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

IN THE HOUSE OF REPRESENTATIVES

JULY 12, 2007

Ms. Solis (for herself, Mr. Abercrombie, Mr. Baca, Mr. Becerra, Mr. Bishop of Georgia, Ms. Bordallo, Ms. Corrine Brown of Florida, Mr. Butterfield, Mr. Cardoza, Ms. Carson, Ms. Castor, Mrs. Christensen, Ms. Clarke, Mr. Clay, Mr. Cleaver, Mr. Clyburn, Mr. Conyers, Mr. Costa, Mr. Crowley, Mr. Cuellar, Mr. Cummings, Mr. Davis of Alabama, Mr. Davis of Illinois, Mr. Ellison, Mr. Johnson of Georgia, Mrs. Jones of Ohio, Mr. Kildee, Ms. KILPATRICK, Ms. Lee, Ms. Jackson-Lee of Texas, Mr. Lewis of Georgia, Ms. Matsui, Mr. Meek of Florida, Mr. Meeks of New York, Ms. Moore of Wisconsin, Mrs. Napolitano, Ms. Norton, Mr. Ortiz, Mr. Pastor, Mr. Payne, Mr. Rangel, Mr. Reyes, Mr. Rush, Mr. Rodriguez, Ms. Ros-Lehtinen, Ms. Roybal-Allard, Mr. Salazar, Mr. Fattah, Mr. Fortuño, Mr. Gonzalez, Mr. Al Green of Texas, Mr. Gene Green of Texas, Mr. Grijalva, Mr. Hastings of Florida, Mr. Hinojosa, Mr. Honda, Mr. Hoyer, Mr. Jackson of Illinois, Mr. Jefferson, Ms. Eddie Bernice Johnson of Texas, Mr. Scott of Georgia, Mr. Scott of Virginia, Mr. Serrano, Mr. Shires, Mr. Thompson of Mississippi, Mr. Towns, Ms. Velázquez, Ms. Waters, Ms. Watson, Mr. Watt, and Mr. Wynn) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, Natural Resources, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To improve the health of minority individuals, and for other purposes.
Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Health Equity and Accountability Act of 2007”.

SEC. 2. TABLE OF CONTENTS.

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Sec. 206. National Health Service Corps; training programs.
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Sec. 302. Collection of race and ethnicity data by the Social Security Administration.
Sec. 303. Revision of HIPAA claims standards.
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TITLE V—IMPROVEMENT OF HEALTH CARE SERVICES

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Sec. 506. Grants to promote positive health behaviors in women and children.
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TITLE I—CULTURALLY AND LINGUISTICALLY APPROPRIATE
HEALTH CARE

SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE
ACT.

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

“TITLE XXX—CULTURALLY AND
LINGUISTICALLY APPROPRIATE
HEALTH CARE

“SEC. 3000. DEFINITIONS.

“In this title:

“(1) APPROPRIATE HEALTH CARE SERVICES.—
The term ‘appropriate health care services’ includes
services or treatments to address prevention and
care of physical, mental, oral, and behavioral dis-
orders or syndromes.

“(2) INDIAN TRIBE.—The term ‘Indian tribe’
means any Indian tribe, band, nation, or other orga-
nized group or community, including any Alaska Na-

tive village or group or regional or village corpora-
tion as defined in or established pursuant to the
Alaska Native Claims Settlement Act (85 Stat. 688)
(43 U.S.C. 1601 et seq.), which is recognized as eli-
gible for the special programs and services provided
by the United States to Indians because of their sta-
tus as Indians.

“(3) LIMITED ENGLISH PROFICIENT.—The
term ‘limited English proficient’ with respect to an
individual means an individual who speaks a primary
language other than English and cannot speak, read,
write, or understand the English language at a level
that permits them to effectively communicate with
clinical or nonclinical staff at a health care organiza-
tion.

“(4) MINORITY.—

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

“(B) POPULATIONS.—The term ‘minority’,
with respect to populations, refers to racial and
ethnic minority groups.
“(5) MINORITY GROUP.—The term ‘minority group’ has the meaning given the term ‘racial and ethnic minority group’.

“(6) RACIAL AND ETHNIC MINORITY GROUP.—The term ‘racial and ethnic minority group’ means American Indians and Alaska Natives, African Americans (including Caribbean Blacks, Africans and other Blacks), Asian Americans, Hispanics (including Latinos), and Native Hawaiians and other Pacific Islanders.

“(7) STATE.—The term ‘State’ means each of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Indian tribes, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

“SEC. 3001. IMPROVING ACCESS TO SERVICES FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.

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

“(1) to improve access to federally conducted and federally assisted programs and activities for individuals who are limited in their English proficiency;

“(2) to require each Federal agency to examine the services it provides and develop and implement
a system by which limited English proficient individuals can obtain meaningful access to those services consistent with, and without substantially burdening, the fundamental mission of the agency;

“(3) to require each Federal agency to ensure that recipients of Federal financial assistance provide meaningful access to their limited English proficient applicants and beneficiaries;

“(4) to ensure that recipients of Federal financial assistance take reasonable steps, consistent with the guidelines set forth in the Limited English Proficient Guidance of the Department of Justice (as issued on June 12, 2002), to ensure meaningful access to their programs and activities by limited English proficient individuals; and

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

“(b) Federally Conducted Programs and Activities.—

“(1) In general.—Not later than 120 days after the date of enactment of this title, each Federal agency that carries out health care-related activities shall prepare a plan to improve access to the
federally conducted health care-related programs
and activities of the agency by limited English pro-
ficient individuals.

“(2) PLAN REQUIREMENT.—Each plan under
paragraph (1) shall be consistent with the standards
set forth in section 102 of the Health Equity and
Accountability Act of 2007, and shall include the
steps the agency will take to ensure that limited
English proficient individuals have access to the
agency’s health care-related programs and activities.
Each agency shall send a copy of such plan to the
Department of Justice, which shall serve as the cen-
tral repository of the agencies’ plans.

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

“(1) IN GENERAL.—Not later than 120 days
after the date of enactment of this title, each Fed-
eral agency providing health care-related Federal fi-
nancial assistance shall ensure that the guidance for
recipients of Federal financial assistance developed
by the agency to ensure compliance with title VI of
the Civil Rights Act of 1964 (42 U.S.C. 2000d et
seq.) is specifically tailored to the recipients of such
assistance and is consistent with the standards de-
scribed in section 102 of the Health Equity and Ae-
countability Act of 2007. Each agency shall send a

copy of such guidance to the Department of Justice

which shall serve as the central repository of the

agencies’ plans. After approval by the Department of

Justice, each agency shall publish its guidance docu-

ment in the Federal Register for public comment.

“(2) REQUIREMENTS.—The agency-specific
guidance developed under paragraph (1) shall—

“(A) detail how the general standards es-
established under section 102 of the Health Eq-
uity and Accountability Act of 2007 will be ap-
plied to the agency’s recipients; and

“(B) take into account the types of health
care services provided by the recipients, the in-
dividuals served by the recipients, and other

factors set out in such standards.

“(3) EXISTING GUIDANCES.—A Federal agency

that has developed a guidance for purposes of title

VI of the Civil Rights Act of 1964 that the Depart-
ment of Justice determines is consistent with the

standards described in section 102 of the Health Eq-
uity and Accountability Act of 2007 shall examine

such existing guidance, as well as the programs and

activities to which such guidance applies, to deter-
mine if modification of such guidance is necessary to comply with this subsection.

“(4) Consultation.—Each Federal agency shall consult with the Department of Justice in establishing the guidances under this subsection.

“(d) Consultations.—

“(1) In general.—In carrying out this section, each Federal agency that carries out health care-related activities shall ensure that stakeholders, such as limited English proficient individuals and their representative organizations, recipients of Federal assistance, and other appropriate individuals or entities, have an adequate and comparable opportunity to provide input with respect to the actions of the agency.

“(2) Evaluation.—Each Federal agency described in paragraph (1) shall evaluate the—

“(A) particular needs of the limited English proficient individuals served by the agency, and by a recipient of assistance provided by the agency;

“(B) burdens of compliance with the agency guidance and its recipients of the requirements of this section; and

“(C) outcomes or effectiveness of services.
“SEC. 3002. NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE.

“Recipients of Federal financial assistance from the Secretary shall, to the extent reasonable and practicable after applying the 4-factor analysis described in title V of the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited-English Proficient Persons (June 12, 2002)—

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

“(2) ensure that staff at all levels and across all disciplines of the organization receive ongoing education and training in culturally and linguistically appropriate service delivery;

“(3) offer and provide language assistance services, including trained bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;
“(4) notify patients of their right to receive language assistance services in their primary language;

“(5) ensure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff, and ensure that family, particularly minor children, and friends are not used to provide interpretation services—

“(A) except in case of emergency; or

“(B) except on request of the patient, who has been informed in his or her preferred language of the availability of free interpretation services;

“(6) make available easily understood patient-related materials, if such materials exist for non-limited English proficient patients, including information or notices about termination of benefits and post signage in the languages of the commonly encountered groups or groups represented in the service area of the organization;

“(7) develop and implement clear goals, policies, operational plans, and management accountability and oversight mechanisms to provide culturally and linguistically appropriate services;

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

“(9) ensure that, consistent with the privacy
protections provided for under the regulations pro-
mulgated under section 264(c) of the Health Insur-
ance Portability and Accountability Act of 1996 (42
U.S.C. 1320d–2 note)—

“(A) data on the individual patient’s race,
ethnicity, and primary language are collected in
health records, integrated into the organiza-
tion’s management information systems, and
periodically updated; and

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

“(10) maintain a current demographic, cultural,
and epidemiological profile of the community as well
as a needs assessment to accurately plan for and im-
plement services that respond to the cultural and
linguistic characteristics of the service area of the
organization;
“(11) develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing and implementing culturally and linguistically appropriate services-related activities;

“(12) ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients;

“(13) regularly make available to the public information about their progress and successful innovations in implementing the standards under this section and provide public notice in their communities about the availability of this information; and

“(14) if requested, regularly make available to the head of each Federal entity from which Federal funds are received, information about their progress and successful innovations in implementing the standards under this section as required by the head of such entity.
“SEC. 3003. ROBERT T. MATSUI CENTER FOR CULTURAL
AND LINGUISTIC COMPETENCE IN HEALTH
CARE.

“(a) ESTABLISHMENT.—The Secretary, acting
through the Director of the Office of Minority Health Dis-
parity Elimination, shall establish and support a center
to be known as the ‘Robert T. Matsui Center for Cultural
and Linguistic Competence in Health Care’ (referred to
in this section as the ‘Center’) to carry out the following
activities:

“(1) REMOTE MEDICAL INTERPRETING.—The
Center shall provide remote medical interpreting, di-
rectly or through contracts, to health care providers
who otherwise would be unable to provide language
interpreting services, at reasonable or no cost as de-
termined appropriate by the Director of the Center.
Methods of interpretation may include remote, si-
multaneous or consecutive interpreting through tele-
phonic systems, video conferencing, and other meth-
ods determined appropriate by the Secretary for pa-
tients with limited English proficiency. The quality
of such interpreting shall be monitored and reported
publicly. Nothing in this paragraph shall be con-
strued to limit the ability of health care providers or
organizations to provide medical interpreting serv-
ices directly and obtain reimbursement for such
services as provided for under the Medicare, Medicaid, or SCHIP programs under titles XVIII, XIX, or XXI of the Social Security Act.

“(2) MODEL LANGUAGE ASSISTANCE PROGRAMS.—The Center shall provide for the collection and dissemination of information on current model language assistance programs and strategies to improve language access to health care for individuals with limited English proficiency, including case studies using de-identified patient information, program summaries, and program evaluations.

“(3) INTERNET HEALTH CLEARINGHOUSE.—The Center shall develop and maintain an Internet clearinghouse to reduce medical errors and improve medical outcomes and reduce health care costs caused by miscommunication with individuals with limited English proficiency or low functional health literacy and reduce or eliminate the duplication of effort to translate materials by—

“(A) developing and making available templates for standard documents that are necessary for patients and consumers to access and make educated decisions about their health care, including—
“(i) administrative and legal documents such as informed consent, advanced directives, and waivers of rights;

“(ii) clinical information such as how to take medications, how to prevent transmission of a contagious disease, and other prevention and treatment instructions;

“(iii) patient education and outreach materials such as immunization notices, health warnings, or screening notices; and

“(iv) additional health or health care-related materials as determined appropriate by the Director of the Center;

“(B) ensuring that the documents posted in English and non-English languages are culturally appropriate;

“(C) allowing public review of the documents before dissemination in order to ensure that the documents are understandable and culturally appropriate for the target populations;

“(D) allowing health care providers to customize the documents for their use;

“(E) facilitating access to these documents;
“(F) providing technical assistance with respect to the access and use of such information; and

“(G) carrying out any other activities the Secretary determines to be useful to fulfill the purposes of the Clearinghouse.

“(4) Provision of Information.—The Center shall provide information relating to culturally and linguistically competent health care for minority populations residing in the United States to all health care providers and health care organizations at no cost. Such information shall include—

“(A) tenets of culturally and linguistically competent care;

“(B) cultural and linguistic competence self-assessment tools;

“(C) cultural and linguistic competence training tools;

“(D) strategic plans to increase cultural and linguistic competence in different types of health care organizations, including regional collaborations among health care organizations; and
“(E) resources for cultural and linguistic competence information for educators, practitioners and researchers.

“(b) DIRECTOR.—The Center shall be headed by a Director who shall be appointed by, and who shall report to, the Deputy Assistant Secretary for Minority Health.

“(c) AVAILABILITY OF LANGUAGE ACCESS.—The Director shall collaborate with all agencies within the Department of Health and Human Services to notify health care providers and health care organizations about the availability of language access services by the Center.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2008 through 2012.

“SEC. 3004. INNOVATIONS IN CULTURAL AND LINGUISTIC COMPETENCE GRANTS.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, the Administrator of the Health Resources and Services Administration, the Secretary of Education, and the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to enable such entities to design, implement, and evaluate innovative, cost-effective programs to improve cultural and linguistic competence in
health care for individuals with limited English proficiency.

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

“(1) be a city, county, Indian tribe, State, territory, community-based and other nonprofit organization, health center or community clinic, university, college, or other entity designated by the Secretary; and

“(2) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

“(c) Use of Funds.—An entity shall use funds received under a grant under this section to—

“(1) develop, implement, and evaluate models of providing real-time cultural competence and interpretation services through in-person interpretation, communications, and computer technology, including the Internet, teleconferencing, or video conferencing;

“(2) develop short-term medical interpretation training courses and incentives for bilingual health care staff who are asked to interpret in the workplace;
“(3) develop formal training programs for individuals interested in becoming dedicated health care interpreters and culturally competent providers;

“(4) provide staff language training instruction which shall include information on the practical limitations of such instruction for non-native speakers; and

“(5) develop other language assistance services as determined appropriate by the Secretary.

“(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to entities that have developed partnerships with organizations or agencies with experience in culturally competent and language access services.

“(e) EVALUATION.—An entity that receives a grant under this section shall submit to the Secretary an evaluation that describes the activities carried out with funds received under the grant, and how such activities improved access to health care services and the quality of health care for individuals with limited English proficiency. Such evaluation shall be collected and disseminated through the Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care established under section 3003.
“(f) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2008 through 2012.

“SEC. 3005. RESEARCH ON CULTURAL AND LANGUAGE COMPETENCE.

“(a) In General.—The Director of the Agency for Healthcare Research and Quality, in collaboration with the Deputy Assistant Secretary for Minority Health, shall expand research concerning—

“(1) the barriers to health care services including mental and behavioral services that are faced by limited English proficient individuals;

“(2) the impact of cultural and language barriers on the quality of health care and the health status of limited English proficient individuals and populations;

“(3) health care providers’ and health administrators’ attitudes, knowledge, and awareness of the barriers described in paragraphs (1) and (2);

“(4) the means by which language access services are provided to limited English proficient individuals and how such services are effective in improving the quality of care;

“(5) the cost-effectiveness of providing language access; and
“(6) optimal approaches for delivering language access.

“(b) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2012.

“SEC. 3006. INFORMATION ABOUT FEDERAL HEALTH PROGRAMS FOR LIMITED ENGLISH PROFICIENT POPULATIONS.

“The Secretary shall provide for a means by which limited English proficient individuals who are seeking information about, or assistance with, Federal health care programs may obtain such information or assistance.”.

SEC. 102. STANDARDS FOR LANGUAGE ACCESS SERVICES.

Not later than 120 days after the date of enactment of this Act, the head of each Federal agency that carries out health care-related activities shall develop and adopt a guidance on language services for those with limited English proficiency who attempt to have access to or participate in such activities that provides at the minimum the factors and principles set forth in the Department of Justice guidance published on June 12, 2002.
SEC. 103. FEDERAL REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES UNDER THE MEDICARE, MEDICAID AND STATE CHILDREN’S HEALTH INSURANCE PROGRAM.

(a) Demonstration Project Promoting Access for Medicare Beneficiaries With Limited English Proficiency.—

(1) In general.—The Secretary shall conduct a demonstration project (in this subsection referred to as the “project”) to demonstrate the impact on costs and health outcomes of providing reimbursement for interpreter services to certain Medicare beneficiaries who are limited English proficient in urban and rural areas.

(2) Scope.—The Secretary shall carry out the project in not less than 30 States or territories through contracts with—

(A) MA plans (under part C of title XVIII of the Social Security Act);

(B) small providers;

(C) hospitals; and

(D) community-based clinics.

(3) Duration.—Each contract entered into under the project shall extend over a period of not longer than 2 years.
(4) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project which shall include recommendations regarding the extension of such project to the entire Medicare program.

(5) EVALUATION.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Office of Minority Health and the National Center on Minority Health and Health Disparities, shall award grants to public and private nonprofit entities that demonstrate experience and capability with respect to cultural and linguistic competence, including Historically Black Colleges and Universities, Hispanic-serving institutions, and other entities directed by and serving representatives of racial and ethnic minority groups, for the evaluation of the project. Such evaluations shall focus on access, utilization, efficiency, cost-effectiveness, patient satisfaction, and select health outcomes.

(b) MEDICAID.—Section 1903(a)(3) of the Social Security Act (42 U.S.C. 1396b(a)(3)) is amended—

(1) in subparagraph (E), by striking “plus” at the end and inserting “and”; and

(2) by adding at the end the following:
“(F) 100 percent of the sums expended with respect to costs incurred during such quarter as are attributable to the provision of language services on behalf of individuals with limited English proficiency who apply for or receive medical assistance under the State plan under this title (including any provisions of the plan implemented pursuant to any waiver authority of the Secretary) or child health assistance under a State child health plan under title XXI; plus”.

(c) SCHIP.—Section 2105(c)(2)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(2)(A)) is amended by inserting before the period at the end the following: “except that expenditures described in, and reimbursable under, section 1903(a)(3)(F) shall not count towards this total”.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2007.

SEC. 104. INCREASING UNDERSTANDING OF AND IMPROVING HEALTH LITERACY.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and the Administrator of the Health Resources and Services Administration, in consultation with the Office of Minority Health, shall award grants to eligible entities to
improve health care for patient populations that have low
functional health literacy.

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

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

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

(c) Use of Funds.—

(1) Agency for Healthcare Research and
Quality.—Grants awarded under subsection (a)
through the Agency for Healthcare Research and
Quality shall be used—

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

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

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

(D) for any other activity determined ap-
propriate by the Director of the Agency.
(2) HEALTH RESOURCES AND SERVICES ADMINISTRATION.—Grants awarded under subsection (a) through the Health Resources and Services Administration shall be used to conduct demonstration projects for interventions for patients with low health literacy that may include—

(A) the development of new disease management programs for patients with low health literacy;

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

(C) the translation of written health materials for patients with low health literacy;

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

(E) the conduct of educational campaigns for patients and providers about low health literacy; and

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

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

(c) Authorization of Appropriations.—There is
authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years
2008 through 2012.

SEC. 105. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-
TURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE SERVICES.

Not later than 1 year after the date of enactment
of this Act and annually thereafter, the Secretary of
Health and Human Services shall enter into a contract
with the Institute of Medicine for the preparation and
publication of a report that describes Federal efforts to
ensure that all individuals have meaningful access to cul-
turally and linguistically appropriate health care services.

Such report shall include—

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

(2) a description of best practices, model pro-
grams, guidelines, and other effective strategies for
providing access to culturally and linguistically ap-
propriate health care services; and

(3) an assessment of the implementation of the
Department of Health and Human Services National
Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care, in particular the implementation of CLAS mandates by recipients of Federal funds.

SEC. 106. DEFINITIONS.

In this title:

(1) INCORPORATED DEFINITIONS.—The definitions contained in section 3000 of the Public Health Service Act, as added by section 101, shall apply.

(2) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.


A payment provider of services or physician or other supplier under part B of title XVIII of the Social Security Act shall be deemed a grant, and not a contract of insurance or guaranty, for the purposes of title VI of the Civil Rights Act of 1964.
TITLE II—HEALTH WORKFORCE DIVERSITY

SEC. 201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXX of the Public Health Service Act, as added by section 101, is amended by adding at the end the following:

“Subtitle A—Diversifying the Health Care Workplace

“SEC. 3011. REPORT ON WORKFORCE DIVERSITY.

“(a) IN GENERAL.—Not later than July 1, 2008, and biannually thereafter, the Secretary, acting through the director of each entity within the Department of Health and Human Services, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on health workforce diversity.

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

“(1) A description of any grant support that is provided by each entity for workforce diversity initiatives with the following information—

“(A) the number of grants made;

“(B) the purpose of the grants;
“(C) the populations served through the grants;

“(D) the organizations and institutions receiving the grants, including specification of the number of Hispanic health professions schools and minority-serving institutions; and

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

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

“(A) the number of underrepresented minority health professionals that will be needed in various disciplines over the next 10 years to achieve population parity;

“(B) the level of funding needed to fully expand and adequately support health professions pipeline programs;

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

“(D) the management strategy necessary to effectively administer and institutionalize health profession pipeline programs;
“(E) the impact that the Government Performance and Results Act (GPRA) has had on evaluating the performance of grantees and whether the GPRA is the best assessment tool for programs under titles VII and VIII; and

“(F) an examination of the role and support for minority-serving institutions and Hispanic health professions schools in training minority health professionals and in increasing their representation at all levels in the Department of Health and Human Services.

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

“(c) PUBLIC AVAILABILITY.—The report under subsection (a) shall be made available for public review and comment.

“SEC. 3012. TECHNICAL CLEARINGHOUSE FOR HEALTH WORKFORCE DIVERSITY.

“(a) IN GENERAL.—The Secretary, acting through the Office of Minority Health, and in collaboration with the Bureau of Health Professions within the Health Resources and Services Administration, shall establish a technical clearinghouse on health workforce diversity within the Office of Minority Health and coordinate current and future clearinghouses.
“(b) INFORMATION AND SERVICES.—The clearing-house established under subsection (a) shall offer the following information and services:

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

“(2) Statistical information relating to under-represented minority representation in health and allied health professions and occupations.

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

“(4) Admissions policies that promote health workforce diversity and are in compliance with Federal and State laws.

“(5) Lists of scholarship, loan repayment, and loan cancellation grants as well as fellowship information for underserved populations for health professions schools.

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

“(c) CONSULTATION.—In carrying out this section, the Secretary shall consult with non-Federal entities, which shall include minority health professional associations to help ensure thoroughness and accuracy of information.
“(d) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2013.

“SEC. 3013. EVALUATION OF WORKFORCE DIVERSITY INITIATIVES.

“(a) In General.—The Secretary, acting through the Bureau of Health Professions within the Health Resources and Services Administration, shall award grants to eligible entities for the conduct of an evaluation of current health workforce diversity initiatives funded by the Department of Health and Human Services.

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

“(1) be a city, county, Indian tribe, State, territory, community-based nonprofit organization, health center, university, college, or other entity determined appropriate by the Secretary;

“(2) with respect to an entity that is not an academic medical center, university, or private research institution, carry out activities under the grant in partnership with an academic medical center, university, or private research institution; and
“(3) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—Amounts awarded under a grant under subsection (a) shall be used to support the following evaluation activities:

“(1) Determinations of measures of health workforce diversity success.

“(2) Assessments of the effects of health workforce diversity on quality, including—

“(A) language access;

“(B) cultural competence;

“(C) patient satisfaction;

“(D) timeliness of care;

“(E) safety of care;

“(F) effectiveness of care;

“(G) efficiency of care;

“(H) patient outcomes;

“(I) community engagement;

“(J) resource allocation;

“(K) organizational structure; and

“(L) other topics determined appropriate by the Secretary.

“(3) The short- and long-term tracking of participants in health workforce diversity pipeline pro-
grams funded by the Department of Health and
Human Services.

“(4) Assessments of partnerships formed
through activities to increase health workforce diver-
sity.

“(5) Assessments of barriers to health work-
force diversity.

“(6) Assessments of policy changes at the Fed-
eral, State, and local levels.

“(7) Assessments of coordination within and be-
tween Federal agencies and other institutions.

“(8) Other activities determined appropriate by
the Secretary.

“(d) REPORT.—Not later than 1 year after the date
of enactment of this title, the Bureau of Health Profes-
sions within the Health Resources and Services Adminis-
tration shall prepare and make available for public com-
ment a report that summarizes the findings made by enti-
ties under grants under this section.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There
is authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years
2008 through 2013.
“SEC. 3014. DATA COLLECTION AND REPORTING BY HEALTH PROFESSIONAL SCHOOLS.

“(a) In General.—The Secretary, acting through the Bureau of Health Professions of the Health Resources and Services Administration and the Office of Minority Health, shall establish an aggregated database on health professional students.

“(b) Requirement To Collect Data.—Each health professional school (including medical, dental, and nursing schools) and allied health profession school and program that receives Federal funds shall collect race, ethnicity, and language proficiency data concerning those students enrolled at such schools or in such programs. In collecting such data, a school or program shall—

“(1) at a minimum, use the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and available language standards; and

“(2) if practicable, collect data on additional population groups if such data can be aggregated into the minimum race and ethnicity data categories.

“(c) Use Of Data.—Data on race, ethnicity, and primary language collected under this section shall be reported to the database established under subsection (a)
on an annual basis. Such data shall be available for public use.

“(d) PRIVACY.—The Secretary shall ensure that all data collected under this section is protected from inappropriate internal and external use by any entity that collects, stores, or receives the data and that such data is collected without personally identifiable information.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2013.

“SEC. 3015. SUPPORT FOR INSTITUTIONS COMMITTED TO WORKFORCE DIVERSITY.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities that demonstrate a commitment to health workforce diversity.

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

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

“(A) Historically Black Colleges and Universities;
“(B) Hispanic-serving health professions schools;

“(C) Hispanic-serving institutions;

“(D) Tribal Colleges and Universities;

“(E) Asian American and Pacific Islander-serving institutions;

“(F) institutions that have programs to recruit and retain underrepresented minority health professionals, in which a significant number of the enrolled participants are underrepresented minorities;

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

“(H) institutions—

“(i) located in communities with predominantly underrepresented minority populations;

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

“(iii) in which at least 20 percent of the enrolled participants are underrepresented minorities; and
“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—Amounts received under a grant under subsection (a) shall be used to expand existing workforce diversity programs, implement new workforce diversity programs, or evaluate existing or new workforce diversity programs, including with respect to mental as well as oral health care professions. Such programs shall enhance diversity by considering minority status as part of an individualized consideration of qualifications. Possible activities may include—

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

“(2) scholarship, fellowship, grant, and loan repayment programs;

“(3) post-baccalaureate programs;

“(4) academic enrichment programs, particularly targeting those who would not be competitive for health professions schools;

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

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

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

“(9) leadership training.

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

“(e) DEFINITION.—In this section, the term ‘Asian American and Pacific Islander-serving institutions’ means institutions—

“(1) that are eligible institutions under section 312(b) of the Higher Education Act of 1965; and

“(2) that, at the time of their application, have an enrollment of undergraduate students that is made up of at least 10 percent Asian American and Pacific Islander students.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $100,000,000 for each of fiscal years 2008 through 2013.
“SEC. 3016. CAREER DEVELOPMENT FOR SCIENTISTS AND RESEARCHERS.

“(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, and the Director of the Agency for Healthcare Research and Quality, shall award grants that expand existing opportunities for scientists and researchers and promote the inclusion of underrepresented minorities in the health professions.

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

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

“(d) Student Loan Reimbursement.—The Secretary shall establish a student loan reimbursement program to provide student loan reimbursement assistance to researchers who focus on racial and ethnic disparities in health. The Secretary shall promulgate regulations to define the scope and procedures for the program under this subsection.

“SEC. 3017. CAREER SUPPORT FOR NON-RESEARCH HEALTH PROFESSIONALS.

“(a) In General.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Administrator of the Substance Abuse and Mental Health Services Administration, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services shall establish a program to award grants to eligible individuals for career support, including leadership training, in non-research-related health care.

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

“(1) be a student in a health professions school,

a graduate of such a school who is working in a
health profession, or a faculty member of such a
school; and

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

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

“(1) support the individual’s health activities or
projects that involve underserved communities, in-
cluding rural communities and racial and ethnic mi-
nority communities;

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

“(3) to pay, or as reimbursement for payments
of, student loans for individuals who are health pro-
fessionals and are focused on health issues affecting
underserved communities, including rural commu-
nities and racial and ethnic minority communities.

“(d) DEFINITION.—In this section, the term ‘career
in non-research-related health care’ means employment or
intended employment in the field of public health, health
policy, health management, health administration, medi-
cine, nursing, pharmacy, allied health, community health,
or other fields determined appropriate by the Secretary,
other than in a position that involves research.
“(e) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2013.

“SEC. 3018. CULTURAL COMPETENCE TRAINING FOR HEALTH CARE PROFESSIONALS.

“(a) In General.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, the Deputy Assistant Secretary for Minority Health, and the Director of the National Center for Minority Health and Health Disparities, shall award grants to eligible entities to test, implement, and evaluate models of cultural competence training, including continuing education, for health care providers.

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

“(1) be an academic medical center, a health center or clinic, a hospital, a health plan, a health system, or a health care professional guild (including a mental health care professional guild);

“(2) partner with a minority-serving institution, minority health professional association, or community-based organization representing minority populations, in addition to a research institution to carry out activities under this grant; and
“(3) prepare and submit to the Secretary an
application at such time, in such manner, and con-
taining such information as the Secretary may re-
quire.
“(c) Authorization of Appropriations.—There
is authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years
2008 through 2013.

“SEC. 3019. REGIONAL MINORITY CENTERS OF EXCEL-
LENCE PROGRAMS.
“(a) Establishment.—The Office of Minority
Health, in collaboration with the Health Resources and
Services Administration and the National Center on Mi-
nority Health and Health Disparities, shall establish and
jointly fund Regional Minority Centers of Excellence Pro-
grams in medically underserved regions through the award
of major funded, long-term cooperative agreements to eli-
gible minority community-based organizations, school dis-
tricts, and health professions organizations.
“(b) Use of Funds.—The Office of Minority Health
shall not award a cooperative agreement to an entity for
a Regional Minority Centers of Excellence Program under
subsection (a) unless the entity agrees that its program
will include—
“(1) recruitment of minority students and faculty; and

“(2) development of curriculum on minority health for health professions students, allied health students, and other health professionals.

“(c) ELIGIBILITY.—To be eligible to receive a cooperative agreement under subsection (a), a minority community-based organization, school district, or profession organization must be recognized for its demonstrated ability to engage minority community involvement in health care programs.

“(d) PRIORITY.—In awarding cooperative agreements under subsection (a), the Office of Minority Health shall give priority to entities that—

“(1) will use the agreement in a geographic area that has a large medically underserved minority population; and

“(2) will use a regional approach through partnerships with other health professions schools, private sector entities, school districts, and community-based organizations that serve the area.”.

SEC. 202. HEALTH CAREERS OPPORTUNITY PROGRAM.

(a) PURPOSE.—It is the purpose of this section to diversify the health care workforce by increasing the number of individuals from disadvantaged backgrounds in the
health and allied health professions by enhancing the academic skills of students from disadvantaged backgrounds and supporting them in successfully competing, entering, and graduating from health professions training programs.

(b) Authorization of Appropriations.—Section 740(c) of the Public Health Service Act (42 U.S.C. 293d(c)) is amended by striking “$29,400,000” and all that follows through “2002” and inserting “$50,000,000 for fiscal year 2008, and such sums as may be necessary for each of fiscal years 2009 through 2013”.

SEC. 203. PROGRAM OF EXCELLENCE IN HEALTH PROFESSIONS EDUCATION FOR UNDERREPRESENTED MINORITIES.

(a) Purpose.—It is the purpose of this section to diversify the health care workforce by supporting programs of excellence in designated health professions schools with a demonstrated set of effective policies, criteria, programs, performance standards, and measures that document commitment and capacity to underrepresented minority populations with a focus on minority health issues, cultural and linguistic competence, and eliminating racial and ethnic disparities in health and health care.
(b) Authorization of Appropriation.—Section 1736(h)(1) of the Public Health Service Act (42 U.S.C. 293(h)(1)) is amended to read as follows:

“(1) Authorization of Appropriations.—

For the purpose of making grants under subsection (a), there are authorized to be appropriated $50,000,000 for fiscal year 2008, and such sums as may be necessary for each of the fiscal years 2009 through 2013.”.

SEC. 204. MINORITY-SERVING INSTITUTIONS AND HISPANIC-SERVING HEALTH PROFESSIONS SCHOOLS.

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

“SEC. 742. MINORITY-SERVING INSTITUTIONS AND HISPANIC-SERVING HEALTH PROFESSIONS SCHOOLS.

“(a) In General.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to minority-serving institutions and Hispanic-serving health professions schools for the purpose of carrying out programs to recruit underrepresented individuals to enroll in and graduate from
such schools, which may include providing scholarships and other financial assistance as appropriate.

“(b) DEFINITIONS.—In this section:

“(1) The term ‘Hispanic-serving health professions school’ means an entity that—

“(A) is a school or program under section 799B;

“(B) has an enrollment of full-time equivalent students that is made up of at least 9 percent Hispanic students;

“(C) has been effective in carrying out programs to recruit Hispanic individuals to enroll in and graduate from the school;

“(D) has been effective in recruiting and retaining Hispanic faculty members; and

“(E) has a significant number of graduates who are providing health services to medically underserved populations or to individuals in health professional shortage areas.

“(2) The term ‘historically Black college or university’ means a part B institution (as defined in section 322(2) of the Higher Education Act of 1965).

“(3) The term ‘minority-serving institution’ means an entity that is—
“(A) an historically Black college or university;

“(B) an Hispanic-serving institution (as defined in section 502(a)(5) of the Higher Education Act of 1965);

“(C) a tribally controlled college or university (as defined in section 2(a)(4) of the Tribally Controlled College or University Assistance Act of 1978);

“(D) an Alaska Native-serving institution (as defined in section 317(b)(2) of the Higher Education Act of 1965); or

“(E) a Native Hawaiian-serving institution (as defined in section 317(b)(4) of the Higher Education Act of 1965).”.

SEC. 205. HEALTH PROFESSIONS STUDENT LOAN FUND; AUTHORIZATIONS OF APPROPRIATIONS REGARDING STUDENTS FROM UNDERREPRESENTED MINORITY COMMUNITIES.

Section 724(f) of the Public Health Service Act (42 U.S.C. 292t(f)) is amended by inserting before paragraph (2) the following:

“(1) IN GENERAL.—With respect to making Federal capital contributions to student loan funds for purposes of subsection (a), there is authorized to
be appropriated $50,000,000 for fiscal year 2008, and such sums as may be necessary for each of the fiscal years 2009 through 2013.”.

SEC. 206. NATIONAL HEALTH SERVICE CORPS; TRAINING PROGRAMS.

(a) In General.—Section 331(b) of the Public Health Service Act (42 U.S.C. 254d(b)) is amended by adding at the end the following:

“(3) The Secretary shall ensure that the individuals with respect to whom activities under paragraphs (1) and (2) are carried out include individuals from disadvantaged backgrounds, including activities carried out to provide health professions students with information on the Scholarship and Repayment Programs.”.

(b) Assignment of Corps Personnel.—

(1) In General.—Section 333(a)(3) of the Public Health Service Corps (42 U.S.C. 254f(a)(3)) is amended to read as follows:

“(3)(A) In approving applications for assignment of members of the Corps the Secretary shall not discriminate against application from entities which are not receiving Federal financial assistance under this Act.

“(B) In approving such applications, the Secretary shall—
“(i) give preference to applications in which a nonprofit entity or public entity shall provide a site to which Corps members may be assigned; and

“(ii) give highest preference to applications—

“(I) from entities described in clause (i) that are federally qualified health centers as defined in section 1905(l)(2)(B) of the Social Security Act; and

“(II) from entities described in clause (i) that primarily serve rural communities, racial and ethnic minorities, and other health disparity populations with annual incomes at or below twice those set forth in the most recent poverty guidelines issued by the Secretary pursuant to section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).”.

(2) PRIORITIES IN ASSIGNMENT OF CORPS PERSONNEL.—Section 333A of the Public Health Service Act (42 U.S.C. 254f-1) is amended—

(A) in subsection (a)—
(i) by redesignating paragraphs (1), (2), and (3) as paragraphs (2), (3), and (4), respectively; and
(ii) by striking “shall—” and inserting “shall—
“(1) give preference to applications as set forth in subsection (a)(3) of section 333;”;
(B) in subsection (b)(1), by striking “subsection (a)(1)(A)” and inserting “subsection (a)(2)(A)”;
(C) by striking “subsection (a)(1)” each place it appears and inserting “subsection (a)(2)”.

(3) Conforming Amendment.—Section 338I(c)(3)(B)(ii) of the Public Health Service Act (42 U.S.C. 254q-1(e)(3)(B)(ii)) is amended by striking “section 333A(a)(1)” and inserting “section 333A(a)(2)”.

(c) Reauthorization of National Health Service Corps Scholarship Program and Loan Repayment Program.—

(1) Reauthorization of Appropriations.—
Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended by striking “$146,250,000” and all that follows through the pe-
period and inserting “$300,000,000 for each of fiscal years 2008 through 2012.”.

(2) SCHOLARSHIPS FOR MEDICAL STUDENTS.—

Section 338H of such Act is further amended by adding at the end the following:

“(d) SCHOLARSHIPS FOR MEDICAL STUDENTS.—For contracts for scholarships under this subpart to individuals who are accepted for enrollment, or enrolled, in a course of study or program described in section 338A(b)(1)(B) that leads to a degree in medicine, osteopathic medicine, dentistry, or mental health services, the Secretary shall, of the amounts appropriated under subsection (a) for a fiscal year, obligate the greater of 10 percent or such amount as necessary to fund ongoing activities related to such contracts.”.

(d) REAUTHORIZATION OF CERTAIN PROGRAMS PROVIDING GRANTS FOR HEALTH PROFESSIONS TRAINING FOR DIVERSITY.—

(1) GRANTS FOR CENTERS OF EXCELLENCE.—

Section 736(h)(1) of the Public Health Service Act (42 U.S.C. 293(h)(1)) is amended by striking “$26,000,000” and all that follows through “2002” and inserting “$50,000,000 for each of fiscal years 2008 through 2012”.

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(2) Educational assistance for individuals from disadvantaged backgrounds.—Section 740(c) of such Act (42 U.S.C. 293d(c)) is amended by striking “$29,400,000” and all that follows through “1999 through 2002.” and inserting “$50,000,000 for each of fiscal years 2008 through 2012.”.

(c) Expansion of residency training programs and primary care services offered by community health centers.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended—

(1) by adding before section 747 the following:

“Subpart I—In General”; and

(2) by adding after section 748 the following:

“Subpart II—Additional Programs

SEC. 749. GRANTS TO EXPAND MEDICAL RESIDENCY TRAINING PROGRAMS AT COMMUNITY HEALTH CENTERS.

“(a) Program Authorized.—The Secretary may make grants to community health centers—

“(1) to establish, at the centers, new or alternative-campus accredited medical residency training programs affiliated with a hospital or other health care facility; or
“(2) to fund new residency positions within existing accredited medical residency training programs at the centers and their affiliated partners.

“(b) Use of Funds.—Amounts from a grant under this section shall be used to cover the costs of establishing or expanding a medical residency training program described in subsection (a), including costs associated with—

“(1) curriculum development;

“(2) equipment acquisition;

“(3) recruitment, training, and retention of residents and faculty; and

“(4) residency stipends.

“(c) Applications.—A community health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(d) Preference.—In selecting recipients for a grant under this section, the Secretary shall give preference to funding medical residency training programs focusing on primary health care.

“(e) Definitions.—In this section:

“(1) The term ‘accredited’, as applied to a new or alternative-campus medical residency training program, means a program that is accredited by a recognized body or bodies approved for such purpose
by the Accreditation Council for Graduate Medical
Education, except that a new medical residency
training program that, by reason of an insufficient
period of operation, is not eligible for accreditation
on or before the date of submission of an application
under subsection (c) shall be deemed accredited if
the Accreditation Council for Graduate Medical
Education finds, after consultation with the appro-
priate accreditation body or bodies, that there is rea-
sonable assurance that the program will meet the ac-
creditation standards of such body or bodies prior to
the date of graduation of the first entering class in
that program.

“(2) The term ‘community health center’ means
a health center as defined in section 330.

“SEC. 749A. GRANTS TO IMPROVE DELIVERY OF PRIMARY
CARE SERVICES IN COMMUNITY HEALTH
CENTERS.

“(a) PRIMARY CARE ACCESS GRANTS.—

“(1) PROGRAM AUTHORIZED.—The Secretary,
acting through the Administrator of the Health Re-
sources and Services Administration, may make
grants to community health centers for the purpose
of increasing the number of medical service pro-
viders associated with such centers.
“(2) GRANTS.—A recipient of a grant under this subsection shall be eligible to receive such grants for a total of 5 fiscal years.

“(3) USE OF FUNDS.—A recipient of a grant under this subsection shall use amounts from the grant for one or more of the following activities:

“(A) To recruit residents for medical residency training programs at the community health center.

“(B) To establish a multi-community physician mentoring program to encourage upper level residents to remain in the State or Territory in which the community health center and medical residency training program are located.

“(C) To enter into contracts for technical assistance for the purpose of recruiting or retaining primary health care staff.

“(D) To enter into contracts for technical assistance in preparing contracts with local providers of primary health care to provide services for medically underserved communities.

“(E) To enter into contracts for the development and implementation of strategies to identify and retain health care professionals and specialists, including oral and mental
health providers, who are willing and able to provide direct actual service to the community health center on a referral basis.

“(4) APPLICATION.—A community health center seeking a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(b) GRANTS FOR PRIMARY CARE FACILITY CAPITAL EXPENDITURES.—

“(1) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to community health centers for the purpose of increasing primary health care capabilities through the construction, expansion, or renovation of facilities.

“(2) GRANTS.—A recipient of a grant under this subsection shall be eligible to receive such grants for a total of 5 fiscal years.

“(3) USE OF FUNDS.—A recipient of a grant under this subsection shall use amounts from the grant for one or more of the following activities:

“(A) To acquire or lease facilities.

“(B) To construct new facilities.
“(C) To repair or modernize existing facilities.

“(D) To purchase or lease medical equipment.

“(c) DEFINITION.—The term ‘community health center’ means a health center as defined in section 330.

“SEC. 749B. AUTHORIZATION OF APPROPRIATIONS.

“There is authorized to be appropriated $200,000,000 for fiscal year 2008 and such sums as may be necessary for each fiscal year thereafter to carry out this subpart.”.

(f) INTERDISCIPLINARY, COMMUNITY-BASED PROGRAMS.—

(1) AREA HEALTH EDUCATION CENTERS.—Section 751(a) of the Public Health Service Act (42 U.S.C. 294a(a)) is amended—

(A) in paragraph (1)(A)—

(i) in clause (i), by inserting at the end before the semicolon the following: “, with an emphasis on such personnel who focus on primary care”;

(ii) by redesignating clauses (ii) through (vii) as clauses (iii) through (viii), respectively; and
(iii) by inserting after clause (i) the following:

“(ii) foster and provide community-based training and education for health professions students in underserved communities and among underserved populations, including but not limited to the National Health Service Corps, community and migrant health centers, rural health clinics, critical access hospitals, tribal health clinics, and public health departments;”; and

(B) by adding at the end the following:

“(3) POINT OF SERVICE ENHANCEMENT GRANTS.—

“(A) IN GENERAL.—The Secretary may award grants to entities receiving an award under paragraph (1) or (2) to improve the effectiveness of the programs operated by such entities or to enable the entities to respond to changes affecting such entities arising since the date of the receipt of the award under paragraph (1) or (2).

“(B) APPLICATION.—To receive an award under this paragraph, an entity described under
subparagraph (A) shall submit to the Secretary
an application at such time, in such manner,
and containing such information as the Sec-
retary may require, including an explanation of
the changes affecting such entity arising since
the date of the receipt by the entity of the
award under paragraph (1) or (2), such as
changes in the demographics of the area served,
the needs of the population served, and the sit-
uations encountered by such population and
such entity.”.

(2) AUTHORIZATION OF APPROPRIATIONS.—
Section 757 of the Public Health Service Act (42
U.S.C. 294g) is amended—

(A) in subsection (a), by striking
“$55,600,000” and all that follows through
“2002” and inserting “$125,000,000 for fiscal
year 2008 and such sums as may be necessary
for each of fiscal years 2009 through 2012”;

(B) by striking subsection (b) and insert-
ing the following:

“(b) ALLOCATION.—

“(1) IN GENERAL.—Of the amounts appro-
priated under subsection (a) that the Secretary
makes available for each fiscal year to carry out section 751, the Secretary shall obligate—

“(A) for awards under paragraph (1) of section 751(a), not more than 25 percent of such amounts in each fiscal year; and

“(B) for awards under paragraphs (2) and (3) of section 751(a), not less than 60 percent of such amounts in each fiscal year.”; and

(C) in subsection (c), by—

(i) striking the subsection designation and heading and inserting the following:

“(c) SENSE OF THE CONGRESS.—It is the sense of the Congress that—”.

(ii) striking paragraph (1); and

(iii) in paragraph (2), by—

(I) striking the paragraph designation and all that follows through “Congress that—”; and

(II) redesignating subparagraphs (A) and (B) as paragraphs (1) and (2) and indenting appropriately.

SEC. 207. LOAN REPAYMENT PROGRAM OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

Section 317F(c) of the Public Health Service Act (42 U.S.C. 247b–7(c)) is amended—
(1) by striking “and” after “1994,”; and

(2) by inserting before the period the following:

“$750,000 for fiscal year 2008, and such sums as
may be necessary for each of the fiscal years 2009
through 2013.”.

SEC. 208. STRENGTHENING AND EXPANDING RURAL
HEALTH PROVIDER NETWORKS.

Section 330A of the Public Health Service Act (42
U.S.C. 254c) is amended—

(1) in subsection (h), by adding at the end the
following:

“(4) RURAL MINORITY, BORDER, AND INDIAN
POPULATIONS.—In making grants under this sec-
tion, the Director of the Office of Rural Health Pol-
icy of the Health Resources and Services Adminis-
tration, in coordination with the Director of the In-
dian Health Service and the Deputy Assistant Sec-
retary for Minority Health, shall make grants to en-
tities that serve rural minority, border, and Indian
populations.

“(5) DIVERSITY HEALTH TRAINING PRO-
GRAMS.—The Director of the Office of Rural Health
Policy of the Health Resources and Services Admin-
istration, in coordination with the Director of the In-
dian Health Service and the Deputy Assistant Sec-
retary for Minority Health, shall coordinate the
awarding of grants under this section with the
awarding of grants and contracts under section 765
to connect and integrate diversity health training
programs.”; and

(2) in subsection (j), by striking “and such
sums as may be necessary for each of fiscal years
2003 through 2006” and inserting “, such sums as
may be necessary for each of fiscal years 2008
through 2010, and $60,000,000 for each of fiscal
years 2011 through 2015”.

SEC. 209. MCNAIR POSTBACCALAUREATE ACHIEVEMENT
PROGRAM.

Section 402E of the Higher Education Act of 1965
(20 U.S.C. 1070a–15) is amended by striking subsection
(f) and inserting the following:

“(f) COLLABORATION IN HEALTH PROFESSION DI-
VERSITY TRAINING PROGRAMS.—The Secretary of Edu-
cation shall coordinate with the Secretary of Health and
Human Services to ensure that there is collaboration be-
tween the goals of the program under this section and pro-
grams of the Health Resources and Services Administra-
tion that promote health workforce diversity. The Sec-
retary of Education shall take such measures as may be
necessary to encourage participants in programs under this section to consider health profession careers.

“(g) FUNDING.—From amounts appropriated pursuant to the authority of section 402A(f), the Secretary shall, to the extent practicable, allocate funds for projects authorized by this section in an amount which is not less than $31,000,000 for each of the fiscal years 2008 through 2014.”.

SEC. 210. ENSURING PROPORTIONAL REPRESENTATION OF INTERESTS OF RURAL AREAS ON MEDPAC.

(a) IN GENERAL.—Section 1805(c)(2) of the Social Security Act (42 U.S.C. 1395b–6(c)(2)) is amended—

(1) in subparagraph (A), by inserting “consistent with subparagraph (E)” after “rural representatives”; and

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

“(E) PROPORTIONAL REPRESENTATION OF INTERESTS OF RURAL AREAS.—In order to pro-
vide a balance between urban and rural rep-
resentatives under subparagraph (A), the pro-
portion of members who represent the interests of health care providers and Medicare bene-
ficiaries located in rural areas shall be no less than the proportion, of the total number of
Medicare beneficiaries, who reside in rural areas.”.

(b) Effective Date.—The amendments made by subsection (a) shall apply with respect to appointments made to the Medicare Payment Advisory Commission after the date of the enactment of this Act.

TITLE III—DATA COLLECTION AND REPORTING

SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) Purpose.—It is the purpose of this section to promote data collection, analysis, and reporting by race, ethnicity, and primary language among federally supported health programs.

(b) Amendment.—Title XXX of the Public Health Service Act, as amended by title II of this Act, is further amended by adding at the end the following:

“Subtitle B—Strengthening Data Collection, Improving Data Analysis, and Expanding Data Reporting

“SEC. 3031. DATA ON RACE, ETHNICITY, AND PRIMARY LANGUAGE.

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

“(A) require the collection, by the agency
or program involved, of data on the race, eth-
nicity, and primary language of each applicant
for and recipient of health-related assistance
under such program—

“(i) using, at a minimum, the cat-
egories for race and ethnicity described in
the 1997 Office of Management and Budg-
et Standards for Maintaining, Collecting,
and Presenting Federal Data on Race and
Ethnicity;

“(ii) using the standards developed
under subsection (e) for the collection of
language data;

“(iii) collecting data for additional
population groups if such groups can be
aggregated into the minimum race and
ethnicity categories; and

“(iv) where practicable, through self-
report;
“(B) with respect to the collection of the data described in subparagraph (A) for applicants and recipients who are minors or otherwise legally incapacitated, require that—

“(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

“(ii) the preferred language of the parent or legal guardian of such an applicant or recipient be collected;

“(C) systematically analyze such data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities in health and health care and when appropriate, for men and women separately, and report the results of such analysis to the Secretary, the Director of the Office for Civil Rights, the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives;

“(D) provide such data to the Secretary on at least an annual basis; and
“(E) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, and primary language data.

“(2) Rules of construction.—Nothing in this subsection shall be construed to—

“(A) permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information; and

“(B) require health care providers to collect data.

“(b) Protection of data.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) is protected—

“(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and
“(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

“(c) NATIONAL PLAN OF THE DATA COUNCIL.—The Secretary shall develop and implement a national plan to ensure the collection of data in a culturally appropriate and competent manner, and to improve the collection, analysis, and reporting of racial, ethnic, and primary language data at the Federal, State, territorial, Tribal, and local levels, including data to be collected under subsection (a). The Data Council of the Department of Health and Human Services, in consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, and other appropriate public and private entities, shall make recommendations to the Secretary concerning the development, implementation, and revision of the national plan. Such plan shall include recommendations on how to—

“(1) implement subsection (a) while minimizing the cost and administrative burdens of data collection and reporting;
“(2) expand awareness among Federal agencies, States, territories, Indian tribes, health providers, health plans, health insurance issuers, and the general public that data collection, analysis, and reporting by race, ethnicity, and primary language is legal and necessary to assure equity and non-discrimination in the quality of health care services;

“(3) ensure that future patient record systems have data code sets for racial, ethnic, and primary language identifiers and that such identifiers can be retrieved from clinical records, including records transmitted electronically;

“(4) improve health and health care data collection and analysis for more population groups if such groups can be aggregated into the minimum race and ethnicity categories, including exploring the feasibility of enhancing collection efforts in States for racial and ethnic groups that comprise a significant proportion of the population of the State;

“(5) provide researchers with greater access to racial, ethnic, and primary language data, subject to privacy and confidentiality regulations; and

“(6) safeguard and prevent the misuse of data collected under subsection (a).
“(d) Compliance With Standards.—Data collected under subsection (a) shall be obtained, maintained, and presented (including for reporting purposes) in accordance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (at a minimum).

“(e) Language Collection Standards.—Not later than 1 year after the date of enactment of this title, the Deputy Assistant Secretary for Minority Health, in consultation with the Office for Civil Rights of the Department of Health and Human Services, shall develop and disseminate Standards for the Classification of Federal Data on Preferred Written and Spoken Language.

“(f) Technical Assistance for the Collection and Reporting of Data.—

“(1) In General.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a health care program or an entity operating under such program to comply with the requirements of this section.

“(2) Types of Assistance.—Assistance provided under this subsection may include assistance to—
“(A) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis;

“(B) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories;

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

“(D) develop educational programs to inform health insurance issuers, health plans, health providers, health-related agencies, and the general public that data collection and reporting by race, ethnicity, and preferred language are legal and essential for eliminating health and health care disparities.

“(g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall provide technical assistance to agencies of the Department of Health and Human Services in meeting
Federal standards for race, ethnicity, and primary language data collection and analysis of racial and ethnic disparities in health and health care in public programs by—

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

“(2) specifying the clinical, diagnostic, or therapeutic measures which should be monitored;

“(3) developing new quality measures relating to racial and ethnic disparities in health and health care;

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

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

“(h) REPORT.—Not later than 2 years after the date of enactment of this title, and biennially thereafter, the Secretary shall submit to the appropriate committees of Congress a report on the effectiveness of data collection, analysis, and reporting on race, ethnicity, and primary language under the programs and activities of the Department of Health and Human Services and under other Federal data collection systems with which the Department interacts to collect relevant data on race and ethnicity. The report shall evaluate the progress made in the De-
department with respect to the national plan under subsection (e) or subsequent revisions thereto.

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

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

“(2) under this Act that provide Federal financial assistance for health care, biomedical research, health services research, and programs designed to improve the public’s health.

“(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2013.

“SEC. 3032. PROVISIONS RELATING TO NATIVE AMERICANS.

“(a) ESTABLISHMENT OF EPIDEMIOLOGY CENTERS.—The Secretary shall establish an epidemiology center in each service area to carry out the functions described in subsection (b). Any new center established after the date of the enactment of the Health Equity and Accountability Act of 2007 may be operated under a grant authorized by subsection (d), but funding under such a grant shall not be divisible.
“(b) Functions of Centers.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, each service area epidemiology center established under this subsection shall, with respect to such service area—

“(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the service area;

“(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

“(3) assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

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

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

“(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban In-
dian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

“(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations to promote public health.

“(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

“(d) GRANTS FOR STUDIES.—

“(1) IN GENERAL.—The Secretary may make grants to Indian Tribes, Tribal Organizations, Urban Indian Organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

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

“(A) the intertribal consortium is incorporated for the primary purpose of improving Indian health; and

“(B) the intertribal consortium is representative of the Indian Tribes or urban In-
dian communities in which the intertribal consortium is located.

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

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

“(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

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

“(C) demonstrate cooperation from Indian tribes or Urban Indian Organizations in the area to be served.

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

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

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

“(C) in collaboration with Indian Tribes, Tribal Organizations, and urban Indian communities, to provide the Service with information regarding ways to improve the health status of Indians.

“(e) Access to Information.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), as such entities are defined in part 164.501 of title 45, Code of Federal Regulations (or a successor regulation). The Secretary shall grant such grantees access to and use of data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.”.

SEC. 302. COLLECTION OF RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:
'SEC. 1150A. COLLECTION OF RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

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

“(1) require the collection of data on the race, ethnicity, and primary language of all applicants for social security account numbers or benefits under title II or part A of title XVIII and all individuals with respect to whom the Commissioner maintains records of wages and self-employment income in accordance with reports received by the Commissioner or the Secretary of the Treasury—

“(A) using, at a minimum, the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and available language standards; and

“(B) where practicable, collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories;

“(2) with respect to the collection of the data described in paragraph (1) for applicants who are...
under 18 years of age or otherwise legally incapacitated, require that—

“(A) such data be collected from the parent or legal guardian of such an applicant; and

“(B) the primary language of the parent or legal guardian of such an applicant or recipient be used;

“(3) require that such data be uniformly analyzed and reported at least annually to the Commissioner of Social Security;

“(4) be responsible for storing the data reported under paragraph (3);

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

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

“(7) ensure that the provision of assistance to an applicant is not denied or otherwise adversely affected because of the failure of the applicant to provide race, ethnicity, and primary language data.

“(b) PROTECTION OF DATA.—The Commissioner of Social Security shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant subsection (a) is protected—
“(1) under the same privacy protections as the Secretary applies to health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

“(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

“(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual providing any such information.

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

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years
2008 through 2013.”.

SEC. 303. REVISION OF HIPAA CLAIMS STANDARDS.

(a) In General.—Not later than 1 year after the
date of enactment of this Act, the Secretary of Health and
Human Services shall revise the regulations promulgated
under part C of title XI of the Social Security Act (42
U.S.C. 1320d et seq.), as added by the Health Insurance
Portability and Accountability Act of 1996 (Public Law
104–191), relating to the collection of data on race, eth-
nicity, and primary language in a health-related trans-
action to require—

(1) the use, at a minimum, of the categories for
race and ethnicity described in the 1997 Office of
Management and Budget Standards for Maintain-
ing, Collecting, and Presenting Federal Data on
Race and Ethnicity;

(2) the establishment of a new data code set for
primary language; and

(3) the designation of the racial, ethnic, and
primary language code sets as “required” for claims
and enrollment data.

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

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

SEC. 304. NATIONAL CENTER FOR HEALTH STATISTICS.

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

(1) in paragraph (1), by striking “2003” and
inserting “2012”;

(2) in paragraph (2), in the first sentence, by
striking “2003” and inserting “2012”; and

(3) in paragraph (3), by striking “2002” and
inserting “2012”.

SEC. 305. GEO-ACCESS STUDY.

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

(1) conduct a study to—

(A) determine which geographic areas of
the United States have shortages of specialty
mental health providers; and
(B) assess the preparedness of specialty mental health providers to deliver culturally and linguistically appropriate services; and

(2) submit a report to the Congress on the results of such study.

SEC. 306. RACIAL, ETHNIC, AND LINGUISTIC DATA COLLECTED BY THE FEDERAL GOVERNMENT.

(a) COLLECTION; SUBMISSION.—Not later than 90 days after the date of the enactment of this Act, and January 31st of each year thereafter, each department, agency, and office of the Federal Government that has collected racial, ethnic, or linguistic data during the preceding calendar year shall submit such data to the Secretary of Health and Human Services.

(b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—Not later than April 30, 2008, and each April 30th thereafter, the Secretary of Health and Human Services, acting through the Director of the National Center on Minority Health and Health Disparities and the Deputy Assistant Secretary for Minority Health, shall—

(1) collect and analyze the racial, ethnic, and linguistic data submitted under subsection (a) for the preceding calendar year;

(2) make publicly available such data and the results of such analysis; and
(3) submit a report to the Congress on such data and analysis.

SEC. 307. HEALTH INFORMATION TECHNOLOGY GRANTS.

(a) AUTHORITY.—The Deputy Assistant Secretary for Minority Health, in coordination with the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the National Center on Minority Health and Health Disparities, may award grants to appropriate entities for the purpose of ensuring appropriate and best practices to collect appropriate data and documents on the reduction of health disparities.

(b) USE OF FUNDS.—A grant received under subsection (a) shall be used to achieve the purpose described in such subsection through one or more of the following:

(1) Purchasing new, or enhancing existing, health information technology.

(2) Providing support and training to providers concerning such technology.

(3) Conducting outreach and education on health information technology and its benefits to patients, physicians, allied health professionals, and advocacy groups in medically underserved commu-
nities (as defined in section 799B of the Public Health Service Act (42 U.S.C. 295p)).

(c) Authorization of Appropriations.—To carry out this section, there are authorized to be appropriated $20,000,000 for each of fiscal years 2008 through 2013.

SEC. 308. STUDY OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.

(a) Study.—The National Coordinator for Health Information Technology shall conduct a study on the development and implementation of health information technology in medically underserved communities. The study shall—

(1) identify barriers to successful implementation of health information technology in these communities;

(2) examine the impact of health information technology on providing quality care and reducing the cost of care to these communities;

(3) examine urban and rural community health systems and determine the impact that health information technology may have on the capacity of primary health providers; and
(4) assess the feasibility and the costs of associated with the use of health information technology in these communities.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the National Coordinator for Health Information Technology shall submit to the Congress a report on the study conducted under subsection (a) and shall include in such report such recommendations for legislation or administrative action as the Coordinator determines appropriate.

SEC. 309. HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.

The National Coordinator for Health Information Technology shall—

(1) identify sources of funds that will be made available to promote and support the planning and adoption of health information technology in medically underserved communities (as defined in section 799B of the Public Health Service Act (42 U.S.C. 295p)), including in urban and rural areas, either through grants or technical assistance;

(2) coordinate with the funding sources to help such communities connect to identified funding; and

(3) collaborate with the Agency for Healthcare Research and Quality, the Health Resources and
Services Administration, and other Federal agencies to support technical assistance, knowledge dissemination, and resource development, to such communities seeking to plan for and adopt technology and establish electronic health information networks across providers.

SEC. 310. DATA COLLECTION AND ANALYSIS GRANTS TO MINORITY-SERVING INSTITUTIONS.

(a) AUTHORITY.—The Secretary of Health and Human Services, acting through the Center on Minority Health and Health Disparities and the Office of Minority Health, may award grants to access and analyze racial and ethnic, and where possible, primary language data to monitor and report on progress to reduce and eliminate racial and ethnic disparities in health and health care.

(b) ELIGIBLE ENTITY.—In this section, the term “eligible entity” means a historically Black college or university, an Hispanic-serving institution, a tribal college or university, or an Asian American and Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.

SEC. 311. HEALTH INFORMATION TECHNOLOGY GRANTS FOR RURAL HEALTH CARE PROVIDERS.

Title II of the Public Health Service Act is amended by adding at the end the following new part:
“PART D—HEALTH INFORMATION TECHNOLOGY

GRANTS

“SEC. 271. GRANTS TO FACILITATE THE WIDESPREAD

ADOPTION OF INTEROPERABLE HEALTH IN-

FORMATION TECHNOLOGY IN RURAL AREAS.

“(a) Competitive Grants to Eligible Entities

in Rural Areas.—

“(1) In general.—The Secretary may award

competitive grants to eligible entities in rural areas

to facilitate the purchase and enhance the utilization

of qualified health information technology systems to

improve the quality and efficiency of health care.

“(2) Eligibility.—To be eligible to receive a

grant under paragraph (1) an entity shall—

“(A) submit to the Secretary an applica-

tion at such time, in such manner, and con-

taining such information as the Secretary may

require;

“(B) submit to the Secretary a strategic

plan for the implementation of data sharing

and interoperability measures;

“(C) be a rural health care provider;

“(D) adopt any applicable core interoper-

ability guidelines (endorsed under other provi-

sions of law);
“(E) agree to notify patients if their individually identifiable health information is wrongfully disclosed;

“(F) demonstrate significant financial need; and

“(G) provide matching funds in accordance with paragraph (4).

“(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to facilitate the purchase and enhance the utilization of qualified health information technology systems and training personnel in the use of such technology.

“(4) MATCHING REQUIREMENT.—To be eligible for a grant under this subsection an entity shall contribute non-Federal contributions to the costs of carrying out the activities for which the grant is awarded in an amount equal to $1 for each $3 of Federal funds provided under the grant.

“(5) LIMIT ON GRANT AMOUNT.—In no case shall the payment amount under this subsection with respect to the purchase or enhanced utilization of qualified health information technology for a rural health care provider, in addition to the amount of any loan made to the provider from a grant to a State under subsection (b) for such purpose, exceed
100 percent of the provider’s costs for such purchase
or enhanced utilization (taking into account costs for
training, implementation, and maintenance).

“(6) Preference in awarding grants.—In awarding grants to eligible entities under this sub-
section, the Secretary shall give preference to each of the following types of applicants:

“(A) An entity that is located in a frontier or other rural underserved area as determined by the Secretary.

“(B) An entity that will link, to the extent practicable, the qualified health information system to a local or regional health information plan or plans.

“(C) A rural health care provider that is a nonprofit hospital or a Federally qualified health center.

“(D) A rural health care provider that is an individual practice or group practice.

“(b) Authorization of Appropriations.—

“(1) In general.—For the purpose of carrying out this section, there is authorized to be appropriated $20,000,000 for fiscal year 2008, $30,000,000 for fiscal year 2009, and such sums as
may be necessary, but not to exceed $30,000,000 for each of fiscal years 2010 through 2012.

“(2) Availability.—Amounts appropriated under paragraph (1) shall remain available through fiscal year 2011.

“(c) Definitions.—In this section:

“(1) Federally qualified health center.—The term ‘Federally qualified health center’ has the meaning given that term in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)).

“(2) Group practice.—The term ‘group practice’ has the meaning given that term in section 1877(h)(4) of the Social Security Act (42 U.S.C. 1395nn(h)(4)).

“(3) Health care provider.—The term ‘health care provider’ means a hospital, skilled nursing facility, home health agency (as defined in subsection (o) of section 1861 of the Social Security Act, 42 U.S.C. 1395x), health care clinic, rural health clinic, Federally qualified health center, group practice, a pharmacist, a pharmacy, a laboratory, a physician (as defined in subsection (r) of such section), a practitioner (as defined in section 1842(b)(18)(CC) of such Act, 42 U.S.C.
1395u(b)(18)(CC)), a health facility operated by or pursuant to a contract with the Indian Health Service, and any other category of facility or clinician determined appropriate by the Secretary.

“(4) HEALTH INFORMATION; INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The terms ‘health information’ and ‘individually identifiable health information’ have the meanings given those terms in paragraphs (4) and (6), respectively, of section 1171 of the Social Security Act (42 U.S.C. 1320d).

“(5) LABORATORY.—The term ‘laboratory’ has the meaning given that term in section 353.

“(6) PHARMACIST.—The term ‘pharmacist’ has the meaning given that term in section 804(a)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(a)(2)).

“(7) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term ‘qualified health information technology’ means a system or components of health information technology that meet any applicable core interoperability guidelines (endorsed under applicable provisions of law) when in use or that use interface software that allows for interoperability in accordance with such guidelines.
“(8) Rural area.—The term ‘rural area’ has the meaning given such term for purposes of section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)).

“(9) Rural health care provider.—The term ‘rural health care provider’ means a health care provider that is located in a rural area.”

TITLE IV—ACCOUNTABILITY AND EVALUATION
Subtitle A—General Provisions

SEC. 401. FEDERAL AGENCY PLAN TO ELIMINATE DISPARITIES AND IMPROVE THE HEALTH OF MINORITY POPULATIONS.

(a) In general.—Not later than September 1, 2008, each Federal health agency shall develop and implement a national strategic action plan to eliminate disparities on the basis of race, ethnicity, and primary language and improve the health and health care of minority populations, through programs relevant to the mission of the agency.

(b) Publication.—Each action plan described in paragraph (1) shall—

(1) be publicly reported in draft form for public review and comment;
(2) include a response to the review and comment described in paragraph (1) in the final plan;

(3) include the agency response to the 2002 Institute of Medicine report, Unequal Treatment—Confronting Racial and Ethnic Disparities in Healthcare;

(4) respond to data and analyses presented in the National Healthcare Disparities Report and the National Healthcare Quality Report published annually by the Agency for Healthcare Research and Quality;

(5) demonstrate progress in meeting the Healthy People 2010 objectives; and

(6) be updated, including progress reports, for inclusion in an annual report to Congress.

SEC. 402. ACCOUNTABILITY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Title XXX of the Public Health Service Act, as amended by titles II and III of this Act, is further amended by adding at the end the following:

“Subtitle C—Strengthening Accountability

“SEC. 3041. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.

“(a) In general.—The Secretary shall establish within the Office for Civil Rights an Office of Health Dis-
parities, which shall be headed by a director to be appointed by the Secretary.

“(b) PURPOSE.—The Office of Health Disparities shall ensure that the health programs, activities, and operations of health entities which receive Federal financial assistance are in compliance with title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin. The activities of the Office shall include the following:

“(1) The development and implementation of an action plan to address racial and ethnic health care disparities, which shall address concerns relating to the Office for Civil Rights as released by the United States Commission on Civil Rights in the report entitled ‘Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity’ (September, 1999) in conjunction with the reports by the Institute of Medicine entitled ‘Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care’, ‘Crossing the Quality Chasm: A New Health System for the 21st Century’, and ‘In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce’ and other related reports by the Institute of Medicine. This plan shall be publicly disclosed for review and
comment and the final plan shall address any com-
ments or concerns that are received by the Office.

“(2) Investigative and enforcement actions
against intentional discrimination and policies and
practices that have a disparate impact on minorities.

“(3) The review of racial, ethnic, and primary
language health data collected by Federal health
agencies to assess health care disparities related to
intentional discrimination and policies and practices
that have a disparate impact on minorities.

“(4) Outreach and education activities relating
to compliance with title VI of the Civil Rights Act.

“(5) The provision of technical assistance for
health entities to facilitate compliance with title VI
of the Civil Rights Act.

“(6) Coordination and oversight of activities of
the civil rights compliance offices established under
section 3042.

“(7) Ensuring compliance with the 1997 Office
of Management and Budget Standards for Maintain-
ing, Collecting, and Presenting Federal Data on
Race, Ethnicity and the available language stand-
ards.
“(c) FUNDING AND STAFF.—The Secretary shall ensure the effectiveness of the Office of Health Disparities by ensuring that the Office is provided with—

“(1) adequate funding to enable the Office to carry out its duties under this section; and

“(2) staff with expertise in—

“(A) epidemiology;

“(B) statistics;

“(C) health quality assurance;

“(D) minority health and health disparities;

“(E) cultural and linguistic competency;

and

“(F) civil rights.

“(d) REPORT.—Not later than December 31, 2008, and annually thereafter, the Secretary, in collaboration with the Director of the Office for Civil Rights and the Director of the Office of Minority Health, shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

“(1) the number of cases filed, broken down by category;
“(2) the number of cases investigated and closed by the office;

“(3) the outcomes of cases investigated;

“(4) the staffing levels of the office including staff credentials;

“(5) the number of other lingering and emerging cases in which civil rights inequities can be demonstrated; and

“(6) the number of cases remaining open and an explanation for their open status.

“(e) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2013.

“SEC. 3042. ESTABLISHMENT OF HEALTH PROGRAM OFFICES FOR CIVIL RIGHTS WITHIN FEDERAL HEALTH AND HUMAN SERVICES AGENCIES.

“(a) In General.—The Secretary shall establish civil rights compliance offices in each agency within the Department of Health and Human Services that administers health programs.

“(b) Purpose of Offices.—Each office established under subsection (a) shall ensure that recipients of Federal financial assistance under Federal health programs
administer their programs, services, and activities in a manner that—

“(1) does not discriminate, either intentionally or in effect, on the basis of race, national origin, language, ethnicity, sex, age, or disability; and

“(2) promotes the reduction and elimination of disparities in health and health care based on race, national origin, language, ethnicity, sex, age, and disability.

“(c) POWERS AND DUTIES.—The offices established in subsection (a) shall have the following powers and duties:

“(1) The establishment of compliance and program participation standards for recipients of Federal financial assistance under each program administered by an agency within the Department of Health and Human Services including the establishment of disparity reduction standards to encompass disparities in health and health care related to race, national origin, language, ethnicity, sex, age, and disability.

“(2) The development and implementation of program-specific guidelines that interpret and apply Department of Health and Human Services guidance under title VI of the Civil Rights Act of 1964
to each Federal health program administered by the agency.

“(3) The development of a disparity-reduction impact analysis methodology that shall be applied to every rule issued by the agency and published as part of the formal rulemaking process under sections 555, 556, and 557 of title 5, United States Code.

“(4) Oversight of data collection, analysis, and publication requirements for all recipients of Federal financial assistance under each Federal health program administered by the agency, and compliance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and the available language standards.

“(5) The conduct of publicly available studies regarding discrimination within Federal health programs administered by the agency as well as disparity reduction initiatives by recipients of Federal financial assistance under Federal health programs.

“(6) Annual reports to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives
on the progress in reducing disparities in health and
health care through the Federal programs adminis-
tered by the agency.

“(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
IN THE DEPARTMENT OF JUSTICE.—

“(1) DEPARTMENT OF HEALTH AND HUMAN
SERVICES.—The Office for Civil Rights in the De-
partment of Health and Human Services shall pro-
vide standard-setting and compliance review inves-
tigation support services to the Civil Rights Compli-
ance Office for each agency.

“(2) DEPARTMENT OF JUSTICE.—The Office
for Civil Rights in the Department of Justice shall
continue to maintain the power to institute formal
proceedings when an agency Office for Civil Rights
determines that a recipient of Federal financial as-
sistance is not in compliance with the disparity re-
duction standards of the agency.

“(e) DEFINITION.—In this section, the term ‘Federal
health programs’ mean programs—

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

“(2) under this Act that provide Federal finan-
cial assistance for health care, biomedical research,
health services research, and programs designed to improve the public’s health.”.

SEC. 403. OFFICE OF MINORITY HEALTH.

Section 1707 of the Public Health Service Act (42 U.S.C. 300u–6) is amended—

(1) by striking subsection (b) and inserting the following:

“(b) DUTIES.—With respect to improving the health of racial and ethnic minority groups, the Secretary, acting through the Deputy Assistant Secretary for Minority Health (in this section referred to as the ‘Deputy Assistant Secretary’), shall carry out the following:

“(1) Establish, implement, monitor, and evaluate short-range and long-range goals and objectives and oversee all other activities within the Public Health Service that relate to disease prevention, health promotion, service delivery, and research concerning minority groups. The heads of each of the agencies of the Service shall consult with the Deputy Assistant Secretary to ensure the coordination of such activities.

“(2) Oversee all activities within the Department of Health and Human Services that relate to reducing or eliminating disparities in health and health care in racial and ethnic minority populations
and in rural and underserved communities, including coordinating—

“(A) the design of programs, support for programs, and the evaluation of programs;

“(B) the monitoring of trends in health and health care;

“(C) research efforts;

“(D) the training of health providers; and

“(E) information and education programs and campaigns.

“(3) Enter into interagency and intra-agency agreements with other agencies of the Public Health Service.

“(4) Ensure that the Federal health agencies and the National Center for Health Statistics collect data on the health status and health care of each minority group, using at a minimum the categories specified in the 1997 OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity as required under subtitle B and available language standards.

“(5) Provide technical assistance to States, local agencies, territories, Indian tribes, and entities for activities relating to the elimination of racial and ethnic disparities in health and health care.
“(6) Support a national minority health resource center to carry out the following:

“(A) Facilitate the exchange of information regarding matters relating to health information, health promotion and wellness, preventive health services, clinical trials, health information technology, and education in the appropriate use of health services.

“(B) Facilitate timely access to culturally and linguistically appropriate information.

“(C) Assist in the analysis of such information.

“(D) Provide technical assistance with respect to the exchange of such information (including facilitating the development of materials for such technical assistance).

“(7) Carry out programs to improve access to health care services for individuals with limited English proficiency, including developing and carrying out programs to provide bilingual or interpretive services through the development and support of the Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care as provided for in section 3003.
“(8) Carry out programs to improve access to health care services and to improve the quality of health care services for individuals with low functional health literacy. As used in the preceding sentence, the term ‘functional health literacy’ means the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

“(9) Advise in matters related to the development, implementation, and evaluation of health professions education on decreasing disparities in health care outcomes, with focus on cultural competency as a method of eliminating disparities in health and health care in racial and ethnic minority populations.

“(10) Assist health care professionals, community and advocacy organizations, academic centers and public health departments in the design and implementation of programs that will improve the quality of health outcomes by strengthening the provider-patient relationship.”;

(2) by redesignating subsections (f) through (h) as subsections (g) through (i), respectively;

(3) by inserting after subsection (d) the following:
“(f) Preparation of Health Professionals to Provide Health Care to Minority Populations.—
The Secretary, in collaboration with the Director of the Bureau of Health Professions and the Deputy Assistant Secretary for Minority Health, shall require that health professional schools that receive Federal funds train future health professionals to provide culturally and linguistically appropriate health care to diverse populations.”;

and

(4) by striking subsection (i) (as so redesignated) and inserting the following:

“(i) Authorization of Appropriations.—For the purpose of carrying out this section, there are authorized to be appropriated $100,000,000 for fiscal year 2008, and such sums as may be necessary for each of fiscal years 2009 through 2013.”.

SEC. 404. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

(a) Establishment.—

(1) In general.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute
or treaties, there is established within the Public
Health Service of the Department of Health and
Human Services the Indian Health Service.

(2) Assistant Secretary of Indian Health.—The Service shall be administered by an
Assistant Secretary of Indian Health, who shall be
appointed by the President, by and with the advice
and consent of the Senate. The Assistant Secretary
shall report to the Secretary. Effective with respect
to an individual appointed by the President, by and
with the advice and consent of the Senate the term
of service of the Assistant Secretary shall be 4 years.
An Assistant Secretary may serve more than 1 term.

(b) Agency.—The Service shall be an agency within
the Public Health Service of the Department, and shall
not be an office, component, or unit of any other agency
of the Department.

c) Functions and Duties.—The Secretary shall
carry out through the Assistant Secretary of the Service—

(1) all functions which were, on the day before
the date of enactment of the Indian Health Care
Amendments of 1988, carried out by or under the
direction of the individual serving as Director of the
Service on such day;
(2) all functions of the Secretary relating to the
maintenance and operation of hospital and health fa-
cilities for Indians and the planning for, and provi-
sion and utilization of, health services for Indians;

(3) all health programs under which health care
is provided to Indians based upon their status as In-
dians which are administered by the Secretary, in-
cluding programs under—

(A) the Indian Health Care Improvement
Act;

(B) the Act of November 2, 1921 (25
U.S.C. 13);

(C) the Act of August 5, 1954 (42 U.S.C.
2001, et seq.);

(D) the Act of August 16, 1957 (42
U.S.C. 2005 et seq.);

(E) the Indian Self-Determination Act (25
U.S.C. 450f, et seq.); and

(F) title XXX of the Public Health Service
Act, as added by this Act; and

(4) all scholarship and loan functions carried
out under title I of the Indian Health Care Improve-
ment Act.

(d) Authority.—
(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the au-

thority—

(A) except to the extent provided for in paragraph (2), to appoint and compensate em-

ployees for the Service in accordance with title 5, United States Code;

(B) to enter into contracts for the procure-

ment of goods and services to carry out the functions of the Service; and

(C) to manage, expend, and obligate all funds appropriated for the Service.

(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

(e) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking the following: “Assistant Secretaries of Health and Human Services (6).” and inserting “Assistant Secretaries of Health and Human Services (7).”.
(2) Positions at Level V.—Section 5316 of such title is amended by striking the following: “Director, Indian Health Service, Department of Health and Human Services.”.

(f) Duties of Assistant Secretary for Indian Health.—Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661) is amended in subsection (a)—

(1) by inserting “(1)” after “(a)”; 

(2) in the second sentence of paragraph (1), as so designated, by striking “a Director,” and inserting “the Assistant Secretary for Indian Health,”;

(3) by striking the third sentence of paragraph (1), as so designated, and all that follows through the end of the subsection (a) of such section and inserting the following: “The Assistant Secretary for Indian Health shall carry out the duties specified in paragraph (2).”; and

(4) by adding after paragraph (1) the following: “(2) The Assistant Secretary for Indian Health shall—

“(A) report directly to the secretary concerning all policy and budget-related matters affecting Indian health;
“(B) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

“(C) advise each Assistant Secretary of the Department of Health and Human Services concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

“(D) advise the heads of other agencies and programs of the Department of Health and Human Services concerning matters of Indian health with respect to which those heads have authority and responsibility; and

“(E) coordinate the activities of the Department of Health and Human Services concerning matters of Indian health.”.

(g) CONTINUED SERVICE BY INCUMBENT.—The individual serving in the position of Director of the Indian Health Service on the date preceding the date of enactment of this Act may serve as Assistant Secretary for Indian Health, at the pleasure of the President after the date of enactment of this Act.

(h) CONFORMING AMENDMENTS.—
(1) Amendments to Indian Health Care Improvement Act.—The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended—

(A) in section 601—

(i) in subsection (c), by striking “Director of the Indian Health Service” both places it appears and inserting “Assistant Secretary for Indian Health”; and

(ii) in subsection (d), by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”; and

(B) in section 816(c)(1), by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

(2) Amendments to Other Provisions of Law.—The following provisions are each amended by striking “Director of the Indian Health Service” each place it appears and inserting “Assistant Secretary for Indian Health”:

(A) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)).
(B) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377 (b) and (e)).

(C) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)).

(i) REFERENCES.—Reference in any other Federal law, Executive order, rule, regulation, or delegation of authority, or any document of or relating to the Director of the Indian Health Service shall be deemed to refer to the Assistant Secretary for Indian Health.

(j) DEFINITIONS.—For purposes of this section, the definitions contained in section 4 of the Indian Health Care Improvement Act shall apply.

SEC. 405. ESTABLISHMENT OF INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN AGENCIES OF THE PUBLIC HEALTH SERVICE.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707 the following section:

"INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN
PUBLIC HEALTH SERVICE

"Sec. 1707A.

"(a) IN GENERAL.—The head of each agency specified in subsection (b)(1) shall establish within the agency an office to be known as the Office of Minority Health.
Each such Office shall be headed by a director, who shall be appointed by the head of the agency within which the Office is established, and who shall report directly to the head of the agency. The head of such agency shall carry out this section (as this section relates to the agency) acting through such Director.

“(b) Specified Agencies.—

“(1) In general.—The agencies referred to in subsection (a) are the following:

“(A) The Centers for Disease Control and Prevention.

“(B) The Health Resources and Services Administration.

“(C) The Substance Abuse and Mental Health Services Administration; and

“(D) The Administration on Aging.

“(c) Composition.—The head of each specified agency shall ensure that the officers and employees of the minority health office of the agency are, collectively, experienced in carrying out community-based health programs for each of the various racial and ethnic minority groups that are present in significant numbers in the United States.

“(d) Duties.—Each Director of a minority health office shall establish and monitor the programs of the speci-
fied agency of such office in order to carry out the fol-
lowing:

“(1) Determine the extent to which the pur-
poses of the programs are being carried out with re-
spect to racial and ethnic minority groups;

“(2) Determine the extent to which members of
such groups are represented among the Federal offi-
cers and employees who administer the programs;
and

“(3) Make recommendations to the head of
such agency on carrying out the programs with re-
spect to such groups. In the case of programs that
provide services, such recommendations shall include
recommendations toward ensuring that—

“(A) the services are equitably delivered
with respect to racial and ethnic minority
groups;

“(B) the programs provide the services in
the language and cultural context that is most
appropriate for the individuals for whom the
services are intended; and

“(C) the programs utilize racial and ethnic
minority community-based organizations to de-
lever services.
“(e) **Biennial Reports to Secretary.**—The head of each specified agency shall submit to the Secretary for inclusion in each biennial report describing—

“(1) the extent to which the minority health office of the agency employs individuals who are members of racial and ethnic minority groups, including a specification by minority group of the number of such individuals employed by such office.

“(f) **Funding.**—

“(1) **Allocations.**—Of the amounts appropriated for a specified agency for a fiscal year, the Secretary must designate an appropriate amount of funds for the purpose of carrying out activities under this section through the minority health office of the agency. In reserving an amount under the preceding sentence for a minority health office for a fiscal year, the Secretary shall reduce, by substantially the same percentage, the amount that otherwise would be available for each of the programs of the designated agency involved.

“(2) **Availability of funds for staffing.**—The purposes for which amounts made available under paragraph may be expended by a minority health office include the costs of employing staff for such office.”.
SEC. 406. OFFICE OF MINORITY HEALTH AT THE CENTERS FOR MEDICARE & MEDICAID SERVICES.

(a) In General.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish within the Centers for Medicare & Medicaid Services an Office of Minority Health (referred to in this section as the “Office”).

(b) Duties.—The Office shall be responsible for the coordination and facilitation of activities of the Centers for Medicare & Medicaid Services to improve minority health and health care and to reduce racial and ethnic disparities in health and health care, which shall include—

(1) creating a strategic plan, which shall be made available for public review, to improve the health and health care of Medicare, Medicaid, and SCHIP beneficiaries;

(2) promoting agency-wide policies relating to health care delivery and financing that could have a beneficial impact on the health and health care of minority populations;

(3) assisting health plans, hospitals, and other health entities in providing culturally and linguistically appropriate health care services;

(4) increasing awareness and outreach activities for minority health care consumers and providers.
about the causes and remedies for health and health care disparities;

(5) developing grant programs and demonstration projects to identify, implement and evaluate innovative approaches to improving the health and health care of minority beneficiaries in the Medicare, Medicaid, and SCHIP programs;

(6) considering incentive programs relating to reimbursement that would reward health entities for providing quality health care for minority populations using established benchmarks for quality of care;

(7) collaborating with the compliance office to ensure compliance with the anti-discrimination provisions under title VI of the Civil Rights Act of 1964;

(8) identifying barriers to enrollment in public programs under the jurisdiction of the Centers for Medicare & Medicaid Services;

(9) monitoring and evaluating on a regular basis the success of minority health programs and initiatives;

(10) publishing an annual report about the activities of the Centers for Medicare & Medicaid Services relating to minority health improvement; and
(11) other activities determined appropriate by the Secretary of Health and Human Services.

(c) STAFF.—The staff at the Office shall include—

(1) one or more individuals with expertise in minority health and racial and ethnic health disparities; and

(2) one or more individuals with expertise in health care financing and delivery in underserved communities.

(d) COORDINATION.—In carrying out its duties under this section, the Office shall coordinate with—

(1) the Office of Minority Health in the Office of the Secretary of Health and Human Services;

(2) the National Centers for Minority Health and Health Disparities in the National Institutes of Health; and

(3) the Office of Minority Health in the Centers for Disease Control and Prevention.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2008, and such sums may be necessary for each of fiscal years 2009 through 2014.
SEC. 407. OFFICE OF MINORITY AFFAIRS AT THE FOOD AND 
DRUG ADMINISTRATION.

Chapter IX of the Federal Food, Drug, and Cosmetic 
Act (21 U.S.C. 391 et seq.) is amended by adding at the 
end the following:

“SEC. 910. OFFICE OF MINORITY AFFAIRS.

“(a) In General.—Not later than 60 days after the 
date of enactment of this section, the Secretary shall es-

tablish within the Office of the Commissioner of Food and 
Drugs an Office of Minority Affairs (referred to in this 
section as the ‘Office’).

“(b) Duties.—The Office shall be responsible for the 
coordination and facilitation of activities of the Food and 
Drug Administration to improve minority health and 
health care and to reduce racial and ethnic disparities in 
health and health care, which shall include—

“(1) promoting policies in the development and 
review of medical products that reduce racial and 
ethnic disparities in health and health care;

“(2) encouraging appropriate data collection, 
analysis, and dissemination of racial and ethnic dif-
ferences using, at a minimum, the categories de-
scribed in the 1997 Office of Management and 
Budget standards, in response to different therapies 
in both adult and pediatric populations;
“(3) providing, in coordination with other appropriate government agencies, education, training, and support to increase participation of minority patients and physicians in clinical trials;

“(4) collecting and analyzing data using, at a minimum, the categories described in the 1997 Office of Management and Budget standards, on the number of participants from minority racial and ethnic backgrounds in clinical trials used to support medical product approvals;

“(5) the identification of methods to reduce language and literacy barriers; and

“(6) publishing an annual report about the activities of the Food and Drug Administration pertaining to minority health.

“(c) STAFF.—The staff of the Office shall include—

“(1) one or more individuals with expertise in the design and conduct of clinical trials of drugs, biological products, and medical devices; and

“(2) one or more individuals with expertise in therapeutic classes or disease states for which medical evidence suggests a difference based on race or ethnicity.

“(d) COORDINATION.—In carrying out its duties under this section, the Office shall coordinate with—
“(1) the Office of Minority Health in the Office of the Secretary of Health and Human Services;

“(2) the National Center for Minority Health and Health Disparities in the National Institutes of Health; and

“(3) the Office of Minority Health in the Centers for Disease Control and Prevention.

“(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2008 through 2013.”.

SEC. 408. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by adding after section 505B the following:

“SEC. 505C. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

“(a) PRE-APPROVAL STUDIES.—If there is evidence that there may be a disparity on the basis of racial or ethnic background as to the safety or effectiveness of a drug, then—
“(1)(A) the investigations required under section 505(b)(1)(A) shall include adequate and well-controlled investigations of the disparity; or

“(B) the evidence required under section 351(a) of the Public Health Service Act for approval of a biologics license application for the drug shall include adequate and well-controlled investigations of the disparity; and

“(2) if the investigations confirm that there is a disparity, the labeling of the drug shall include appropriate information about the disparity.

“(b) Post-Market Studies.—

“(1) In general.—If there is evidence that there may be a disparity on the basis of racial or ethnic background as to the safety or effectiveness of a drug for which there is an approved application under section 505 or a license under section 351 of the Public Health Service Act, the Secretary may by order require the holder of the approved application or license to conduct, by a date specified by the Secretary, post-marketing studies to investigate the disparity.

“(2) Labeling.—If the Secretary determines that the post-market studies confirm that there is a disparity described in paragraph (1), the labeling of
the drug shall include appropriate information about
the disparity.

“(3) STUDY DESIGN.—The Secretary may
specify all aspects of study design, including the
number of studies and study participants, in the
order requiring post-market studies of the drug.

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

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

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

“(1) evidence that there is a disparity on the
basis of racial or ethnic background as to safety or
effectiveness of a drug in the same chemical class as
the drug;

“(2) evidence that there is a disparity on the
basis of racial or ethnic background in the way the
drug is metabolized; and
“(3) other evidence as the Secretary may determine.

“(d) Applications Under Section 505(b)(2) and 505(j).—

“(1) In General.—A drug for which an application has been submitted or approved under section 505(j) shall not be considered ineligible for approval under that section or misbranded under section 502 on the basis that the labeling of the drug omits information relating to a disparity on the basis of racial or ethnic background as to the safety or effectiveness of the drug, whether derived from investigations or studies required under this section or derived from other sources, when the omitted information is protected by patent or by exclusivity under clause (iii) or (iv) of section 505(j)(5)(B).

“(2) Labeling.—Notwithstanding clauses (iii) and (iv) of section 505(j)(5)(B), the Secretary may require that the labeling of a drug approved under section 505(j) that omits information relating to a disparity on the basis of racial or ethnic background as to the safety or effectiveness of the drug include a statement of any appropriate contraindications, warnings, or precautions related to the disparity that the Secretary considers necessary.”.
(b) Enforcement.—Section 502 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352) is amended by adding at the end the following:

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

(e) Drug Fees.—Section 736(a)(1)(A)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h) is amended by adding after “are required” the following:

“, including supplements required under section 505C”.

SEC. 409. UNITED STATES COMMISSION ON CIVIL RIGHTS.

(a) Coordination Within Department of Justice of Activities Regarding Health Disparities.—Section 3 of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975a) is amended—

(1) in paragraph (1)(B), by striking “and” at the end;

(2) in paragraph (2), in the matter after and below subparagraph (D), by striking the period and inserting “; and”; and

(3) by adding at the end the following:

“(3) shall, with respect to activities carried out in health care and correctional facilities toward the
goal of eliminating health disparities between the
general population and members of racial or ethnic
minority groups, coordinate such activities of—

“(A) the Office for Civil Rights within the
Department of Justice;

“(B) the Office of Justice Programs within
the Department of Justice;

“(C) the Office for Civil Rights within the
Department of Health and Human Services;

and

“(D) the Office of Minority Health within
the Department of Health and Human Services
(headed by the Deputy Assistant Secretary for
Minority Health).”.

(b) Authorization of Appropriations.—Section
5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
1975c) is amended by striking the first sentence and in-
serting the following: “For the purpose of carrying out
this Act, there are authorized to be appropriated
$30,000,000 for fiscal year 2008, and such sums as may
be necessary for each of the fiscal years 2009 through
2013.”.
SEC. 410. SENSE OF CONGRESS CONCERNING FULL FUNDING OF ACTIVITIES TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES.

(a) FINDINGS.—Congress makes the following findings:

(1) The health status of the American populace is declining and the United States currently ranks below most industrialized nations in health status measured by longevity, sickness, and mortality.

(2) Racial and ethnic minority populations tend have the poorest health status and face substantial cultural, social, and economic barriers to obtaining quality health care.

(3) Efforts to improve minority health have been limited by inadequate resources (funding, staffing, and stewardship) and accountability.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) funding should be doubled by fiscal year 2008 for the National Center for Minority Health Disparities, the Office of Civil Rights in the Department of Health and Human Services, the National Institute of Nursing Research, and the Office of Minority Health;

(2) adequate funding by fiscal year 2008, and subsequent funding increases, should be provided for
health professions training programs, the Racial and Ethnic Approaches to Community Health (REACH) at the Center for Disease Control and Prevention, the Minority HIV/AIDS Initiative, and the Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) Program at the Agency for Healthcare Research and Quality;

(3) current and newly-created health disparity elimination incentives, programs, agencies, and departments under this Act (and the amendments made by this Act) should receive adequate staffing and funding by fiscal year 2008; and

(4) stewardship and accountability should be provided to Congress and the President for measurable and sustainable progress toward health disparity elimination.

SEC. 411. GUIDELINES FOR DISEASE SCREENING FOR MINORITY PATIENTS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall convene a series of meetings to develop guidelines for disease screening for minority patient populations which have a higher than average risk for many chronic diseases and cancers.
(b) PARTICIPANTS.—In convening meetings under subsection (a), the Secretary shall ensure that meeting participants include representatives of—

(1) professional societies and associations;

(2) minority health organizations;

(3) health care researchers and providers, including those with expertise in minority health;

(4) Federal health agencies, including the Office of Minority Health and the National Institutes of Health; and

(5) other experts determined appropriate by the Secretary.

(c) DISEASES.—Screening guidelines for minority populations shall be developed under subsection (a) for—

(1) hypertension;

(2) hypercholesterolemia;

(3) diabetes;

(4) cardiovascular disease;

(5) cancers, including breast, prostate, colon, cervical, and lung cancer;

(6) asthma;

(7) diabetes;

(8) kidney diseases;

(9) eye diseases and disorders, including glaucoma;
(10) HIV/AIDS and sexually transmitted diseases;
(11) uterine fibroids;
(12) autoimmune disease;
(13) mental health conditions;
(14) dental health conditions and oral diseases;
(15) environmental and related health illnesses and conditions;
(16) Sickle cell disease;
(17) violence and injury prevention and control;
(18) genetic and related conditions;
(19) heart disease and stroke;
(20) tuberculosis;
(21) chronic obstructive pulmonary disease; and
(22) other diseases determined appropriate by the Secretary.

(d) Dissemination.—Not later than 24 months after the date of enactment of this title, the Secretary shall publish and disseminate to health care provider organizations the guidelines developed under subsection (a).

(e) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, sums as may be necessary for each of fiscal years 2008 through 2013.
SEC. 412. NATIONAL CENTER FOR MINORITY HEALTH AND
HEALTH DISPARITIES REAUTHORIZATION.

(a) In General.—Section 485E of the Public Health Service Act (42 U.S.C. 287c-31) is amended—

(1) by striking subsection (e) and inserting the following:

“(e) Duties of the Director.—

“(1) Interagency Coordination of Minority Health and Health Disparities Activities.—With respect to minority health and health disparities, the Director of the Center shall plan, coordinate, and evaluate research and other activities conducted or supported by the agencies of the National Institutes of Health. In carrying out the preceding sentence, the Director of the Center shall evaluate the minority health and health disparity activities of each of such agencies and shall provide for the timely periodic re-evaluation of such activities.

“(2) Consultations.—The Director of the Center shall carry out this subpart (including developing and revising the plan and budget required in subsection (f)) in consultation with the Directors of the agencies (or a designee of the Directors) of the National Institutes of Health, with the advisory councils of the agencies, and with the advisory council established under section (j).
“(3) Coordination of activities.—The Director of the Center shall act as the primary Federal official with responsibility for coordinating all minority health disparities research and other health disparities research conducted or supported by the National Institutes of Health and shall—

“(A) represent the health disparities research program of the National Institutes of Health including the minority health disparities research program at all relevant executive branch task forces, committees, and planning activities;

“(B) maintain communications with all relevant Public Health Service agencies, including the Indian Health Service and various other departments of the Federal Government, to ensure the timely transmission of information concerning advances in minority health disparities research and other health disparities research between these various agencies for dissemination to affected communities and health care providers;

“(C) undertake research to further refine and develop the conceptual, definitional, and methodological issues involved in health dispari-
ties research and to further the understanding
of the cause of disparities; and

“(D) engage with national and community-
based organizations and health provider groups,
led by and serving racial and ethnic minorities,
to—

“(i) increase education, awareness,
and participation with respect to the Cen-
ter’s activities and areas of research focus;
and

“(ii) accelerate the translation of re-
search findings into programs including
those carried out by community-based or-
ganizations.”;

(2) in subsection (f)—

(A) by striking the subsection heading and
inserting the following: “COMPREHENSIVE
PLAN FOR RESEARCH; BUDGET ESTIMATE; AL-
LOCATION OF APPROPRIATIONS.—”;

(B) in paragraph (1)—

(i) by striking the paragraph designa-
tion, the paragraph heading, the matter
preceding subparagraph (A), and subpara-
graph (A) and inserting the following:
“(1) IN GENERAL.—Subject to the provisions of this section and other applicable law, the Director of the Center, in consultation with the Director of NIH, the Directors of the other agencies of the National Institutes of Health, and the advisory council established under subsection (j) shall—

“(A) annually review and revise a comprehensive plan (referred to in this section as ‘the plan’) and budget for the conduct and support of all minority health and health disparities research and other health disparities research activities of the agencies of the National Institutes of Health that includes time-based targeted objectives with measurable outcomes and assure that the annual review and revision of the plan uses an established trans-NIH process subject to timely review, approval, and dissemination;”;

(ii) in subparagraph (D), by striking “, with respect to amounts appropriated for activities of the Center,”;

(iii) by striking subparagraph (F) and inserting the following:

“(F) ensure that the plan and budget are presented to and considered by the Director in...
a clear and timely process during the formulation of the overall annual budget for the National Institutes of Health;”;

(iv) by redesignating subparagraphs (G) and (H) as subparagraphs (I) and (J), respectively; and

(v) by inserting after subparagraph (F), the following:

“(G) annually submit to the Congress a report on the progress made with respect to the plan;

“(H) create and implement a plan for the systematic review of research activities supported by the National Institutes of Health that are within the mission of both the Center and other agencies of the National Institutes of Health, by establishing mechanisms for—

“(i) tracking minority health and health disparity research conducted within the agencies and assessing the appropriateness of this research with regard to the overall goals and objectives of the plan;

“(ii) the early identification of applications and proposals for grants, contracts, and cooperative agreements supporting ex-
tramural training, research, and development, that are submitted to the agencies and that are within the mission of the Center;

“(iii) providing the Center with the written descriptions and scientific peer review results of such applications and proposals;

“(iv) enabling the agencies to consult with the Director of the Center prior to final approval of such applications and proposals; and

“(v) reporting to the Director of the Center all such applications and proposals that are approved for funding by the agencies;”; and

(C) in paragraph (2)—

(i) in subparagraph (D), by striking “and” at the end;

(ii) in subparagraph (E), by striking the period and inserting “; and”; and

(iii) by adding at the end the following:

“(F) the number and type of personnel needs of the Center.”;
(3) in subsection (h)—

(A) in paragraph (1), by striking “endow-
ments at centers of excellence under section
736.” and inserting the following: “endowments
at—

“(A) centers of excellence under section
736; and

“(B) centers of excellence under section
485F.; and

(B) in paragraph (2)(A), by striking “aver-
age” and inserting “median”; and

(4) by inserting after subsection (j), the fol-
lowing:

“(k) REPRESENTATION OF MINORITIES AMONG RE-
searchers.—The Secretary, in collaboration with the Di-
rector of the Center, shall determine, by means of the col-
lection and reporting of aggregated and disaggregated
data, the extent to which racial and ethnic minority groups
are represented among senior physicians and scientists of
the national research institutes and among physicians and
scientists conducting research with funds provided by such
institutes, and as appropriate, carry out activities to in-
crease the extent of such representation, including devel-
oping a pipeline of minority researchers interested in the
study of health and health disparities, as well as attracting
minority scientists in social and behavioral science fields who can bring their expertise to the study of health disparities.

“(l) CANCER RESEARCH.—The Secretary, in collaboration with the Director of the Center, shall designate and support a cancer prevention, control, and population science center to address the significantly elevated rate of morbidity and mortality from cancer in racial and ethnic minority populations. Such designated center shall be housed within an existing, stand-alone cancer center at a minority-serving institution that has a demonstrable commitment to and expertise in cancer research in the basic, clinical, and population sciences.”.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out section 485E of the Public Health Service Act (42 U.S.C.287c–31), as amended by subsection (a), there are authorized to be appropriated $240,000,000 for fiscal year 2008 and such sums as may be necessary for each of fiscal years 2009 through 2012.

(2) EXPENDITURE.—The Director of the National Center on Minority Health and Health Disparities shall expend amounts appropriated for activities under such section 485E in accordance with such section and other applicable law and in collabo-
ration with the Director of National Institutes of Health and the directors of other institutes and centers of the National Institutes of Health.

(3) Management.—All amounts expended for minority health and health disparities research activities under this subsection shall be reported programmatically to and approved by the Director of the National Center on Minority Health and Health Disparities under such section 485E, in accordance with the plan described under subsection (f)(1)(A) of such section 485E.

Subtitle B—Improving Environmental Justice

SEC. 421. CODIFICATION OF EXECUTIVE ORDER 12898.

(a) In General.—The President of the United States is authorized and directed to execute, administer, and enforce as a matter of Federal law the provisions of Executive Order 12898, dated February 11, 1994, ("Federal Actions To Address Environmental Justice In Minority Populations and Low-Income Populations") with such modifications as are provided in this section.

(b) Definition of Environmental Justice.—For purposes of carrying out the provisions of Executive Order 12898, the following definitions shall apply:
(1) The term “environmental justice” means the fair treatment and meaningful involvement of all people regardless of race, color, national origin, educational level, or income with respect to the development, implementation, and enforcement of environmental laws and regulations in order to ensure that—

(A) minority and low-income communities have access to public information relating to human health and environmental planning, regulations, and enforcement; and

(B) no minority or low-income population is forced to shoulder a disproportionate burden of the negative human health and environmental impacts of pollution or other environmental hazard.

(2) The term “fair treatment” means policies and practices that ensure that no group of people, including racial, ethnic, or socioeconomic groups bear disproportionately high and adverse human health or environmental effects resulting from Federal agency programs, policies, and activities.

(c) Judicial Review and Rights of Action.—The provisions of section 6–609 of Executive Order 12898 shall not apply for purposes of this Act.
SEC. 422. IMPLEMENTATION OF RECOMMENDATIONS BY ENVIRONMENTAL PROTECTION AGENCY.

(a) INSPECTOR GENERAL RECOMMENDATIONS.—The Administrator of the Environmental Protection Agency shall, as promptly as practicable, carry out each of the following recommendations of the Inspector General of the agency as set forth in Report No. 2006–P-00034 entitled “EPA needs to conduct environmental justice reviews of its programs, policies and activities”:

(1) The recommendation that the Agency’s program and regional offices identify which programs, policies, and activities need environmental justice reviews and require these offices to establish a plan to complete the necessary reviews.

(2) The recommendation that the Administrator of the Agency ensure that these reviews determine whether the programs, policies, and activities may have a disproportionately high and adverse health or environmental impact on minority and low-income populations.

(3) The recommendation that each program and regional office develop specific environmental justice review guidance for conducting environmental justice reviews.

(4) The recommendation that the Administrator designate a responsible office to compile results of
environmental justice reviews and recommend appropriate actions.

(b) GAO RECOMMENDATIONS.—In developing rules under laws administered by the Environmental Protection Agency, the Administrator of the Agency shall, as promptly as practicable, carry out each of the following recommendations of the Comptroller General of the United States as set forth in GAO Report numbered GAO–05–289 entitled “EPA Should Devote More Attention to Environmental Justice when Developing Clean Air Rules”:

(1) The recommendation that the Administrator ensure that workgroups involved in developing a rule devote attention to environmental justice while drafting and finalizing the rule.

(2) The recommendation that the Administrator enhance the ability of such workgroups to identify potential environmental justice issues through such steps as providing workgroup members with guidance and training to helping them identify potential environmental justice problems and involving environmental justice coordinators in the workgroups when appropriate.

(3) The recommendation that the Administrator improve assessments of potential environmental justice impacts in economic reviews by identifying the
data and developing the modeling techniques needed to assess such impacts.

(4) The recommendation that the Administrator direct appropriate Agency officers and employees to respond fully when feasible to public comments on environmental justice, including improving the Agency’s explanation of the basis for its conclusions, together with supporting data.

(e) 2004 INSPECTOR GENERAL REPORT.—The Administrator of the Environmental Protection Agency shall, as promptly as practicable, carry out each of the following recommendations of the Inspector General of the Agency as set forth in the report entitled “EPA Needs to Consistently Implement the Intent of the Executive Order on Environmental Justice” (Report No. 2004–P–00007):

(1) The recommendation that the Agency clearly define the mission of the Office of Environmental Justice (OEJ) and provide Agency staff with an understanding of the roles and responsibilities of the Office.

(2) The recommendation that the Agency establish (through issuing guidance or a policy statement from the Administrator) specific time frames for the development of definitions, goals, and measurements regarding environmental justice and provide the re-
gions and program offices a standard and consistent
definition for a minority and low-income community,
with instructions on how the Agency will implement
and operationalize environmental justice into the
Agency’s daily activities.

(3) The recommendation that the Agency en-
sure the comprehensive training program currently
under development includes standard and consistent
definitions of the key environmental justice concepts
(such as “low-income”, “minority”, and “dispropor-
tionately impacted”) and instructions for implemen-
tation of those concepts.

(d) REPORT.—The Administrator shall submit an ini-
tial report to Congress within 6 months after the enact-
ment of this Act regarding the Administrator’s strategy
for implementing the recommendations referred to in sub-
sections (a), (b), and (c). Thereafter, the Administrator
shall provide semi-annual reports to Congress regarding
the Administrator’s progress in implementing such rec-
ommendations and modifying the Administrator’s emer-
gency management procedures to incorporate environ-
mental justice in the Agency’s Incident Command Struc-
ture (in accordance with the December 18, 2006, letter
from the Deputy Administrator to the Acting Inspector
General of the agency).
SEC. 423. GRANT PROGRAM.

(a) DEFINITIONS.—In this section:

(1) DIRECTOR.—The term “Director” means the Director of the Centers for Disease Control and Prevention, acting in collaboration with the Administrator of the Environmental Protection Agency and the Director of the National Institute of Environmental Health Sciences.

(2) ELIGIBLE ENTITY.—The term “eligible entity” means a State or local community that—

(A) bears a disproportionate burden of exposure to environmental health hazards;

(B) has established a coalition—

(i) with not less than 1 community-based organization; and

(ii) with not less than 1—

(I) public health entity;

(II) health care provider organization; or

(III) academic institution, including any minority-serving institution (including an Hispanic-serving institution, a historically Black college or university, and a tribal college or university);
(C) ensures planned activities and funding streams are coordinated to improve community health; and

(D) submits an application in accordance with subsection (c).

(b) ESTABLISHMENT.—The Director shall establish a grant program under which eligible entities shall receive grants to conduct environmental health improvement activities.

(c) APPLICATION.—To receive a grant under this section, an eligible entity shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may require.

(d) COOPERATIVE AGREEMENTS.—An eligible entity may use a grant under this section—

(1) to promote environmental health; and

(2) to address environmental health disparities.

(e) AMOUNT OF COOPERATIVE AGREEMENT.—

(1) IN GENERAL.—The Director shall award grants to eligible entities at the 2 different funding levels described in this subsection.

(2) LEVEL 1 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use
the funds to identify environmental health problems and solutions by—

(i) establishing a planning and prioritizing council in accordance with subparagraph (B); and

(ii) conducting an environmental health assessment in accordance with subparagraph (C).

(B) Planning and Prioritizing Council.—

(i) In general.—A prioritizing and planning council established under subparagraph (A)(i) (referred to in this paragraph as a “PPC”) shall assist the environmental health assessment process and environmental health promotion activities of the eligible entity.

(ii) Membership.—Membership of a PPC shall consist of representatives from various organizations within public health, planning, development, and environmental services and shall include stakeholders from vulnerable groups such as children, the elderly, disabled, and minority ethnic groups that are often not actively involved
in democratic or decision-making processes.

(iii) DUTIES.—A PPC shall—

(I) identify key stakeholders and engage and coordinate potential partners in the planning process;

(II) establish a formal advisory group to plan for the establishment of services;

(III) conduct an in-depth review of the nature and extent of the need for an environmental health assessment, including a local epidemiological profile, an evaluation of the service provider capacity of the community, and a profile of any target populations; and

(IV) define the components of care and form essential programmatic linkages with related providers in the community.

(C) ENVIRONMENTAL HEALTH ASSESSMENT.—
(i) **IN GENERAL.**—A PPC shall carry out an environmental health assessment to identify environmental health concerns.

(ii) **ASSESSMENT PROCESS.**—The PPC shall—

(I) define the goals of the assessment;

(II) generate the environmental health issue list;

(III) analyze issues with a systems framework;

(IV) develop appropriate community environmental health indicators;

(V) rank the environmental health issues;

(VI) set priorities for action;

(VII) develop an action plan; and

(VIII) implement the plan; and

(IX) evaluate progress and planning for the future.

(D) **EVALUATION.**—Each eligible entity that receives a grant under this paragraph shall evaluate, report, and disseminate program findings and outcomes.
(E) Technical assistance.—The Director may provide such technical and other non-financial assistance to eligible entities as the Director determines to be necessary.

(3) Level 2 Cooperative Agreements.—

(A) Eligibility.—

(i) In general.—The Director shall award grants under this paragraph to eligible entities that have already—

(I) established broad-based collaborative partnerships; and

(II) completed environmental assessments.

(ii) No Level 1 Requirement.—To be eligible to receive a grant under this paragraph, an eligible entity is not required to have successfully completed a Level 1 Cooperative Agreement (as described in paragraph (2)).

(B) Use of Grant Funds.—An eligible entity awarded a grant under this paragraph shall use the funds to further activities to carry out environmental health improvement activities, including—
(i) addressing community environmental health priorities in accordance with paragraph (2)(C)(ii), including—

(I) air quality;

(II) water quality;

(III) solid waste;

(IV) land use;

(V) housing;

(VI) food safety;

(VII) crime;

(VIII) injuries; and

(IX) healthcare services;

(ii) building partnerships between planning, public health, and other sectors, to address how the built environment impacts food availability and access and physical activity to promote healthy behaviors and lifestyles and reduce overweight and obesity, asthma, respiratory conditions, dental, oral and mental health conditions, and related co-morbidities;

(iii) establishing programs to address—

(I) how environmental and social conditions of work and living choices
influence physical activity and dietary intake; or

(II) how those conditions influence the concerns and needs of people who have impaired mobility and use assistance devices, including wheelchairs and lower limb prostheses; and

(iv) convening intervention programs that examine the role of the social environment in connection with the physical and chemical environment in—

(I) determining access to nutritional food; and

(II) improving physical activity to reduce morbidity and increase quality of life.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $25,000,000 for fiscal year 2008; and

(2) such sums as may be necessary for fiscal years 2009 through 2012.
SEC. 424. ADDITIONAL RESEARCH ON THE RELATIONSHIP BETWEEN THE BUILT ENVIRONMENT AND THE HEALTH OF COMMUNITY RESIDENTS.

(a) Definition of Eligible Institution.—In this section, the term “eligible institution” means a public or private nonprofit institution that submits to the Secretary of Health and Human Services (in this section referred to as the “Secretary”) and the Administrator of the Environmental Protection Agency (in this section referred to as the “Administrator”) an application for a grant under the grant program authorized under subsection (b)(2) at such time, in such manner, and containing such agreements, assurances, and information as the Secretary and Administrator may require.

(b) Research Grant Program.—

(1) Definition of Health.—In this section, the term “health” includes—

(A) levels of physical activity;

(B) consumption of nutritional foods;

(C) rates of crime;

(D) air, water, and soil quality;

(E) risk of injury;

(F) accessibility to healthcare services; and

(G) other indicators as determined appropriate by the Secretary.
(2) GRANTS.—The Secretary, in collaboration with the Administrator, shall provide grants to eligible institutions to conduct and coordinate research on the built environment and its influence on individual and population-based health.

(3) RESEARCH.—The Secretary shall support research that—

(A) investigates and defines the causal links between all aspects of the built environment and the health of residents;

(B) examines—

(i) the extent of the impact of the built environment (including the various characteristics of the built environment) on the health of residents;

(ii) the variance in the health of residents by—

(I) location (such as inner cities, inner suburbs, and outer suburbs); and

(II) population subgroup (such as children, the elderly, the disadvantaged); or

(iii) the importance of the built environment to the total health of residents,
which is the primary variable of interest from a public health perspective;

(C) is used to develop—

(i) measures to address health and the connection of health to the built environment; and

(ii) efforts to link the measures to travel and health databases; and

(D) distinguishes carefully between personal attitudes and choices and external influences on observed behavior to determine how much an observed association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

(E)(i) identifies or develops effective intervention strategies to promote better health among residents with a focus on behavioral interventions and enhancements of the built environment that promote increased use by residents; and

(ii) in developing the intervention strategies under clause (i), ensures that the interven-
tion strategies will reach out to high-risk populations, including racial and ethnic minorities and low-income urban and rural communities.

(4) PRIORITY.—In providing assistance under the grant program authorized under paragraph (2), the Secretary and the Administrator shall give priority to research that incorporates—

(A) Minority-serving institutions as grantees;

(B) interdisciplinary approaches; or

(C) the expertise of the public health, physical activity, urban planning, and transportation research communities in the United States and abroad.

TITLE V—IMPROVEMENT OF HEALTH CARE SERVICES

SEC. 501. HEALTH EMPOWERMENT ZONES.

(a) HEALTH EMPOWERMENT ZONE PROGRAMS.—

(1) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and the Deputy Assistant Secretary for Minority Health, and in cooperation with the Director of the Office of Community Services and the Director of the National Center for Minority Health and Health Disparities, shall make grants to
partnerships of private and public entities to establish health empowerment zone programs in communities that disproportionately experience disparities in health status and health care for the purpose described in paragraph (2).

(2) USE OF FUNDS.—

(A) IN GENERAL.—Subject to subparagraph (B), the purpose of a health empowerment zone program under this section shall be to assist individuals, businesses, schools, minority health associations, non-profit organizations, community-based organizations, hospitals, health care clinics, foundations, and other entities in communities that disproportionately experience disparities in health status and health care which are seeking—

(i) to improve the health or environment of minority individuals in the community and to reduce disparities in health status and health care by assisting individuals in accessing Federal programs;

(ii) to coordinate the efforts of governmental and private entities regarding the elimination of racial and ethnic disparities in health status and health care; and
(iii) to increase the adoption and use of health information technology by providers in racial and ethnic minority and rural communities to improve quality of care; enhance minority and rural consumer awareness; understand, adopt, and use health information technology to improve health literacy and health self-management; and foster improved coordination of health services and care quality.

(B) Medicare and Medicaid.—A health empowerment zone program under this section shall not provide any assistance (other than referral and follow-up services) that is duplicative of programs under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 and 1396 et seq.).

(3) Distribution.—The Secretary shall make at least 1 grant per Health and Human Services region under this section to a partnership for a health empowerment zone program in communities that disproportionately experience disparities in health status and health care that is located in a territory or possession of the United States.
(4) APPLICATION.—To obtain a grant under this section, a partnership shall submit to the Secretary an application in such form and in such manner as the Secretary may require. An application under this paragraph shall—

(A) demonstrate that the communities to be served by the health empowerment zone program are those that disproportionately experience disparities in health status and health care;

(B) set forth a strategic plan for accomplishing the purpose described in paragraph (2), by—

(i) describing the coordinated health, economic, human, community, and physical development plan and related activities proposed for the community;

(ii) describing the extent to which local institutions and organizations have contributed and will contribute to the planning process and implementation;

(iii) identifying the projected amount of Federal, State, local, and private resources that will be available in the area and the private and public partnerships to
be used (including any participation by or cooperation with universities, colleges, foundations, non-profit organizations, medical centers, hospitals, health clinics, school districts, or other private and public entities);

(iv) identifying the funding requested under any Federal program in support of the proposed activities;

(v) identifying benchmarks for measuring the success of carrying out the strategic plan;

(vi) demonstrating the ability to reach and service the targeted underserved minority community populations in a culturally appropriate and linguistically responsive manner; and

(vii) demonstrating a capacity and infrastructure to provide long-term community response that is culturally appropriate and linguistically responsive to communities that disproportionately experience disparities in health and health care; and

(C) include such other information as the Secretary may require.
(5) **Preference.**—In awarding grants under this subsection, the Secretary shall give preference to proposals from indigenous community entities that have an expertise in providing culturally appropriate and linguistically responsive services to communities that disproportionately experience disparities in health and health care.

(b) **Federal Assistance for Health Empowerment Zone Grant Programs.**—The Secretary, the Administrator of the Small Business Administration, the Secretary of Agriculture, the Secretary of Education, the Secretary of Labor, and the Secretary of Housing and Urban Development shall each—

(1) where appropriate, provide entity-specific technical assistance and evidence-based strategies to communities that disproportionately experience disparities in health status and health care to further the purposes served by a health empowerment zone program established with a grant under subsection (a);

(2) identify all programs administered by the Department of Health and Human Services, Small Business Administration, Department of Agriculture, Department of Education, Department of Labor, and the Department of Housing and Urban Development.
Development, respectively, that may be used to further the purpose of a health empowerment zone program established with a grant under subsection (a); and

(3) in administering any program identified under paragraph (2), consider the appropriateness of giving priority to any individual or entity located in communities that disproportionately experience disparities in health status and health care served by a health empowerment zone program established with a grant under subsection (a), if such priority would further the purpose of the health empowerment zone program.

(e) Health Empowerment Zone Coordinating Committee.—

  (1) Establishment.—For each health empowerment zone program established with a grant under subsection (a), the Secretary acting through the Director of Office of Minority Health and the Administrator of the Health Resources and Services Administration shall establish a health empowerment zone coordinating committee.

  (2) Duties.—Each coordinating committee established, in coordination with the Deputy Assistant Secretary for Minority Health and the Administrator
of the Health Resources and Services Administration, shall provide technical assistance and evidence-based strategies to the grant recipient involved, including providing guidance on research, strategies, health outcomes, program goals, management, implementation, monitoring, assessment, and evaluation processes.

(3) Membership.—

(A) Appointment.—The Deputy Assistant Secretary for Minority Health and the Administrator of the Health Resources and Services Administration, in consultation with the respective grant recipient shall appoint the members of each coordinating committee.

(B) Composition.—The Deputy Assistant Secretary for Minority Health, and the Administrator of the Health Resources and Services Administration shall ensure that each coordinating committee established—

   (i) has not more than 20 members;

   (ii) includes individuals from communities that disproportionately experience disparities in health status and health care;
(iii) includes community leaders and leaders of community-based organizations;

(iv) includes representatives of academia and lay and professional organizations and associations including those having expertise in medicine (including dental and oral medicine), technical, social, and behavioral science, health policy, health information technology, advocacy, cultural and linguistic competency, research management, and organization; and

(v) represents a reasonable cross-section of knowledge, views, and application of expertise on societal, ethical, behavioral, educational, policy, legal, cultural, linguistic, and technological workforce issues related to eliminating disparities in health and health care.

(C) Individual Qualifications.—The Deputy Assistant Secretary for Minority Health and the Administrator of the Health Resources and Services Administration may not appoint an individual to serve on a coordinating committee unless the individual meets the following qualifications:
(i) The individual is not employed by the Federal Government.

(ii) The individual has appropriate experience, including experience in the areas of community development, cultural and linguistic competency, reducing and eliminating racial and ethnic disparities in health and health care, or minority health.

(D) SELECTION.—In selecting individuals to serve on a coordinating committee, the Deputy Assistant Secretary for Minority Health and the Administrator Health Resources and Services Administration shall give due consideration to the recommendations of the Congress, industry leaders, the scientific community (including the Institute of Medicine), academia, community based non-profit organizations, minority health and related organizations, the education community, State and local governments, and other appropriate organizations.

(E) CHAIRPERSON.—The Deputy Assistant Secretary for Minority Health and the Administrator of the Health Resources and Services Administration, in consultation with the members of the coordinating committee involved, shall
designate a chairperson of the coordinating committee, who shall serve for a term of 3 years and who may be reappointed at the expiration of each such term.

(F) TERMS.—Each member of a coordinating committee shall be appointed for a term of 1 to 3 years in overlapping staggered terms, as determined by the Deputy Assistant Secretary for Minority Health and the Administrator of the Health Resources and Services Administration at the time of appointment, and may be reappointed at the expiration of each such term.

(G) VACANCIES.—A vacancy on a coordinating committee shall be filled in the same manner in which the original appointment was made.

(4) MEETINGS.—A coordinating committee shall meet at least twice each year, at the call of the coordinating committee’s chairperson and in consultation with the Deputy Assistant Secretary for Minority Health and the Administrator Health Resources and Services Administration.

(5) REPORT.—Each coordinating committee shall transmit to the Congress an annual report
that, with respect to the health empowerment zone program involved, includes the following:

(A) A review of the program’s effectiveness in achieving stated goals and outcomes.

(B) A review of the program’s management and the coordination of the entities involved, including the representation and involvement of communities experiencing health disparities.

(C) A review of the activities in the program’s portfolio and components.

(D) An identification of policy issues raised by the program.

(E) An assessment of the program’s capacity, infrastructure, and number of underserved minority communities engaged.

(F) Recommendations for new program goals, research areas, enhanced approaches, partnerships, coordination and management mechanisms, and projects to be established to achieve the program’s stated goals, to improve outcomes, monitoring, and evaluation.

(G) A review of the degree of minority entity participation in the program, and an identi-
calcification of a strategy to increase such participa-
tion.

(H) Any other reviews or recommendations
determined to be appropriate by the coordi-
nating committee.

(d) REPORT.—The Deputy Assistant Secretary for
Minority Health and the Administrator of the Health Re-
sources and Services Administration shall submit a joint
annual report to the appropriate committees of Congress
on the results of the implementation of programs under
this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There
are authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years
2008 through 2013.

SEC. 502. AMENDMENT TO THE PUBLIC HEALTH SERVICE
ACT.

Title XXX of the Public Health Service Act, as
amended by titles II, III, and IV of this Act, is further
amended by adding at the end the following:
Subtitle D—Reconstruction and Improvement Grants for Public Health Care Facilities Serving Pacific Islanders and the Insular Areas

SEC. 3051. GRANT SUPPORT FOR QUALITY IMPROVEMENT INITIATIVES.

“(a) In General.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Centers for Medicare & Medicaid Services, shall award grants to eligible entities for the conduct of demonstration projects to improve the quality of and access to health care.

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

“(1) be a health center, hospital, health plan, health system, community clinic, or other health entity determined appropriate by the Secretary—

“(A) that, by legal mandate or explicitly adopted mission, provides patients with access to services regardless of their ability to pay;

“(B) that provides care or treatment for a substantial number of patients who are unin-
sured, are receiving assistance under a State program under title XIX of the Social Security Act, or are members of vulnerable populations, as determined by the Secretary; and

“(C)(i) with respect to which, not less than 50 percent of the entity’s patient population is made up of racial and ethnic minorities; or

“(ii) that—

“(I) serves a disproportionate percentage of local, minority racial and ethnic patients, or that has a patient population, at least 50 percent of which is limited English proficient; and

“(II) provides an assurance that amounts received under the grant will be used only to support quality improvement activities in the racial and ethnic population served; and

“(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(e) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants under subsection (b)(2) that—
“(1) demonstrate an intent to operate as part of a health care partnership, network, collaborative, coalition, or alliance where each member entity contributes to the design, implementation, and evaluation of the proposed intervention; or

“(2) intend to use funds to carry out system-wide changes with respect to health care quality improvement, including—

“(A) improved systems for data collection and reporting;

“(B) innovative collaborative or similar processes;

“(C) group programs with behavioral or self-management interventions;

“(D) case management services;

“(E) physician or patient reminder systems;

“(F) educational interventions; or

“(G) other activities determined appropriate by the Secretary.

“(d) USE OF FUNDS.—An entity shall use amounts received under a grant under subsection (a) to support the implementation and evaluation of health care quality improvement activities or minority health and health care disparity reduction activities that include—
“(1) with respect to health care systems, activities relating to improving—

“(A) patient safety;
“(B) timeliness of care;
“(C) effectiveness of care;
“(D) efficiency of care;
“(E) patient centeredness; and
“(F) health information technology; and

“(2) with respect to patients, activities relating to—

“(A) staying healthy;
“(B) getting well;
“(C) living with illness or disability; and
“(D) coping with end of life issues.

“(e) COMMON DATA SYSTEMS.—The Secretary shall provide financial and other technical assistance to grantees under this section for the development of common data systems.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2013.

“SEC. 3052. CENTERS OF EXCELLENCE.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services
Administration, shall designate centers of excellence at public hospitals, and other health systems serving large numbers of minority patients, that—

“(1) meet the requirements of section 3051(b)(1);

“(2) demonstrate excellence in providing care to minority populations; and

“(3) demonstrate excellence in reducing disparities in health and health care.

“(b) REQUIREMENTS.—A hospital or health system that serves as a Center of Excellence under subsection (a) shall—

“(1) design, implement, and evaluate programs and policies relating to the delivery of care in racially, ethnically, and linguistically diverse populations;

“(2) provide training and technical assistance to other hospitals and health systems relating to the provision of quality health care to minority populations; and

“(3) develop activities for graduate or continuing medical education that institutionalize a focus on cultural competence training for health care providers.
“(c) Authorization of Appropriations.—There
is authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years
2008 through 2013.

“SEC. 3053. RECONSTRUCTION AND IMPROVEMENT GRANTS
FOR PUBLIC HEALTH CARE FACILITIES SERVING PACIFIC ISLANDERS AND THE INSULAR AREAS.

“(a) In General.—The Secretary shall provide di-
rect financial assistance to designated health care pro-
viders and community health centers in American Samoa,
Guam, the Commonwealth of the Northern Mariana Is-
lands, the United States Virgin Islands, Puerto Rico, and
Hawaii for the purposes of reconstructing and improving
health care facilities and services.

“(b) Eligibility.—To be eligible to receive direct fi-
nancial assistance under subsection (a), an entity shall be
a public health facility or community health center located
in American Samoa, Guam, or the Commonwealth of the
Northern Mariana Islands, the United States Virgin Is-
lands, Puerto Rico, and Hawaii that—

“(1) is owned or operated by—

“(A) the government of American Samoa,
Guam, or the Commonwealth of the Northern
Mariana Islands, the United States Virgin Is-
lands, Puerto Rico, and Hawaii or a unit of local government; or

“(B) a nonprofit organization; and

“(2)(A) provides care or treatment for a substantial number of patients who are uninsured, receiving assistance under a State program under a title XVIII of the Social Security Act, or a State program under title XIX of such Act, or who are members of a vulnerable population, as determined by the Secretary; or

“(B) serves a disproportionate percentage of local, minority racial and ethnic patients.

“(c) REPORT.—Not later than 180 days after the date of enactment of this title and annually thereafter, the Secretary shall submit to the Congress and the President a report that includes an assessment of health resources and facilities serving populations in American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii. In preparing such report, the Secretary shall—

“(1) consult with and obtain information on all health care facilities needs from the entities described in subsection (b); and
“(2) include all amounts of Federal assistance received by each entity in the preceding fiscal year;

“(3) review the total unmet needs of each jurisdiction for health care facilities, including needs for renovation and expansion of existing facilities; and

“(4) include a strategic plan for addressing the needs of each jurisdiction identified in the report.

“(d) Authorization of Appropriations.—There is authorized to be appropriated such sums as necessary to carry out this section.”.

SEC. 503. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND SCHIP.

(a) Medicaid Program.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking “paragraph (2)” and inserting “paragraphs (2) and (4)”;

(2) by adding at the end the following new paragraph:

“(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for undocumented residents who are lawfully residing in the United States (including battered undocumented residents described in section
431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

“(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

“(ii) CHILDREN.—Individuals under 21 years of age, including optional targeted low-income children described in section 1905(u)(2)(B).

“(B) In the case of a State that has elected to provide medical assistance to a category of undocumented residents under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an undocumented resident on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.”.

(b) SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (C) and (D) as subparagraph (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

“(C) Section 1903(v)(4) (relating to optional coverage of categories of lawfully residing immigrant children), but only if the State has
elected to apply such section to the category of children under title XIX.”.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2007, and apply to medical assistance and child health assistance furnished on or after such date.

SEC. 504. BORDER HEALTH GRANTS.

(a) ELIGIBLE ENTITY DEFINED.—In this section, the term “eligible entity” means a State, public institution of higher education, local government, tribal government, nonprofit health organization, community health center, or community clinic receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b), that is located in the border area.

(b) AUTHORIZATION.—From funds appropriated under subsection (f), the Secretary of Health and Human Services (in this section referred to as the “Secretary”), acting through the United States members of the United States-Mexico Border Health Commission, shall award grants to eligible entities to address priorities and recommendations to improve the health of border area residents that are established by—

(1) the United States members of the United States-Mexico Border Health Commission;

(2) the State border health offices; and
(3) the Secretary.

(e) Application.—An eligible entity that desires a grant under subsection (b) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) Use of Funds.—An eligible entity that receives a grant under subsection (b) shall use the grant funds for—

(1) programs relating to—

(A) maternal and child health;

(B) primary care and preventative health;

(C) public health and public health infrastructure;

(D) health education and promotion;

(E) oral health;

(F) mental and behavioral health;

(G) substance abuse;

(H) health conditions that have a high prevalence in the border area;

(I) medical and health services research;

(J) workforce training and development;

(K) community health workers or promotoras;
(L) health care infrastructure problems in
the border area (including planning and con-
struction grants);
(M) health disparities in the border area;
(N) environmental health; and
(O) outreach and enrollment services with
respect to Federal programs (including pro-
grams authorized under titles XIX and XXI of
the Social Security Act (42 U.S.C. 1396 and
1397aa)); and
(2) other programs determined appropriate by
the Secretary.
(e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
vided to an eligible entity awarded a grant under sub-
section (b) shall be used to supplement and not supplant
other funds available to the eligible entity to carry out the
activities described in subsection (d).
(f) AUTHORIZATION OF APPROPRIATIONS.—There is
authorized to be appropriated to carry out this section,
$200,000,000 for fiscal year 2008, and such sums as may
be necessary for each succeeding fiscal year.
SEC. 505. CANCER PREVENTION AND TREATMENT DEM-
ONSTRATION FOR ETHNIC AND RACIAL MI-
NORITIES.
(a) DEMONSTRATION.—
(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct demonstration projects (in this section referred to as “demonstration projects”) for the purpose of developing models and evaluating methods that—

(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

(B) improve clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services and referral patterns among those target individuals with cancer;

(C) eliminate disparities in the rate of preventive cancer screening measures, such as pap smears, prostate cancer screenings, and CT scans for lung cancer among target individuals; and

(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for persons with limited English proficiency.
(2) TARGET INDIVIDUAL DEFINED.—In this section, the term “target individual” means an individual of a racial and ethnic minority group, as defined by section 1707 of the Public Health Service Act (42 U.S.C. 300u–6) who is entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act.

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall evaluate best practices in the private sector, community programs, and academic research of methods that reduce disparities among individuals of racial and ethnic minority groups in the prevention and treatment of cancer and shall design the demonstration projects based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement at least nine demonstration projects, including the following:

(A) Two projects for each of the following major racial and ethnic minority groups:

(i) American Indians and Alaska Natives, Eskimos and Aleuts.

(ii) Asian Americans.
(iii) Blacks/African Americans.

(iv) Hispanic/Latino Americans.

(v) Native Hawaiians and other Pacific Islanders.

The two projects must target different ethnic subpopulations.

(B) One project within the Pacific Islands or United States insular areas.

(C) At least one project each in a rural area and inner-city area.

(3) Expansion of Projects; Implementation of Demonstration Project Results.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

(A) reduce expenditures under the Medicare program under title XVIII of the Social Security Act; or

(B) do not increase expenditures under the Medicare program and reduce racial and ethnic health disparities in the quality of health care services provided to target individuals and increase satisfaction of beneficiaries and health care providers;
the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(c) **Report to Congress.**—

(1) **In general.**—Not later than 2 years after the date the Secretary implements the initial demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects.

(2) **Contents of report.**—Each report under paragraph (1) shall include the following:

(A) A description of the demonstration projects.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration projects.

(C) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.
(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 506. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN AND CHILDREN.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

“SEC. 399R. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN AND CHILDREN.

“(a) GRANTS AUTHORIZED.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities to promote positive health behaviors for women and children in target populations, especially racial and ethnic minority women and children in medically underserved communities.

“(b) USE OF FUNDS.—Grants awarded pursuant to subsection (a) may be used to support community health workers—

“(1) to educate and provide outreach regarding enrollment in health insurance including the State.
Children’s Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act, and Medicaid under title XIX of such Act;

“(2) to educate, guide, and provide outreach in a community setting regarding health problems prevalent among women and children and especially among racial and ethnic minority women and children;

“(3) to educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

“(A) poor nutrition;

“(B) physical inactivity;

“(C) being overweight or obese;

“(D) tobacco use;

“(E) alcohol and substance use;

“(F) injury and violence;

“(G) risky sexual behavior;

“(H) mental health problems;

“(I) dental and oral health problems; and

“(J) understanding informed consent;

“(4) to educate and guide regarding effective strategies to promote positive health behaviors within the family;
“(5) to promote community wellness and awareness; and

“(6) to educate and refer target populations to appropriate health care agencies and community-based programs and organizations in order to increase access to quality health care services, including preventive health services.

“(c) APPLICATION.—

“(1) IN GENERAL.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

“(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

“(A) describe the activities for which assistance under this section is sought;

“(B) contain an assurance that with respect to each community health worker program receiving funds under the grant awarded, such program provides training and supervision to community health workers to enable such workers to provide authorized program services;

“(C) contain an assurance that the applicant will evaluate the effectiveness of commu-
nity health worker programs receiving funds under the grant;

“(D) contain an assurance that each com-

munity health worker program receiving funds under the grant will provide services in the cul-
tural context most appropriate for the individ-

duals served by the program;

“(E) contain a plan to document and dis-

seminate project description and results to other States and organizations as identified by the Secretary; and

“(F) describe plans to enhance the capac-

ity of individuals to utilize health services and health-related social services under Federal, State, and local programs by—

“(i) assisting individuals in estab-

lishing eligibility under the programs and in receiving the services or other benefits of the programs; and

“(ii) providing other services as the Secretary determines to be appropriate, that may include transportation and trans-

lation services.
“(d) Priority.—In awarding grants under subsection (a), the Secretary shall give priority to those applicants—

“(1) who propose to target geographic areas—

“(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured; and

“(B) with a high percentage of families for whom English is not their primary language.

“(2) with experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

“(3) with documented community activity and experience with community health workers.

“(e) Collaboration with Academic Institutions.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions, including minority-serving institutions. Nothing in this section shall be construed to require such collaboration.

“(f) Quality Assurance and Cost-Effectiveness.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this
section and for assuring the cost-effectiveness of such pro-
grams.

“(g) MONITORING.—The Secretary shall monitor
community health worker programs identified in approved
applications and shall determine whether such programs
are in compliance with the guidelines established under
subsection (f).

“(h) TECHNICAL ASSISTANCE.—The Secretary may
provide technical assistance to community health worker
programs identified in approved applications with respect
to planning, developing, and operating programs under the
grant.

“(i) REPORT TO CONGRESS.—

“(1) IN GENERAL.—Not later than 4 years
after the date on which the Secretary first awards
grants under subsection (a), the Secretary shall sub-
mit to Congress a report regarding the grant
project.

“(2) CONTENTS.—The report required under
paragraph (1) shall include the following:

“(A) A description of the programs for
which grant funds were used.

“(B) The number of individuals served.

“(C) An evaluation of—
“(i) the effectiveness of these programs;

“(ii) the cost of these programs; and

“(iii) the impact of the project on the health outcomes of the community residents.

“(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

“(E) Recommendations regarding training to enhance career opportunities for community health workers.

“(j) DEFINITIONS.—In this section:

“(1) COMMUNITY HEALTH WORKER.—The term ‘community health worker’ means an individual who promotes health or nutrition within the community in which the individual resides—

“(A) by serving as a liaison between communities and health care agencies;

“(B) by providing guidance and social assistance to community residents;

“(C) by enhancing community residents’ ability to effectively communicate with health care providers;
“(D) by providing culturally and linguistically appropriate health or nutrition education;

“(E) by advocating for individual and community health, including dental, oral, mental, and environmental health, or nutrition needs; and

“(F) by providing referral and followup services.

“(2) COMMUNITY SETTING.—The term ‘community setting’ means a home or a community organization located in the neighborhood in which a participant resides.

“(3) ELIGIBLE ENTITY.—The term ‘eligible entity’ means—

“(A) a unit of State, territorial, local, or tribal government (including a federally recognized tribe or Alaska native villages); or

“(B) a community-based organization.

“(4) MEDICALLY UNDERSERVED COMMUNITY.—The term ‘medically underserved community’ means a community—

“(A) that has a substantial number of individuals who are members of a medically un-
derserved population, as defined by section 330(b)(3); and

“(B) a significant portion of which is a health professional shortage area as designated under section 332.

“(5) SUPPORT.—The term ‘support’ means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

“(6) TARGET POPULATION.—The term ‘target population’ means women of reproductive age, regardless of their current childbearing status and children under 21 years of age.

“(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2008, 2009, 2010, 2011, and 2012.”

SEC. 507. EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:
“(M) Exception for citizens of freely associated states.—With respect to eligibility for benefits for the specified Federal programs described in paragraph (3), paragraph (1) shall not apply to any individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with—

“(i) section 141 of the Compact of Free Association between the Government of the United States and the Government of the Federated States of Micronesia, approved by Congress in the Compact of Free Association Amendments Act of 2003;

“(ii) section 141 of the Compact of Free Association between the Government of the United States and the Government of the Republic of the Marshall Islands, approved by Congress in the Compact of Free Association Amendments Act of 2003; or

“(iii) section 141 of the Compact of Free Association between the Government of the United States and the Government
of Palau, approved by Congress in Public
 Law 99–658 (100 Stat. 3672).”.

(b) MEDICAID EXCEPTION.—Section 402(b)(2) of the
Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by
adding at the end the following:

“(G) MEDICAID EXCEPTIONS FOR CITIZENS OF FREELY ASSOCIATED STATES.—With
respect to eligibility for benefits for the pro-
grams defined in subparagraphs (A) and (C) of
paragraph (3) (relating to Medicaid), paragraph
(1) shall not apply to any individual who law-
fully resides in the United States (including ter-
ritories and possessions of the United States) in
accordance with a Compact of Free Association
referred to in subsection (a)(2)(M).”.

(c) QUALIFIED ALIEN.—Section 431(b) of the Per-
sonal Responsibility and Work Opportunity Reconciliation
Act of 1996 (8 U.S.C. 1641(b)) is amended—
(1) in paragraph (6), by striking “or” at the
end;
(2) in paragraph (7), by striking the period at
the end and inserting “; or”; and
(3) by adding at the end the following:
“(8) an individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with a Compact of Free Association referred to in section 402(a)(2)(M).”.

(d) **FINANCIAL TREATMENT UNDER MEDICAID.—** Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking “subsection (g)” and inserting “subsections (g) and (h)”; and

(2) by adding at the end the following new subsection:

“(h) The limitations of subsections (f) and (g) shall not apply with respect to medical assistance provided to an individual described in section 431(b)(8) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.”.

(e) **INCREASED FMAP.—** The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by inserting before the period at the end the following: “and for services furnished to individuals described in section 431(b)(8) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996”.

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SEC. 508. MEDICARE GRADUATE MEDICAL EDUCATION.

(a) Clarification of Congressional Intent Regarding the Counting of Residents in a Nonhospital Setting.—

(1) D-GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended by adding at the end the following new sentences: “For purposes of the preceding sentence, the term ‘all, or substantially all, of the costs for the training program’ means the stipends and benefits provided to the resident and other amounts, if any, as determined by the hospital and the entity operating the nonhospital setting. The hospital is not required to pay the entity any amounts other than those determined by the hospital and the entity in order for the hospital to be considered to have incurred all, or substantially all, of the costs for the training program in that setting.”.

(2) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by adding at the end the following new sentences: “For purposes of the preceding sentence, the term ‘all, or substantially all, of the costs for the training program’ means the stipends and benefits provided to the resident and other amounts, if any, as determined by the hospital and the entity oper-
ating the nonhospital setting. The hospital is not re-
quired to pay the entity any amounts other than
those determined by the hospital and the entity in
order for the hospital to be considered to have in-
curred all, or substantially all, of the costs for the
training program in that setting.”.

(3) EFFECTIVE DATE.—The amendments made
by this subsection shall take effect on January 1,
2008.

(b) CLARIFICATION OF ELIGIBILITY OF A NONRURAL
HOSPITAL THAT HAS A TRAINING PROGRAM WITH AN
INTEGRATED RURAL TRACK.—

(1) IN GENERAL.—Section 1886(h)(4)(H) of
the Social Security Act (42 U.S.C.
1395ww(h)(4)(H)) is amended—

(A) in clause (iv), by inserting “(as defined
in clause (v))” after “an integrated rural
track”; and

(B) by adding at the end the following new
clause:

“(v) DEFINITION OF ACCREDITED
TRAINING PROGRAM WITH AN INTEGRATED
RURAL TRACK.—For purposes of clause
(iv), the term ‘accredited training program
with an integrated rural track’ means an
accredited medical residency training program located in an urban area which offers a curriculum for all residents in the program that includes the following characteristics:

“(I) A minimum of 3 block months of rural rotations. During such 3 block months, the resident is in a rural area for 4 weeks or a month.

“(II) A stated mission for training rural physicians.

“(III) A minimum of 3 months of obstetrical training, or an equivalent longitudinal experience.

“(IV) A minimum of 4 months of pediatric training that includes neonatal, ambulatory, inpatient, and emergency experiences through rotations, or an equivalent longitudinal experience.

“(V) A minimum of 2 months of emergency medicine rotations, or an equivalent longitudinal experience.”.
(2) EFFECTIVE DATE.—The amendments made by this subsection apply with respect to—

(A) payments to hospitals under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for cost reporting periods beginning on or after January 1, 2008; and

(B) payments to hospitals under section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)) for discharges occurring on or after January 1, 2008.

SEC. 509. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

(a) EXPANDED FUNDING.—The Secretary, in collaboration with the Director of the Office of Minority Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Administrator of the Substance Abuse and Mental Health Services Administration, shall provide funds and carry out activities to expand the Minority HIV/AIDS Initiative.

(b) USE OF FUNDS.—The additional funds made available under this section may be used, through the Minority AIDS Initiative, to support the following activities:
(1) Providing technical assistance and infrastructure support to reduce HIV/AIDS in minority populations.

(2) Increasing minority populations’ access to HIV/AIDS prevention and care services.

(3) Building strong community programs and partnerships to address HIV prevention and the health care needs of specific racial and ethnic minority populations.

(c) PRIORITY INTERVENTIONS.—Within the racial and ethnic minority populations referred to in subsection (b), priority in conducting intervention services shall be given to—

(1) women;

(2) youth;

(3) men who engage in homosexual activity;

(4) persons who engage in intravenous drug abuse;

(5) homeless individuals; and

(6) individuals incarcerated or in the penal system.

(d) AUTHORIZATION OF APPROPRIATIONS.—For carrying out this section, there are authorized to be appropriated $610,000,000 for fiscal year 2008 and such sums
as may be necessary for each of fiscal years 2009 through 2012.

SEC. 510. GRANTS FOR RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH.

(a) PURPOSE.—It is the purpose of this section to provide for the awarding of grants to assist communities in mobilizing and organizing resources in support of effective and sustainable programs that will reduce or eliminate disparities in health and health care experienced by racial and ethnic minority individuals.

(b) AUTHORITY.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, in consultation with the Office of Minority Health, shall award grants to eligible entities to assist in designing, implementing, and evaluating culturally and linguistically appropriate, evidence-based, and community-driven sustainable strategies to eliminate racial and ethnic health and health care disparities.

(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

(1) represent a coalition—

(A) whose principal purpose is to develop and implement interventions to reduce or eliminate a health or health care disparity in a tar-
geted racial or ethnic minority group in the
community served by the coalition; and

(B) that includes—

(i) at least 3 members selected from
among—

(I) public health departments;

(II) community-based organizations;

(III) university and research organizations;

(IV) Indian tribes, tribal organizations, urban Indian organizations, national or regional Indian organizations, or the Indian Health Service;

(V) organizations serving Native Hawaiians;

(VI) organizations serving Pacific Islanders; and

(VII) interested public or private health care providers or organizations as deemed appropriate by the Secretary; and

(ii) at least 1 member from a community-based organization that represents the
targeted racial or ethnic minority group;

and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, which shall include—

(A) a description of the targeted racial or ethnic populations in the community to be served under the grant;

(B) a description of at least 1 health disparity that exists in the racial or ethnic targeted populations, including infant mortality, breast and cervical cancer screening and management, cardiovascular disease, diabetes, child and adult immunization levels, HIV/AIDS, hepatitis B, tuberculosis, or asthma, or other health priority areas as designated by the Secretary; and

(C) a demonstration of a proven record of accomplishment of the coalition members in serving and working with the targeted community.

(d) SUSTAINABILITY.—The Secretary shall give priority to an eligible entity under this section if the entity agrees that, with respect to the costs to be incurred by
the entity in carrying out the activities for which the grant was awarded, the entity (and each of the participating partners in the coalition represented by the entity) will maintain its expenditures of non-Federal funds for such activities at a level that is not less than the level of such expenditures during the fiscal year immediately preceding the first fiscal year for which the grant is awarded.

(e) NONDUPLICATION.—Funds provided through this grant program should supplement, not supplant, existing Federal funding, and the funds should not be used to duplicate the activities of the other health disparity grant programs in this Act.

(f) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other non-financial assistance necessary to meet the requirements of this section.

(g) DISSEMINATION.—The Secretary shall encourage and enable grantees to share best practices, evaluation results, and reports using the Internet, conferences, and other pertinent information regarding the projects funded by this section, including the outreach efforts of the Office of Minority Health and the Centers for Disease Control and Prevention. Such information shall be publicly avail-
able, and posted on the Internet website of relevant Government agencies.

(h) Administrative Burdens.—The Secretary shall make every effort to minimize duplicative or unnecessary administrative burdens on grantees.

SEC. 511. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.

(a) Clarification of Payment for Clinical Laboratory Tests Furnished by Critical Access Hospitals.—

(1) In General.—Section 1834(g)(4) of the Social Security Act (42 U.S.C. 1395m(g)(4)) is amended—

(A) in the heading, by striking “NO BENEFICIARY COST-SHARING” and inserting “TREATMENT OF”;

(B) by adding at the end the following new sentence: “For purposes of the preceding sentence and section 1861(mm)(3), clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether—

“(A) the individual with respect to whom such services are furnished is physically present
in the critical access hospital at the time the specimen is collected;

“(B) such individual is registered as an outpatient on the records of, and receives such services directly from, the critical access hospital; or

“(C) payment is (or, but for this subsection, would be) available for such services under the fee schedule established under section 1833(h).”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to cost reporting periods beginning on or after October 1, 2008.

(b) ELIMINATION OF ISOLATION TEST FOR COST-BASED AMBULANCE REIMBURSEMENT.—

(1) IN GENERAL.—Section 1834(l)(8) of the Social Security Act (42 U.S.C. 1395m(l)(8)) is amended—

(A) in subparagraph (B)—

(i) by striking “owned and”; and

(ii) by inserting “(including when such services are provided by the entity under an arrangement with the hospital)” after “hospital”; and
(B) by striking the comma at the end of paragraph (B) and all that follows and inserting a period.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2008.

(c) PROVISION OF A MORE FLEXIBLE ALTERNATIVE TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT REQUIREMENT.—

(1) IN GENERAL.—Section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)) is amended—

(A) in subparagraph (B)(iii), by striking “provides not more than” and inserting “subject to subparagraph (F), provides not more than”; and

(B) by adding at the end the following new subparagraph:

“(F) ALTERNATIVE TO 25 INPATIENT BED LIMIT REQUIREMENT.—

“(i) IN GENERAL.—A State may elect to treat a facility, with respect to the designation of the facility for a cost reporting period, as satisfying the requirement of subparagraph (B)(iii) relating to a max-
minimum number of acute care inpatient beds
if the facility elects, in accordance with a
method specified by the Secretary and be-
fore the beginning of the cost reporting pe-
period, to meet the requirement under clause
(ii).

“(ii) ALTERNATE REQUIREMENT.—
The requirement under this clause, with
respect to a facility and a cost reporting
period, is that the total number of inpa-
tient bed days described in subparagraph
(B)(iii) during such period will not exceed
7,300. For purposes of this subparagraph,
an individual who is an inpatient in a bed
in the facility for a single day shall be
counted as one inpatient bed day.

“(iii) WITHDRAWAL OF ELECTION.—
The option described in clause (i) shall not
apply to a facility for a cost reporting pe-
period if the facility (for any two consecutive
cost reporting periods during the previous
5 cost reporting periods) was treated under
such option and had a total number of in-
patient bed days for each of such two cost
reporting periods that exceeded the number specified in such clause.”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

SEC. 512. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (Z), by striking “and” at the end;

(B) in subparagraph (AA), by inserting “and” at the end; and

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

“(BB) marriage and family therapist services (as defined in subsection (ccc)(1)) and mental health counselor services (as defined in subsection (ccc)(3));”.
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(2) DEFINITIONS.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

“(e)(1) The term ‘marriage and family therapist services’ means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

“(2) The term ‘marriage and family therapist’ means an individual who—

“(A) possesses a master’s or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;
“(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

“(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

“(3) The term ‘mental health counselor services’ means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

“(4) The term ‘mental health counselor’ means an individual who—

“(A) possesses a master’s or doctor’s degree in mental health counseling or a related field;
“(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

“(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.”.

(3) Provision for payment under part B.—Section 1832(a)(2)(B) of such Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

“(v) marriage and family therapist services and mental health counselor services;”.

(4) Amount of payment.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking “and (V)” and inserting “(V)”; and

(B) by inserting before the semicolon at the end the following: “, and (W) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(BB), the amounts paid shall be 80 percent of the lesser of the actual charge for
the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)”.

(5) **Exclusion of Marriage and Family Therapist Services and Mental Health Counselor Services from Skilled Nursing Facility Prospective Payment System.**—Section 1888(e)(2)(A)(ii) of such Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting “marriage and family therapist services (as defined in section 1861(ccc)(1)), mental health counselor services (as defined in section 1861(ccc)(3)),” after “qualified psychologist services,”.

(6) **Inclusion of Marriage and Family Therapists and Mental Health Counselors as Practitioners for Assignment of Claims.**—Section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

“(vii) A marriage and family therapist (as defined in section 1861(ccc)(2)).

“(viii) A mental health counselor (as defined in section 1861(ccc)(4)).”.

(b) **Coverage of Certain Mental Health Services Provided in Certain Settings.**—
(1) **RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.**—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or by a clinical social worker (as defined in subsection (hh)(1)),” and inserting “, by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (ccc)(2)), or by a mental health counselor (as defined in subsection (ccc)(4)),”.

(2) **HOSPICE PROGRAMS.**—Section 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or one marriage and family therapist (as defined in subsection (ccc)(2))” after “social worker”.

(e) **AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.**—Section 1861(ee)(2)(G) of the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting “marriage and family therapist (as defined in subsection (ccc)(2)),” after “social worker,”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2008.
SEC. 513. ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 512, is amended by adding at the end of the following new subsection:

“Rural Community Hospital; Rural Community Hospital Services

“(ddd)(1) The term ‘rural community hospital’ means a hospital (as defined in subsection (e)) that—

“(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

“(B) subject to paragraph (2), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

“(C) makes available 24-hour emergency care services;

“(D) subject to paragraph (3), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2008; and

“(E) applies to the Secretary for such designation.

“(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.
“(3) Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

“(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2008) with the same service area (as defined by the Secretary in regulations in effect on such date).

“(B) A facility obtaining a new provider number pursuant to a change of ownership.

“(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2008.

“(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.

“(5) Nothing in this subsection shall be construed as prohibiting a rural community hospital participating in the demonstration program under Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2313) from qualifying as a rural community hospital if the rural community hospital meets the conditions other-
wise applicable to hospitals under subsection (e) and section 1866.”.

(b) PAYMENT.—

(1) INPATIENT HOSPITAL SERVICES.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended by adding at the end the following new subsection:

“Payment for Inpatient Services Furnished in Rural Community Hospitals

“(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(ddd)(1)(E)—

“(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

“(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).”.

(2) OUTPATIENT SERVICES.—Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:
“(n) Payment for Outpatient Services Furnished in Rural Community Hospitals.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in section 1861(ddd)(1)(E)—

“(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U), or

“(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).”.

(3) Exemption from 30-percent reduction in reimbursement for bad debt.—Section 1861(v)(1)(T) of such Act (42 U.S.C. 1395x(v)(1)(T)) is amended by inserting “(other than for a rural community hospital)” after “In determining such reasonable costs for hospitals”.

(c) Beneficiary Cost-Sharing for Outpatient Services.—Section 1834(n) of such Act (as added by subsection (b)(2)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(2) by inserting “(1)” after “(n)”; and
(3) by adding at the end the following:

“(2) The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

“(A) For items and services that would have been paid under section 1833(t) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

“(B) For items and services that would have been paid under section 1833(h) if furnished by a provider or supplier, no cost-sharing shall apply.

“(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.”.

(d) CONFORMING AMENDMENTS.—

(1) PART A PAYMENT.—Section 1814(b) of such Act (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by inserting “other than inpatient hospital services furnished by a rural community hospital,” after “critical access hospital services,”.
(2) **PART B PAYMENT.**—Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (2), in the matter before subparagraph (A), by striking “and (I)” and inserting “(I), and (K)”;

(B) by striking “and” at the end of paragraph (8);

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

(D) by adding at the end the following:

“(10) in the case of outpatient services furnished by a rural community hospital, the amounts described in section 1834(n).”.

(3) **TECHNICAL AMENDMENTS.**—

(A) **CONSULTATION WITH STATE AGENCIES.**—Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking “and (dd)(2)” and inserting “(dd)(2), (mm)(1), and (ddd)(1)”.

(B) **PROVIDER AGREEMENTS.**—Section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting “section 1834(n)(2),” after “section 1833(b),”.
(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2007.

SEC. 514. MEDICARE REMOTE MONITORING PILOT PROJECTS.

(a) PILOT PROJECTS.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct pilot projects under title XVIII of the Social Security Act for the purpose of providing incentives to home health agencies to utilize home monitoring and communications technologies that—

(A) enhance health outcomes for Medicare beneficiaries; and

(B) reduce expenditures under such title.

(2) SITE REQUIREMENTS.—

(A) URBAN AND RURAL.—The Secretary shall conduct the pilot projects under this section in both urban and rural areas.

(B) SITE IN A SMALL STATE.—The Secretary shall conduct at least 3 of the pilot projects in a State with a population of less than 1,000,000.
(3) Definition of home health agency.—

In this section, the term “home health agency” has the meaning given that term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(b) Medicare beneficiaries within the scope of projects.—The Secretary shall specify the criteria for identifying those Medicare beneficiaries who shall be considered within the scope of the pilot projects under this section for purposes of the application of subsection (c) and for the assessment of the effectiveness of the home health agency in achieving the objectives of this section. Such criteria may provide for the inclusion in the projects of Medicare beneficiaries who begin receiving home health services under title XVIII of the Social Security Act after the date of the implementation of the projects.

(e) Incentives.—

(1) Performance targets.—The Secretary shall establish for each home health agency participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

(A) Adjusted historical performance target.—The Secretary shall establish for the agency—
(i) a base expenditure amount equal to the average total payments made to the agency under parts A and B of title XVIII of the Social Security Act for Medicare beneficiaries determined to be within the scope of the pilot project in a base period determined by the Secretary; and

(ii) an annual per capita expenditure target for such beneficiaries, reflecting the base expenditure amount adjusted for risk and adjusted growth rates.

(B) COMPARATIVE PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments under such parts A and B during the pilot project for comparable individuals in the same geographic area that are not determined to be within the scope of the pilot project.

(2) INCENTIVE.—Subject to paragraph (3), the Secretary shall pay to each participating home care agency an incentive payment for each year under the pilot project equal to a portion of the Medicare savings realized for such year relative to the performance target under paragraph (1).
(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit incentive payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (including incentive payments under this subsection) do not exceed the amount that the Secretary estimates would have been expended if the pilot projects under this section had not been implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act as the Secretary determines to be appropriate for the conduct of the pilot projects under this section.

(e) REPORT TO CONGRESS.—Not later than 5 years after the date that the first pilot project under this section is implemented, the Secretary shall submit to Congress a report on the pilot projects. Such report shall contain a detailed description of issues related to the expansion of the projects under subsection (f) and recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(f) EXPANSION.—If the Secretary determines that any of the pilot projects under this section enhance health outcomes for Medicare beneficiaries and reduce expenditures under title XVIII of the Social Security Act, the Sec-
Secretary may initiate comparable projects in additional areas.

(g) Incentive Payments Have No Effect on Other Medicare Payments to Agencies.—An incentive payment under this section—

(1) shall be in addition to the payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services; and

(2) shall have no effect on the amount of such payments.

SEC. 515. RURAL HEALTH QUALITY ADVISORY COMMISSION AND DEMONSTRATION PROJECTS.

(a) Rural Health Quality Advisory Commission.—

(1) Establishment.—Not later than 6 months after the date of the enactment of this section, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a commission to be known as the Rural Health Quality Advisory Commission (in this section referred to as the “Commission”).

(2) Duties of Commission.—

(A) National plan.—The Commission shall develop, coordinate, and facilitate imple-
mentation of a national plan for rural health quality improvement. The national plan shall—

(i) identify objectives for rural health quality improvement;

(ii) identify strategies to eliminate known gaps in rural health system capacity and improve rural health quality; and

(iii) provide for Federal programs to identify opportunities for strengthening and aligning policies and programs to improve rural health quality.

(B) Demonstration Projects.—The Commission shall design demonstration projects to test alternative models for rural health quality improvement, including with respect to both personal and population health.

(C) Monitoring.—The Commission shall monitor progress toward the objectives identified pursuant to paragraph (1)(A).

(3) Membership.—

(A) Number.—The Commission shall be composed of 11 members appointed by the Secretary.

(B) Selection.—The Secretary shall select the members of the Commission from
among individuals with significant rural health care and health care quality expertise, including expertise in clinical health care, health care quality research, population or public health, or purchaser organizations.

(4) CONTRACTING AUTHORITY.—Subject to the availability of funds, the Commission may enter into contracts and make other arrangements, as may be necessary to carry out the duties described in paragraph (2).

(5) STAFF.—Upon the request of the Commission, the Secretary may detail, on a reimbursable basis, any of the personnel of the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Health Care Quality and Research, or the Centers for Medicare & Medicaid Services to the Commission to assist in carrying out this subsection.

(6) REPORTS TO CONGRESS.—Not later than 1 year after the establishment of the Commission, and annually thereafter, the Commission shall submit a report to the Congress on rural health quality. Each such report shall include the following:
(A) An inventory of relevant programs and recommendations for improved coordination and integration of policy and programs.

(B) An assessment of achievement of the objectives identified in the national plan developed under paragraph (2) and recommendations for realizing such objectives.

(C) Recommendations on Federal legislation, regulations, or administrative policies to enhance rural health quality and outcomes.

(b) Rural Health Quality Demonstration Projects.—

(1) In general.—Not later than 270 days after the date of the enactment of this section, the Secretary, in consultation with the Rural Health Quality Advisory Commission, the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services, shall make grants to eligible entities for 5 demonstration projects to implement and evaluate methods for improving the quality of health care in rural communities. Each such demonstration project shall include—

(A) alternative community models that—
(i) will achieve greater integration of personal and population health services; and

(ii) address safety, effectiveness, patient- or community-centeredness, timeliness, efficiency, and equity (the six aims identified by the Institute of Medicine of the National Academies in its report entitled “Crossing the Quality Chasm: A New Health System for the 21st Century” released on March 1, 2001);

(B) innovative approaches to the financing and delivery of health services to achieve rural health quality goals; and

(C) development of quality improvement support structures to assist rural health systems and professionals (such as workforce support structures, quality monitoring and reporting, clinical care protocols, and information technology applications).

(2) ELIGIBLE ENTITIES.—In this subsection, the term “eligible entity” means a consortium that—

(A) shall include—
(i) at least one health care provider or health care delivery system located in a rural area; and

(ii) at least one organization representing multiple community stakeholders; and

(B) may include other partners such as rural research centers.

(3) Consultation.—In developing the program for awarding grants under this subsection, the Secretary shall consult with the Administrator of the Agency for Healthcare Research and Quality, rural health care providers, rural health care researchers, and private and non-profit groups (including national associations) which are undertaking similar efforts.

(4) Expedited Waivers.—The Secretary shall expedite the processing of any waiver that—

(A) is authorized under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.); and

(B) is necessary to carry out a demonstration project under this subsection.

(5) Demonstration Project Sites.—The Secretary shall ensure that the 5 demonstration
projects funded under this subsection are conducted at a variety of sites representing the diversity of rural communities in the Nation.

(6) DURATION.—Each demonstration project under this subsection shall be for a period of 4 years.

(7) INDEPENDENT EVALUATION.—The Secretary shall enter into an arrangement with an entity that has experience working directly with rural health systems for the conduct of an independent evaluation of the program carried out under this subsection.

(8) REPORT.—Not later than one year after the conclusion of all of the demonstration projects funded under this subsection, the Secretary shall submit a report to the Congress on the results of such projects. The report shall include—

(A) an evaluation of patient access to care, patient outcomes, and an analysis of the cost effectiveness of each such project; and

(B) recommendations on Federal legislation, regulations, or administrative policies to enhance rural health quality and outcomes.

(c) APPROPRIATION.—
(1) **In general.**—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section $30,000,000 for the period of fiscal years 2008 through 2012.

(2) **Availability.**—

(A) **In general.**—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2012.

(B) **Report.**—For purposes of carrying out subsection (b)(8), funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2013.

(3) **Reservation.**—Of the amount appropriated under paragraph (1), the Secretary shall reserve—

(A) $5,000,000 to carry out subsection (a);

and

(B) $25,000,000 to carry out subsection (b), of which—

(i) 2 percent shall be for the provision of technical assistance to grant recipients; and

(ii) 5 percent shall be for independent evaluation under subsection (b)(7).
SEC. 516. RURAL HEALTH CARE SERVICES.

Section 330A of the Public Health Service Act (42 U.S.C. 254c) is amended to read as follows:

“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT, AND SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS.

“(a) PURPOSE.—The purpose of this section is to provide for grants—

“(1) under subsection (b), to promote rural health care services outreach;

“(2) under subsection (c), to provide for the planning and implementation of integrated health care networks in rural areas;

“(3) under subsection (d), to assist rural communities in the Delta Region to reduce health disparities and to promote and enhance health system development; and

“(4) under subsection (e), to provide for the planning and implementation of small rural health care provider quality improvement activities.

“(b) RURAL HEALTH CARE SERVICES OUTREACH GRANTS.—
“(1) **GRANTS.**—The Director of the Office of Rural Health Policy of the Health Resources and Services Administration may award grants to eligible entities to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The Director may award the grants for periods of not more than 3 years.

“(2) **ELIGIBILITY.**—To be eligible to receive a grant under this subsection for a project, an entity—

“(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas;

“(B) shall represent a consortium composed of members—

“(i) that include 3 or more independently-owned health care entities; and
“(ii) that may be nonprofit or for-
profit entities; and

“(C) shall not previously have received a
grant under this subsection for the same or a
similar project, unless the entity is proposing to
expand the scope of the project or the area that
will be served through the project.

“(3) APPLICATIONS.—To be eligible to receive a
grant under this subsection, an eligible entity shall
prepare and submit to the Director an application at
such time, in such manner, and containing such in-
formation as the Director may require, including—

“(A) a description of the project that the
eligible entity will carry out using the funds
provided under the grant;

“(B) a description of the manner in which
the project funded under the grant will meet
the health care needs of rural populations in
the local community or region to be served;

“(C) a plan for quantifying how health
care needs will be met through identification of
the target population and benchmarks of service
delivery or health status, such as—
“(i) quantifiable measurements of health status improvement for projects focusing on health promotion; or

“(ii) benchmarks of increased access to primary care, including tracking factors such as the number and type of primary care visits, identification of a medical home, or other general measures of such access;

“(D) a description of how the local community or region to be served will be involved in the development and ongoing operations of the project;

“(E) a plan for sustaining the project after Federal support for the project has ended;

“(F) a description of how the project will be evaluated;

“(G) the administrative capacity to submit annual performance data electronically as specified by the Director; and

“(H) other such information as the Director determines to be appropriate.

“(e) Rural Health Network Development Grants.—

“(1) Grants.—
“(A) IN GENERAL.—The Director may award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to—

“(i) achieve efficiencies and economies of scale;

“(ii) expand access to, coordinate, and improve the quality of the health care delivery system through development of organizational efficiencies;

“(iii) implement health information technology to achieve efficiencies, reduce medical errors, and improve quality;

“(iv) coordinate care and manage chronic illness; and

“(v) strengthen the rural health care system as a whole in such a manner as to show a quantifiable return on investment to the participants in the network.

“(B) GRANT PERIODS.—The Director may award such a rural health network development grant—
“(i) for a period of 3 years for implementation activities; or

“(ii) for a period of 1 year for planning activities to assist in the initial development of an integrated health care network, if the proposed participants in the network do not have a history of collaborative efforts and a 3-year grant would be inappropriate.

“(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity—

“(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas;

“(B) shall represent a network composed of participants—

“(i) that include 3 or more independently-owned health care entities; and
“(ii) that may be nonprofit or for-profit entities; and
“(C) shall not previously have received a grant under this subsection (other than a 1-year grant for planning activities) for the same or a similar project.

“(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

“(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

“(B) an explanation of the reasons why Federal assistance is required to carry out the project;

“(C) a description of—

“(i) the history of collaborative activities carried out by the participants in the network;
“(ii) the degree to which the participants are ready to integrate their functions; and
“(iii) how the local community or region to be served will benefit from and be involved in the activities carried out by the network;
“(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the integration activities carried out by the network, including a description of—
“(i) return on investment for the community and the network members; and
“(ii) other quantifiable performance measures that show the benefit of the network activities;
“(E) a plan for sustaining the project after Federal support for the project has ended;
“(F) a description of how the project will be evaluated;
“(G) the administrative capacity to submit annual performance data electronically as specified by the Director; and
“(H) other such information as the Director determines to be appropriate.

“(d) DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT GRANTS.—

“(1) GRANTS.—The Director may award grants to eligible entities to support reduction of health disparities, improve access to health care, and enhance rural health system development in the Delta Region.

“(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas.

“(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—
“(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

“(B) an explanation of the reasons why Federal assistance is required to carry out the project;

“(C) a description of the manner in which the project funded under the grant will meet the health care needs of the Delta Region;

“(D) a description of how the local community or region to be served will experience increased access to quality health care services as a result of the activities carried out by the entity;

“(E) a description of how health disparities will be reduced or the health system will be improved;

“(F) a plan for sustaining the project after Federal support for the project has ended;

“(G) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided or how the health care system improves its performance;
“(H) a description of how the grantee will develop an advisory group made up of representatives of the communities to be served to provide guidance to the grantee to best meet community need; and

“(I) other such information as the Director determines to be appropriate.

“(e) SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

“(1) GRANTS.—The Director may award grants to provide for the planning and implementation of small rural health care provider quality improvement activities. The Director may award the grants for periods of 1 to 3 years.

“(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity—

“(A) shall be—

“(i) a rural public or rural nonprofit private health care provider or provider of health care services, such as a rural health clinic; or

“(ii) another rural provider or network of small rural providers identified by the Director as a key source of local care; and
“(B) shall not previously have received a grant under this subsection for the same or a similar project.

“(3) PREFERENCE.—In awarding grants under this subsection, the Director shall give preference to facilities that qualify as rural health clinics under title XVIII of the Social Security Act.

“(4) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

“(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

“(B) an explanation of the reasons why Federal assistance is required to carry out the project;

“(C) a description of the manner in which the project funded under the grant will assure continuous quality improvement in the provision of services by the entity;

“(D) a description of how the local community or region to be served will experience increased access to quality health care services as
a result of the activities carried out by the entity;

“(E) a plan for sustaining the project after Federal support for the project has ended;

“(F) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided; and

“(G) other such information as the Director determines to be appropriate.

“(f) General Requirements.—

“(1) Prohibited Uses of Funds.—An entity that receives a grant under this section may not use funds provided through the grant—

“(A) to build or acquire real property; or

“(B) for construction.

“(2) Coordination with Other Agencies.—

The Director shall coordinate activities carried out under grant programs described in this section, to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar grant programs, to maximize the effect of public dollars in funding meritorious proposals.

“(g) Report.—Not later than September 30, 2010, the Secretary shall prepare and submit to the appropriate
committees of Congress a report on the progress and accomplish-ments of the grant programs described in sub-sections (b), (c), (d), and (e).

“(h) DEFINITIONS.—In this section:

“(1) The term ‘Delta Region’ has the meaning given to the term ‘region’ in section 382A of the Consolidated Farm and Rural Development Act (7 U.S.C. 2009aa).

“(2) The term ‘Director’ means the Director of the Office of Rural Health Policy of the Health Resources and Services Administration.

“(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $40,000,000 for fiscal year 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.”

SEC. 517. COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.

Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended by adding at the end the following:

“(s) MISCELLANEOUS PROVISIONS.—

“(1) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

“(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community
health center from contracting with a federally
certified rural health clinic (as defined by sec-
tion 1861(aa)(2) of the Social Security Act) for
the delivery of primary health care services that
are available at the rural health clinic to indi-
viduals who would otherwise be eligible for free
or reduced cost care if that individual were able
to obtain that care at the community health
center. Such services may be limited in scope to
those primary health care services available in
that rural health clinic.

“(B) ASSURANCES.—In order for a rural
health clinic to receive funds under this section
through a contract with a community health
center under paragraph (1), such rural health
clinic shall establish policies to ensure—

“(i) nondiscrimination based upon the
ability of a patient to pay; and

“(ii) the establishment of a sliding fee
scale for low-income patients.”.

SEC. 518. FACILITATING THE PROVISION OF TELEHEALTH
SERVICES ACROSS STATE LINES.

(a) IN GENERAL.—For purposes of expediting the
provision of telehealth services, for which payment is made
under the Medicare program, across State lines, the Sec-
retary of Health and Human Services shall, in consulta-
tion with representatives of States, physicians, health care
practitioners, and patient advocates, encourage and facili-
tate the adoption of provisions allowing for multistate
practitioner practice across State lines.

(b) DEFINITIONS.—In subsection (a):

(1) TELEHEALTH SERVICE.—The term “tele-
health service” has the meaning given that term in
subparagraph (F) of section 1834(m)(4) of the So-
cial Security Act (42 U.S.C. 1395m(m)(4)).

(2) PHYSICIAN, PRACTITIONER.—The terms
“physician” and “practitioner” have the meaning
given those terms in subparagraphs (D) and (E), re-
spectively, of such section.

(3) MEDICARE PROGRAM.—The term “Medicare
program” means the program of health insurance
administered by the Secretary of Health and Human
Services under title XVIII of the Social Security Act
(42 U.S.C. 1395 et seq.).