretary of
23 Health and Human Services, and the Director of the Na-
24 tional Institutes of Health. With respect to the fiscal year
25 involved, the report shall—

1 (1) describe and evaluate the progress made in
 2 health disparities research conducted or supported
 3 by institutes and centers of the National Institutes
 4 of Health;

5 (2) summarize and analyze expenditures made
 6 for activities with respect to health disparities re-
 7 search conducted or supported by the National Insti-
 8 tutes of Health;

9 (3) include a separate statement applying the
 10 requirements of paragraphs (1) and (2) specifically
 11 to minority health disparities research; and

12 (4) contain such recommendations as the Direc-
 13 tor of the Institute considers appropriate.

14 **TITLE X—ADDRESSING SOCIAL**
 15 **DETERMINANTS AND IM-**
 16 **PROVING ENVIRONMENTAL**
 17 **JUSTICE**

18 **Subtitle A—In General**

19 **SEC. 1001. DEFINITIONS.**

20 In this title:

21 (1) DETERMINANTS OF HEALTH.—The term
 22 “determinants of health”—

23 (A) means the range of personal, social,
 24 economic, and environmental factors that influ-
 25 ence health status; and

1 (B) includes social determinants of health
2 (which are sometimes referred to as “social and
3 economic determinants of health”, “socio-
4 economic determinants of health”, “environ-
5 mental determinants of health”, “social drivers
6 of inequality”, or “personal determinants of
7 health”).

8 (2) ENVIRONMENTAL DETERMINANTS OF
9 HEALTH.—The term “environmental determinants
10 of health” means the broad physical (including man-
11 made and natural), psychological, social, spiritual,
12 cultural, and aesthetic environment.

13 (3) BUILT ENVIRONMENT.—The term “built
14 environment” means the components of the environ-
15 ment, and the location of these components in a geo-
16 graphically defined space, that are created or modi-
17 fied by individuals to form the physical and social
18 characteristics of a community or enhance quality of
19 human life, including—

20 (A) homes, schools, and places of work and
21 worship;

22 (B) parks, recreation areas, and green-
23 ways;

24 (C) transportation systems;

1 (D) business, industry, and agriculture;
2 and

3 (E) land-use plans, projects, and policies
4 that impact the physical or social characteris-
5 tics of a community, including access to services
6 and amenities.

7 (4) PERSONAL DETERMINANTS OF HEALTH.—
8 The term “personal determinants of health” means
9 an individual’s behavior, biology, and genetics.

10 (5) SOCIAL DETERMINANTS OF HEALTH.—The
11 term “social determinants of health” means a subset
12 of determinants of the health of individuals and en-
13 vironments (such as communities, neighborhoods,
14 and societies) that describe an individual’s or group
15 of people’s social identity, describe the social and
16 economic resources to which such individual or
17 group has access, and describe the conditions in
18 which an individual or group of people works, lives,
19 and plays.

20 (6) ECONOMIC DETERMINANTS OF HEALTH.—
21 The term “economic determinants of health” refers
22 to income and social status. Higher income and so-
23 cioeconomic status are linked to decreased rates of
24 morbidity and mortality, with higher socioeconomic
25 status correlated with better health and longer life,

1 and lower socioeconomic status correlated with an
2 increased risk of illness and death.

3 **SEC. 1002. FINDINGS.**

4 Congress finds as follows:

5 (1) Social determinants of health are the great-
6 est predictors of health outcomes.

7 (2) Social determinants of health, including
8 health-related behaviors, social and economic factors,
9 and physical environment factors account for 80 per-
10 cent of health outcomes, whereas clinical care ac-
11 counts for 20 percent of improved health outcomes.
12 Yet, in 2017, public health spending represented
13 only 2.5 percent of all health spending in the United
14 States.

15 (3) There are more opportunities to improve
16 health for everyone when we understand that health
17 starts, first, not in a medical setting, but in our
18 families, in our schools and workplaces, in our
19 neighborhoods, in the air we breathe, and in the
20 water we drink.

21 (4)(A) Healthy People 2020 identifies health
22 and health care quality as a function of not only ac-
23 cess to health care, but also the social determinants
24 of health, categorized into the following: neighbor-

1 hoods and the built environment; social and commu-
2 nity context; education; and economic stability.

3 (B) The following examples illustrate the nexus
4 between the unequal distribution of the social deter-
5 minants of health and health disparities:

6 (i) The built environment influences resi-
7 dents' level of physical activity. Neighborhoods
8 with high levels of poverty are significantly less
9 likely to have places where children can be
10 physically active, such as parks, green spaces,
11 and bike paths and lanes. Neighborhoods and
12 communities can provide opportunities for phys-
13 ical activity and support active lifestyles
14 through accessible and safe parks and open
15 spaces and through land use policy, zoning, and
16 healthy community design.

17 (ii) Emotional and physical health and
18 well-being are directly impacted by perceived
19 levels of safety, such as unlit streets at night.
20 Community members have expressed that safety
21 is not only a barrier to accessing programs and
22 services that increase quality of life but they
23 are also not able to access physical activity in
24 their community through the built environment.

1 (iii) Historical and institutional racism in
2 the United States has shaped the way in which
3 social and economic resources and exposure to
4 health promoting environments are distributed.
5 Income, education, occupation, neighborhood
6 conditions, schools, workplaces, the use of
7 health and social services, and experiences with
8 the criminal justice system are all highly pat-
9 terned by race, with people of color experiencing
10 more that is health harming. Finding ways to
11 uncouple the link between race and access to re-
12 sources and healthy environments is a principal
13 means of reducing health disparities. Addition-
14 ally, the anticipation of racism itself causes
15 higher psychological and cardiovascular stress
16 levels that are linked to poor health outcomes.
17 Remedying discriminatory practices at the indi-
18 vidual and systemic levels will likely reduce
19 health disparities caused by this unequal dis-
20 tribution of stress.

21 (iv) Poor health among Native Americans
22 has largely been driven by post-colonial oppres-
23 sion and historical trauma. The expropriation of
24 native lands and territories to the American
25 state had severe consequences on Native Amer-

1 ican health. This resulted in the deprivation of
2 traditional food sources—and nutrients—for
3 Native Americans and also the destruction of
4 traditional economies and community organiza-
5 tion. Today, Native Americans have twice the
6 rate of diabetes of non-Hispanic Whites. Rec-
7 ognition of the origins of the diabetes as having
8 a social and community context, rather than
9 just individual responsibility and genetic pre-
10 disposition, will shape better policy to provide
11 food security.

12 (v) In the context of prisons, overcrowding
13 has led to the deterioration of the physical and
14 mental health of individuals after they leave
15 prison. In particular, the mass incarceration of
16 African-American males as a result of unequal
17 contact with and treatment in the criminal jus-
18 tice system has contributed to an overburdening
19 of certain infectious diseases within the African-
20 American community. As a social institution,
21 incarceration amplifies existing adverse health
22 conditions by concentrating diseases and harm-
23 ful health behaviors such as tobacco use, drug
24 use, and violence.

1 (vi) Educational attainment is the strong-
2 est predictor of adult mortality. It is a basic
3 component of socioeconomic status that shapes
4 earning potential to access resources that pro-
5 mote health. People with more education are
6 less likely to report that they are in poor health,
7 and are also less likely to have diabetes and
8 other chronic diseases.

9 (vii) Individuals with lower levels of edu-
10 cational attainment are much more likely to re-
11 port to be current smokers. In 2017, smoking
12 prevalence was 36.8 percent among adults with
13 a GED diploma, 23.1 percent with less than a
14 high school diploma, and 18.7 percent with a
15 high school diploma, while dropping signifi-
16 cantly to 7.1 percent among adults with an un-
17 dergraduate college degree and 4.1 percent with
18 a postgraduate college degree.

19 (viii) Income inequality differences account
20 for a large part of health disparities.. For ex-
21 ample, children living in poverty experience
22 poorer housing conditions, increased exposure
23 to indoor allergens and toxins (such as pes-
24 ticides, lead, mercury, radon, air pollution, and
25 carcinogens), increased food insecurity, and

1 more psychological stress. These experiences
2 culminate in worse adult health as compared
3 with children with higher socioeconomic status.
4 Specifically, children living in lower socio-
5 economic neighborhoods have higher rates of
6 asthma due to higher rates of psychological
7 stress resulting from higher rates of violence.
8 Food insecurity is associated with obesity and
9 racial and ethnic minorities have higher rates of
10 food insecurity.

11 (ix) Lesbian, gay, bisexual, transgender,
12 queer or questioning, intersex, and asexual or
13 allied (referred to in this section as
14 “LGBTQIA”) individuals face health disparities
15 linked to societal stigma, discrimination, and
16 denial of their civil and human rights. Discrimi-
17 nation against LGBTQIA individuals has been
18 associated with high rates of psychiatric dis-
19 orders, substance abuse, and suicide. Experi-
20 ences of violence and victimization are frequent
21 for LGBTQIA individuals, and have long-last-
22 ing effects on the individual and the commu-
23 nity. Personal, family, and social acceptance of
24 sexual orientation and gender identity affects

1 the mental health and personal safety of
2 LGBTQIA individuals.

3 (x) Individuals in older and cheaper hous-
4 ing are at higher risks to be exposed to lead,
5 particularly in housing built prior to 1960. The
6 threat of lead poisoning disproportionately af-
7 fects vulnerable populations, with children living
8 in poverty (5.6 percent) and Black children
9 (5.6) experiencing the highest rates. According
10 to the Department of Housing and Urban De-
11 velopment, about 3,600,000 homes nationwide
12 that house young children have lead hazards
13 such as contaminated drinking water, peeling
14 paint, contaminated dust, or toxic soil. The
15 combined cost of medical treatment and special
16 education for lead poisoned children averages
17 about \$5,600 per child per year, and lead poi-
18 soning costs the United States an estimated
19 \$50,000,000,000 annually.

20 (xi) According to the report Healthy Peo-
21 ple 2020, individuals with disabilities, as a
22 group, experience health disparities in routine
23 public health arenas such as health behaviors,
24 clinical preventive services, and chronic condi-

1 tions. Compared with individuals without dis-
2 abilities, individuals with disabilities are—

3 (I) less likely to receive recommended
4 preventive health care services, such as
5 routine teeth cleanings and cancer
6 screenings;

7 (II) at a high risk for poor health out-
8 comes such as obesity, hypertension, falls-
9 related injuries, and mood disorders such
10 as depression; and

11 (III) more likely to engage in
12 unhealthy behaviors that put their health
13 at risk, such as cigarette smoking and in-
14 adequate physical activity.

15 (5) Laws and regulations that improve opportu-
16 nities to live in safe neighborhoods with more social
17 cohesion, attain higher education, sustain stable em-
18 ployment, and bridge class differences help foster
19 the health and safety of individuals.

20 (6) The global public health community has
21 reached consensus through the Rio Political Declara-
22 tion of Social Determinants of Health adopted by
23 the World Health Organization in October 2011 that
24 “[c]ollaboration in coordinated and intersectoral pol-
25 icy actions has proven to be effective. Health in All

1 Policies, an initiative of the American Public Health
2 Association, together with intersectoral cooperation
3 and action, is one promising approach to enhance
4 accountability in other sectors of health, as well as
5 the promotion of health equity and more inclusive
6 and productive societies.”.

7 **SEC. 1003. HEALTH IMPACT ASSESSMENTS.**

8 (a) FINDINGS.—Congress makes the following find-
9 ings:

10 (1) Health Impact Assessment is a tool to help
11 planners, health officials, decision makers, and the
12 public make more informed decisions about the po-
13 tential health effects of proposed plans, policies, pro-
14 grams, and projects in order to maximize health
15 benefits and minimize harms.

16 (2) Health Impact Assessments fosters commu-
17 nity leadership, ownership and participation in deci-
18 sion-making processes.

19 (3) Health Impact Assessments can build com-
20 munity support and reduce opposition to a project or
21 policy, thereby facilitating economic growth by aid-
22 ing the development of consensus regarding new de-
23 velopment proposals.

24 (4) Health Impact Assessments facilitate col-
25 laboration across sectors.

1 (b) PURPOSES.—It is the purpose of this section to—

2 (1) provide more information about the poten-
3 tial human health effects of policy decisions and the
4 distribution of those effects;

5 (2) improve how health is considered in plan-
6 ning and decision-making processes; and

7 (3) build stronger, healthier communities
8 through the use of Health Impact Assessments.

9 (c) HEALTH IMPACT ASSESSMENTS.—Part P of title
10 III of the Public Health Service Act (42 U.S.C. 280g et
11 seq.), as amended by section 744, is further amended by
12 adding at the end the following:

13 **“SEC. 399V-12. HEALTH IMPACT ASSESSMENTS.**

14 “(a) DEFINITIONS.—In this section:

15 “(1) ADMINISTRATOR.—The term ‘Adminis-
16 trator’ means the Administrator of the Environ-
17 mental Protection Agency.

18 “(2) DIRECTOR.—The term ‘Director’ means
19 the Director of the Centers for Disease Control and
20 Prevention.

21 “(3) HEALTH IMPACT ASSESSMENT.—The term
22 ‘health impact assessment’ means a systematic proc-
23 ess that uses an array of data sources and analytic
24 methods and considers input from stakeholders to
25 determine the potential effects of a proposed policy,

1 plan, program, or project on the health of a popu-
2 lation and the distribution of those effects within the
3 population. Such term includes identifying and rec-
4 ommending appropriate actions on monitoring and
5 maximizing potential benefits and minimizing the
6 potential harms.

7 “(4) HEALTH DISPARITY.—The term ‘health
8 disparity’ means a particular type of health dif-
9 ference that is closely linked with social, economic,
10 or environmental disadvantage and that adversely
11 affects groups of people who have systematically ex-
12 perience greater obstacles to health based on their
13 racial or ethnic group; religion; socioeconomic status;
14 gender; age; mental health; cognitive, sensory, or
15 physical disability; sexual orientation or gender iden-
16 tity; geographic location; citizenship status; or other
17 characteristics historically linked to discrimination
18 or exclusion.

19 “(b) ESTABLISHMENT.—The Secretary, acting
20 through the Director and in collaboration with the Admin-
21 istrator, shall—

22 “(1) in consultation with the Director of the
23 National Center for Chronic Disease Prevention and
24 Health Promotion and relevant offices within the
25 Department of Housing and Urban Development,

1 the Department of Transportation, and the Depart-
2 ment of Agriculture, establish a program at the Na-
3 tional Center for Environmental Health at the Cen-
4 ters for Disease Control and Prevention focused on
5 advancing the field of health impact assessment that
6 includes—

7 “(A) collecting and disseminating best
8 practices;

9 “(B) administering capacity building
10 grants to States to support grantees in initi-
11 ating health impact assessments, in accordance
12 with subsection (d);

13 “(C) providing technical assistance;

14 “(D) developing training tools and pro-
15 viding training on conducting health impact as-
16 sessment and the implementation of built envi-
17 ronment and health indicators;

18 “(E) making information available, as ap-
19 propriate, regarding the existence of other com-
20 munity healthy living tools, checklists, and indi-
21 ces that help connect public health to other sec-
22 tors, and tools to help examine the effect of the
23 indoor built environment and building codes on
24 population health;

1 “(F) conducting research and evaluations
2 of health impact assessments; and

3 “(G) awarding competitive extramural re-
4 search grants;

5 “(2) develop guidance and guidelines to conduct
6 health impact assessments in accordance with sub-
7 section (c); and

8 “(3) establish a grant program to allow States
9 to fund eligible entities to conduct health impact as-
10 sements.

11 “(c) GUIDANCE.—

12 “(1) IN GENERAL.—Not later than 1 year after
13 the date of enactment of the Health Equity and Ac-
14 countability Act of 2020, the Secretary, acting
15 through the Director, shall issue final guidance for
16 conducting the health impact assessments. In devel-
17 oping such guidance the Secretary shall—

18 “(A) consult with the Director of the Na-
19 tional Center for Environmental Health and,
20 the Director of the National Center for Chronic
21 Disease Prevention and Health Promotion, and
22 relevant offices within the Department of Hous-
23 ing and Urban Development, the Department of
24 Transportation, and the Department of Agri-
25 culture; and

1 “(B) consider available international health
2 impact assessment guidance, North American
3 health impact assessment practice standards,
4 and recommendations from the National Acad-
5 emy of Science.

6 “(2) CONTENT.—The guidance under this sub-
7 section shall include—

8 “(A) background on national and inter-
9 national efforts to bridge urban planning, cli-
10 mate forecasting, and public health institutions
11 and disciplines, including a review of health im-
12 pact assessment best practices internationally;

13 “(B) evidence-based direct and indirect
14 pathways that link land-use planning, transpor-
15 tation, and housing policy and objectives to
16 human health outcomes;

17 “(C) data resources and quantitative and
18 qualitative forecasting methods to evaluate both
19 the status of health determinants and health ef-
20 fects, including identification of existing pro-
21 grams that can disseminate these resources;

22 “(D) best practices for inclusive public in-
23 volvement in conducting health impact assess-
24 ments; and

1 “(E) technical assistance for other agen-
2 cies seeking to develop their own guidelines and
3 procedures for health impact assessment.

4 “(d) GRANT PROGRAM.—

5 “(1) IN GENERAL.—The Secretary, acting
6 through the Director and in collaboration with the
7 Administrator, shall—

8 “(A) award grants to States to fund eligi-
9 ble entities for capacity building or to prepare
10 health impact assessments; and

11 “(B) ensure that States receiving a grant
12 under this subsection further support training
13 and technical assistance for grantees under the
14 program by funding and overseeing appropriate
15 local, State, Tribal, Federal, institution of high-
16 er education, or nonprofit health impact assess-
17 ment experts to provide such technical assist-
18 ance.

19 “(2) APPLICATIONS.—

20 “(A) IN GENERAL.—To be eligible to re-
21 ceive a grant under this section, an eligible enti-
22 ty shall—

23 “(i) be a State, Indian tribe, or tribal
24 organization that includes individuals or
25 populations the health of which are, or will

1 be, affected by an activity or a proposed
2 activity; and

3 “(ii) submit to the Secretary an appli-
4 cation in accordance with this subsection,
5 at such time, in such manner, and con-
6 taining such additional information as the
7 Secretary may require.

8 “(B) INCLUSION.—An application under
9 this subsection shall include a list of proposed
10 activities that require or would benefit from
11 conducting a health impact assessment within
12 six months of awarding funds. The list should
13 be accompanied by supporting documentation,
14 including letters of support, from potential con-
15 ductors of health impact assessments for the
16 listed proposed activities. Each application
17 should also include an assessment by the eligi-
18 ble entity of the health of the population of its
19 jurisdiction and describe potential adverse or
20 positive effects on health that the proposed ac-
21 tivities may create.

22 “(C) PREFERENCE.—Preference in award-
23 ing funds under this section may be given to el-
24 igible entities that demonstrate the potential to
25 significantly improve population health or lower

1 health care costs as a result of potential health
2 impact assessment work.

3 “(3) USE OF FUNDS.—

4 “(A) IN GENERAL.—An entity receiving a
5 grant under this section shall use such grant
6 funds to conduct health impact assessment ca-
7 pacity building or to fund subgrantees in con-
8 ducting a health impact assessment for a pro-
9 posed activity in accordance with this sub-
10 section.

11 “(B) PURPOSES.—The purposes of a
12 health impact assessment under this subsection
13 are—

14 “(i) to facilitate the involvement of
15 tribal, State, and local public health offi-
16 cials in community planning, transpor-
17 tation, housing, and land use decisions and
18 other decisions affecting the built environ-
19 ment to identify any potential health con-
20 cern or health benefit relating to an activ-
21 ity or proposed activity;

22 “(ii) to provide for an investigation of
23 any health-related issue of concern raised
24 in a planning process, an environmental

1 impact assessment process, or policy ap-
2 praisal relating to a proposed activity;

3 “(iii) to describe and compare alter-
4 natives (including no-action alternatives) to
5 a proposed activity to provide clarification
6 with respect to the potential health out-
7 comes associated with the proposed activity
8 and, where appropriate, to the related ben-
9 efit-cost or cost-effectiveness of the pro-
10 posed activity and alternatives;

11 “(iv) to contribute, when applicable,
12 to the findings of a planning process, pol-
13 icy appraisal, or an environmental impact
14 statement with respect to the terms and
15 conditions of implementing a proposed ac-
16 tivity or related mitigation recommenda-
17 tions, as necessary;

18 “(v) to ensure that the dispropor-
19 tionate distribution of negative impacts
20 among vulnerable populations is minimized
21 as much as possible;

22 “(vi) to engage affected community
23 members and ensure adequate opportunity
24 for public comment on all stages of the
25 health impact assessment;

1 “(vii) where appropriate, to consult
2 with local and county health departments
3 and appropriate organizations, including
4 planning, transportation, and housing or-
5 ganizations and providing them with infor-
6 mation and tools regarding how to conduct
7 and integrate health impact assessment
8 into their work; and

9 “(viii) to inspect homes, water sys-
10 tems, and other elements that pose risks to
11 lead exposure, with an emphasis on areas
12 that pose a higher risk to children.

13 “(4) ASSESSMENTS.—Health impact assess-
14 ments carried out using grant funds under this sec-
15 tion shall—

16 “(A) take appropriate health factors into
17 consideration as early as practicable during the
18 planning, review, or decision-making processes;

19 “(B) assess the effect on the health of in-
20 dividuals and populations of proposed policies,
21 projects, or plans that result in modifications to
22 the built environment; and

23 “(C) assess the distribution of health ef-
24 fects across various factors, such as race, in-

1 come, ethnicity, age, disability status, gender,
2 and geography.

3 “(5) ELIGIBLE ACTIVITIES.—

4 “(A) IN GENERAL.—Eligible entities fund-
5 ed under this subsection shall conduct an eval-
6 uation of any proposed activity to determine
7 whether it will have a significant adverse or
8 positive effect on the health of the affected pop-
9 ulation in the jurisdiction of the eligible entity,
10 based on the criteria described in subparagraph
11 (B).

12 “(B) CRITERIA.—The criteria described in
13 this subparagraph include, as applicable to the
14 proposed activity, the following:

15 “(i) Any substantial adverse effect or
16 significant health benefit on health out-
17 comes or factors known to influence health,
18 including the following:

19 “(I) Physical activity.

20 “(II) Injury.

21 “(III) Mental health.

22 “(IV) Accessibility to health-pro-
23 moting goods and services.

24 “(V) Respiratory health.

25 “(VI) Chronic disease.

1 “(VII) Nutrition.

2 “(VIII) Land use changes that
3 promote local, sustainable food
4 sources.

5 “(IX) Infectious disease.

6 “(X) Health disparities.

7 “(XI) Existing air quality,
8 ground or surface water quality or
9 quantity, or noise levels.

10 “(XII) Lead exposure.

11 “(XIII) Drinking water quality
12 and accessibility.

13 “(ii) Other factors that may be con-
14 sidered, including—

15 “(I) the potential for a proposed
16 activity to result in systems failure
17 that leads to a public health emer-
18 gency;

19 “(II) the probability that the pro-
20 posed activity will result in a signifi-
21 cant increase in tourism, economic de-
22 velopment, or employment in the ju-
23 risdiction of the eligible entity;

24 “(III) any other significant po-
25 tential hazard or enhancement to

1 human health, as determined by the
2 eligible entity; or

3 “(IV) whether the evaluation of a
4 proposed activity would duplicate an-
5 other analysis or study being under-
6 taken in conjunction with the pro-
7 posed activity.

8 “(C) FACTORS FOR CONSIDERATION.—In
9 evaluating a proposed activity under subpara-
10 graph (A), an eligible entity may take into con-
11 sideration any reasonable, direct, indirect, or
12 cumulative effect that can be clearly related to
13 potential health effects and that is related to
14 the proposed activity, including the effect of
15 any action that is—

16 “(i) included in the long-range plan
17 relating to the proposed activity;

18 “(ii) likely to be carried out in coordi-
19 nation with the proposed activity;

20 “(iii) dependent on the occurrence of
21 the proposed activity; or

22 “(iv) likely to have a disproportionate
23 impact on high-risk or vulnerable popu-
24 lations.

1 “(6) REQUIREMENTS.—A health impact assess-
2 ment prepared with funds awarded under this sub-
3 section shall incorporate the following, after con-
4 ducting the screening phase (identifying projects or
5 policies for which a health impact assessment would
6 be valuable and feasible) through the application
7 process:

8 “(A) SCOPING.—Identifying which health
9 effects to consider and the research methods to
10 be utilized.

11 “(B) ASSESSING RISKS AND BENEFITS.—
12 Assessing the baseline health status and factors
13 known to influence the health status in the af-
14 fected community, which may include aggreg-
15 ating and synthesizing existing health assess-
16 ment evidence and data from the community.

17 “(C) DEVELOPING RECOMMENDATIONS.—
18 Suggesting changes to proposals to promote
19 positive or mitigate adverse health effects.

20 “(D) REPORTING.—Synthesizing the as-
21 sessment and recommendations and commu-
22 nicating the results to decision makers.

23 “(E) MONITORING AND EVALUATING.—
24 Tracking the decision and implementation effect
25 on health determinants and health status.

1 “(7) PLAN.—An eligible entity that is awarded
2 a grant under this section shall develop and imple-
3 ment a plan, to be approved by the Director, for
4 meaningful and inclusive stakeholder involvement in
5 all phases of the health impact assessment. Stake-
6 holders may include community leaders, community-
7 based organizations, youth-serving organizations,
8 planners, public health experts, State and local pub-
9 lic health departments and officials, health care ex-
10 perts or officials, housing experts or officials, and
11 transportation experts or officials.

12 “(8) SUBMISSION OF FINDINGS.—An eligible
13 entity that is awarded a grant under this section
14 shall submit the findings of any funded health im-
15 pact assessment activities to the Secretary and make
16 these findings publicly available.

17 “(9) ASSESSMENT OF IMPACTS.—An eligible en-
18 tity that is awarded a grant under this section shall
19 ensure the assessment of the distribution of health
20 impacts (related to the proposed activity) across
21 race, ethnicity, income, age, gender, disability status,
22 and geography.

23 “(10) CONDUCT OF ASSESSMENT.—To the
24 greatest extent feasible, a health impact assessment
25 shall be conducted under this section in a manner

1 that respects the needs and timing of the decision-
2 making process it evaluates.

3 “(11) **METHODOLOGY.**—In preparing a health
4 impact assessment under this subsection, an eligible
5 entity or partner shall follow the guidance published
6 under subsection (c).

7 “(e) **HEALTH IMPACT ASSESSMENT DATABASE.**—
8 The Secretary, acting through the Director and in collabo-
9 ration with the Administrator, shall establish, maintain,
10 and make publicly available a health impact assessment
11 database, including—

12 “(1) a catalog of health impact assessments re-
13 ceived under this section;

14 “(2) an inventory of tools used by eligible enti-
15 ties to conduct health impact assessments; and

16 “(3) guidance for eligible entities with respect
17 to the selection of appropriate tools described in
18 paragraph (2).

19 “(f) **EVALUATION OF GRANTEE ACTIVITIES.**—The
20 Secretary shall award competitive grants to Prevention
21 Research Centers, or nonprofit organizations or academic
22 institutions with expertise in health impact assessments
23 to—

1 mental Protection Agency (referred to in this section as
2 the ‘Administrator’), shall award grants to public agencies
3 or private nonprofit institutions to implement evidence-
4 based programming to improve human health through im-
5 provements to the built environment and subsequently
6 human health, by addressing—

7 “(1) levels of physical activity;

8 “(2) consumption of nutritional foods;

9 “(3) rates of crime;

10 “(4) air, water, and soil quality;

11 “(5) risk or rate of injury;

12 “(6) accessibility to health-promoting goods and
13 services;

14 “(7) chronic disease rates;

15 “(8) community design;

16 “(9) housing;

17 “(10) transportation options; and

18 “(11) other factors, as the Secretary determines
19 appropriate.

20 “(b) APPLICATIONS.—A public agency or private
21 nonprofit institution desiring a grant under this section
22 shall submit to the Secretary an application at such time,
23 in such manner, and containing such agreements, assur-
24 ances, and information as the Secretary, in consultation
25 with the Administrator, may require.

1 “(c) RESEARCH.—The Secretary, in consultation
2 with the Administrator, shall support, through grants
3 awarded under this section, research that—

4 “(1) uses evidence-based research to improve
5 the built environment and human health;

6 “(2) examines—

7 “(A) the scope and intensity of the impact
8 that the built environment (including the var-
9 ious characteristics of the built environment)
10 has on the human health; or

11 “(B) the distribution of such impacts by—

12 “(i) location; and

13 “(ii) population subgroup;

14 “(3) is used to develop—

15 “(A) measures and indicators to address
16 health impacts and the connection of health to
17 the built environment;

18 “(B) efforts to link the measures to trans-
19 portation, land use, and health databases; and

20 “(C) efforts to enhance the collection of
21 built environment surveillance data;

22 “(4) distinguishes carefully between personal
23 attitudes and choices and external influences on be-
24 havior to determine how much the association be-
25 tween the built environment and the health of resi-

1 dents, versus the lifestyle preferences of the people
2 that choose to live in the neighborhood, reflects the
3 physical characteristics of the neighborhood; and

4 “(5)(A) identifies or develops effective interven-
5 tion strategies focusing on enhancements to the built
6 environment that promote increased use physical ac-
7 tivity, access to nutritious foods, or other health-pro-
8 moting activities by residents; and

9 “(B) in developing the intervention strategies
10 under subparagraph (A), ensures that the interven-
11 tion strategies will reach out to high-risk or vulner-
12 able populations, including low-income urban and
13 rural communities and aging populations, in addi-
14 tion to the general population.

15 “(d) SURVEYS.—The Secretary may allow recipients
16 of grants under this section to use such grant funds to
17 support the expansion of national surveys and data track-
18 ing systems to provide more detailed information about
19 the connection between the built environment and health.

20 “(e) PRIORITY.—In awarding grants under this sec-
21 tion, the Secretary and the Administrator shall give pri-
22 ority to entities with programming that incorporates—

23 “(1) interdisciplinary approaches; or

24 “(2) the expertise of the public health, physical
25 activity, urban planning, land use, and transpor-

1 tation research communities in the United States
2 and abroad.

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated such sums as may be
5 necessary to carry out this section. The Secretary may al-
6 locate not more than 20 percent of the amount so appro-
7 priated for a fiscal year for purposes of conducting re-
8 search under subsection (c).”.

9 **SEC. 1004. IMPLEMENTATION OF RECOMMENDATIONS BY**
10 **ENVIRONMENTAL PROTECTION AGENCY.**

11 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The
12 Administrator of the Environmental Protection Agency
13 (referred to in this section as the “Administrator”) shall,
14 as promptly as practicable, carry out each of the following
15 recommendations of the Inspector General of the Environ-
16 mental Protection Agency as described in the report enti-
17 tled “EPA Needs to Conduct Environmental Justice Re-
18 views of Its Programs, Policies and Activities” (Report
19 No. 2006–P–00034):

20 (1) The recommendation that the program and
21 regional offices of the Environmental Protection
22 Agency identify which programs, policies, and activi-
23 ties need environmental justice reviews and the Ad-
24 ministrator require those offices to establish a plan
25 to complete the necessary reviews.

1 (2) The recommendation that the Administrator
2 ensure that the reviews described in paragraph (1)
3 determine whether the programs, policies, and activi-
4 ties may have a disproportionately high and adverse
5 health or environmental impact on minority and low-
6 income populations.

7 (3) The recommendation that each program
8 and regional office of the Environmental Protection
9 Agency develop specific environmental justice review
10 guidance for conducting environmental justice re-
11 views.

12 (4) The recommendation that the Administrator
13 designate a responsible office to compile results of
14 environmental justice reviews and recommend appro-
15 priate actions.

16 (b) GAO RECOMMENDATIONS.—In promulgating reg-
17 ulations of the Environmental Protection Agency, the Ad-
18 ministrator shall, as promptly as practicable, carry out
19 each of the following recommendations of the Comptroller
20 General of the United States as described in the report
21 entitled “EPA Should Devote More Attention to Environ-
22 mental Justice when Developing Clean Air Rules” (GAO-
23 05-289):

24 (1) The recommendation that the Administrator
25 ensure that workgroups involved in developing a rule

1 devote attention to environmental justice while draft-
2 ing and finalizing the rule.

3 (2) The recommendation that the Administrator
4 enhance the ability of the workgroups described in
5 paragraph (1) to identify potential environmental
6 justice issues through steps such as—

7 (A) providing workgroup members with
8 guidance and training to help those members
9 identify potential environmental justice prob-
10 lems; and

11 (B) involving environmental justice coordi-
12 nators in the workgroups if appropriate.

13 (3) The recommendation that the Administrator
14 improve assessments of potential environmental jus-
15 tice impacts in economic reviews by identifying the
16 data and developing the modeling techniques needed
17 to assess those impacts.

18 (4) The recommendation that the Administrator
19 direct appropriate officers and employees of the En-
20 vironmental Protection Agency, if feasible, to re-
21 spond fully to public comments on environmental
22 justice, including by—

23 (A) improving the explanation by the Ad-
24 ministrator of the basis for any conclusions re-
25 lating to environmental justice; and

1 (B) including in an explanation under sub-
2 paragraph (A) supporting data.

3 (c) 2004 INSPECTOR GENERAL REPORT.—

4 (1) IN GENERAL.—The Administrator shall, as
5 promptly as practicable, carry out each of the fol-
6 lowing recommendations of the Inspector General of
7 the Environmental Protection Agency as described
8 in the report entitled “EPA Needs to Consistently
9 Implement the Intent of the Executive Order on En-
10 vironmental Justice” (Report No. 2004–P–00007):

11 (A) The recommendation that the Admin-
12 istrator clearly define the mission of the Office
13 of Environmental Justice and provide Environ-
14 mental Protection Agency staff with an under-
15 standing of the roles and responsibilities of that
16 Office.

17 (B) The recommendation that the Admin-
18 istrator—

19 (i) establish, through the issuance of
20 guidance or a policy statement, specific
21 timeframes for the development of defini-
22 tions, goals, and measurements regarding
23 environmental justice; and

24 (ii) provide the regions and program
25 offices a standard and consistent definition

1 for a minority and low-income community,
2 with instructions on how the Environ-
3 mental Protection Agency will implement
4 and put into operation environmental jus-
5 tice in the daily activities of the Environ-
6 mental Protection Agency.

7 (C) The recommendation that the Adminis-
8 trator ensure that the comprehensive training
9 program that was under development (as of the
10 date of the report) includes standard and con-
11 sistent definitions of the key environmental jus-
12 tice concepts, such as “low-income”, “minor-
13 ity”, and “disproportionately impacted”, and
14 instructions for implementation of those con-
15 cepts.

16 (2) REPORTS.—

17 (A) INITIAL REPORT.—Not later than 180
18 days after the date of enactment of this Act,
19 the Administrator shall submit to Congress an
20 initial report on the strategy of the Adminis-
21 trator for implementing the recommendations
22 described in subparagraphs (A), (B), and (C) of
23 paragraph (1).

24 (B) SUBSEQUENT REPORTS.—After sub-
25 mitting the initial report under subparagraph

1 (A), the Administrator shall submit to Congress
2 semiannual reports on the progress of the Ad-
3 ministrator in—

4 (i) implementing the recommendations
5 referred to in subparagraph (A); and

6 (ii) modifying the emergency manage-
7 ment procedures of the Administrator to
8 incorporate environmental justice in the
9 Incident Command Structure of the Envi-
10 ronmental Protection Agency, in accord-
11 ance with the December 18, 2006, letter
12 from the Deputy Administrator to the Act-
13 ing Inspector General of the Environ-
14 mental Protection Agency.

15 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,
16 PROTECTING PEOPLE AND THEIR FAMILIES FROM
17 RADON.—

18 (1) FINDINGS.—Congress finds that radon is a
19 naturally occurring radioactive gas that is—

20 (A) recognized as the leading cause of lung
21 cancer among nonsmokers; and

22 (B) a particular environmental threat for
23 low-income and minority individuals because of
24 the lack of information about radon levels in
25 the homes of those individuals.

1 (2) IMPLEMENTATION.—Not later than 180
2 days after the date of enactment of this Act, the Ad-
3 ministrator shall implement the action plan entitled
4 “Protecting People and Families from Radon: A
5 Federal Action Plan for Saving Lives” (June 20,
6 2011), in consultation with the Director of the Cen-
7 ters for Disease Control and Prevention and any
8 other Federal agencies referred to in the action plan.

9 (3) SPECIFIC STEPS.—In carrying out para-
10 graph (2), the Administrator shall ensure that—

11 (A) the workgroup comprised of the Fed-
12 eral agencies participating in the development
13 of the action plan referred to in paragraph (2)
14 implements specific steps within the existing
15 authority and activities of each Federal agency
16 to reduce exposure to radon; and

17 (B) not later than the date that is 1 year
18 after the date on which the Administrator be-
19 gins implementation of the action plan de-
20 scribed in paragraph (2), the workgroup de-
21 scribed in subparagraph (A) meets to assess
22 and recognize achievements of the plan.

23 (4) REPORT.—After the progress meeting of
24 the workgroup under paragraph (3)(B), the Admin-
25 istrator shall submit to Congress a report on the im-

1 plementation of the action plan described in para-
2 graph (2), including the challenges remaining and
3 the progress in reducing radon exposure, particularly
4 for low-income and minority families.

5 (e) FEDERAL ACTION PLAN FOR PREVENTING
6 CHILDHOOD LEAD POISONING.—

7 (1) FINDINGS.—Congress finds that—

8 (A) the effects of lead poisoning are irre-
9 versible and cost the United States millions an-
10 nually in medical and education costs;

11 (B) the cognitive effects suffered by chil-
12 dren exposed to lead result in a lifetime of
13 health and behavioral problems, which makes
14 prevention efforts more critical; and

15 (C) the risk is especially high for vulner-
16 able minority populations who are more likely
17 to live in older homes, where lead-based paint
18 is more likely to be present.

19 (2) ACTION PLAN.—Not later than 180 days
20 after the date of enactment of this Act, the Adminis-
21 trator, in consultation with the Director of the Cen-
22 ters for Disease Control and Prevention and other
23 relevant Federal agencies, shall develop an action
24 plan to reduce exposure to lead.

1 (3) SPECIFIC STEPS.—In carrying out para-
2 graph (2), the Administrator shall—

3 (A) establish a working group, comprised
4 of representatives of the Federal agencies par-
5 ticipating in the development of the action plan
6 described in paragraph (2), to make rec-
7 ommendations for the implementation of spe-
8 cific steps within the existing authority and ac-
9 tivities of each Federal agency to reduce expo-
10 sure to lead; and

11 (B) assist other Federal agencies in the de-
12 velopment of materials on the hazards of lead-
13 based paint for the purpose of educating ten-
14 ants and landlords, how to recognize potential
15 sources of exposure, and how to remediate those
16 sources.

17 **SEC. 1005. GRANT PROGRAM TO CONDUCT ENVIRON-**
18 **MENTAL HEALTH IMPROVEMENT ACTIVITIES**
19 **AND TO IMPROVE SOCIAL DETERMINANTS OF**
20 **HEALTH.**

21 (a) DEFINITIONS.—In this section:

22 (1) DIRECTOR.—The term “Director” means
23 the Director of the Centers for Disease Control and
24 Prevention, acting in collaboration with the Adminis-
25 trator of the Environmental Protection Agency and

1 the Director of the National Institute of Environ-
2 mental Health Sciences.

3 (2) ELIGIBLE ENTITY.—The term “eligible enti-
4 ty” means a State or local community that—

5 (A) bears a disproportionate burden of ex-
6 posure to environmental health hazards;

7 (B) bears a disproportionate burden of ex-
8 posure to unhealthy living conditions, low
9 standard housing conditions, low socioeconomic
10 status, poor nutrition, less opportunity for edu-
11 cational attainment, disproportionately high un-
12 employment rates, or lower literacy levels and
13 access to information;

14 (C) has established a coalition—

15 (i) with not less than 1 community-
16 based organization or demonstration pro-
17 gram; and

18 (ii) with not less than 1—

19 (I) public health entity;

20 (II) health care provider organi-
21 zation;

22 (III) academic institution, includ-
23 ing any minority-serving institution
24 (including a Hispanic-serving institu-
25 tion, a historically Black college or

1 university, or a Tribal College or Uni-
2 versity);

3 (IV) child-serving institution; or

4 (V) landlord or housing provider
5 working on lead remediation;

6 (D) ensures planned activities and funding
7 streams are coordinated to improve community
8 health; and

9 (E) submits an application in accordance
10 with subsection (c).

11 (b) ESTABLISHMENT.—The Director shall establish a
12 grant program under which eligible entities shall receive
13 grants to conduct environmental health improvement ac-
14 tivities and to improve social determinants of health.

15 (c) APPLICATION.—To receive a grant under this sec-
16 tion, an eligible entity shall submit an application to the
17 Director at such time, in such manner, and accompanied
18 by such information as the Director may require.

19 (d) USE OF GRANT FUNDS.—An eligible entity may
20 use a grant under this section—

21 (1) to promote environmental health;

22 (2) to address environmental health disparities
23 among all populations, including children; and

24 (3) to address racial and ethnic disparities in
25 social determinants of health.

1 (e) AMOUNT OF COOPERATIVE AGREEMENT.—The
2 Director shall award grants to eligible entities at the fol-
3 lowing 3 funding levels:

4 (1) LEVEL 1 COOPERATIVE AGREEMENTS.—

5 (A) IN GENERAL.—An eligible entity
6 awarded a grant under this paragraph shall use
7 the funds to identify environmental health prob-
8 lems and solutions by—

9 (i) establishing a planning and
10 prioritizing council in accordance with sub-
11 paragraph (B); and

12 (ii) conducting an environmental
13 health assessment in accordance with sub-
14 paragraph (C).

15 (B) PLANNING AND PRIORITIZING COUN-
16 CIL.—

17 (i) IN GENERAL.—A prioritizing and
18 planning council established under sub-
19 paragraph (A)(i) (referred to in this para-
20 graph as a “PPC”) shall assist the envi-
21 ronmental health assessment process and
22 environmental health promotion activities
23 of the eligible entity.

24 (ii) MEMBERSHIP.—Membership of a
25 PPC shall consist of representatives from

1 various organizations within public health,
2 planning, development, and environmental
3 services and shall include stakeholders
4 from vulnerable groups such as children,
5 the elderly, disabled, and minority ethnic
6 groups that are often not actively involved
7 in democratic or decision-making proc-
8 esses.

9 (iii) DUTIES.—A PPC shall—

10 (I) identify key stakeholders and
11 engage and coordinate potential part-
12 ners in the planning process;

13 (II) establish a formal advisory
14 group to plan for the establishment of
15 services;

16 (III) conduct an in-depth review
17 of the nature and extent of the need
18 for an environmental health assess-
19 ment, including a local epidemiological
20 profile, an evaluation of the service
21 provider capacity of the community,
22 and a profile of any target popu-
23 lations; and

24 (IV) define the components of
25 care and form essential programmatic

1 linkages with related providers in the
2 community.

3 (C) ENVIRONMENTAL HEALTH ASSESS-
4 MENT.—

5 (i) IN GENERAL.—A PPC shall carry
6 out an environmental health assessment to
7 identify environmental health concerns.

8 (ii) ASSESSMENT PROCESS.—The
9 PPC shall—

10 (I) define the goals of the assess-
11 ment;

12 (II) generate the environmental
13 health issue list;

14 (III) analyze issues with a sys-
15 tems framework;

16 (IV) develop appropriate commu-
17 nity environmental health indicators;

18 (V) rank the environmental
19 health issues;

20 (VI) set priorities for action;

21 (VII) develop an action plan;

22 (VIII) implement the plan; and

23 (IX) evaluate progress and plan-
24 ning for the future.

1 (D) EVALUATION.—Each eligible entity
2 that receives a grant under this paragraph shall
3 evaluate, report, and disseminate program find-
4 ings and outcomes.

5 (E) TECHNICAL ASSISTANCE.—The Direc-
6 tor may provide such technical and other non-
7 financial assistance to eligible entities as the
8 Director determines to be necessary.

9 (2) LEVEL 2 COOPERATIVE AGREEMENTS.—

10 (A) ELIGIBILITY.—

11 (i) IN GENERAL.—The Director shall
12 award grants under this paragraph to eli-
13 gible entities that have already—

14 (I) established broad-based col-
15 laborative partnerships; and

16 (II) completed environmental as-
17 sessments.

18 (ii) NO LEVEL 1 REQUIREMENT.—To
19 be eligible to receive a grant under this
20 paragraph, an eligible entity is not re-
21 quired to have successfully completed a
22 Level 1 Cooperative Agreement (as de-
23 scribed in paragraph (1)).

24 (B) USE OF GRANT FUNDS.—An eligible
25 entity awarded a grant under this paragraph

1 shall use the funds to further activities to carry
2 out environmental health improvement activi-
3 ties, including—

4 (i) addressing community environ-
5 mental health priorities in accordance with
6 paragraph (1)(C)(ii), including—

7 (I) geography;

8 (II) the built environment;

9 (III) air quality;

10 (IV) water quality;

11 (V) land use;

12 (VI) solid waste;

13 (VII) housing;

14 (VIII) violence;

15 (IX) socioeconomic status;

16 (X) ethnicity, social construct

17 and language preference;

18 (XI) educational attainment;

19 (XII) employment;

20 (XIII) food safety, accessibility,

21 and affordability;

22 (XIV) nutrition;

23 (XV) health care services; and

24 (XVI) injuries;

1 (ii) building partnerships between
2 planning, public health, and other sectors,
3 including child-serving institutions, to ad-
4 dress how the built environment impacts
5 food availability and access and physical
6 activity to promote healthy behaviors and
7 lifestyles and reduce overweight and obe-
8 sity, musculoskeletal diseases, respiratory
9 conditions, dental, oral and mental health
10 conditions, poverty, and related co-
11 morbidities;

12 (iii) establishing programs to ad-
13 dress—

14 (I) how environmental and social
15 conditions of work and living choices
16 influence physical activity and dietary
17 intake; or

18 (II) how the conditions described
19 in subclause (I) influence the concerns
20 and needs of people who have im-
21 paired mobility and use assistance de-
22 vices, including wheelchairs, lower
23 limb prostheses, and hip, knee, and
24 other joint replacements; and

1 (iv) convening intervention and dem-
2 onstration programs that examine the role
3 of the social environment in connection
4 with the physical and chemical environ-
5 ment in—

6 (I) determining access to nutri-
7 tional food;

8 (II) improving physical activity to
9 reduce overweight, obesity, and co-
10 morbidities and increase quality of
11 life; and

12 (III) location and access to med-
13 ical facilities.

14 (3) LEVEL 3 COOPERATIVE AGREEMENTS.—

15 (A) IN GENERAL.—An eligible entity
16 awarded a grant under this paragraph shall use
17 the funds to identify and address racial and
18 ethnic disparities in social determinants of
19 health by creating demonstration programs that
20 assess the feasibility of establishing a federally
21 funded comprehensive program and describe
22 key outcomes that address racial and ethnic dis-
23 parities in social determinants of health.

24 (B) PROGRAM DESIGN.—

1 (i) EVALUATION.—No later than 1
2 year after enactment of this Act, the Di-
3 rector shall evaluate the best practices of
4 existing programs from the private, public,
5 community based, and academically sup-
6 ported initiatives focused on reducing dis-
7 parities in the social determinants of
8 health for racial and ethnic populations.

9 (ii) DEMONSTRATION PROJECTS.—
10 Not later than two years after the date of
11 enactment of this Act, the Director shall
12 implement at least ten demonstration
13 projects including at least one project for
14 each major racial and ethnic minority
15 group, each of which is unique to the cul-
16 tural and linguistic needs of each of the
17 following groups:

18 (I) Native Americans and Alaska
19 Natives.

20 (II) Asian Americans.

21 (III) African Americans/Blacks.

22 (IV) Hispanic/Latino-Americans.

23 (V) Native Hawaiians and Pacific
24 Islanders.

1 (iii) REPORT TO CONGRESS.—No later
2 than 2 years after the implementation of
3 the initial demonstration projects, the Di-
4 rector shall submit to Congress a report
5 which includes—

6 (I) a description of each dem-
7 onstration project and design;

8 (II) an evaluation of the cost-ef-
9 fectiveness of each project's preven-
10 tion and treatment efforts;

11 (III) an evaluation of the cultural
12 and linguistic appropriateness of each
13 project by racial and ethnic group;
14 and

15 (IV) an evaluation of the bene-
16 ficiary's health status improvement
17 under the demonstration project.

18 (iv) ANY OTHER INFORMATION
19 DEEMED APPROPRIATE BY THE DIREC-
20 TOR.—The Director shall require eligible
21 entities awarded a grant under this para-
22 graph to report any other information the
23 Director determines appropriate to be
24 shared by or developed by such entity, in-
25 cluding the following:

1 (I) Developing models and evalu-
2 ating methods that improve the cul-
3 tural and linguistically appropriate
4 services provided through the Centers
5 for Disease Control and Prevention to
6 target individuals impacted by health
7 disparities based on their race, eth-
8 nicity, and gender.

9 (II) Promoting the collaboration
10 between primary and specialty care
11 health care providers and patients, to
12 ensure patients impacted by health
13 disparities based on race, ethnicity,
14 and gender are receiving comprehen-
15 sive and organized treatment and
16 care.

17 (III) Educating health care pro-
18 fessionals on the causes and effects of
19 disparities in the social determinants
20 of health as it relates to minority and
21 racial and ethnic communities and the
22 need for culturally and linguistically
23 appropriate care in the prevention and
24 treatment of high-impact diseases.

1 (IV) Encouraging collaboration
2 among community and patient-based
3 organizations which work to address
4 disparities in the social determinants
5 of health as it relates to high-impact
6 diseases in minority and racial and
7 ethnic populations.

8 (f) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to carry out this sec-
10 tion—

11 (1) \$25,000,000 for fiscal year 2021; and

12 (2) such sums as may be necessary for fiscal
13 years 2022 through 2024.

14 **SEC. 1006. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
15 **BETWEEN THE BUILT ENVIRONMENT AND**
16 **THE HEALTH OF COMMUNITY RESIDENTS.**

17 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
18 section, the term “eligible institution” means a public or
19 private nonprofit institution that submits to the Secretary
20 of Health and Human Services (in this section referred
21 to as the “Secretary”) and the Administrator of the Envi-
22 ronmental Protection Agency (in this section referred to
23 as the “Administrator”) an application for a grant under
24 the grant program authorized under subsection (b)(2) at
25 such time, in such manner, and containing such agree-

1 ments, assurances, and information as the Secretary and
2 Administrator may require.

3 (b) RESEARCH GRANT PROGRAM.—

4 (1) DEFINITION OF HEALTH.—In this section,
5 the term “health” includes—

6 (A) levels of physical activity;

7 (B) degree of mobility due to factors such
8 as musculoskeletal diseases, arthritis, and obe-
9 sity;

10 (C) consumption of nutritional foods;

11 (D) rates of crime;

12 (E) air, water, and soil quality;

13 (F) risk of injury;

14 (G) accessibility to health care services;

15 (H) levels of educational attainment; and

16 (I) other indicators as determined appro-
17 priate by the Secretary.

18 (2) GRANTS.—The Secretary, in collaboration
19 with the Administrator, shall provide grants to eligi-
20 ble institutions to conduct and coordinate research
21 on the built environment and its influence on indi-
22 vidual and population-based health.

23 (3) RESEARCH.—The Secretary shall support
24 research that—

- 1 (A) investigates and defines the causal
2 links between all aspects of the built environ-
3 ment and the health of residents;
- 4 (B) examines—
- 5 (i) the extent of the impact of the
6 built environment (including the various
7 characteristics of the built environment) on
8 the health of residents;
- 9 (ii) the variance in the health of resi-
10 dents by—
- 11 (I) location (such as inner cities,
12 inner suburbs, and outer suburbs);
13 and
- 14 (II) population subgroup (includ-
15 ing children, the elderly, the disadvan-
16 taged); or
- 17 (iii) the importance of the built envi-
18 ronment to the total health of residents,
19 which is the primary variable of interest
20 from a public health perspective;
- 21 (C) is used to develop—
- 22 (i) measures to address health and the
23 connection of health to the built environ-
24 ment; and

1 (ii) efforts to link the measures to
2 travel and health databases;

3 (D) distinguishes carefully between per-
4 sonal attitudes and choices and external influ-
5 ences on observed behavior to determine how
6 much an observed association between the built
7 environment and the health of residents, versus
8 the lifestyle preferences of the people that
9 choose to live in the neighborhood, reflects the
10 physical characteristics of the neighborhood;
11 and

12 (E)(i) identifies or develops effective inter-
13 vention strategies to promote better health
14 among residents with a focus on behavioral
15 interventions and enhancements of the built en-
16 vironment that promote increased use by resi-
17 dents; and

18 (ii) in developing the intervention strate-
19 gies under clause (i), ensures that the interven-
20 tion strategies will reach out to high-risk popu-
21 lations, including racial and ethnic minorities,
22 low-income urban and rural communities, and
23 children.

24 (4) PRIORITY.—In providing assistance under
25 the grant program authorized under paragraph (2),

1 the Secretary and the Administrator shall give pri-
2 ority to research that incorporates—

3 (A) minority-serving institutions as grant-

4 ees;

5 (B) interdisciplinary approaches; or

6 (C) the expertise of the public health,

7 physical activity, nutrition and health care (in-

8 cluding child health), urban planning, and

9 transportation research communities in the

10 United States and abroad.

11 **SEC. 1007. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**

12 **TION.**

13 (a) FINDINGS.—Congress finds that—

14 (1) humans share an environment with a wide

15 variety of habitats and ecosystems that nurture and

16 sustain a diversity of species;

17 (2) the abundance of natural resources in the

18 environment forms the basis for the economy and

19 has greatly contributed to human development

20 throughout history;

21 (3) the accelerated pace of human development

22 over the last several hundred years has significantly

23 impacted—

24 (A) the natural environment and its re-

25 sources;

1 (B) the health and diversity of plant and
2 animal life;

3 (C) the availability of critical habitats;

4 (D) the quality of the air and water; and

5 (E) the global climate;

6 (4) the intervention of the Federal Government
7 is necessary to minimize and mitigate human impact
8 on the environment—

9 (A) for the benefit of public health;

10 (B) to maintain air quality and water qual-
11 ity;

12 (C) to sustain the diversity of plants and
13 animals;

14 (D) to combat global climate change; and

15 (E) to protect the environment;

16 (5) laws and regulations in the United States
17 have been enacted and promulgated to minimize and
18 mitigate human impact on the environment for the
19 benefit of public health, to maintain air quality and
20 water quality, to sustain wildlife, and to protect the
21 environment; and

22 (6) attempts to repeal or weaken key environ-
23 mental safeguards pose dangers to the public health,
24 air quality, water quality, wildlife, and the environ-
25 ment.

1 (b) STATEMENT OF POLICY.—It is the policy of the
2 Federal Government to work in conjunction with States,
3 territories, Tribal governments, international organiza-
4 tions, and foreign governments as a steward of the envi-
5 ronment for the benefit of public health, to maintain air
6 quality and water quality, to sustain the diversity of plant
7 and animal species, to combat global climate change, and
8 to protect the environment for future generations.

9 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
10 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
11 TIONS, LAWS, OR OTHER AGENCY DECISIONS.—

12 (1) STUDY.—Not later than 30 days after the
13 date of enactment of this Act, the President shall
14 seek to enter into an arrangement under which the
15 National Academy of Sciences shall conduct a study
16 to determine the impact on public health, air quality,
17 water quality, wildlife, and the environment of the
18 following regulations, laws, and other agency deci-
19 sions:

20 (A) CLEAN WATER.—

21 (i) The final rule of the Environ-
22 mental Protection Agency and the Corps of
23 Engineers entitled “Final Revisions to the
24 Clean Water Act Regulatory Definitions of
25 ‘Fill Material’ and ‘Discharge of Fill Mate-

1 rial'” (67 Fed. Reg. 31129 (May 9,
2 2002)).

3 (ii) The final rule of the Environ-
4 mental Protection Agency entitled “Na-
5 tional Pollutant Discharge Elimination
6 System Permit Regulation for Con-
7 centrated Animal Feeding Operations: Re-
8 moval of Vacated Elements in Response to
9 2011 Court Decision” (77 Fed. Reg.
10 44494 (July 30, 2012)).

11 (iii) The final rule entitled “With-
12 drawal of Revisions to the Water Quality
13 Planning and Management Regulation and
14 Revisions to the National Pollutant Dis-
15 charge Elimination System Program in
16 Support of Revisions to the Water Quality
17 Planning and Management Regulation”
18 (68 Fed. Reg. 13608 (March 19, 2003)).

19 (iv) The final rule of the Environ-
20 mental Protection Agency entitled “Con-
21 solidated Permit Regulations: RCRA Haz-
22 ardous Waste; SDWA Underground Injec-
23 tion Control; CWA National Pollutant Dis-
24 charge Elimination System; CWA Section
25 404 Dredge or Fill Programs; and CAA

1 Prevention of Significant Deterioration”
2 (45 Fed. Reg. 33290 (May 19, 1980)),
3 with respect to the definition of the “wa-
4 ters of the United States”.

5 (v) The final rule of the Corps of En-
6 gineers and the Environmental Protection
7 Agency entitled “Definition of ‘Waters of
8 the United States’—Recodification of Pre-
9 Existing Rules” (84 Fed. Reg. 56626 (Oc-
10 tober 22, 2019)).

11 (vi) The final rule of the Corps of En-
12 gineers and the Environmental Protection
13 Agency entitled “The Navigable Waters
14 Protection Rule: Definition of ‘Waters of
15 the United States’” (85 Fed. Reg. 22250
16 (April 21, 2020)).

17 (B) FORESTS AND LAND MANAGEMENT.—

18 (i) The Healthy Forests Restoration
19 Act of 2003 (16 U.S.C. 6501 et seq.).

20 (ii) The application of section 553(e)
21 of title 5, United States Code, such that a
22 State may petition for a special rule for
23 the National Forest System inventoried
24 roadless areas within the State.

1 (iii) The final rules entitled “National
2 Forest System Land Management Plan-
3 ning” (77 Fed. Reg. 21162 (April 9,
4 2012)) and “National Forest System Land
5 Management Planning” (81 Fed. Reg.
6 90723 (December 15, 2016)).

7 (iv) The final rule entitled “Oil Shale
8 Management—General” (73 Fed. Reg.
9 69414 (November 18, 2008)).

10 (v) The record of decision described in
11 the notice of availability entitled “Notice of
12 Availability of Approved Land Use Plan
13 Amendments/Record of Decision for Allo-
14 cation of Oil Shale and Tar Sands Re-
15 sources on Lands Administered by the Bu-
16 reau of Land Management in Colorado,
17 Utah, and Wyoming and Final Pro-
18 grammatic Environmental Impact State-
19 ment” (78 Fed. Reg. 19518 (April 1,
20 2013)).

21 (C) SCIENTIFIC REVIEW.—The final rule
22 entitled “Interagency Cooperation Under the
23 Endangered Species Act” (73 Fed. Reg. 76272
24 (December 16, 2008)), as amended by the final
25 rule entitled “Endangered and Threatened

1 Wildlife and Plants; Regulations for Inter-
2 agency Cooperation” (84 Fed. Reg. 44976 (Au-
3 gust 27, 2019)).

4 (2) METHOD.—In conducting the study under
5 paragraph (1), the National Academy of Sciences
6 may use and compare existing scientific studies re-
7 garding the regulations, laws, and other agency deci-
8 sions described in paragraph (1).

9 (3) REPORT.—Not later than 270 days after
10 the date on which the President enters into the ar-
11 rangement under paragraph (1), the National Acad-
12 emy of Sciences shall make publicly available and
13 shall submit to Congress and to the head of each de-
14 partment and agency of the Federal Government
15 that issued, implements, or would implement a regu-
16 lation, law, or other agency decision described in
17 paragraph (1), a report that includes—

18 (A) a description of the impact of each
19 regulation, law, or other agency decision de-
20 scribed in paragraph (1) on public health, air
21 quality, water quality, wildlife, and the environ-
22 ment, compared to the impact of preexisting
23 regulations, laws, or other agency decisions in
24 effect, as applicable, including—

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
15 other agency decisions described in paragraph
16 (1), which may include recommendations for
17 the adoption of any regulation or law in place
18 or proposed 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, law, or other agency decision described in subsection
25 (c)(1) shall submit to Congress a plan describing the steps

1 the department or agency will take, or has taken, to re-
2 store or improve protections for public health and the envi-
3 ronment in whole or in part that were in existence prior
4 to the issuance of the applicable regulation, law, or other
5 agency decision.

6 **SEC. 1008. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
7 **WATER HORIZON OIL RIG EXPLOSION IN THE**
8 **GULF COAST.**

9 (a) STUDY.—The Comptroller General of the United
10 States 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 of the United States
20 shall—

21 (1) assess the type, size, and scope of programs
22 administered by the Secretary of Health and Human
23 Services that focus on the provision of health care
24 to communities on the Gulf Coast;

1 (2) identify the merits and disadvantages asso-
2 ciated with each of the programs;

3 (3) perform an analysis of the costs and bene-
4 fits of the programs; and

5 (4) determine whether there is any duplication
6 of programs.

7 (c) REPORT.—Not later than 180 days after the date
8 of enactment of this Act, the Comptroller General of the
9 United States shall submit to Congress a report that in-
10 cludes—

11 (1) the findings of the study conducted under
12 subsection (a); and

13 (2) recommendations for improving access to
14 health care for racial and ethnic minorities.

15 **SEC. 1009. ESTABLISH AN INTERAGENCY COUNSEL AND**
16 **GRANT PROGRAMS ON SOCIAL DETER-**
17 **MINANTS OF HEALTH.**

18 (a) SHORT TITLE.—This section may be cited as the
19 “Social Determinants Accelerator Act of 2020”.

20 (b) FINDINGS; PURPOSES.—

21 (1) FINDINGS.—Congress finds the following:

22 (A) There is a significant body of evidence
23 showing that economic and social conditions
24 have a powerful impact on individual and popu-

1 lation health outcomes and well-being, as well
2 as medical costs.

3 (B) State, local, and Tribal governments
4 and the service delivery partners of such gov-
5 ernments face significant challenges in coordi-
6 nating benefits and services delivered through
7 the Medicaid program and other social services
8 programs because of the fragmented and com-
9 plex nature of Federal and State funding and
10 administrative requirements.

11 (C) The Federal Government should
12 prioritize and proactively assist State and local
13 governments to strengthen the capacity of State
14 and local governments to improve health and
15 social outcomes for individuals, thereby improv-
16 ing cost-effectiveness and return on investment.

17 (2) PURPOSES.—The purposes of this section
18 are as follows:

19 (A) To establish effective, coordinated Fed-
20 eral technical assistance to help State and local
21 governments to improve outcomes and cost-ef-
22 fectiveness of, and return on investment from,
23 health and social services programs.

24 (B) To build a pipeline of State and locally
25 designed, cross-sector interventions and strate-

1 gies that generate rigorous evidence about how
2 to improve health and social outcomes, and in-
3 crease the cost-effectiveness of, and return on
4 investment from, Federal, State, local, and
5 Tribal health and social services programs.

6 (C) To enlist State and local governments
7 and the service providers of such governments
8 as partners in identifying Federal statutory,
9 regulatory, and administrative challenges in im-
10 proving the health and social outcomes of, cost-
11 effectiveness of, and return on investment from,
12 Federal spending on individuals enrolled in
13 Medicaid.

14 (D) To develop strategies to improve
15 health and social outcomes without denying
16 services to, or restricting the eligibility of, vul-
17 nerable populations.

18 (c) SOCIAL DETERMINANTS ACCELERATOR COUN-
19 CIL.—

20 (1) ESTABLISHMENT.—The Secretary of Health
21 and Human Services (referred to in this section as
22 the “Secretary”), in coordination with the Adminis-
23 trator of the Centers for Medicare & Medicaid Serv-
24 ices (referred to in this section as the “Adminis-
25 trator”), shall establish an interagency council, to be

1 known as the Social Determinants Accelerator Inter-
2 agency Council (referred to in this section as the
3 “Council”) to achieve the purposes listed in sub-
4 section (b)(2).

5 (2) MEMBERSHIP.—

6 (A) FEDERAL COMPOSITION.—The Council
7 shall be composed of at least one designee from
8 each of the following Federal agencies:

9 (i) The Office of Management and
10 Budget.

11 (ii) The Department of Agriculture.

12 (iii) The Department of Education.

13 (iv) The Indian Health Service.

14 (v) The Department of Housing and
15 Urban Development.

16 (vi) The Department of Labor.

17 (vii) The Department of Transpor-
18 tation.

19 (viii) Any other Federal agency the
20 Chair of the Council determines necessary.

21 (B) DESIGNATION.—

22 (i) IN GENERAL.—The head of each
23 agency specified in subparagraph (A) shall
24 designate at least one employee to serve as
25 a member of the Council.

1 (ii) RESPONSIBILITIES.—An employee
2 described in this clause shall be a senior
3 employee of the agency—

4 (I) whose responsibilities relate
5 to authorities, policies, and procedures
6 with respect to the health and well-
7 being of individuals receiving medical
8 assistance under a State plan (or a
9 waiver of such plan) under title XIX
10 of the Social Security Act (42 U.S.C.
11 1396 et seq.); or

12 (II) who has authority to imple-
13 ment and evaluate transformative ini-
14 tiatives that harness data or conducts
15 rigorous evaluation to improve the im-
16 pact and cost-effectiveness of federally
17 funded services and benefits.

18 (C) HHS REPRESENTATION.—In addition
19 to the designees under subparagraph (A), the
20 Council shall include designees from at least 3
21 agencies within the Department of Health and
22 Human Services, including the Centers for
23 Medicare & Medicaid Services, at least one of
24 whom shall meet the criteria under this section.

1 (D) OMB ROLE.—The Director of the Of-
2 fice of Management and Budget shall facilitate
3 the timely resolution of Federal Government-
4 wide and multiagency issues to help the Council
5 achieve consensus recommendations described
6 under this section.

7 (E) NON-FEDERAL COMPOSITION.—The
8 Comptroller General of the United States may
9 designate up to 6 Council designees—

10 (i) who have relevant subject matter
11 expertise, including expertise implementing
12 and evaluating transformative initiatives
13 that harness data and conduct evaluations
14 to improve the impact and cost-effective-
15 ness of Federal Government services; and

16 (ii) that each represent—

17 (I) State, local, and Tribal health
18 and human services agencies;

19 (II) public housing authorities or
20 State housing finance agencies;

21 (III) State and local government
22 budget offices;

23 (IV) State Medicaid agencies; or

24 (V) national consumer advocacy
25 organizations.

1 (F) CHAIR.—

2 (i) IN GENERAL.—The Secretary shall
3 select the Chair of the Council from among
4 the members of the Council.

5 (ii) INITIATING GUIDANCE.—The
6 Chair, on behalf of the Council, shall iden-
7 tify and invite individuals from diverse en-
8 tities to provide the Council with advice
9 and information pertaining to addressing
10 social determinants of health, including—

11 (I) individuals from State and
12 local government health and human
13 services agencies;

14 (II) individuals from State Med-
15 icaid agencies;

16 (III) individuals from State and
17 local government budget offices;

18 (IV) individuals from public
19 housing authorities or State housing
20 finance agencies;

21 (V) individuals from nonprofit or-
22 ganizations, small businesses, and
23 philanthropic organizations;

24 (VI) advocates;

25 (VII) researchers; and

1 (VIII) any other individuals the
2 Chair determines to be appropriate.

3 (3) DUTIES.—The duties of the Council are—

4 (A) to make recommendations to the Sec-
5 retary and the Administrator regarding the cri-
6 teria for making awards under this section;

7 (B) to identify Federal authorities and op-
8 portunities for use by States or local govern-
9 ments to improve coordination of funding and
10 administration of Federal programs, the bene-
11 ficiaries of whom include individuals, and which
12 may be unknown or underutilized and to make
13 information on such authorities and opportuni-
14 ties publicly available;

15 (C) to provide targeted technical assistance
16 to States developing a social determinants ac-
17 celerator plan under this section, including
18 identifying potential statutory or regulatory
19 pathways for implementation of the plan and
20 assisting in identifying potential sources of
21 funding to implement the plan;

22 (D) to report to Congress annually on the
23 subjects set forth in this section;

24 (E) to develop and disseminate evaluation
25 guidelines and standards that can be used to

1 reliably assess the impact of an intervention or
2 approach that may be implemented pursuant to
3 this section on outcomes, cost-effectiveness of,
4 and return on investment from Federal, State,
5 local, and Tribal governments, and to facilitate
6 technical assistance, where needed, to help to
7 improve State and local evaluation designs and
8 implementation;

9 (F) to seek feedback from State, local, and
10 Tribal governments, including through an an-
11 nual survey by an independent third party, on
12 how to improve the technical assistance the
13 Council provides to better equip State, local,
14 and Tribal governments to coordinate health
15 and social service programs;

16 (G) to solicit applications for grants under
17 this section; and

18 (H) to coordinate with other cross-agency
19 initiatives focused on improving the health and
20 well-being of low-income and at-risk populations
21 in order to prevent unnecessary duplication be-
22 tween agency initiatives.

23 (4) SCHEDULE.—Not later than 60 days after
24 the date of the enactment of this Act, the Council
25 shall convene to develop a schedule and plan for car-

1 rying out the duties described in this section, includ-
2 ing solicitation of applications for the grants under
3 this section.

4 (5) REPORT TO CONGRESS.—The Council shall
5 submit an annual report to Congress, which shall in-
6 clude—

7 (A) a list of the Council members;

8 (B) activities and expenditures of the
9 Council;

10 (C) summaries of the interventions and ap-
11 proaches that will be supported by State, local,
12 and Tribal governments that received a grant
13 under this section, including—

14 (i) the best practices and evidence-
15 based approaches such governments plan
16 to employ to achieve the purposes listed in
17 this section; and

18 (ii) a description of how the practices
19 and approaches will impact the outcomes,
20 cost-effectiveness of, and return on invest-
21 ment from, Federal, State, local, and Trib-
22 al governments with respect to such pur-
23 poses;

24 (D) the feedback received from State and
25 local governments on ways to improve the tech-

1 nical assistance of the Council, including find-
2 ings from a third-party survey and actions the
3 Council plans to take in response to such feed-
4 back; and

5 (E) the major statutory, regulatory, and
6 administrative challenges identified by State,
7 local, and Tribal governments that received a
8 grant under subsection (d), and the actions that
9 Federal agencies are taking to address such
10 challenges.

11 (6) FACA APPLICABILITY.—The Federal Advi-
12 sory Committee Act (5 U.S.C. App.) shall not apply
13 to the Council.

14 (7) COUNCIL PROCEDURES.—The Secretary, in
15 consultation with the Comptroller General of the
16 United States and the Director of the Office of Man-
17 agement and Budget, shall establish procedures for
18 the Council to—

19 (A) ensure that adequate resources are
20 available to effectively execute the responsibil-
21 ities of the Council;

22 (B) effectively coordinate with other rel-
23 evant advisory bodies and working groups to
24 avoid unnecessary duplication;

1 (C) create transparency to the public and
2 Congress with regard to Council membership,
3 costs, and activities, including through use of
4 modern technology and social media to dissemi-
5 nate information; and

6 (D) avoid conflicts of interest that would
7 jeopardize the ability of the Council to make de-
8 cisions and provide recommendations.

9 (d) SOCIAL DETERMINANTS ACCELERATOR GRANTS
10 TO STATES OR LOCAL GOVERNMENTS.—

11 (1) GRANTS TO STATES, LOCAL GOVERNMENTS,
12 AND TRIBES.—Not later than 180 days after the
13 date of the enactment of this Act, the Administrator,
14 in consultation with the Secretary and the Council,
15 shall award on a competitive basis not more than 25
16 grants to eligible applicants described in this sub-
17 section, for the development of social determinants
18 accelerator plans, as described in this subsection.

19 (2) ELIGIBLE APPLICANT.—An eligible appli-
20 cant described in this subsection is a State, local, or
21 Tribal health or human services agency that—

22 (A) demonstrates the support of relevant
23 parties across relevant State, local, or Tribal ju-
24 risdictions; and

1 (B) in the case of an applicant that is a
2 local government agency, provides to the Sec-
3 retary a letter of support from the lead State
4 health or human services agency for the State
5 in which the local government is located.

6 (3) AMOUNT OF GRANT.—The Administrator,
7 in coordination with the Council, shall determine the
8 total amount that the Administrator will make avail-
9 able to each grantee under this subsection.

10 (4) APPLICATION.—An eligible applicant seek-
11 ing a grant under this subsection shall include in the
12 application the following information:

13 (A) The target population (or populations)
14 that would benefit from implementation of the
15 social determinants accelerator plan proposed to
16 be developed by the applicant.

17 (B) A description of the objective or objec-
18 tives and outcome goals of such proposed plan,
19 which shall include at least one health outcome
20 and at least one other important social out-
21 come.

22 (C) The sources and scope of inefficiencies
23 that, if addressed by the plan, could result in
24 improved cost-effectiveness of or return on in-

1 vestment from Federal, State, local, and Tribal
2 governments.

3 (D) A description of potential interventions
4 that could be designed or enabled using such
5 proposed plan.

6 (E) The State, local, Tribal, academic,
7 nonprofit, community-based organizations, and
8 other private sector partners that would partici-
9 pate in the development of the proposed plan
10 and subsequent implementation of programs or
11 initiatives included in such proposed plan.

12 (F) Such other information as the Admin-
13 istrator, in consultation with the Secretary and
14 the Council, determines necessary to achieve the
15 purposes of this section.

16 (5) USE OF FUNDS.—A recipient of a grant
17 under this subsection may use funds received
18 through the grant for the following purposes:

19 (A) To convene and coordinate with rel-
20 evant government entities and other stake-
21 holders across sectors to assist in the develop-
22 ment of a social determinant accelerator plan.

23 (B) To identify populations of individuals
24 receiving medical assistance under a State plan
25 (or a waiver of such plan) under title XIX of

1 the Social Security Act (42 U.S.C. 1396 et
2 seq.) who may benefit from the proposed ap-
3 proaches to improving the health and well-being
4 of such individuals through the implementation
5 of the proposed social determinants accelerator
6 plan.

7 (C) To engage qualified research experts to
8 advise on relevant research and to design a pro-
9 posed evaluation plan, in accordance with the
10 standards and guidelines issued by the Admin-
11 istrator.

12 (D) To collaborate with the Council to sup-
13 port the development of social determinants ac-
14 celerator plans.

15 (E) To prepare and submit a final social
16 determinants accelerator plan to the Council.

17 (6) CONTENTS OF PLANS.—A social deter-
18 minant accelerator plan developed under this sub-
19 section shall include the following:

20 (A) A description of the target population
21 (or populations) that would benefit from imple-
22 mentation of the social determinants accelerator
23 plan, including an analysis describing the pro-
24 jected impact on the well-being of individuals
25 described in paragraph (5)(B).

1 (B) A description of the interventions or
2 approaches designed under the social deter-
3 minants accelerator plan and the evidence for
4 selecting such interventions or approaches.

5 (C) The objectives and outcome goals of
6 such interventions or approaches, including at
7 least one health outcome and at least one other
8 important social outcome.

9 (D) A plan for accessing and linking rel-
10 evant data to enable coordinated benefits and
11 services for the jurisdictions described in this
12 section and an evaluation of the proposed inter-
13 ventions and approaches.

14 (E) A description of the State, local, Trib-
15 al, academic, nonprofit, or community-based or-
16 ganizations, or any other private sector organi-
17 zations that would participate in implementing
18 the proposed interventions or approaches, and
19 the role each would play to contribute to the
20 success of the proposed interventions or ap-
21 proaches.

22 (F) The identification of the funding
23 sources that would be used to finance the pro-
24 posed interventions or approaches.

1 (G) A description of any financial incen-
2 tives that may be provided, including outcome-
3 focused contracting approaches to encourage
4 service providers and other partners to improve
5 outcomes of, cost-effectiveness of, and return on
6 investment from, Federal, State, local, or Tribal
7 government spending.

8 (H) The identification of the applicable
9 Federal, State, local, or Tribal statutory and
10 regulatory authorities, including waiver authori-
11 ties, to be leveraged to implement the proposed
12 interventions or approaches.

13 (I) A description of potential consider-
14 ations that would enhance the impact,
15 scalability, or sustainability of the proposed
16 interventions or approaches and the actions the
17 grant awardee would take to address such con-
18 siderations.

19 (J) A proposed evaluation plan, to be car-
20 ried out by an independent evaluator, to meas-
21 ure the impact of the proposed interventions or
22 approaches on the outcomes of, cost-effective-
23 ness of, and return on investment from, Fed-
24 eral, State, local, and Tribal governments.

1 (K) Precautions for ensuring that vulner-
2 able populations will not be denied access to
3 Medicaid or other essential services as a result
4 of implementing the proposed plan.

5 (e) FUNDING.—

6 (1) IN GENERAL.—Out of any money in the
7 Treasury not otherwise appropriated, there is appro-
8 priated to carry out this section \$25,000,000 to re-
9 main available for obligation until the date that is
10 5 years after the date of enactment of this section.

11 (2) RESERVATION OF FUNDS.—

12 (A) IN GENERAL.—Of the funds made
13 available under paragraph (1), the Secretary
14 shall reserve not less than 20 percent to award
15 grants to eligible applicants for the development
16 of social determinants accelerator plans under
17 this section intended to serve rural populations.

18 (B) EXCEPTION.—In the case of a fiscal
19 year for which the Secretary determines that
20 there are not sufficient eligible applicants to
21 award up to 25 grants under subsection (d)
22 that are intended to serve rural populations and
23 the Secretary cannot satisfy the 20-percent re-
24 quirement, the Secretary may reserve an
25 amount that is less than 20 percent of amounts

1 made available under paragraph (1) to award
2 grants for such purpose.

3 (3) **RULE OF CONSTRUCTION.**—Nothing in this
4 section shall prevent Federal agencies represented
5 on the Council from contributing additional funding
6 from other sources to support activities to improve
7 the effectiveness of the Council.

8 **SEC. 1010. CORRECTING HURTFUL AND ALIENATING**
9 **NAMES IN GOVERNMENT EXPRESSION**
10 **(CHANGE).**

11 (a) **SHORT TITLE.**—This section may be cited as the
12 “Correcting Hurtful and Alienating Names in Government
13 Expression (CHANGE) Act”.

14 (b) **DEFINITIONS.**—In this section:

15 (1) **EMPLOYEE.**—The term “employee” has the
16 meaning given the term in section 2105 of title 5,
17 United States Code.

18 (2) **EXECUTIVE AGENCY.**—The term “Executive
19 agency” has the meaning given the term in section
20 105 of title 5, United States Code.

21 (3) **OFFICER.**—The term “officer” has the
22 meaning given the term in section 2104 of title 5,
23 United States Code.

24 (4) **PROHIBITED TERM.**—The term “prohibited
25 term” means—

1 (A) the term “alien”, when used to refer to
2 an individual who is not a citizen or national of
3 the United States; and

4 (B) the term “illegal alien”, when used to
5 refer to an individual who—

6 (i) is unlawfully present in the United
7 States; or

8 (ii) lacks a lawful immigration status
9 in the United States.

10 (c) MODERNIZATION OF LANGUAGE REFERRING TO
11 INDIVIDUALS WHO ARE NOT CITIZENS OR NATIONALS OF
12 THE UNITED STATES.—

13 (1) IN GENERAL.—Except as provided in para-
14 graph (2), on and after the date of enactment of this
15 Act, an Executive agency may not use a prohibited
16 term in any proposed or final rule, regulation, inter-
17 pretation, publication, other document, display, or
18 sign issued by the Executive agency.

19 (2) EXCEPTION.—An Executive agency may use
20 a prohibited term under paragraph (1) if the Execu-
21 tive agency uses the prohibited term while quoting
22 or reproducing text written by a source that is not
23 an officer or employee of the Executive agency.

24 (d) UNIFORM DEFINITION.—

1 (1) IN GENERAL.—Chapter 1 of title 1, United
2 States Code, is amended by adding at the end the
3 following:

4 **“§ 9. Definition of ‘foreign national’**

5 “In determining the meaning of any Act of Congress
6 or any ruling, regulation, or interpretation of an adminis-
7 trative bureau or agency of the United States, the term
8 ‘foreign national’ means any individual that is not an indi-
9 vidual who—

10 “(1) is a citizen of the United States; or

11 “(2) though not a citizen of the United States,
12 owes permanent allegiance to the United States.”.

13 (2) TECHNICAL AMENDMENT.—The table of
14 sections for chapter 1 of title 1, United States Code,
15 is amended by adding at the end the following:

“9. Definition of ‘foreign national’.”.

16 (e) REFERENCES.—

17 (1) IN GENERAL.—Any reference in any Fed-
18 eral statute, rule, regulation, Executive order, publi-
19 cation, or other document of the United States—

20 (A) to the term “alien”, when used to refer
21 to an individual who is not a citizen or national
22 of the United States, is deemed to refer to the
23 term “foreign national”; and

24 (B) to the term “illegal alien” is deemed to
25 refer to the term “undocumented foreign na-

1 tional”, when used to refer to an individual
2 who—

3 (i) is unlawfully present in the United
4 States; or

5 (ii) lacks a lawful immigration status
6 in the United States.

7 (2) CONFORMING AMENDMENTS.—

8 (A) Section 421(5)(A)(ii)(II) of the Con-
9 gressional Budget and Impoundment Control
10 Act of 1974 (2 U.S.C. 658(5)(A)(ii)(II)) is
11 amended—

12 (i) by striking “illegal, deportable, and
13 excludable aliens” and inserting “undocu-
14 mented foreign nationals and deportable
15 and excludable foreign nationals”; and

16 (ii) by striking “illegal aliens” each
17 place it appears and inserting “undocu-
18 mented foreign nationals”.

19 (B) Section 432(e) of the Homeland Secu-
20 rity Act of 2002 (6 U.S.C. 240(e)) is amended
21 by striking “illegal alien” and inserting “un-
22 documented foreign national”.

23 (C) Section 439 of the Antiterrorism and
24 Effective Death Penalty Act of 1996 (8 U.S.C.
25 1252c) is amended in the section heading by

1 striking “**ILLEGAL ALIENS**” and inserting
2 “**UNDOCUMENTED FOREIGN NATIONALS**”.

3 (D) Section 280(b)(3)(A)(iii) of the Immi-
4 gration and Nationality Act (8 U.S.C.
5 1330(b)(3)(A)(iii)) is amended by striking “ille-
6 gal aliens” and inserting “undocumented for-
7 eign nationals”.

8 (E) Section 286(r)(3)(ii) of the Immigra-
9 tion and Nationality Act (8 U.S.C.
10 1356(r)(3)(ii)) is amended by striking “illegal
11 aliens” and inserting “undocumented foreign
12 nationals”.

13 (F) Title V of the Immigration Reform
14 and Control Act of 1986 (Public Law 99–603;
15 100 Stat. 3443) is amended—

16 (i) in the title heading, by striking
17 “**ILLEGAL ALIENS**” and inserting
18 “**UNDOCUMENTED FOREIGN**
19 **NATIONALS**”; and

20 (ii) in section 501 (8 U.S.C. 1365)—

21 (I) in the section heading, by
22 striking “**ILLEGAL ALIENS**” and in-
23 serting “**UNDOCUMENTED FOR-**
24 **EIGN NATIONALS**”;

1 (II) in subsection (b), in the sub-
2 section heading, by striking “ILLEGAL
3 ALIENS” and inserting “UNDOCU-
4 MENTED FOREIGN NATIONALS”; and
5 (III) by striking “illegal alien”
6 each place such term appears and in-
7 serting “undocumented foreign na-
8 tional”.

9 (G) Section 332 of the Omnibus Consoli-
10 dated Appropriations Act, 1997 (8 U.S.C.
11 1366) is amended by striking “illegal aliens”
12 each place it appears and inserting “undocu-
13 mented foreign nationals”.

14 (H) Section 411(d) of the Personal Re-
15 sponsibility and Work Opportunity Reconcili-
16 ation Act of 1996 (8 U.S.C. 1621(d)) is amend-
17 ed in the subsection heading by striking “ILLE-
18 GAL ALIENS” and inserting “UNDOCUMENTED
19 FOREIGN NATIONALS”.

20 (I) Section 40125(a)(2) of title 49, United
21 States Code, is amended by striking “illegal
22 aliens” and inserting “undocumented foreign
23 nationals”.

1 **Subtitle B—Gun Violence**

2 **SEC. 1011. FINDINGS.**

3 Congress finds as follows:

4 (1) On average, 86 Americans are killed by
5 guns each day.

6 (2) An estimated 39,773 people were killed by
7 guns in 2017, of which two-thirds committed suicide.

8 (3) Gun violence disproportionately affects com-
9 munities of color, especially African Americans (who
10 comprise around 14 percent of the United States
11 population but account for more than half the coun-
12 try’s gun homicide victims).

13 (4) On average, there is more than one mass
14 shooting each day in the United States.

15 **SEC. 1012. REAFFIRMING RESEARCH AUTHORITY OF THE**
16 **CENTERS FOR DISEASE CONTROL AND PRE-**
17 **VENTION.**

18 (a) **IN GENERAL.**—Section 391 of the Public Health
19 Service Act (42 U.S.C. 280b) is amended—

20 (1) in subsection (a)(1), by striking “research
21 relating to the causes, mechanisms, prevention, diag-
22 nosis, treatment of injuries, and rehabilitation from
23 injuries;” and inserting the following: “research, in-
24 cluding data collection, relating to—

1 “(A) the causes, mechanisms, prevention,
2 diagnosis, and treatment of injuries, including
3 with respect to gun violence; and

4 “(B) rehabilitation from such injuries;”;
5 and

6 (2) by adding at the end the following new sub-
7 section:

8 “(c) NO ADVOCACY OR PROMOTION OF GUN CON-
9 TROL.—Nothing in this section shall be construed to—

10 “(1) authorize the Secretary to give assistance,
11 make grants, or enter into cooperative agreements or
12 contracts for the purpose of advocating or promoting
13 gun control; or

14 “(2) permit a recipient of any assistance, grant,
15 cooperative agreement, or contract under this section
16 to use such assistance, grant, agreement, or contract
17 for the purpose of advocating or promoting gun con-
18 trol.”.

19 **SEC. 1013. NATIONAL VIOLENT DEATH REPORTING SYSTEM.**

20 The Secretary of Health and Human Services, acting
21 through the Director of the Centers for Disease Control
22 and Prevention, shall improve, particularly through the in-
23 clusion of additional States, the National Violent Death
24 Reporting System, as authorized by sections 301(a) and
25 391(a) of the Public Service Health Act (42 U.S.C.

1 241(a), 280(b)). Participation in the system by the States
2 shall be voluntary.

3 **SEC. 1014. REPORT ON EFFECTS OF GUN VIOLENCE ON**
4 **PUBLIC HEALTH.**

5 Not later than one year after the date of the enact-
6 ment of this Act, and annually thereafter, the Surgeon
7 General shall submit to Congress a report on the effects
8 on public health, including mental health, of gun violence
9 in the United States during the preceding year, and the
10 status of actions taken to address such effects.

11 **SEC. 1015. REPORT ON EFFECTS OF GUN VIOLENCE ON**
12 **MENTAL HEALTH IN MINORITY COMMU-**
13 **NITIES.**

14 Not later than one year after the date of the enact-
15 ment of this Act, the Deputy Assistant Secretary for Mi-
16 nority Health in the Office of the Secretary of Health and
17 Human Services shall submit to the Congress a report on
18 the effects of gun violence on public health, including men-
19 tal health, in minority communities in the United States,
20 and the status of actions taken to address such effects.

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