

119TH CONGRESS
2D SESSION

S. 5066

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

IN THE SENATE OF THE UNITED STATES

JULY 22, 2026

Mr. PADILLA (for himself, Mr. BOOKER, Ms. HIRONO, and Mr. WARNOCK) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Equity and
5 Accountability Act of 2026”.

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

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

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- Sec. 10202. Improving SNAP efficacy.
- Sec. 10203. Streamlining nutrition access for older adults and adults with disabilities.

- Sec. 10204. Enrollment and outreach pilot program for older adults, kinship families, and adults with disabilities.
- Sec. 10205. Food delivery under supplemental nutrition assistance program.
- Sec. 10206. Commodity supplemental food program.
- Sec. 10207. Seniors farmers' market nutrition program.
- Sec. 10208. Infrastructure funding for farmers' markets; local procurement pilot program.

CHAPTER 2—CLOSING THE MEAL GAP

- Sec. 10211. Elimination of time limit.
- Sec. 10212. Inclusion of Puerto Rico in supplemental nutritional assistance program.

Subtitle D—Universal School Meals

- Sec. 10301. Short title.
- Sec. 10302. Effective date.

CHAPTER 1—SCHOOL BREAKFAST PROGRAM

- Sec. 10311. Free school breakfast program.

CHAPTER 2—SCHOOL LUNCH PROGRAM

- Sec. 10321. Apportionment to States.
- Sec. 10322. Nutritional and other program requirements.
- Sec. 10323. Special assistance program.
- Sec. 10324. Price for paid lunch.
- Sec. 10325. Summer food service program for children.
- Sec. 10326. Summer electronic benefit transfer for children program.
- Sec. 10327. Child and adult care food program.
- Sec. 10328. Meals and supplements for children in afterschool care.
- Sec. 10329. Pilot projects.
- Sec. 10330. Fresh fruit and vegetable program.
- Sec. 10331. Training, technical assistance, and Food Service Management Institute.
- Sec. 10332. Reimbursement of school meal delinquent debt program.
- Sec. 10333. Conforming amendments.

CHAPTER 3—ELEMENTARY AND SECONDARY EDUCATION DATA

- Sec. 10341. Measure of poverty.

CHAPTER 4—AMENDMENTS TO OTHER PROGRAMS AND LAWS

- Sec. 10351. Supplemental nutrition assistance program.
- Sec. 10352. Higher Education Act of 1965.
- Sec. 10353. Elementary and Secondary Education Act of 1965.
- Sec. 10354. America COMPETES Act.
- Sec. 10355. Workforce Innovation and Opportunity Act.
- Sec. 10356. National Science Foundation Authorization Act of 2002.
- Sec. 10357. Child care and development block grant.
- Sec. 10358. Children's Health Act of 2000.
- Sec. 10359. Juvenile justice and delinquency prevention.

TITLE XI—PROTECTIONS TO COMBAT REGULATORY HARM TO HEALTH EQUITY

- Sec. 11001. Repeal of Executive orders.
- Sec. 11002. Statutory restoration and reestablishment of Federal offices and programs.
- Sec. 11003. Reinstatement of Federal data collection standards.
- Sec. 11004. Reinstatement of anti-discrimination requirements for Federal contractors.
- Sec. 11005. Reaffirmation and codification of disparate impact liability.
- Sec. 11006. Limitations on future Executive action.
- Sec. 11007. Severability.
- Sec. 11008. Authorization of appropriations.

1 **TITLE I—DATA COLLECTION**

2 **AND REPORTING**

3 **SEC. 1001. STRENGTHENING DATA COLLECTION, IMPROV-**

4 **ING DATA ANALYSIS, AND EXPANDING DATA**

5 **REPORTING.**

6 (a) AMENDMENTS TO THE PUBLIC HEALTH SERVICE

7 ACT.—

8 (1) PURPOSES.—The purposes of the amend-

9 ments made by this subsection are to—

10 (A) promote culturally and linguistically

11 appropriate data collection, analysis, and re-

12 porting by race, ethnicity, sex, primary lan-

13 guage, sexual orientation, disability status, gen-

14 der identity, age, and socioeconomic status in

15 federally supported health programs; and

16 (B) ensure that data with respect to race

17 and ethnicity is collected in accordance with the

18 Revisions to OMB’s Statistical Policy Directive

19 No. 15: Standards for Maintaining, Collecting,

1 and Presenting Federal Data on Race and Eth-
 2 nicity (89 Fed. Reg. 22182; March 29, 2024).

3 (2) AHRQ GENERAL AUTHORITIES.—Section
 4 902(a) of the Public Health Service Act (42 U.S.C.
 5 299a(a)) is amended—

6 (A) in paragraph (8), by striking “and” at
 7 the end;

8 (B) in paragraph (9), by striking the pe-
 9 riod at the end and inserting “; and”; and

10 (C) by adding at the end the following:

11 “(10) cultural and linguistic competence of
 12 health care services and of data collection activities
 13 described under section 3101.”.

14 (3) DEFINITION OF RACIAL AND ETHNIC MI-
 15 NORITY GROUP.—

16 (A) IN GENERAL.—Section 1707(g)(1) of
 17 the Public Health Service Act (42 U.S.C.
 18 300u–6(g)(1)) is amended to read as follows:

19 “(1)(A) The term ‘racial and ethnic minority
 20 group’ means a group of individuals who are any of
 21 the following:

22 “(i) American Indian or Alaska Native.

23 “(ii) Asian.

24 “(iii) Black or African American, including
 25 individuals of African ancestry.

1 “(iv) Hispanic or Latino.

2 “(v) Middle Eastern or North African.

3 “(vi) Native Hawaiian or Pacific Islander.

4 “(B) The terms listed in clauses (i) through (vi)
5 of subparagraph (A) shall have the meanings given
6 such terms for purposes of the Revisions to OMB’s
7 Statistical Policy Directive No. 15: Standards for
8 Maintaining, Collecting, and Presenting Federal
9 Data on Race and Ethnicity (89 Fed. Reg. 22182;
10 March 29, 2024).”.

11 (B) REFERENCES.—Except as otherwise
12 specified, any reference to the term “racial and
13 ethnic minority group” in any Federal regula-
14 tion, guidance, order, or document for establish-
15 ment or implementation of any federally con-
16 ducted or supported health care or public health
17 program, activity, or survey shall be treated as
18 having the definition given to such term in sec-
19 tion 1707(g) of the Public Health Service Act
20 (42 U.S.C. 300u–6(g)).

21 (C) SIMILAR TERMINOLOGY.—Not later
22 than 2 years after the date of enactment of this
23 Act, the Secretary of Health and Human Serv-
24 ices shall—

1 (i) identify all regulations, guidance,
 2 orders, and documents of the Department
 3 of Health and Human Services for estab-
 4 lishment or implementation of a health
 5 care or public health program, activity, or
 6 survey that use, without a definition, ter-
 7 minology that is similar to the term “racial
 8 and ethnic minority group”; and

9 (ii) take such actions as may be nec-
 10 essary to clarify whether the definition of
 11 the term “racial and ethnic minority
 12 group” in section 1707(g)(1) of the Public
 13 Health Service Act (42 U.S.C. 300u-
 14 6(g)(1)), as amended by subparagraph (A),
 15 applies to such terminology.

16 (4) OFFICE OF MINORITY HEALTH DUTIES.—

17 Section 1707(b)(6) of the Public Health Service Act
 18 (42 U.S.C. 300u-6(b)(6)) is amended by inserting “,
 19 and subgroups of racial and ethnic minority groups,
 20 and collects and reports such data consistent with
 21 the Revisions to OMB’s Statistical Policy Directive
 22 No. 15: Standards for Maintaining, Collecting, and
 23 Presenting Federal Data on Race and Ethnicity (89
 24 Fed. Reg. 22182; March 29, 2024) and the stand-

ards developed under section 3101(a)(2)(B)” after
 “the health status of each minority group”.

(5) OFFICE OF THE NATIONAL COORDINATOR
 FOR HEALTH INFORMATION TECHNOLOGY.—Section
 3001 of the Public Health Service Act (42 U.S.C.
 300jj–11) is amended—

(A) in subsection (b)—

(i) in paragraph (10), by striking
 “and” at the end;

(ii) in paragraph (11), by striking the
 period at the end and inserting “; and”;
 and

(iii) by adding at the end the fol-
 lowing:

“(12) ensures the interoperability of health in-
 formation systems among federally conducted or
 supported health care or public health programs,
 State health agencies, and social service agencies.”;
 and

(B) by amending clause (vii) in subsection
 (c)(3)(A) to read as follows:

“(vii) Strategies to enhance the use of
 health information technology in improving
 the quality of health care; reducing medical
 errors; reducing health disparities and en-

1 suring the provision of equitable health
 2 services; improving public health; increas-
 3 ing prevention and coordination with com-
 4 munity resources; ensuring interoperability
 5 among federally conducted or supported
 6 health care or public health programs,
 7 State health agencies, and social service
 8 agencies; and improving the continuity of
 9 care among health care settings.”.

10 (6) DATA COLLECTION, ANALYSIS, AND QUAL-
 11 ITY.—Section 3101(a) of the Public Health Service
 12 Act (42 U.S.C. 300kk(a)) is amended—

13 (A) in paragraphs (1)(A), (1)(C), (2)(B)
 14 and (2)(E), by striking “and disability status”
 15 and inserting “sexual orientation, gender iden-
 16 tity, age, disability status, and socioeconomic
 17 status”;

18 (B) in paragraph (1)—

19 (i) in subparagraph (C), by striking “;
 20 and” and inserting a semicolon; and

21 (ii) by striking subparagraph (D) and
 22 inserting the following:

23 “(D) data for additional population groups
 24 if such groups can be aggregated into the data

1 collection standards described under paragraph
2 (2); and

3 “(E) data that is disaggregated by popu-
4 lation groups, except in cases in which such
5 disaggregation is statistically unreliable and the
6 head of the program, activity, or survey docu-
7 ments such unreliability;”;

8 (C) in paragraph (2)—

9 (i) by amending subparagraph (A) to
10 read as follows:

11 “(A) with respect to data on race and eth-
12 nicity, use the standards provided in the Revi-
13 sions to OMB’s Statistical Policy Directive No.
14 15: Standards for Maintaining, Collecting, and
15 Presenting Federal Data on Race and Ethnicity
16 (89 Fed. Reg. 22182; March 29, 2024);”;

17 (ii) in subparagraph (B), as amended
18 by subparagraph (A), by adding before the
19 semicolon “that are equivalent, as prac-
20 ticable, to the standards described in sub-
21 paragraph (A)”;

22 (iii) in subparagraph (C)—

23 (I) in clause (i), by striking
24 “and” at the end;

1 (II) in clause (ii), striking “is a
2 minor or legally incapacitated” and
3 inserting “is a minor, requires assist-
4 ance with communication in speech or
5 writing, or is legally incapacitated”;
6 and

7 (III) by adding at the end the
8 following:

9 “(iii) collects data in a manner that is
10 culturally and linguistically appropriate
11 and does not include questions unrelated
12 to, or that could potentially deter, care,
13 such as questions related to immigration
14 status; and

15 “(iv) prohibits assignment of an indi-
16 vidual to a population group by a provider
17 or institution;”;

18 (D) in paragraph (3), by amending sub-
19 paragraph (B) to read as follows:

20 “(B) develop interoperability and security
21 systems for data management among federally
22 conducted or supported health care or public
23 health programs, State health agencies, and so-
24 cial service agencies.”; and

25 (E) by adding at the end the following:

1 “(4) RESPONSES.—In collecting data under this
2 subsection, the Secretary shall—

3 “(A) allow respondents to select multiple
4 race or ethnicities and provide detailed write-in
5 responses, consistent with the Revisions to
6 OMB’s Statistical Policy Directive No. 15:
7 Standards for Maintaining, Collecting, and Pre-
8 senting Federal Data on Race and Ethnicity
9 (89 Fed. Reg. 22182; March 29, 2024); and

10 “(B) ensure that any responses selecting
11 multiple race or ethnicities, and write-in re-
12 sponses described in subparagraph (A), are re-
13 tained by the Secretary and coded for anal-
14 ysis.”.

15 (b) COROLLARY PROVISIONS.—

16 (1) RECOMMENDATIONS BY THE DATA COUN-
17 CIL.—The Data Council of the Department of
18 Health and Human Services, in consultation with
19 the Director of the National Center for Health Sta-
20 tistics, the Deputy Assistant Secretary for Minority
21 Health, the Deputy Assistant Secretary for Women’s
22 Health, the Administrator of the Centers for Medi-
23 care & Medicaid Services, the National Coordinator
24 for Health Information Technology, and other ap-
25 propriate public and private entities and officials,

1 shall make recommendations to the Secretary of
2 Health and Human Services concerning how to—

3 (A) implement the amendments made by
4 this section, while minimizing the cost and ad-
5 ministrative burdens of data collection and re-
6 porting on all parties, including patients and
7 providers, without reducing data granularity or
8 deviating from the standards provided in the
9 Revisions to OMB’s Statistical Policy Directive
10 No. 15: Standards for Maintaining, Collecting,
11 and Presenting Federal Data on Race and Eth-
12 nicity (89 Fed. Reg. 22182; March 29, 2024);

13 (B) require Federal agencies administering
14 programs, activities, or surveys described in sec-
15 tion 3101(a) of the Public Health Service Act
16 (42 U.S.C. 300kk(a)) to monitor and report
17 rates of missing or incomplete data required
18 under such section and improve the complete-
19 ness of such data;

20 (C) expand awareness among Federal
21 agencies, States, territories, Indian Tribes,
22 counties, municipalities, health providers, health
23 plans, and the general public that data collec-
24 tion, analysis, and reporting by race, ethnicity,
25 sex, primary language, sexual orientation, gen-

der identity, age, socioeconomic status, and disability status is legal and necessary to ensure equity and nondiscrimination in the quality of health care services;

(D) ensure that future patient record systems—

(i) follow Federal standards promulgated under the HITECH Act (42 U.S.C. 201 note) for the collection and meaningful use of electronic health data on race, ethnicity, sex, primary language, sexual orientation, gender identity, age, socioeconomic status, and disability status; and

(ii) are consistent with the United States Core Data for Interoperability data classes and use of structured, coded data elements and standardized value sets for race, ethnicity, sex, primary language, sexual orientation, gender identity, age, socioeconomic status, and disability status that support interoperability;

(E) improve health and health care data collection and analysis for more population groups if such groups can be aggregated into minimum race and ethnicity categories, includ-

1 ing exploring the feasibility of enhancing collec-
2 tion efforts in States, counties, and municipali-
3 ties for racial and ethnic groups that comprise
4 a significant proportion of the population of the
5 State, county, or municipality;

6 (F) subject to all applicable privacy and
7 confidentiality requirements, including HIPAA
8 privacy and security law as defined in section
9 3009(a) of the Public Health Service Act (42
10 U.S.C. 300jj–19(a)), provide researchers with
11 greater access to racial, ethnic, primary lan-
12 guage, sex, sexual orientation, gender identity,
13 age, socioeconomic status, and disability status
14 data, including de-identified, disaggregated
15 datasets for research and public reporting, in-
16 cluding for analysis of intersectional disparities
17 across demographics;

18 (G) ensure the cultural and linguistic com-
19 petence of entities that receive Federal support
20 to collect and report data pursuant to the
21 amendments made by subsection (a); and

22 (H) safeguard and prevent the misuse of
23 data collected under section 3101 of the Public
24 Health Service Act (42 U.S.C. 300kk), as
25 amended by subsection (a)(6), without limiting

1 the lawful collection, reporting, and use of
2 disaggregated demographic data.

3 (2) RULES OF CONSTRUCTION.—Nothing in
4 this section shall be construed to—

5 (A) permit the use of information collected
6 under this section or any provision amended by
7 this section in a manner that would adversely
8 affect any individual providing any such infor-
9 mation, including adverse effects to the rel-
10 atives of the individual and to the community
11 or communities of the individual; or

12 (B) diminish any requirements on health
13 care providers to collect data, including such re-
14 quirements in effect on or after the date of en-
15 actment of this Act.

16 (3) TECHNICAL ASSISTANCE FOR THE ANALYSIS
17 OF HEALTH DISPARITY DATA.—The Secretary of
18 Health and Human Services, acting through the Di-
19 rector of the Agency for Healthcare Research and
20 Quality, and in coordination with the Assistant Sec-
21 retary for Planning and Evaluation, the Adminis-
22 trator of the Centers for Medicare & Medicaid Serv-
23 ices, the Director of the National Center for Health
24 Statistics, the Director of the National Institutes of
25 Health, and the National Coordinator for Health In-

1 formation Technology, shall provide technical assist-
2 ance to agencies of the Department of Health and
3 Human Services in meeting Federal standards for
4 health disparity data collection and for analysis of
5 racial, ethnic, nationality, sex, gender, sexual ori-
6 entation, gender identity, geographical, age, primary
7 language, disability status, socioeconomic, and other
8 disparities in health and health care in programs
9 conducted or supported by such agencies by—

10 (A) identifying appropriate quality assur-
11 ance mechanisms to monitor for health dispari-
12 ties;

13 (B) specifying the clinical, diagnostic, or
14 therapeutic measures which should be mon-
15 itored;

16 (C) developing new quality measures relat-
17 ing to racial and ethnic disparities and their
18 overlap with other disparity factors in health
19 and health care;

20 (D) identifying the level at which data
21 analysis should be conducted;

22 (E) sharing data with external organiza-
23 tions for research and quality improvement pur-
24 poses; and

1 (F) identifying and addressing issues relat-
2 ing to the interoperability of Federal- and
3 State-level health information systems which
4 undermine the ability of health-related pro-
5 grams collecting data under this section to
6 achieve the purposes described in subsection
7 (a)(1).

8 (4) AUTHORIZATION OF APPROPRIATIONS.—To
9 carry out this subsection, subsection (a), and the
10 amendments made by subsection (a), there are au-
11 thorized to be appropriated such sums as may be
12 necessary for each of fiscal years 2027 through
13 2031.

14 (c) ADDITIONAL AMENDMENTS TO THE PUBLIC
15 HEALTH SERVICE ACT.—Title XXXIV of the Public
16 Health Service Act, as added by titles II and III of this
17 Act, is further amended by inserting after subtitle B the
18 following:

1 **“Subtitle C—Strengthening Data**
 2 **Collection, Improving Data**
 3 **Analysis, and Expanding Data**
 4 **Reporting**

5 **“SEC. 3431. ESTABLISHING GRANTS FOR DATA COLLECTION**
 6 **IMPROVEMENT ACTIVITIES.**

7 “(a) IN GENERAL.—The Secretary, acting through
 8 the Director of the Agency for Healthcare Research and
 9 Quality and in consultation with the Deputy Assistant
 10 Secretary for Minority Health, the Director of the Na-
 11 tional Institutes of Health, the Assistant Secretary for
 12 Planning and Evaluation, the National Coordinator for
 13 Health Information Technology, and the Director of the
 14 National Center for Health Statistics, shall establish a
 15 technical assistance program under which the Secretary
 16 provides grants to eligible entities to assist such entities
 17 in complying with section 3101.

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

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

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

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

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

17 “(5) develop educational programs to train
18 health providers, health care organizations, health
19 plans, health-related agencies, and frontline health
20 care workers on how to collect and report
21 disaggregated data in a culturally and linguistically
22 appropriate manner, including the privacy and con-
23 fidentiality interests of individuals from whom the
24 data is collected.

1 “(c) ELIGIBLE ENTITY.—To be eligible for grants
2 under this section, an entity shall—

3 “(1) be a State, territory, Indian Tribe, munic-
4 ipality, county, health provider, health care organiza-
5 tion, or health plan making a demonstrated effort to
6 bring data collections into compliance with section
7 3101;

8 “(2) be in compliance with the standards pro-
9 vided in the Revisions to OMB’s Statistical Policy
10 Directive No. 15: Standards for Maintaining, Col-
11 lecting, and Presenting Federal Data on Race and
12 Ethnicity (89 Fed. Reg. 22182; March 29, 2024);
13 and

14 “(3) agree to require training for personnel im-
15 plementing the requirements of section 3101 on cul-
16 turally appropriate, standardized data collection.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section
19 such sums as may be necessary for each of fiscal years
20 2027 through 2031.

21 **“SEC. 3432. OVERSAMPLING OF UNDERREPRESENTED**
22 **GROUPS IN FEDERAL HEALTH SURVEYS.**

23 “(a) NATIONAL REQUIREMENT.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Director of the National Center for

1 Health Statistics, and other officials within the De-
2 partment of Health and Human Services as the Sec-
3 retary determines appropriate, shall develop and im-
4 plement a sustainable national requirement applica-
5 ble to all Federal health surveys and program data
6 collections for the oversampling of underrepresented
7 populations within the categories of race, ethnicity,
8 sex, primary language, sexual orientation, disability
9 status, gender identity, age, and socioeconomic sta-
10 tus as determined appropriate by the Secretary.
11 Such national requirement shall include—

12 “(A) minimum sample thresholds for the
13 oversampling of underrepresented populations;
14 and

15 “(B) a requirement for oversampling of
16 Middle Easterners and North Africans, Asian
17 Americans, American Indians, Alaska Natives,
18 Native Hawaiians, and Pacific Islanders.

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

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

1 governmental organizations, and government
2 agencies working with underrepresented popu-
3 lations;

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

8 “(C) consult on, and use as models, the
9 2014 National Health Interview Survey over-
10 sample of Native Hawaiian and Pacific Islander
11 populations, the 2016 Behavioral Risk Factor
12 Survey of Health Risk Behaviors Among Arab
13 Adults Within the State of Michigan, and the
14 2017 Behavioral Risk Factor Surveillance Sys-
15 tem oversample of American Indian and Alaska
16 Native communities.

17 “(b) PROGRESS REPORT.—Not later than 2 years
18 after the date of enactment of this section, the Secretary
19 shall submit to the Congress a progress report, which shall
20 include the national requirement under subsection (a)(1).

21 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this section, there are authorized to be appro-
23 priated such sums as may be necessary for each of fiscal
24 years 2027 through 2031.”.

1 (d) REPORT TO CONGRESS.—Not later than 2 years
 2 after the date of enactment of this Act, the Secretary of
 3 Health and Human Services shall submit a report to Con-
 4 gress on the implementation of this section, including the
 5 amendments made by this section.

6 **SEC. 1002. ELIMINATION OF PREREQUISITE OF DIRECT AP-**
 7 **PROPRIATIONS FOR DATA COLLECTION AND**
 8 **ANALYSIS.**

9 Section 3101 of the Public Health Service Act (42
 10 U.S.C. 300kk), as amended by section 1001(a), is further
 11 amended—

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

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

15 **SEC. 1003. COLLECTION OF DATA FOR THE MEDICARE PRO-**
 16 **GRAM.**

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

20 **“SEC. 1150D. COLLECTION OF DATA FOR THE MEDICARE**
 21 **PROGRAM.**

22 “(a) REQUIREMENT.—

23 “(1) IN GENERAL.—The Commissioner of So-
 24 cial Security (in this section referred to as the ‘Com-
 25 missioner’), in consultation with the Administrator

1 of the Centers for Medicare & Medicaid Services (in
 2 this section referred to as the ‘Administrator’), shall
 3 collect data on the race, ethnicity, sex, primary lan-
 4 guage, sexual orientation, gender identity, socio-
 5 economic status, age, and disability status of all ap-
 6 plicants for social security benefits under title II or
 7 Medicare benefits under title XVIII.

8 “(2) DATA COLLECTION STANDARDS.—

9 “(A) IN GENERAL.—In collecting data
 10 under paragraph (1), the Commissioner shall at
 11 least use the standards for data collection devel-
 12 oped under section 3101 of the Public Health
 13 Service Act (42 U.S.C. 300kk) or the standards
 14 developed by the Office of Management and
 15 Budget, as the baseline standard, consistent
 16 with the Office of Management and Budget
 17 Statistical Policy Directive No. 15: Standards
 18 for Maintaining, Collecting, and Presenting
 19 Federal Data on Race and Ethnicity, or any
 20 successor Office of Management and Budget di-
 21 rective.

22 “(B) NO STANDARDS AVAILABLE.—In the
 23 event there are no standards for the demo-
 24 graphic groups listed under paragraph (1), the
 25 Commissioner shall consult with stakeholder

1 groups representing the various identities as
2 well as with the Office of Minority Health with-
3 in the Centers for Medicare & Medicaid Serv-
4 ices to develop appropriate standards.

5 “(3) DATA FOR ADDITIONAL POPULATION
6 GROUPS.—Where practicable, the data collected by
7 the Commissioner under paragraph (1) shall include
8 data for additional population groups if such groups
9 can be aggregated into the race and ethnicity cat-
10 egories outlined by the data collection standards de-
11 scribed in paragraph (2)(A).

12 “(4) COLLECTION OF DATA FOR MINORS AND
13 LEGALLY INCAPACITATED INDIVIDUALS.—With re-
14 spect to the collection of the data described in para-
15 graph (1) of applicants who are under 18 years of
16 age or otherwise legally incapacitated, the Commis-
17 sioner shall require that—

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

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

23 “(5) QUALITY OF DATA.—The Commissioner
24 shall periodically review the quality and complete-

1 ness of the data collected under paragraph (1) and
2 make adjustments as necessary to improve both.

3 “(6) TRANSMISSION OF DATA.—Upon enroll-
4 ment for Medicare benefits under title XVIII, the
5 Commissioner shall transmit the demographic data
6 of an individual as collected under paragraph (1) to
7 the Centers for Medicare & Medicaid Services.

8 “(7) ANALYSIS AND REPORTING OF DATA.—
9 With respect to the data transmitted under para-
10 graph (6), the Administrator, in consultation with
11 the Commissioner, shall—

12 “(A) require that such data be uniformly
13 analyzed and that such analysis be reported at
14 least annually to Congress;

15 “(B) incorporate such data in other anal-
16 ysis and reporting on health disparities and the
17 provision of inequitable health care services by
18 a health care provider, as appropriate;

19 “(C) make such data available to research-
20 ers, under the protections outlined in paragraph
21 (8);

22 “(D) provide opportunities to individuals
23 enrolled for Medicare benefits under title XVIII
24 to submit updated data;

1 “(E) ensure that the provision of assist-
 2 ance or benefits to an applicant, or their rel-
 3 atives, is not denied or otherwise adversely af-
 4 fected because of the failure of the applicant to
 5 provide any of the data collected under para-
 6 graph (1); and

7 “(F) ensure that the provision of assist-
 8 ance or benefit to an applicant or their relatives
 9 is not denied or otherwise adversely affected be-
 10 cause of the content of the data provided by the
 11 applicant, except where it is required by law.

12 “(8) PROTECTION OF DATA.—The Commis-
 13 sioner shall ensure (through the promulgation of
 14 regulations or otherwise) that all data collected pur-
 15 suant to paragraph (1) is protected—

16 “(A) under the same privacy protections as
 17 the Secretary applies to health data under the
 18 regulations promulgated under section 264(c) of
 19 the Health Insurance Portability and Account-
 20 ability Act of 1996 (relating to the privacy of
 21 individually identifiable health information and
 22 other protections); and

23 “(B) from all inappropriate internal use by
 24 any entity that collects, stores, or receives the
 25 data, including use of such data in determina-

1 tions of eligibility (or continued eligibility) in
 2 health plans, and from other inappropriate
 3 uses, as defined by the Secretary.

4 “(b) RULE OF CONSTRUCTION.—Nothing in this sec-
 5 tion shall be construed to permit the use of information
 6 collected under this section in a manner that would ad-
 7 versely affect any individual providing any such informa-
 8 tion.

9 “(c) TECHNICAL ASSISTANCE.—The Secretary may,
 10 either directly or by grant or contract, provide technical
 11 assistance to enable any entity to comply with the require-
 12 ments of this section or with regulations implementing this
 13 section.

14 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 15 are authorized to be appropriated to carry out this section
 16 \$500,000,000 for fiscal year 2027 and \$100,000,000 for
 17 each fiscal year thereafter.”.

18 **SEC. 1004. REVISION OF HIPAA CLAIMS STANDARDS.**

19 (a) IN GENERAL.—Not later than 1 year after the
 20 date of enactment of this Act, the Secretary of Health and
 21 Human Services shall revise the regulations promulgated
 22 under part C of title XI of the Social Security Act (42
 23 U.S.C. 1320d et seq.) (relating to the collection of data
 24 on demographics in a health-related transaction) to re-
 25 quire—

1 (1) the use, at a minimum, of standards for
2 data collection on race, ethnicity, sex, primary lan-
3 guage, sexual orientation, gender identity, age, dis-
4 ability status, and socioeconomic status developed
5 under section 3101 of the Public Health Service Act
6 (42 U.S.C. 300kk), as amended by section
7 1001(a)(6); and

8 (2) in consultation with the Office of the Na-
9 tional Coordinator for Health Information Tech-
10 nology, the designation of the appropriate racial,
11 ethnic, primary language, disability, sex, and other
12 code sets as required for claims and enrollment data.

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

19 (c) COMPLIANCE.—The Secretary of Health and
20 Human Services shall require that entities comply with the
21 new standards developed under subsection (a) not later
22 than 2 years after the final promulgation of such stand-
23 ards.

1 **SEC. 1005. NATIONAL CENTER FOR HEALTH STATISTICS.**

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

4 (1) in paragraph (1), by striking “2003” and
5 inserting “2027”;

6 (2) in paragraph (2), in the first sentence, by
7 striking “2003” and inserting “2027”; and

8 (3) in paragraph (3), by striking “2002” and
9 inserting “2027”.

10 **SEC. 1006. DISPARITIES DATA COLLECTED BY THE FED-**
11 **ERAL GOVERNMENT.**

12 (a) REPOSITORY OF GOVERNMENT DATA.—The Sec-
13 retary of Health and Human Services, in coordination
14 with the officials referenced in subsection (b), shall estab-
15 lish a centralized electronic repository of Federal Govern-
16 ment data on factors related to the health and well-being
17 of the population of the United States.

18 (b) COLLECTION; SUBMISSION.—Not later than 180
19 days after the date of enactment of this Act, and January
20 31 of each year thereafter, each department, agency, and
21 office of the Federal Government that has collected data
22 on race, ethnicity, sex, primary language, sexual orienta-
23 tion, gender identity, age, disability status, or socio-
24 economic status during the preceding calendar year shall
25 submit such data to the repository of Federal Government
26 data established under subsection (a).

1 (c) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
2 Not later than April 30, 2027, and April 30 of each year
3 thereafter, the Secretary of Health and Human Services,
4 acting through the Assistant Secretary for Planning and
5 Evaluation, the Assistant Secretary for Health, the Direc-
6 tor of the Agency for Healthcare Research and Quality,
7 the Director of the National Center for Health Statistics,
8 the Administrator of the Centers for Medicare & Medicaid
9 Services, the Director of the National Institute on Minor-
10 ity Health and Health Disparities, and the Deputy Assist-
11 ant Secretary for Minority Health, shall—

12 (1) prepare and make available datasets for
13 public use that relate to disparities in health status,
14 health care access, health care quality, health out-
15 comes, public health, the provision of equitable
16 health services, and other areas of health and well-
17 being by factors that include race, ethnicity, sex, pri-
18 mary language, sexual orientation, gender identity,
19 disability status, age, and socioeconomic status;

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

23 (3) submit a report to the Congress on the
24 availability and use of such data by public stake-
25 holders.

1 **SEC. 1007. DATA COLLECTION AND ANALYSIS GRANTS TO**
2 **MINORITY-SERVING INSTITUTIONS.**

3 (a) **AUTHORITY.**—The Secretary of Health and
4 Human Services, acting through the Director of the Na-
5 tional Institute on Minority Health and Health Disparities
6 and the Deputy Assistant Secretary for Minority Health,
7 shall award grants to eligible entities to access and analyze
8 racial and ethnic data on disparities in health and health
9 care, and where possible other data on disparities in health
10 and health care, to monitor and report on progress to re-
11 duce and eliminate disparities in health and health care.

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

16 (1) A part B institution, as defined in section
17 322 of the Higher Education Act of 1965 (20
18 U.S.C. 1061).

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

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

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

1 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
 2 out this section, there are authorized to be appropriated
 3 such sums as may be necessary for each of fiscal years
 4 2027 through 2031.

5 **SEC. 1008. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
 6 **RESPECT TO RACIAL AND ETHNIC BACK-**
 7 **GROUND.**

8 (a) IN GENERAL.—Chapter V of the Federal Food,
 9 Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amend-
 10 ed by inserting after section 505G (21 U.S.C. 355h) the
 11 following:

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

15 “(a) PREAPPROVAL STUDIES.—If there is evidence of
 16 a racial or ethnic disparity in safety or effectiveness with
 17 respect to a drug or biological product, then—

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

22 “(B) in the case of a biological product, the evi-
 23 dence required under section 351(a) of the Public
 24 Health Service Act for approval of a biologics license
 25 application for the biological product shall include

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

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

8 “(b) POSTMARKET STUDIES.—

9 “(1) IN GENERAL.—If there is evidence of a ra-
10 cial or ethnic disparity in safety or effectiveness with
11 respect to a drug for which there is an approved ap-
12 plication under section 505 of this Act or of a bio-
13 logical product for which there is an approved li-
14 cense under section 351 of the Public Health Service
15 Act, the Secretary may by order require the holder
16 of the approved application or license to conduct, by
17 a date specified by the Secretary, postmarket studies
18 to investigate the disparity.

19 “(2) LABELING.—If the Secretary determines
20 that the postmarket studies confirm that there is a
21 disparity described in paragraph (1), the labeling of
22 the drug or biological product shall include appro-
23 priate information about the disparity.

24 “(3) STUDY DESIGN.—The Secretary may, in
25 an order under paragraph (1), specify all aspects of

1 the design of the postmarket studies required under
2 such paragraph for a drug or biological product, in-
3 cluding the number of studies and study partici-
4 pants, and the other demographic characteristics of
5 the study participants.

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

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

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

16 “(1) IN GENERAL.—A drug for which an appli-
17 cation has been submitted or approved under section
18 505(j) shall not be considered ineligible for approval
19 under that section or misbranded under section 502
20 on the basis that the labeling of the drug omits in-
21 formation relating to a disparity on the basis of ra-
22 cial or ethnic background as to the safety or effec-
23 tiveness of the drug, whether derived from investiga-
24 tions or studies required under this section or de-
25 rived from other sources, when the omitted informa-

1 tion is protected by patent or by exclusivity under
2 section 505(j)(5)(F).

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

12 “(d) DEFINITION.—In this section, the term ‘evi-
13 dence of a racial or ethnic disparity in safety or effective-
14 ness’, with respect to a drug or biological product, in-
15 cludes—

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

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

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

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

4 “(hh) If it is a drug and the holder of the approved
 5 application under section 505 or license under section 351
 6 of the Public Health Service Act for the drug has failed
 7 to complete the investigations or studies required under
 8 section 505H, or comply with any other requirement of
 9 such section 505H.”.

10 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
 11 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
 12 379h(a)(1)(A)(ii)) is amended by inserting after “are not
 13 required” the following: “, including postmarket studies
 14 required under section 505H,”.

15 **SEC. 1009. IMPROVING HEALTH DATA REGARDING NATIVE**
 16 **HAWAIIANS AND PACIFIC ISLANDERS.**

17 Part B of title III of the Public Health Service Act
 18 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
 19 tion 317V (42 U.S.C. 247b–24) the following:

20 **“SEC. 317W. NATIVE HAWAIIAN AND PACIFIC ISLANDER**
 21 **HEALTH DATA.**

22 “(a) DEFINITIONS.—In this section:

23 “(1) INSULAR AREA.—The term ‘insular area’
 24 means Guam, the Commonwealth of the Northern
 25 Mariana Islands, American Samoa, the United

1 States Virgin Islands, the Federated States of Mi-
 2 cronesia, the Republic of Palau, or the Republic of
 3 the Marshall Islands.

4 “(2) NATIVE HAWAIIANS AND PACIFIC ISLAND-
 5 ERS (NHPI).—The term ‘Native Hawaiians and Pa-
 6 cific Islanders’ or ‘NHPI’ means people having ori-
 7 gins in any of the original peoples of American
 8 Samoa, the Commonwealth of the Northern Mariana
 9 Islands, the Federated States of Micronesia, Guam,
 10 Hawaii, the Republic of the Marshall Islands, the
 11 Republic of Palau, or any other Pacific Island.

12 “(3) NHPI STAKEHOLDER GROUPS.—The term
 13 ‘NHPI stakeholder group’ includes each of the fol-
 14 lowing:

15 “(A) COMMUNITY GROUP.—A group of
 16 NHPI who are organized at the community
 17 level, and may include a church group, social
 18 service group, national advocacy organization,
 19 or cultural group.

20 “(B) NONPROFIT, NONGOVERNMENTAL
 21 ORGANIZATION.—A group of NHPI with a dem-
 22 onstrated history of addressing NHPI issues,
 23 including a NHPI coalition.

24 “(C) DESIGNATED ORGANIZATION.—An
 25 entity established to represent NHPI popu-

lations and which has statutory responsibilities to provide, or has community support for providing, health care.

“(D) GOVERNMENT REPRESENTATIVES OF NHPI POPULATIONS.—Representatives from Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands.

“(b) PRELIMINARY HEALTH SURVEY.—

“(1) IN GENERAL.—The Secretary, acting through the Director of the National Center for Health Statistics of the Centers for Disease Control and Prevention (referred to in this section as ‘NCHS’), shall conduct a preliminary health survey in order to identify the major areas and regions in the continental United States, Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands in which NHPI people reside.

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

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

3 “(B) required for developing or imple-
4 menting the national strategy under subsection
5 (c).

6 “(3) METHODOLOGY.—Methodology for the
7 health survey described in paragraph (1), including
8 plans for designing questions, implementation, sam-
9 pling, and analysis, shall be developed in consulta-
10 tion with NHPI stakeholder groups.

11 “(4) TIMEFRAME.—The survey required under
12 this subsection shall be completed not later than 18
13 months after the date of enactment of the Health
14 Equity and Accountability Act of 2026.

15 “(c) NATIONAL STRATEGY.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Director of the NCHS and other agen-
18 cies within the Department of Health and Human
19 Services as the Secretary determines appropriate,
20 shall develop and implement a sustainable national
21 strategy for identifying and evaluating the health
22 status and health care needs of NHPI populations
23 living in the continental United States, Hawaii,
24 American Samoa, the Commonwealth of the North-
25 ern Mariana Islands, the Federated States of Micro-

1 nesia, Guam, the Republic of Palau, and the Repub-
 2 lic of the Marshall Islands.

3 “(2) CONSULTATION.—In developing and imple-
 4 menting a national strategy, as described in para-
 5 graph (1), not later than 180 days after the date of
 6 enactment of the Health Equity and Accountability
 7 Act of 2026, the Secretary—

8 “(A) shall consult with representatives of
 9 NHPI stakeholder groups; and

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

12 “(d) PROGRESS REPORT.—Not later than 2 years
 13 after the date of enactment of the Health Equity and Ac-
 14 countability Act of 2026, the Secretary shall submit to
 15 Congress a progress report, which shall include the na-
 16 tional strategy described in subsection (c)(1).

17 “(e) STUDY AND REPORT BY THE HEALTH AND
 18 MEDICINE DIVISION.—

19 “(1) IN GENERAL.—The Secretary shall seek to
 20 enter into an agreement with the Health and Medi-
 21 cine Division of the National Academies of Sciences,
 22 Engineering, and Medicine to conduct a study, with
 23 input from stakeholders in insular areas, on each of
 24 the following:

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

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

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

12 “(D) The progress toward implementation
13 of recommendations of the Committee on
14 Health Care Services in the United States—As-
15 sociated Pacific Basin that are set forth in the
16 1998 report entitled ‘Pacific Partnerships for
17 Health: Charting a New Course’.

18 “(2) REPORT.—An agreement described in
19 paragraph (1) shall require the Health and Medicine
20 Division to submit to the Secretary and to Congress,
21 not later than 2 years after the date of the enact-
22 ment of the Health Equity and Accountability Act of
23 2026, a report containing a description of the results
24 of the study conducted under paragraph (1), includ-
25 ing the conclusions and recommendations of the

1 Health and Medicine Division for each of the items
 2 described in subparagraphs (A) through (D) of such
 3 paragraph.

4 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
 5 carry out this section, there are authorized to be appro-
 6 priated such sums as may be necessary for fiscal years
 7 2027 through 2031.”.

8 **SEC. 1010. DATA COLLECTION REGARDING PANDEMIC PRE-**
 9 **PAREDNESS, TESTING, INFECTIONS, AND**
 10 **DEATHS.**

11 (a) SKILLED NURSING FACILITIES QUALITY RE-
 12 PORTING.—Section 1819 of the Social Security Act (42
 13 U.S.C. 1395i–3) is amended by adding at the end the fol-
 14 lowing new subsection:

15 “(l) REQUIREMENTS RELATING TO REPORTING DUR-
 16 ING PUBLIC HEALTH EMERGENCIES.—During a public
 17 health emergency declared by the Secretary pursuant to
 18 section 319 of the Public Health Service Act, a skilled
 19 nursing facility shall, not later than 1 year after the first
 20 day of such declaration, and monthly thereafter during the
 21 application of such declaration, submit to the Secretary
 22 the following information, with respect to such facility and
 23 the residents of such facility:

1 “(1) Information described in section
2 483.80(g)(1) of title 42, Code of Federal Regula-
3 tions.

4 “(2) The age, race, ethnicity, sex, sexual ori-
5 entation, gender identity, socioeconomic status, dis-
6 ability status, and preferred language of the resi-
7 dents of such skilled nursing facility.”.

8 (b) TRANSPARENCY OF DEMOGRAPHIC INFORMATION
9 IN CERTAIN SETTINGS.—

10 (1) DEMOGRAPHIC INFORMATION.—The Sec-
11 retary of Health and Human Services shall post the
12 following information with respect to skilled nursing
13 facilities (as defined in section 1819(a) of the Social
14 Security Act (42 U.S.C. 1395i–3(a))), congregate
15 care settings (including skilled nursing facilities, as-
16 sisted living facilities, prisons and jails, residential
17 behavioral health care and psychiatric facilities, and
18 facilities providing services for aging adults and peo-
19 ple with disabilities), and nursing facilities (as de-
20 fined in section 1919(a) of such Act (42 U.S.C.
21 1396r(a))) on the Nursing Home Compare website
22 (as described in section 1819(i) of such Act (42
23 U.S.C. 1395i–3(i))), or a successor website, aggre-
24 gated by State:

1 (A) The age, race, ethnicity, sex, sexual
2 orientation, gender identity, socioeconomic sta-
3 tus, disability status, and preferred language of
4 the residents of such skilled nursing facilities,
5 congregate care settings (including skilled nurs-
6 ing facilities, assisted living facilities, prisons
7 and jails, residential behavioral health care and
8 psychiatric facilities, and facilities providing
9 services for aging adults and people with dis-
10 abilities), and nursing facilities with suspected
11 or confirmed infections, including residents pre-
12 viously treated for COVID–19.

13 (B) The age, race, ethnicity, sex, sexual
14 orientation, gender identity, socioeconomic sta-
15 tus, disability status, and preferred language
16 relating to total deaths and public health emer-
17 gency-related deaths among residents of such
18 skilled nursing facilities, congregate settings
19 (including skilled nursing facilities, assisted liv-
20 ing facilities, prisons and jails, residential be-
21 havioral health care and psychiatric facilities,
22 and facilities providing services for aging adults
23 and people with disabilities), and nursing facili-
24 ties.

(c) **EQUITABLE DATA COLLECTION AND DISCLOSURE**
REGARDING PANDEMICS.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) as amended by section 1003, is further amended by adding at the end the following new section:

“(a) IN GENERAL.—Not later than 60 days after the Secretary submits to Congress written notification of the determination that a disease or disorder presents a public health emergency or that a public health emergency other-

1 wise exists, subject to subsections (b) and (c), the Sec-
2 retary, acting through the Director of the Centers for Dis-
3 ease Control and Prevention and the Administrator of the
4 Centers for Medicare & Medicaid Services and in consulta-
5 tion with the Director of the Indian Health Service, shall
6 collect and make publicly available on the website of the
7 Centers for Disease Control and Prevention and the Cen-
8 ters for Medicare & Medicaid Services, and update every
9 day during a pandemic, data collected across all surveil-
10 lance systems relating to a public health emergency de-
11 clared under section 319 of the Public Health Service Act
12 that is caused by a disease (as determined by the Sec-
13 retary), disaggregated by race, ethnicity, sex, sexual ori-
14 entation, gender identity, age, preferred language, socio-
15 economic status, disability status, and county. Such data
16 shall include the following:

17 “(1) Data relating to all testing for the patho-
18 gen or pathogens causing the pandemic, including
19 the number of individuals tested and the number of
20 tests that were positive.

21 “(2) Data relating to treatment for the patho-
22 gen causing the pandemic, including hospitalizations
23 and intensive care unit admissions.

24 “(3) Data relating to pandemic outcomes, in-
25 cluding total fatalities and case fatality rates (ex-

1 pressed as the proportion of individuals who were in-
 2 fected with the pathogen causing the pandemic and
 3 died from the pathogen).

4 “(4) In the case a vaccine is developed in re-
 5 sponse to a pandemic, data relating to such vaccina-
 6 tion, including—

7 “(A) the number of vaccines administered;

8 “(B) the number of vaccinations offered,
 9 accepted, and refused;

10 “(C) the most common reasons for refusal;
 11 and

12 “(D) the percentage of vaccine doses allo-
 13 cated and administered to each priority group.

14 “(b) APPLICATION OF CERTAIN STANDARDS WITH
 15 RESPECT TO DATA COLLECTION.—To the extent prac-
 16 ticable, data collected under subsection (a) shall follow
 17 standards developed by the Department of Health and
 18 Human Services Office of Minority Health and be col-
 19 lected, analyzed, and reported in accordance with the
 20 standards promulgated by the Assistant Secretary for
 21 Planning and Evaluation under title XXXI of the Public
 22 Health Service Act.

23 “(c) PRIVACY.—In publishing data pursuant to sub-
 24 section (a), the Secretary shall take all necessary steps to

1 protect the privacy of individuals whose information is in-
 2 cluded in such data, including—

3 “(1) complying with privacy protections pro-
 4 vided under the regulations promulgated under sec-
 5 tion 264(c) of the Health Insurance and Account-
 6 ability Act of 1996; and

7 “(2) protections from all inappropriate internal
 8 use by an entity that collects, stores, or receives the
 9 data, including use of such data in determinations of
 10 eligibility (or continued eligibility) in health plans,
 11 and from inappropriate uses.”.

12 (d) REPORT REQUIREMENTS FOLLOWING PUBLIC
 13 HEALTH EMERGENCIES.—

14 (1) PUBLICLY AVAILABLE SUMMARY.—Not later
 15 than 60 days after the date on which the Secretary
 16 of Health and Human Services certifies that a public
 17 health emergency declared under section 319 of the
 18 Public Health Service Act has ended, the Secretary
 19 shall make publicly available on the website of the
 20 Department of Health and Human Services a sum-
 21 mary of the final statistics related to such emer-
 22 gency.

23 (2) REPORT TO CONGRESS.—Not later than 60
 24 days after the date on which the Secretary of Health
 25 and Human Services certifies that a public health

1 emergency declared under section 319 of the Public
2 Health Service Act has ended, the Secretary shall
3 submit to the Committee on Health, Education,
4 Labor, and Pensions and the Committee on Finance
5 of the Senate and the Committee on Energy and
6 Commerce and the Committee on Ways and Means
7 of the House of Representatives a report—

8 (A) describing the testing, hospitalization,
9 mortality rates, vaccination rates, and preferred
10 language of patients associated with the pan-
11 demic by race and ethnicity, rural and urban
12 areas (as defined in section 1886(d)(2)(D) of
13 the Social Security Act (42 U.S.C.
14 1395ww(d)(2)(D))), and congregate care set-
15 tings (including skilled nursing facilities, as-
16 sisted living facilities, prisons and jails, residen-
17 tial behavioral health care and psychiatric facili-
18 ties, and facilities providing services for aging
19 adults and people with disabilities) and noncon-
20 gregate care settings (as such terms are defined
21 by the Secretary); and

22 (B) proposing evidenced-based response
23 strategies to safeguard the health of these com-
24 munities in future pandemics.

1 **SEC. 1011. COMMISSION ON ENSURING DATA FOR HEALTH**
2 **EQUITY.**

3 (a) IN GENERAL.—Not later than 30 days after the
4 date of enactment of this Act, the Secretary of Health and
5 Human Services (referred to in this section as the “Sec-
6 retary”) shall establish a commission, to be known as the
7 “Commission on Ensuring Data for Health Equity” (re-
8 ferred to in this section as the “Commission”) to provide
9 clear and robust guidance to improve the collection, anal-
10 ysis, and use of demographic data in responding to future
11 public health emergencies.

12 (b) MEMBERSHIP AND CHAIRPERSON.—

13 (1) MEMBERSHIP.—The Commission shall be
14 composed of—

15 (A) the Assistant Secretary for Prepared-
16 ness and Response;

17 (B) the Director of the Centers for Disease
18 Control and Prevention;

19 (C) the Director of the National Institutes
20 of Health;

21 (D) the Commissioner of Food and Drugs;

22 (E) the Administrator of the Federal
23 Emergency Management Agency;

24 (F) the Director of the National Institute
25 on Minority Health and Health Disparities;

1 (G) the Director of the Indian Health
2 Service;

3 (H) the Administrator of the Centers for
4 Medicare & Medicaid Services;

5 (I) the Director of the Agency for
6 Healthcare Research and Quality;

7 (J) the Surgeon General;

8 (K) the Administrator of the Health Re-
9 sources and Services Administration;

10 (L) the Director of the Office of Minority
11 Health;

12 (M) the Director of the Office on Women's
13 Health;

14 (N) the Chairperson of the National Coun-
15 cil on Disability;

16 (O) at least 4 State, local, territorial, and
17 Tribal public health officials representing de-
18 partments of public health, or an Urban Indian
19 health representative, who shall represent juris-
20 dictions from different regions of the United
21 States with relatively high concentrations of
22 historically marginalized populations and rural
23 populations, to be appointed by the Secretary;

24 (P) the National Coordinator for Health
25 Information Technology;

1 (Q) at least 3 independent individuals with
 2 expertise on racially and ethnically diverse rep-
 3 resentation with knowledge or field experience
 4 with community-based participatory research on
 5 racial and ethnic disparities in public health, to
 6 be appointed by the Secretary; and

7 (R) at least 4 individuals with expertise on
 8 health equity and demographic data disparities
 9 with knowledge of, or field experience in, lan-
 10 guage, disability status, sex, sexual orientation,
 11 gender identity, or socioeconomic status.

12 (2) CHAIRPERSON.—The Assistant Secretary
 13 for Preparedness and Response shall serve as the
 14 Chairperson of the Commission.

15 (c) DUTIES.—The Commission shall—

16 (1) examine barriers to collecting, analyzing,
 17 and using demographic data in public health;

18 (2) determine how to best use such data to pro-
 19 mote health equity across the United States and re-
 20 duce racial, Tribal, and other demographic dispari-
 21 ties in health outcomes;

22 (3)(A) gather available data related to treat-
 23 ment of individuals with disabilities during the
 24 COVID–19 pandemic and other public health emer-
 25 gencies, including access to vaccinations, denial of

1 treatment for preexisting conditions, removal or de-
 2 nial of disability related equipment (including ven-
 3 tilators and continuous positive airway pressure
 4 (commonly referred to as “CPAP”) machines), and
 5 data on completion of do-not-resuscitate orders; and

6 (B) identify barriers to obtaining accurate and
 7 timely data related to treatment of such individuals;

8 (4) solicit input from public health officials,
 9 community-connected organizations, health care pro-
 10 viders, State and local agency officials, Tribal offi-
 11 cials, and other experts on barriers to, and best
 12 practices for, collecting demographic data; and

13 (5) recommend policy changes that the data in-
 14 dicates are necessary to reduce demographic dispari-
 15 ties in health outcomes.

16 (d) REPORT.—Not later than 1 year after the date
 17 of the enactment of this Act, the Commission shall submit
 18 to Congress, and publish on the website of the Department
 19 of Health and Human Services, a report containing—

20 (1) the findings of the Commission pursuant to
 21 subsection (c);

22 (2) to the extent possible, an analysis of—

23 (A) racial and other demographic dispari-
 24 ties in COVID–19 mortality, including an anal-
 25 ysis of comorbidities and case fatality rates;

1 (B) sex, sexual orientation, and gender
2 identity disparities in COVID–19 treatment and
3 mortality; and

4 (C) Federal Government policies that dis-
5 parately exacerbate the COVID–19 impact, and
6 recommendations to improve racial and other
7 demographic disparities in health outcomes;

8 (3) an analysis of COVID–19 treatment of indi-
9 viduals with disabilities, including equity of access to
10 treatment and equipment and intersections of dis-
11 ability status with other demographic factors, includ-
12 ing race;

13 (4) an analysis of what demographic data is
14 currently being collected, the accuracy of that data
15 and any gaps, how this data is currently being used
16 to inform efforts to combat COVID–19, and what
17 resources are needed to supplement existing public
18 health data collection; and

19 (5) the Commission’s recommendations with re-
20 spect to—

21 (A) how to enhance State, local, territorial,
22 and Tribal capacity to conduct public health re-
23 search on COVID–19 and in future public
24 health emergencies, with a focus on expanded
25 capacity to analyze data on disparities cor-

1 related with race, ethnicity, income, sex, sexual
2 orientation, gender identity, age, disability sta-
3 tus, specific geographic areas, and other rel-
4 evant demographic characteristics;

5 (B) how to collect, process, and disclose to
6 the public the data described in subparagraph
7 (A) in a way that maintains individual privacy
8 while helping direct the State, local, and Tribal
9 response to public health emergencies;

10 (C) how to improve demographic data col-
11 lection related to COVID–19 and other public
12 health emergencies in the short-term and long-
13 term, including how to continue to grow and
14 value the Tribal sovereignty of data and infor-
15 mation concerning urban and rural Tribal com-
16 munities;

17 (D) how to improve transparency and eq-
18 uity of treatment for individuals with disabil-
19 ities during the COVID–19 public health emer-
20 gency and future public health emergencies; and

21 (E) how to support State, local, and Tribal
22 capacity to eliminate barriers to vaccinations,
23 testing, and treatment during the COVID–19
24 public health emergency and future public
25 health emergencies.

1 (e) STAFF OF COMMISSION.—

2 (1) ADDITIONAL STAFF.—The Chairperson of
3 the Commission may appoint and fix the pay of ad-
4 ditional staff to the Commission as the Chairperson
5 considers appropriate.

6 (2) APPLICABILITY OF CERTAIN CIVIL SERVICE
7 LAWS.—The staff of the Commission may be ap-
8 pointed without regard to the provisions of title 5,
9 United States Code, governing appointments in the
10 competitive service, and may be paid without regard
11 to the provisions of chapter 51 and subchapter III
12 of chapter 53 of that title relating to classification
13 and General Schedule pay rates.

14 (3) DETAILEES.—Any Federal Government em-
15 ployee may be detailed to the Commission without
16 reimbursement from the Commission, and the
17 detailee shall retain the rights, status, and privileges
18 of his or her regular employment without interrup-
19 tion.

20 (f) COORDINATION WITH OTHER EFFORTS.—The
21 Secretary shall, in establishing the Commission under this
22 section, take such steps as may be necessary to ensure
23 that the work of the Commission does not overlap with,
24 or otherwise duplicate, other Federal Government efforts

1 with respect to ensuring health equity in data collection
2 in public health emergencies.

3 (g) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated such sums as may be
5 necessary to carry out this section.

6 **SEC. 1012. TASK FORCE ON PREVENTING BIAS IN AI AND**
7 **ALGORITHMS.**

8 (a) IN GENERAL.—Not later than 30 days after the
9 date of enactment of this Act, the Secretary of Health and
10 Human Services (referred to in this section as the “Sec-
11 retary”) shall establish a Task Force to be known as the
12 “Task Force on Preventing AI and Algorithmic Bias in
13 Health Care” (referred to in this section as the “Task
14 Force”) to provide clear and robust guidance on how to
15 ensure that the development and integration of artificial
16 intelligence and algorithmic technologies within the health
17 care service delivery process does not exacerbate health
18 disparities and inequities, expands access to health care
19 services, and improves health care delivery.

20 (b) MEMBERSHIP AND CHAIRPERSON.—

21 (1) MEMBERSHIP.—The Task Force shall be
22 composed of—

23 (A) the Chief Information Officer of the
24 Department of Health and Human Services;

1 (B) the Director of the Centers for Disease
2 Control and Prevention;

3 (C) the Director of the National Institutes
4 of Health;

5 (D) the Commissioner of Food and Drugs;

6 (E) the Administrator of the Federal
7 Emergency Management Agency;

8 (F) the Director of the National Institute
9 on Minority Health and Health Disparities;

10 (G) the Director of the Indian Health
11 Service;

12 (H) the Administrator of the Centers for
13 Medicare & Medicaid Services;

14 (I) the Director of the Agency for
15 Healthcare Research and Quality;

16 (J) the Surgeon General;

17 (K) the Administrator of the Health Re-
18 sources and Services Administration;

19 (L) the Director of the Office of Minority
20 Health;

21 (M) the Director of the Office on Women's
22 Health;

23 (N) the Chairperson of the National Coun-
24 cil on Disability;

1 (O) the National Coordinator for Health
2 Information Technology;

3 (P) at least 4 State, local, territorial, and
4 Tribal public health officials representing de-
5 partments of public health, or an Urban Indian
6 health representative, who shall represent juris-
7 dictions from different regions of the United
8 States with relatively high concentrations of
9 historically marginalized populations, to be ap-
10 pointed by the Secretary;

11 (Q) at least 3 independent individuals with
12 expertise on racially and ethnically diverse rep-
13 resentation with knowledge or field experience
14 with community-based participatory research on
15 racial and ethnic disparities in public health, to
16 be appointed by the Secretary; and

17 (R) at least 4 individuals with expertise on
18 health equity and demographic data disparities
19 with knowledge of, or field experience in, lan-
20 guage, disability status, sex, sexual orientation,
21 gender identity, or socioeconomic status.

22 (2) CHAIRPERSON.—The Chief Information Of-
23 ficer of the Department of Health and Human Serv-
24 ices (or the Chief Information Officer's designee)
25 shall serve as the Chairperson of the Task Force.

1 (c) DUTIES.—The Task Force shall—

2 (1) examine artificial intelligence and algo-
3 rithms in the health care service sector, including
4 the health care delivery process relative to the use
5 of autonomous human decision makers;

6 (2) identify the risks of health care system utili-
7 zation of artificial intelligence and algorithms in
8 terms of civil rights, civil liberties, and discrimina-
9 tory bias in health care access, quality, and out-
10 comes; and

11 (3) prepare and submit the report under sub-
12 section (d).

13 (d) REPORT.—Not later than 1 year after the date
14 of enactment of this Act, the Task Force shall—

15 (1) submit a written report of the findings of
16 the examination under subsection (c)(1) and rec-
17 ommendations to Congress with respect to imple-
18 mentation of artificial intelligence and algorithms in
19 health care delivery and mitigation of the risks asso-
20 ciated with that implementation; and

21 (2) publish such report on the website of the
22 Department of Health and Human Services.

23 (e) PUBLIC COMMENT.—Not later than 60 days after
24 the date of the enactment of this Act, the Task Force shall
25 publish in the Federal Register a notice providing for a

1 public comment period on the duties and activities of the
 2 Task Force of not less than 90 days, beginning on the
 3 date of that publication.

4 (f) STAFF OF COMMISSION.—

5 (1) ADDITIONAL STAFF.—The Chairperson of
 6 the Task Force may appoint and fix the pay of addi-
 7 tional staff to the Task Force as the Chairperson
 8 considers appropriate.

9 (2) APPLICABILITY OF CERTAIN CIVIL SERVICE
 10 LAWS.—The staff of the Task Force may be ap-
 11 pointed without regard to the provisions of title 5,
 12 United States Code, governing appointments in the
 13 competitive service, and may be paid without regard
 14 to the provisions of chapter 51 and subchapter III
 15 of chapter 53 of that title relating to classification
 16 and General Schedule pay rates.

17 (3) DETAILEES.—Any Federal Government em-
 18 ployee may be detailed to the Task Force without re-
 19 imbursement from the Task Force, and the detailee
 20 shall retain the rights, status, and privileges of his
 21 or her regular employment without interruption.

22 **SEC. 1013. REPORT ON HEALTH OF MIDDLE EASTERN AND**
 23 **NORTH AFRICAN POPULATIONS.**

24 (a) STUDY REQUIRED.—The Secretary of Health and
 25 Human Services (referred to in this section as the “Sec-

1 retary”) shall conduct or support a comprehensive study
 2 regarding the unique health patterns and outcomes of
 3 MENA populations.

4 (b) REQUIREMENTS FOR STUDY.—The comprehen-
 5 sive study under subsection (a) shall include an enumera-
 6 tion of MENA populations across the United States,
 7 disaggregated by subpopulation, and with respect to each
 8 such population and subpopulation—

9 (1) the rates of—

10 (A) health risk factors, including—

11 (i) behaviors, such as tobacco use, ex-
 12 cessive alcohol consumption, physical inac-
 13 tivity, and unhealthy diet;

14 (ii) physiological factors, such as obe-
 15 sity, diabetes, high blood pressure, high
 16 blood sugar, and high cholesterol;

17 (iii) environmental factors, such as ex-
 18 posure to toxic chemicals, air and water
 19 pollution, and unsafe working conditions,
 20 including prevalence of work-related inju-
 21 ries;

22 (iv) genetic factors, such as family
 23 history of chronic diseases, presence of
 24 specific gene mutations, and racial and
 25 ethnic predisposition to certain conditions;

(v) demographic characteristics, such as age, geographic location, and English language proficiency; and

(vi) social determinants of health, such as household income, health insurance coverage, socioeconomic status, education level, housing instability, educational and employment opportunities, and access to culturally and linguistically appropriate service providers;

(B) prevalence of chronic disease or illness, including—

(i) cancers, such as breast, lung, cervical, prostate, colorectal, liver, stomach, and oral cancer;

(ii) cardiovascular conditions, such as heart disease, atrial fibrillation, and stroke;

(iii) respiratory conditions, such as asthma, chronic obstructive pulmonary disease, and lung disease;

(iv) musculoskeletal conditions, such as osteoporosis and carpal tunnel syndrome;

(v) neurological conditions, such as Parkinson's disease, Alzheimer's and other

1 related dementias, epilepsy, and cerebral
2 palsy;

3 (vi) infectious diseases, such as HIV/
4 AIDS, hepatitis B and C, and tuberculosis;
5 and

6 (vii) autoimmune diseases, such as
7 lupus, multiple sclerosis, ulcerative colitis,
8 and rheumatoid arthritis;

9 (C) prevalence of disability and disorder,
10 including—

11 (i) vision impairments, such as blind-
12 ness and low vision;

13 (ii) hearing conditions, such as deaf-
14 ness and varying degrees of hearing loss;

15 (iii) physical impairments, such as
16 musculoskeletal conditions, amputation,
17 paralysis, repetitive strain injuries, and
18 other conditions that affect movement or
19 require assistive devices;

20 (iv) intellectual or developmental con-
21 ditions, such as Down syndrome, Prader-
22 Willi syndrome, Angelman syndrome, au-
23 tism, and attention-deficit/hyperactive dis-
24 order (ADHD), as well as other conditions

1 that affect cognitive abilities, learning, and
2 adaptive behaviors;

3 (v) mental or behavioral conditions,
4 such as depression, anxiety, insomnia,
5 sleep apnea, bipolar disorder, schizo-
6 phrenia, and traumatic brain injury;

7 (vi) substance use disorders, such as
8 disorders in use of alcohol, opioids, stimu-
9 lants, and cannabis, and risk factors stem-
10 ming from such disorders, such as liver
11 damage and gastrointestinal issues;

12 (vii) genetic or blood disorders, such
13 as sickle cell anemia, G6PD deficiency, hy-
14 pertension, and thalassemia; and

15 (viii) endocrine disorders, such as dia-
16 betes, polycystic ovary syndrome (PCOS),
17 and hypothyroidism;

18 (D) maternal and reproductive health out-
19 comes, including maternal morbidity and mor-
20 tality, infertility, and postpartum depression;

21 (E) nutritional health outcomes, including
22 malnutrition and vitamin D and iron defi-
23 ciencies, among other vitamin deficiencies;

24 (F) child and adolescent health outcomes,
25 such as pediatric developmental delays, child-

1 hood obesity, and early-onset chronic condi-
 2 tions;

3 (G) dental and oral health outcomes, in-
 4 cluding tooth loss, gum disease, and tooth
 5 decay;

6 (H) domestic violence, dating violence, sex-
 7 ual assault, sexual harassment, and stalking;
 8 and

9 (I) morbidity and mortality, including the
 10 rates of morbidity and mortality associated with
 11 the rates referenced in subparagraphs (A)
 12 through (H);

13 (2) analysis of—

14 (A) the factors and conditions that con-
 15 tribute most to—

16 (i) the rates described in paragraph
 17 (1); and

18 (ii) the rates by which MENA sub-
 19 populations reported the outcomes ref-
 20 erenced in subparagraphs (B) and (C) as
 21 a disease, illness, disorder, or disability;

22 (B) the leading causes of morbidity and
 23 mortality and pregnancy-associated morbidity
 24 and mortality;

1 (C) the extent to which access to health
2 care facilities contributes to the associated out-
3 comes of care, including the rates described in
4 paragraph (1); and

5 (D) the disparities between MENA sub-
6 populations and between the aggregate MENA
7 population and other racial and ethnic popu-
8 lations in the rates described in paragraph (1);
9 (3) analysis, enumeration, or quantification of
10 any other health or health-related parameters the
11 Secretary determines necessary; and

12 (4) analysis of the extent to which any or all of
13 the design, implementation, and evaluation of Fed-
14 eral health programs contribute to the health fac-
15 tors, outcomes, and conditions described in para-
16 graphs (1) through (3).

17 (c) CONSULTATION.—The Secretary shall—

18 (1) carry out this section in consultation, as ap-
19 propriate, with the Director of the Census Bureau,
20 the Director of the Centers for Disease Control and
21 Prevention, the Director of the National Institutes
22 of Health, the Assistant Secretary for Mental Health
23 and Substance Use, and other stakeholders (includ-
24 ing community-based organizations); and

1 (2) determine through such consultation the
2 subpopulations to be used for purposes of
3 disaggregation of data pursuant to subsection (b).

4 (d) ONLINE PORTAL.—Upon conclusion of the com-
5 prehensive study under this section, the Secretary shall
6 establish a public online portal to catalogue the results of
7 the study, its underlying data, and information in the re-
8 port submitted pursuant to subsection (e)(2).

9 (e) REPORTING.—

10 (1) INTERIM REPORT.—Not later than 2 years
11 after the date of enactment of this Act, the Sec-
12 retary shall submit to Congress a report outlining
13 the challenges associated with, and progress toward
14 implementing, health data collection for MENA pop-
15 ulations as a distinct category and the plan for com-
16 pleting a comprehensive study regarding the unique
17 health patterns and outcomes of MENA populations.

18 (2) FINAL REPORT.—Not later than 30 days
19 after the conclusion of the comprehensive study
20 under this section, and not later than 2 years after
21 the date of submission of the interim report under
22 paragraph (1), the Secretary shall submit to Con-
23 gress a report describing—

24 (A) the results of the study conducted
25 under this section; and

1 (B) the rulemakings and other actions the
2 agencies described in subsection (c)(1) can un-
3 dertake to more equitably include MENA indi-
4 viduals in their programs, including whether
5 and to what extent additional resources are
6 needed to increase rates of response among
7 MENA populations to Federal health surveys.

8 (f) PRIVACY.—

9 (1) IN GENERAL.—In carrying out the com-
10 prehensive study under this section, the Secretary
11 shall implement robust privacy protections to safe-
12 guard the personal data of the individuals involved.

13 (2) MINIMUM PROTECTIONS.—The privacy pro-
14 tections referred to in paragraph (1) include the fol-
15 lowing:

16 (A) Personally identifiable information,
17 such as names or addresses, shall not be col-
18 lected when unnecessary for the purposes of the
19 study.

20 (B) Any personally identifiable information
21 that is collected shall be securely destroyed
22 upon completion of the intended use of such in-
23 formation.

24 (C) All privacy protections and data han-
25 dling procedures shall be clearly communicated

1 to any individuals who may be subjects of the
 2 study, including through informed consent if
 3 applicable.

4 (3) PROHIBITION ON INCLUSION OF PII IN ON-
 5 LINE PORTAL OR REPORTS.—The Secretary shall not
 6 include any personally identifiable information on
 7 the online portal under subsection (d) or in the re-
 8 ports under subsection (e).

9 (g) VIOLATIONS.—Any person who, by virtue of an
 10 official position or affiliation with the Secretary—

11 (1) has possession of, or access to, any record
 12 containing individually identifiable information the
 13 disclosure of which is prohibited by or under this
 14 section; and

15 (2) knowingly discloses such a record to any
 16 person or agency not entitled to receive the record,
 17 shall be guilty of a misdemeanor and fined not more than
 18 \$25,000.

19 (h) DEFINITIONS.—In this section:

20 (1) MENA.—The term “MENA”, with respect
 21 to individuals or populations, includes individuals or
 22 populations who identify with or belong to one or
 23 more nationalities or ethnic groups originating in a
 24 country (or portion thereof) in the Middle Eastern
 25 and North African region (such as Lebanese, Ira-

1 nians, Egyptians, Moroccans, Yemenis, Chaldeans,
 2 Imazighen, Kurds, Palestinians, and Yazidis).

3 (2) PERSONALLY IDENTIFIABLE INFORMATION
 4 DEFINED.—The term “personally identifiable infor-
 5 mation” means individually identifying information
 6 for or about an individual, including information
 7 likely to disclose the location or specific identity of
 8 a participating individual, regardless of whether the
 9 information is encoded, encrypted, hashed, or other-
 10 wise protected, including—

11 (A) a first and last name;

12 (B) a home or other physical address;

13 (C) contact information (including a post-
 14 al, email or internet protocol address, or tele-
 15 phone or facsimile number);

16 (D) a social security number, driver license
 17 number, passport number, or student identifica-
 18 tion number; and

19 (E) any other information, including date
 20 of birth, racial or ethnic background, or reli-
 21 gious affiliation, that would serve to identify
 22 any individual.

23 (i) AUTHORIZATION OF APPROPRIATIONS.—There
 24 are authorized to be appropriated such sums as may be
 25 necessary to carry out this section.

1 **SEC. 1014. INCLUSION OF PUERTO RICO IN NATIONAL SUR-**
 2 **VEY ON DRUG USE AND HEALTH.**

3 Section 505(d) of the Public Health Service Act (42
 4 U.S.C. 290aa-4(d)) is amended by adding at the end the
 5 following:

6 “(3) INCLUSION OF PUERTO RICO.—Beginning
 7 with fiscal year 2027, annual surveys carried out
 8 under this section shall include Puerto Rico.”.

9 **TITLE II—CULTURALLY AND LIN-**
 10 **GUISTICALLY APPROPRIATE**
 11 **HEALTH AND HEALTH CARE**

12 **SEC. 2001. DEFINITIONS.**

13 In this title, the definitions in section 3400 of the
 14 Public Health Service Act, as added by section 2004, shall
 15 apply.

16 **SEC. 2002. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
 17 **UALS WITH LIMITED ENGLISH PROFICIENCY.**

18 (a) PURPOSE.—It is the purpose of this section—

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

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

1 and meaningful access to those services consistent
2 with, and without substantially burdening, the fun-
3 damental mission of the agency;

4 (3) to require each Federal agency to translate
5 any English language written material prepared for
6 the general public into the top 15 non-English lan-
7 guages in the United States (according to the most
8 recent data from the American Community Survey
9 or its replacement) within established timelines de-
10 scribed in subsection (b)(2)(C)(v);

11 (4) to require each Federal agency to ensure
12 that recipients of Federal financial assistance pro-
13 vide meaningful access to applicants and bene-
14 ficiaries who are individuals with limited English
15 proficiency and culturally competent services to all
16 individuals;

17 (5) to ensure that recipients of Federal finan-
18 cial assistance take reasonable steps, consistent with
19 the guidelines set forth in the “Guidance to Federal
20 Financial Assistance Recipients Regarding Title VI
21 Prohibition Against National Origin Discrimination
22 Affecting Limited English Proficient Persons” (67
23 Fed. Reg. 41455 (June 18, 2002)), to ensure cul-
24 turally and linguistically appropriate access to their

1 programs and activities by individuals with limited
 2 English proficiency; and

3 (6) to ensure compliance with title VI of the
 4 Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
 5 and section 1557 of the Patient Protection and Af-
 6 fordable Care Act (42 U.S.C. 18116) (prohibiting
 7 health care providers and organizations from dis-
 8 criminating in the provision of services).

9 (b) FEDERALLY CONDUCTED PROGRAMS AND AC-
 10 TIVITIES.—

11 (1) IN GENERAL.—Not later than 120 days
 12 after the date of enactment of this Act, each Federal
 13 agency providing financial assistance to, or admin-
 14 istering, a health program or activity described in
 15 section 2003(a) shall prepare a plan or update a
 16 plan to improve culturally and linguistically appro-
 17 priate access to such program or activity with re-
 18 spect to individuals with limited English proficiency.
 19 Not later than 1 year after the date of enactment
 20 of this Act, each such Federal agency shall ensure
 21 that such plan is fully implemented.

22 (2) PLAN REQUIREMENT.—Each plan under
 23 paragraph (1) shall include—

24 (A) the steps the agency will take to en-
 25 sure that individuals with limited English pro-

1 ficiency have access to each health program or
2 activity supported or administered by the agen-
3 cy;

4 (B) the policies and procedures for identi-
5 fying, assessing, and meeting the culturally and
6 linguistically appropriate language needs of its
7 beneficiaries, including those who are individ-
8 uals with limited English proficiency, served by
9 such a program or activity;

10 (C) the steps the agency will take for such
11 program or activity to be culturally and linguis-
12 tically appropriate by—

13 (i) providing a range of language as-
14 sistance options;

15 (ii) giving notice to individuals with
16 limited English proficiency of the right to
17 competent language services;

18 (iii) training staff (at least annually);

19 (iv) monitoring and assessing the
20 quality of the language services (at least
21 annually); and

22 (v) translating any English language
23 written material prepared for the general
24 public into the top 15 non-English lan-
25 guages in the United States (according to

1 the most recent data from the American
2 Community Survey or its replacement)
3 within established timelines that ensure
4 that high-quality, culturally competent
5 translated material is provided promptly
6 within not more than 15 calendar days in
7 general and within not more than 7 cal-
8 endar days in the case of any national
9 emergency or State disaster declaration;

10 (D) the steps the agency will take for such
11 program or activity to provide reasonable ac-
12 commodations necessary for all individuals, in-
13 cluding individuals with limited English pro-
14 ficiency and other groups, to understand com-
15 munications from the agency;

16 (E) the steps the agency will take to en-
17 sure that applications, forms, and other signifi-
18 cant documents for such program or activity
19 are competently translated into the primary
20 language of a client that is an individual with
21 limited English proficiency where such mate-
22 rials are needed to improve access of such client
23 to such program or activity;

24 (F) the resources the agency will provide
25 to improve cultural and linguistic appropriate-

ness to assist recipients of Federal funds to improve access to health care-related programs and activities for individuals with limited English proficiency;

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

(H) the resources the agency will provide to ensure that family, particularly minor children, and friends are not used to provide interpretation services, except as permitted under section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116); and

(I) the steps the agency will take and resources the agency will provide to ensure that individuals know their rights, including the ability to and procedures to file a complaint.

(3) SUBMISSION OF PLAN TO DOJ.—Each agency that is required to prepare a plan under paragraph (1) shall—

(A) consult with populations who are directly impacted by policies in the plan and their

1 representatives in the development of the plan;
2 and

3 (B) when the plan is finalized, send a copy
4 of the plan, and any subsequent material up-
5 dates to such plan, to the Attorney General,
6 who shall serve as the central repository of all
7 such plans.

8 **SEC. 2003. ENSURING STANDARDS FOR CULTURALLY AND**
9 **LINGUISTICALLY APPROPRIATE SERVICES IN**
10 **HEALTH CARE.**

11 (a) **APPLICABILITY.**—This section shall apply to any
12 health program or activity—

13 (1) of which any part is receiving Federal fi-
14 nancial assistance, including credits, subsidies, or
15 contracts of insurance; or

16 (2) that is carried out (including indirectly
17 through contracts, subcontracts, or other support)
18 by an executive agency or any entity established
19 under title I of the Patient Protection and Afford-
20 able Care Act (42 U.S.C. 18001 et seq.) (or amend-
21 ments made thereby).

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

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

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

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

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

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

1 level most appropriate for the individuals belonging
2 to the relevant language group—

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

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

8 (C) signage; and

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

11 (5) shall develop and implement clear goals,
12 policies, operational plans, and management, ac-
13 countability, and oversight mechanisms in collabora-
14 tion with the relevant communities served to provide
15 culturally and linguistically appropriate services and
16 infuse them throughout the planning and operations
17 of the program or activity;

18 (6) shall conduct initial and ongoing, at least
19 annually, organizational assessments of culturally
20 and linguistically appropriate services-related activi-
21 ties and integrate valid linguistic, competence-related
22 National Standards for Culturally and Linguistically
23 Appropriate Services (CLAS) measures into the in-
24 ternal audits, performance improvement programs,
25 patient satisfaction assessments, continuous quality

1 improvement activities, and outcomes-based evalua-
2 tions of the program or activity and develop ways to
3 standardize assessments;

4 (7) shall ensure that, consistent with the pri-
5 vacy protections provided for under the regulations
6 promulgated under section 264(c) of the Health In-
7 surance Portability and Accountability Act of 1996
8 (42 U.S.C. 1320d–2 note; Public Law 104–191),
9 data on an individual required to be collected pursu-
10 ant to section 3101 of the Public Health Service Act
11 (42 U.S.C. 300kk), including the individual’s alter-
12 native format preferences and policy modification
13 needs, are—

14 (A) collected in health records;

15 (B) integrated into the management infor-
16 mation systems of the program or activity;

17 (C) reported in such a way as to be inter-
18 operable with health information systems at the
19 Federal and State levels; and

20 (D) periodically updated;

21 (8) shall maintain a current demographic, cul-
22 tural, and epidemiological profile of the community,
23 conduct regular assessments of community health
24 assets and needs, and use the results of such assess-
25 ments to accurately plan for and implement services

1 that respond to the cultural and linguistic character-
2 istics of the service area of the program or activity;

3 (9) shall develop participatory, collaborative
4 partnerships with community-based organizations
5 and utilize a variety of formal and informal mecha-
6 nisms to facilitate community and patient involve-
7 ment in designing, implementing, and evaluating
8 policies and practices to ensure culturally and lin-
9 guistically appropriate service-related activities;

10 (10) shall ensure that conflict and grievance
11 resolution processes are culturally and linguistically
12 appropriate and capable of identifying, preventing,
13 and resolving cross-cultural conflicts or complaints
14 by patients;

15 (11) shall annually—

16 (A) make available to the public—

17 (i) information about the progress and
18 successful innovations of the program or
19 activity in implementing the standards
20 under this section; and

21 (ii) translated materials of such infor-
22 mation that is culturally and linguistically
23 appropriate to the communities served
24 under this section; and

1 (B) provide public notice in such commu-
2 nities about the availability of such information;
3 and

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

10 (c) COMMENTS ACCEPTED THROUGH NOTICE AND
11 COMMENT RULEMAKING.—An executive agency carrying
12 out a program or activity described in subsection (a)—

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

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

19 (3) shall ensure that any such comments that
20 are not submitted in English are considered, during
21 the agency's review of such comments, equally as
22 such comments that are submitted in English.

1 **SEC. 2004. CULTURALLY AND LINGUISTICALLY APPRO-**
 2 **PRIATE HEALTH CARE IN THE PUBLIC**
 3 **HEALTH SERVICE ACT.**

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

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

9 **“SEC. 3400. DEFINITIONS.**

10 “(a) IN GENERAL.—In this title:

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

14 “(2) COMMUNITY HEALTH WORKER.—The term
 15 ‘community health worker’ means a frontline health
 16 worker who is a trusted member of the community
 17 in which the worker serves or who has an unusually
 18 close understanding of the community served that
 19 enables the worker to build trusted relationships,
 20 serve as a liaison between health and social services
 21 and the community, facilitate access to services, and
 22 improve the quality and cultural competence of serv-
 23 ice delivery.

24 “(3) CULTURAL.—The term ‘cultural’ means
 25 relating to integrated patterns of human behavior
 26 that include the language, thoughts, communica-

1 tions, actions, customs, beliefs, values, age, and in-
 2 stitutions of racial, ethnic, religious, or social
 3 groups, including lesbian, gay, bisexual, transgender,
 4 queer, and questioning individuals, and individuals
 5 with physical and mental disabilities.

6 “(4) CULTURALLY AND LINGUISTICALLY AP-
 7 PROPRIATE.—The term ‘culturally and linguistically
 8 appropriate’ means being respectful of and respon-
 9 sive to the cultural and linguistic needs of all indi-
 10 viduals.

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

23 “(6) GRIEVANCE RESOLUTION PROCESS.—The
 24 term ‘grievance resolution process’ means all aspects

1 of dispute resolution including filing complaints,
2 grievance and appeal procedures, and court action.

3 “(7) HEALTH CARE GROUP.—The term ‘health
4 care group’ means a group of physicians organized,
5 at least in part, for the purposes of providing physi-
6 cian services under the Medicaid program under title
7 XIX of the Social Security Act, the State Children’s
8 Health Insurance Program under title XXI of such
9 Act, or the Medicare program under title XVIII of
10 such Act, including a provider of services under part
11 B of such title XVIII, and may include a hospital,
12 a hospice provider, a palliative care provider, and
13 any other individual or entity furnishing services
14 covered under any such program that is affiliated
15 with the health care group.

16 “(8) HEALTH CARE.—The term ‘health care’
17 includes all health care needed throughout the life
18 cycle and the end of life.

19 “(9) HEALTH CARE SERVICES.—The term
20 ‘health care services’ means services that address
21 physical and mental health conditions, as well as
22 conditions impacted by social determinants of health,
23 in all care settings throughout the life cycle and the
24 end of life.

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

5 “(11) HEALTH EDUCATOR.—The term ‘health
 6 educator’ includes a professional with a bacca-
 7 laureate degree who is responsible for designing, im-
 8 plementing, and evaluating individual and population
 9 health promotion, health education (including edu-
 10 cation on end-of-life care options), end-of-life care,
 11 or chronic disease prevention programs.

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

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

21 “(14) INDIVIDUAL WITH LIMITED ENGLISH
 22 PROFICIENCY.—The term ‘individual with limited
 23 English proficiency’ means an individual who self-
 24 identifies on the Census as speaking English less
 25 than ‘very well’.

1 “(15) INTEGRATED HEALTH CARE DELIVERY
2 SYSTEM.—The term ‘integrated health care delivery
3 system’ means an interdisciplinary system that
4 brings together providers from the primary health,
5 mental health, substance use disorder, hospice and
6 palliative care, and related disciplines to improve the
7 health outcomes of an individual and the community.
8 Such providers may include hospitals, health, mental
9 health, or substance use prevention and treatment
10 clinics and providers, home health agencies, home-
11 and community-based services providers, congregate
12 settings (including any skilled nursing facilities, as-
13 sisted living facilities, prisons and jails, residential
14 behavioral health care and psychiatric facilities, shel-
15 ters, and facilities providing services for older adults
16 and individuals with disabilities), ambulatory sur-
17 gery centers, rehabilitation centers, employed, inde-
18 pendent, or contracted physicians, and oral health
19 care providers.

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

1 “(17) LANGUAGE ACCESS.—The term ‘language
2 access’ means the provision of language services to
3 an individual with limited English proficiency or an
4 individual with communication disabilities designed
5 to enhance that individual’s access to, understanding
6 of, or benefit from health care services or health
7 care-related services.

8 “(18) LANGUAGE ASSISTANCE SERVICES.—The
9 term ‘language assistance services’ includes—

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

17 “(B) written translation, performed by a
18 qualified translator, of written content in paper
19 or electronic form into languages other than
20 English; and

21 “(C) taglines.

22 “(19) MINORITY POPULATIONS.—The term ‘mi-
23 nority populations’ means individuals of racial and
24 ethnic minority groups, individuals of sexual and

1 gender minority groups, and individuals with a dis-
2 ability.

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

11 “(21) QUALIFIED INDIVIDUAL WITH A DIS-
12 ABILITY.—The term ‘qualified individual with a dis-
13 ability’ means, with respect to a health program or
14 activity, an individual with a disability who, with or
15 without reasonable modifications to policies, prac-
16 tices, or procedures, the removal of architectural,
17 communication, or transportation barriers, or the
18 provision of auxiliary aids and services, meets the es-
19 sential eligibility requirements for the receipt of aids,
20 benefits, or services offered or provided by the health
21 program or activity.

22 “(22) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH A DISABILITY.—The term ‘qualified
23 interpreter for an individual with a disability’, with
24 respect to an individual with a disability—
25

1 “(A) means an interpreter for such indi-
 2 vidual who by means of a remote interpreting
 3 service or an onsite appearance—

4 “(i) adheres to generally accepted in-
 5 terpreter ethics principles, including client
 6 confidentiality; and

7 “(ii) is able to interpret effectively, ac-
 8 curately, and impartially, both receptively
 9 and expressively, using any necessary spe-
 10 cialized vocabulary, terminology, and phra-
 11 seology; and

12 “(B) may include—

13 “(i) sign language interpreters;

14 “(ii) oral transliterators, which are in-
 15 dividuals who represent or spell in the
 16 characters of another alphabet; and

17 “(iii) cued language transliterators,
 18 which are individuals who represent or
 19 spell by using a small number of
 20 handshapes.

21 “(23) QUALIFIED INTERPRETER FOR AN INDI-
 22 VIDUAL WITH LIMITED ENGLISH PROFICIENCY.—

23 The term ‘qualified interpreter for an individual with
 24 limited English proficiency’ means an interpreter

1 who by means of a remote interpreting service or an
 2 onsite appearance—

3 “(A) adheres to generally accepted inter-
 4 preter ethics principles, including client con-
 5 fidentiality;

6 “(B) has demonstrated proficiency in
 7 speaking and understanding both spoken
 8 English and one or more other spoken lan-
 9 guages; and

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

15 “(24) QUALIFIED TRANSLATOR.—The term
 16 ‘qualified translator’ means a translator who—

17 “(A) adheres to generally accepted trans-
 18 lator ethics principles, including client confiden-
 19 tiality;

20 “(B) has demonstrated proficiency in writ-
 21 ing and understanding both written English
 22 and one or more other written non-English lan-
 23 guages; and

24 “(C) is able to translate effectively, accu-
 25 rately, and impartially to and from such lan-

1 guages and English, using any necessary spe-
 2 cialized vocabulary, terminology, and phrase-
 3 ology.

4 “(25) RACIAL AND ETHNIC MINORITY GROUP.—
 5 The term ‘racial and ethnic minority group’ has the
 6 meaning given such term in section 1707(g).

7 “(26) SECRETARY.—The term ‘Secretary’
 8 means the Secretary of Health and Human Services,
 9 acting through the Director of the Agency for
 10 Healthcare Research and Quality.

11 “(27) SEXUAL AND GENDER MINORITY
 12 GROUP.—The term ‘sexual and gender minority
 13 group’ includes lesbian, gay, bisexual, and
 14 transgender populations, as well as those whose sex-
 15 ual orientation, gender identity and expression, or
 16 reproductive development varies from traditional, so-
 17 cietal, cultural, or physiological norms.

18 “(28) SIGHT TRANSLATION.—The term ‘sight
 19 translation’ means the transmission of a written
 20 message in one language into a spoken or signed
 21 message in another language, or an alternative for-
 22 mat in English or another language.

23 “(29) STATE.—Notwithstanding section 2, the
 24 term ‘State’ means each of the several States, the
 25 District of Columbia, the Commonwealth of Puerto

1 Rico, the United States Virgin Islands, Guam,
2 American Samoa, and the Commonwealth of the
3 Northern Mariana Islands.

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

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

20 “(32) UNDERSERVED COMMUNITIES.—The
21 term ‘underserved communities’ means populations
22 sharing particular characteristics, or geographic
23 communities, who have been systematically denied a
24 full opportunity to participate in aspects of eco-
25 nomic, social, and civic life, such as—

“(A) Black, Latino, Indigenous, and Native American persons, Asian Americans, Native Hawaiians and Pacific Islanders, Middle Easterners and North Africans, and other persons of color;

“(B) members of religious minorities;

“(C) lesbian, gay, bisexual, transgender, and queer persons;

“(D) individuals with a disability;

“(E) persons who live in rural areas;

“(F) older adults; and

“(G) persons otherwise adversely affected by persistent poverty or inequality.

“(33) VIDEO REMOTE INTERPRETING SERVICES.—The term ‘video remote interpreting services’ means the provision, in health care services or health care-related services, through a qualified interpreter for an individual with limited English proficiency, of video remote interpreting services that are—

“(A) in real-time, full-motion video, and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and

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

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

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

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

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

7 “(a) ESTABLISHMENT.—The Secretary shall estab-
 8 lish and support a center to be known as the ‘Robert T.
 9 Matsui Center for Culturally and Linguistically Appro-
 10 priate Health Care’ (referred to in this section as the
 11 ‘Center’) to carry out each of the following activities:

12 “(1) INTERPRETATION SERVICES.—

13 “(A) IN GENERAL.—The Center shall pro-
 14 vide resources via the internet to identify and
 15 link health care providers to competent and
 16 qualified interpreter and translation services.

17 “(B) TRAINING.—For purposes of pro-
 18 viding the services described in subparagraph
 19 (A), the Center shall adopt a language access
 20 plan that includes training requirements for
 21 Center staff to provide such services.

22 “(2) TRANSLATION OF WRITTEN MATERIAL.—

23 “(A) VITAL DOCUMENTS.—The Center
 24 shall provide, directly or through contract, to
 25 providers of health care services and health

1 care-related services, at no cost to such pro-
2 viders and in a timely and reasonable manner,
3 vital documents—

4 “(i) which may be submitted by an
5 entity described in subparagraph (C) for
6 translation into non-English languages, or
7 alternative formats, at a fifth-grade read-
8 ing level; and

9 “(ii) from competent translation serv-
10 ices, the quality of which shall be mon-
11 itored and reported publicly.

12 “(B) FORMS.—For each form developed or
13 revised by the Secretary that will be used by in-
14 dividuals with limited English proficiency in
15 health care or health care-related settings, the
16 Center shall, not later than 45 calendar days of
17 the Secretary receiving final approval of the
18 form from the Office of Management and
19 Budget—

20 “(i) translate the form, at a min-
21 imum, into the top 15 non-English lan-
22 guages in the United States according to
23 the most recent data from the American
24 Community Survey or its replacement; and

1 “(ii) post all translated forms on the
2 Center’s website.

3 “(C) ENTITIES.—

4 “(i) IN GENERAL.—An entity de-
5 scribed in this subparagraph is—

6 “(I) an entity that operates a
7 health program or activity, any part
8 of which receives Federal financial as-
9 sistance;

10 “(II) an entity established under
11 title I of the Patient Protection and
12 Affordable Care Act that administers
13 a health program or activity; or

14 “(III) the Department of Health
15 and Human Services.

16 “(ii) HEALTH PROGRAM OR ACTIV-
17 ITY.—For purposes of clause (i), the term
18 ‘health program or activity’ has the mean-
19 ing given such term in section 92.4 of title
20 45, Code of Federal Regulations, as in ef-
21 fect on July 5, 2024.

22 “(3) TOLL-FREE CUSTOMER SERVICE TELE-
23 PHONE NUMBER.—The Center shall provide,
24 through a toll-free number, a customer service line
25 for individuals with limited English proficiency that

1 is linked to the toll-free telephone number 1–800–
2 MEDICARE and a toll-free telephone hotline pro-
3 vided for pursuant to section 1311(d)(4)(B) of the
4 Patient Protection and Affordable Care Act by an
5 Exchange established under title I of such Act—

6 “(A) to obtain information about federally
7 conducted or funded health programs, including
8 the Medicare program under title XVIII of the
9 Social Security Act, the Medicaid program
10 under title XIX of such Act, and the State Chil-
11 dren’s Health Insurance Program under title
12 XXI of such Act, and coverage available
13 through an Exchange established under title I
14 of the Patient Protection and Affordable Care
15 Act, and other sources of free or reduced care
16 including federally qualified health centers, enti-
17 ties receiving assistance under title X, and pub-
18 lic health departments;

19 “(B) to obtain assistance with applying for
20 or accessing these programs and understanding
21 Federal notices written in English; and

22 “(C) to learn how to access language serv-
23 ices.

24 “(4) HEALTH INFORMATION CLEARING-
25 HOUSE.—

1 “(A) IN GENERAL.—The Center shall de-
2 velop and maintain, and make available on the
3 internet and in print, an information clearing-
4 house that includes the information described in
5 subparagraphs (B) through (G)—

6 “(i) to facilitate the provision of lan-
7 guage services by providers of health care
8 services and health care-related services to
9 reduce medical errors;

10 “(ii) to improve health outcomes, to
11 improve cultural competence, and to reduce
12 health care costs caused by
13 miscommunication with individuals with
14 limited English proficiency; and

15 “(iii) to reduce or eliminate the dupli-
16 cation of efforts to translate materials.

17 “(B) DOCUMENT TEMPLATES.—The Cen-
18 ter shall collect and evaluate for accuracy, de-
19 velop, and make available templates for stand-
20 ard documents that are necessary for patients
21 and consumers to access and make educated de-
22 cisions about their health care, including tem-
23 plates for each of the following:

24 “(i) Administrative and legal docu-
25 ments, including—

1 “(I) intake forms;

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

10 “(III) forms informing patients
11 of the compliance and consent re-
12 quirements pursuant to the regula-
13 tions under section 264(c) of the
14 Health Insurance Portability and Ac-
15 countability Act of 1996; and

16 “(IV) documents concerning in-
17 formed consent, advanced directives,
18 and waivers of rights.

19 “(ii) Clinical information, such as how
20 to take medications, how to prevent trans-
21 mission of a contagious disease, and other
22 prevention and treatment instructions.

23 “(iii) Public health, patient education,
24 and outreach materials, such as immuniza-

tion notices, health warnings, or screening notices.

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

“(C) STRUCTURE OF FORMS.—In operating the clearinghouse, the Center shall—

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

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

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

“(iv) facilitate access to such documents;

“(v) provide technical assistance with respect to the access and use of such information; and

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

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

10 “(E) CULTURALLY AND LINGUISTICALLY
11 APPROPRIATE MATERIALS.—The Center shall
12 provide, at no cost, to all health care providers
13 and all providers of health care-related services,
14 information relating to culturally and linguis-
15 tically appropriate health care for minority pop-
16 ulations residing in the United States, includ-
17 ing—

18 “(i) tenets of culturally and linguis-
19 tically appropriate care;

20 “(ii) culturally and linguistically ap-
21 propriate self-assessment tools;

22 “(iii) culturally and linguistically ap-
23 propriate training tools;

24 “(iv) strategic plans to increase cul-
25 tural and linguistic appropriateness in dif-

1 ferent types of providers of health care
2 services and health care-related services,
3 including regional collaborations among
4 health care organizations for health care
5 services and health care-related services;
6 and

7 “(v) culturally and linguistically ap-
8 propriate information for educators, practi-
9 tioners, students, and researchers.

10 “(F) TRANSLATION GLOSSARIES.—The
11 Center shall—

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

17 “(ii) make such glossaries available—

18 “(I) free of charge;

19 “(II) in each language in which
20 the Center translates forms under
21 paragraph (2)(B);

22 “(III) in alternative formats in
23 accordance with the Americans with
24 Disabilities Act of 1990 (42 U.S.C.
25 12101 et seq.); and

1 “(IV) in paper format upon re-
2 quest.

3 “(G) INFORMATION ABOUT PROGRESS.—
4 The Center shall—

5 “(i) regularly collect and make pub-
6 licly available information about the
7 progress of entities receiving grants under
8 section 3402 regarding successful innova-
9 tions in implementing the requirements of
10 this subsection; and

11 “(ii) provide public notice in the enti-
12 ties’ communities about the availability of
13 such information.

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

18 “(c) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
19 rector of the Center shall collaborate with the Deputy As-
20 sistant Secretary for Minority Health, the Administrator
21 of the Centers for Medicare & Medicaid Services, and the
22 Administrator of the Health Resources and Services Ad-
23 ministration to notify health care providers and health
24 care organizations about the availability of language ac-
25 cess services by the Center.

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

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

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

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

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

18 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 19 are authorized to be appropriated to carry out this section
 20 \$5,000,000 for each of fiscal years 2027 through 2031.

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

24 “(a) IN GENERAL.—

1 “(1) GRANTS.—The Secretary shall award
2 grants to eligible entities to enable such entities to
3 design, implement, and evaluate innovative, cost-ef-
4 fective programs to improve culturally and linguis-
5 tically appropriate access to health care services for
6 individuals with limited English proficiency and com-
7 munication disabilities.

8 “(2) COORDINATION.—In making grants under
9 this section, and in the design and implementation
10 of the program established under this section, the
11 Secretary shall coordinate with, and ensure the par-
12 ticipation of, other agencies including the Health Re-
13 sources and Services Administration, the National
14 Institute on Minority Health and Health Disparities,
15 the Tribal Affairs component of the Office of Inter-
16 governmental and External Affairs of the Depart-
17 ment of Health and Human Services, and the Office
18 of Minority Health.

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

21 “(1) a city, county, Indian Tribe, State, or sub-
22 division thereof;

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

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

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

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

5 “(6) a public hospital;

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

7 or

8 “(8) any other entity designated by the Sec-
9 retary.

10 “(c) APPLICATION.—An eligible entity seeking a
11 grant under this section shall prepare and submit to the
12 Secretary an application, at such time, in such manner,
13 and containing such additional information as the Sec-
14 retary may reasonably require.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(14) ensure that culturally competent care and
2 language assistance are available to individuals with
3 limited English proficiency.

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

9 “(f) EVALUATION.—

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

1 “(2) BY SECRETARY.—The Director of the
2 Agency for Healthcare Research and Quality shall
3 evaluate or arrange with other individuals or organi-
4 zations to evaluate projects funded under this sec-
5 tion.

6 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 \$5,000,000 for each of fiscal years 2027 through 2031.

9 **“SEC. 3403. RESEARCH ON CULTURAL AND LANGUAGE COM-
10 PETENCE.**

11 “(a) IN GENERAL.—The Secretary shall expand re-
12 search concerning language access in the provision of
13 health care services.

14 “(b) ELIGIBILITY.—The Secretary may conduct the
15 research described in subsection (a) or enter into contracts
16 with other individuals or organizations to conduct such re-
17 search.

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

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

24 “(2) To identify health care providers’ and
25 health administrators’ knowledge and awareness of

1 the barriers to quality health care services that are
2 faced by individuals with limited English proficiency
3 and communication disabilities.

4 “(3) To identify optimal approaches for deliver-
5 ing language access.

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

8 “(A) the collection by providers of health
9 care services and health care-related services of
10 data on the race, ethnicity, age, disability, and
11 primary language of recipients of such services,
12 taking into account existing research conducted
13 by the Government or private sector;

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

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

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

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

1 “(A) provider type;

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

4 “(C) type of encounter;

5 “(D) time of encounter, including whether
6 the encounter occurs during regular business
7 hours and after hours; and

8 “(E) location of encounter.

9 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section
11 \$5,000,000 for each of fiscal years 2027 through 2031.”.

12 **SEC. 2005. PILOT PROGRAM FOR IMPROVEMENT AND DE-**
13 **VELOPMENT OF STATE MEDICAL INTER-**
14 **PRETING SERVICES.**

15 (a) GRANTS AUTHORIZED.—The Secretary of Health
16 and Human Services (referred to in this section as the
17 “Secretary”) shall award 1 grant in accordance with this
18 section to each of 3 States (to be selected by the Sec-
19 retary) to assist each such State in designing, imple-
20 menting, and evaluating a statewide program to provide
21 onsite interpreter services under the State Medicaid plan.

22 (b) GRANT PERIOD.—A grant awarded under this
23 section is authorized for the period of 3 fiscal years begin-
24 ning on October 1, 2026, and ending on September 30,
25 2029.

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

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

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

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

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

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

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

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

24 (A) a statewide health care information
25 technology system that is designed to achieve

1 efficiencies and economies of scale with respect
2 to onsite interpreter services provided to health
3 care providers in the State participating in the
4 State Medicaid plan; and

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

7 (i) procuring and scheduling inter-
8 preter services for qualified LEP enrollees;

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

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

16 (iv) consulting regularly with organi-
17 zations representing LEP consumers, in-
18 terpreters, and health care providers; and

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

24 (e) APPLICATION.—To receive a grant under this sec-
25 tion, a State shall submit an application at such time and

1 containing such information as the Secretary may require,
 2 which shall include the following:

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

6 (2) A description of the extent to which the
 7 program will—

8 (A) use the grant funds for the purposes
 9 described in subsection (d);

10 (B) meet the health care needs of rural
 11 populations of the State; and

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

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

21 (f) DEFINITIONS.—In this section:

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

24 (A) who is limited English proficient; and

1 (B) who is enrolled in a State Medicaid
2 plan.

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

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

12 (4) UNITED STATES.—The term “United
13 States” has the meaning given the term in section
14 1101(a)(2) of the Social Security Act (42 U.S.C.
15 1301(a)(2)), for purposes of title XIX of such Act
16 (42 U.S.C. 1396 et seq.).

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

21 (h) FUNDING.—

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

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

5 (3) INCREASED FEDERAL FINANCIAL PARTICI-
 6 PATION.—Section 1903(a)(2)(E) of the Social Secu-
 7 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended by
 8 inserting “(or, in the case of a State that was
 9 awarded a grant under section 2005 of the Health
 10 Equity and Accountability Act of 2026, 100 percent
 11 for each quarter occurring during the grant period
 12 specified in subsection (b) of such section)” after
 13 “75 percent”.

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

17 **SEC. 2006. TRAINING TOMORROW’S DOCTORS FOR CUL-**
 18 **TURALLY AND LINGUISTICALLY APPRO-**
 19 **PRIATE CARE: GRADUATE MEDICAL EDU-**
 20 **CATION.**

21 (a) DIRECT GRADUATE MEDICAL EDUCATION.—Sec-
 22 tion 1886(h)(4) of the Social Security Act (42 U.S.C.
 23 1395ww(h)(4)) is amended by adding at the end the fol-
 24 lowing new subparagraph:

1 “(L) TREATMENT OF CULTURALLY AND
 2 LINGUISTICALLY APPROPRIATE TRAINING.—In
 3 determining a hospital’s number of full-time
 4 equivalent residents for purposes of this sub-
 5 section, all the time that is spent by an intern
 6 or resident in an approved medical residency
 7 training program for education and training in
 8 culturally and linguistically appropriate service
 9 delivery, which shall include all medically under-
 10 served populations (as defined in section
 11 330(b)(3) of the Public Health Service Act),
 12 shall be counted toward the determination of
 13 full-time equivalency.”.

14 (b) INDIRECT MEDICAL EDUCATION.—Section
 15 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
 16 1395ww(d)(5)(B)) is amended by adding at the end the
 17 following new clause:

18 “(xiv) The provisions of subparagraph
 19 (L) of subsection (h)(4) shall apply under
 20 this subparagraph in the same manner as
 21 they apply under such subsection.”.

22 (c) EFFECTIVE DATE.—The amendments made by
 23 subsections (a) and (b) shall apply with respect to pay-
 24 ments made to hospitals on or after the date that is 1
 25 year after the date of the enactment of this Act.

1 **SEC. 2007. FEDERAL REIMBURSEMENT FOR CULTURALLY**
2 **AND LINGUISTICALLY APPROPRIATE SERV-**
3 **ICES UNDER THE MEDICARE, MEDICAID, AND**
4 **STATE CHILDREN'S HEALTH INSURANCE**
5 **PROGRAMS.**

6 (a) LANGUAGE ACCESS GRANTS FOR MEDICARE
7 PROVIDERS.—

8 (1) ESTABLISHMENT.—

9 (A) IN GENERAL.—Not later than 6
10 months after the date of the enactment of this
11 Act, the Secretary of Health and Human Serv-
12 ices (in this subsection referred to as the “Sec-
13 retary”), acting through the Centers for Medi-
14 care & Medicaid Services and in consultation
15 with the Center for Medicare and Medicaid In-
16 novation (as referred to in section 1115A of the
17 Social Security Act (42 U.S.C. 1315a)), shall
18 establish a demonstration program under which
19 the Secretary shall award grants to eligible
20 Medicare service providers to provide culturally
21 and linguistically appropriate services to Medi-
22 care beneficiaries who are limited English pro-
23 ficient, including beneficiaries who live in eth-
24 nically, racially, geographically,
25 socioeconomically diverse and underserved com-
26 munities.

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

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

10 (D) GRANT PERIOD.—Except as provided
 11 in paragraph (2)(D), each grant awarded under
 12 this subsection shall be for a 3-year period.

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

16 (A) MEDICARE PROVIDER.—The entity
 17 must be—

18 (i) a provider of services under part A
 19 of title XVIII of the Social Security Act
 20 (42 U.S.C. 1395c et seq.);

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

23 (iii) a Medicare Advantage organiza-
 24 tion offering a Medicare Advantage plan

1 under part C of such title (42 U.S.C.
2 1395w-21 et seq.); or

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

6 (B) UNDERSERVED COMMUNITIES.—The
7 entity must serve a community that, with re-
8 spect to necessary language services for improv-
9 ing access and utilization of health care among
10 individuals who are limited English proficient,
11 is disproportionately underserved.

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

17 (D) REPORTING.—In the case of a grantee
18 that received a grant under this subsection in
19 a previous year, such grantee is only eligible for
20 continued payments under a grant under this
21 subsection if the grantee met the reporting re-
22 quirements under paragraph (9) for such year.
23 If a grantee fails to meet the requirements of
24 such paragraph for the first year of a grant, the
25 Secretary may terminate the grant and solicit

1 applications from new grantees to participate in
2 the demonstration program.

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

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

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

9 (C) at least 10 grants to organizations de-
10 scribed in paragraph (2)(A)(iii); and

11 (D) at least 10 grants to sponsors de-
12 scribed in paragraph (2)(A)(iv).

13 (4) CONSIDERATIONS IN AWARDING GRANTS.—

14 (A) VARIATION AMONG GRANTEEES.—In
15 awarding grants under this subsection, the Sec-
16 retary shall select grantees to ensure the fol-
17 lowing:

18 (i) The grantees provide many dif-
19 ferent types of language services.

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

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

4 (iv) The grantees represent each Cen-
5 ters for Medicare & Medicaid Services re-
6 gion, as defined by the Secretary.

7 (v) The grantees serve Medicare bene-
8 ficiaries in at least 2 large metropolitan
9 statistical areas with diverse populations,
10 including diversity in race, ethnicity, sexual
11 orientation, gender identity, disability sta-
12 tus, and socioeconomic status.

13 (B) PRIORITY FOR PARTNERSHIPS WITH
14 COMMUNITY ORGANIZATIONS AND AGENCIES.—
15 In awarding grants under this subsection, the
16 Secretary shall give priority to eligible entities
17 that have a partnership with 1 or more of the
18 following entities that have experience in pro-
19 viding language services:

20 (i) A community organization.

21 (ii) A consortium of community orga-
22 nizations, State agencies, and local agen-
23 cies.

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

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

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

11 (i) interpreter and translation services
12 that—

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

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

20 (bb) if the grantee operates
21 in a State that does not have
22 statewide health care interpreter
23 standards, utilize competent in-
24 terpreters who follow the Na-
25 tional Council on Interpreting in

1 Health Care’s Code of Ethics and
2 Standards of Practice and com-
3 ply with the requirements of sec-
4 tion 1557 of the Patient Protec-
5 tion and Affordable Care Act (42
6 U.S.C. 18116) as published in
7 the Federal Register on May 18,
8 2016, 81 Fed. Reg. 31375; and
9 (II) in the case of interpreter
10 services, are provided through—
11 (aa) onsite interpretation;
12 (bb) telephonic interpreta-
13 tion; or
14 (cc) video interpretation;
15 and
16 (ii) the direct provision of health care
17 or health care-related services by a com-
18 petent bilingual health care provider.
19 (C) EXCEPTIONS.—
20 (i) IN GENERAL.—The requirements
21 of subparagraph (B)(i)(I) do not apply,
22 with respect to interpreter and translation
23 services and a grantee—

1 (I) in the case of a Medicare ben-
 2 eficiary who is limited English pro-
 3 ficient, if—

4 (aa) such beneficiary has
 5 been informed, in the bene-
 6 ficiary's primary language, of the
 7 availability of free interpreter
 8 and translation services and the
 9 beneficiary instead requests that
 10 a family member, friend, or other
 11 person provide such services; and

12 (bb) the grantee documents
 13 such request in the beneficiary's
 14 medical record; or

15 (II) subject to clause (ii), in the
 16 case of a medical emergency where
 17 the delay directly associated with ob-
 18 taining a competent interpreter or
 19 translation services would jeopardize
 20 the health of the patient.

21 (ii) CLARIFICATION.—Clause (i)(II)
 22 shall not be construed to exempt emer-
 23 gency rooms or similar entities that regu-
 24 larly provide health care services in med-
 25 ical emergencies to patients who are indi-

viduals who are limited English proficient from any applicable legal or regulatory requirements related to providing competent interpreter and translation services without undue delay.

(D) MEDICARE ADVANTAGE ORGANIZATIONS AND PDP SPONSORS.—A grantee that is a Medicare Advantage organization or a prescription drug plan sponsor must provide at least 50 percent of the grant funds that the grantee receives under this subsection directly to the entity's network providers (including all health providers and pharmacists) for the purpose of providing support for such providers to provide competent language services to Medicare beneficiaries who are individuals who are limited English proficient.

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

(6) DETERMINATION OF AMOUNT OF GRANT PAYMENTS.—

1 (A) IN GENERAL.—Payments to grantees
2 under this subsection shall be calculated based
3 on the estimated numbers of Medicare bene-
4 ficiaries who are limited English proficient in a
5 grantee’s service area utilizing—

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

14 (ii) data provided by the grantee, if
15 the grantee routinely collects data on the
16 primary language of the Medicare bene-
17 ficiaries that the grantee serves and the
18 Secretary determines that the data is accu-
19 rate and shows a greater number of indi-
20 viduals who are limited English proficient
21 than would be estimated using the data
22 under clause (i).

23 (B) DISCRETION OF SECRETARY.—Subject
24 to subparagraph (C), the amount of payment
25 made to a grantee under this subsection may be

1 modified annually at the discretion of the Sec-
2 retary, based on changes in the data under sub-
3 paragraph (A) with respect to the service area
4 of a grantee for the year.

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

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

12 (A) ensure that clinical and support staff
13 receive appropriate ongoing education and
14 training in linguistically appropriate service de-
15 livery;

16 (B) ensure the linguistic competence of bi-
17 lingual providers;

18 (C) offer and provide appropriate language
19 services at no additional charge to each patient
20 who is limited English proficient for all points
21 of contact between the patient and the grantee,
22 in a timely manner during all hours of oper-
23 ation;

24 (D) not less frequently than annually, no-
25 tify Medicare beneficiaries of their right to re-

1 ceive language services in their primary lan-
2 guage without charge;

3 (E) post signage in the primary languages
4 commonly used by the patient population in the
5 service area of the organization; and

6 (F) ensure that—

7 (i) primary language data are col-
8 lected for recipients of language services
9 and such data are consistent with stand-
10 ards developed under title XXXIV of the
11 Public Health Service Act, as added by
12 section 2002 of this Act, to the extent such
13 standards are available upon the initiation
14 of the demonstration program; and

15 (ii) consistent with the privacy protec-
16 tions provided under the regulations pro-
17 mulgated pursuant to section 264(c) of the
18 Health Insurance Portability and Account-
19 ability Act of 1996 (42 U.S.C. 1320d-2
20 note), if the recipient of language services
21 is a minor or is incapacitated, primary lan-
22 guage data must also be collected on the
23 parent or legal guardian of such recipient.

24 (8) NO COST SHARING.—Medicare beneficiaries
25 who are limited English proficient shall not have to

1 pay cost sharing or co-payments for competent lan-
2 guage services provided under this demonstration
3 program.

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

9 (A) The number of Medicare beneficiaries
10 to whom competent language services are pro-
11 vided, disaggregated by age and entitlement
12 basis (on the basis of age, disability, or deter-
13 mination of end stage renal disease).

14 (B) The primary languages of those Medi-
15 care beneficiaries.

16 (C) The types of language services pro-
17 vided to such beneficiaries.

18 (D) Whether such language services were
19 provided by employees of the grantee or
20 through a contract with external contractors or
21 agencies.

22 (E) The types of interpretation services
23 provided to such beneficiaries, and the approxi-
24 mate length of time such service is provided to
25 such beneficiaries.

1 (F) The costs of providing competent lan-
2 guage services.

3 (G) An account of the training or accredi-
4 tation of bilingual staff, interpreters, and trans-
5 lators providing services funded by the grant
6 under this subsection.

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

13 (A) An analysis of the patient outcomes
14 and the costs of furnishing care to the Medicare
15 beneficiaries who are individuals who are lim-
16 ited English proficient participating in the
17 project as compared to such outcomes and costs
18 for such Medicare beneficiaries not partici-
19 pating, based on the data provided under para-
20 graph (9) and any other information available
21 to the Secretary.

22 (B) The effect of delivering language serv-
23 ices on—

24 (i) Medicare beneficiary access to care
25 and utilization of services;

1 (ii) the efficiency and cost-effective-
2 ness of health care delivery;

3 (iii) patient satisfaction with respect
4 to both health service delivery and lan-
5 guage assistance;

6 (iv) health outcomes; and

7 (v) the provision of culturally appro-
8 priate services provided to such bene-
9 ficiaries.

10 (C) The extent to which bilingual staff, in-
11 terpreters, and translators providing services
12 under such demonstration were trained or ac-
13 credited and the nature of accreditation or
14 training needed by type of provider, service, or
15 other category as determined by the Secretary
16 to ensure the provision of high-quality interpre-
17 tation, translation, or other language services to
18 Medicare beneficiaries if such services are ex-
19 panded pursuant to section 1115A(c) of the So-
20 cial Security Act (42 U.S.C. 1315a(c)).

21 (D) Recommendations, if any, regarding
22 the extension of such project to the entire Medi-
23 care Program, subject to the provisions of such
24 section 1115A(c).

1 (11) APPROPRIATIONS.—There is appropriated
 2 to carry out this subsection, in equal parts from the
 3 Federal Hospital Insurance Trust Fund under sec-
 4 tion 1817 of the Social Security Act (42 U.S.C.
 5 1395i) and the Federal Supplementary Medical In-
 6 surance Trust Fund under section 1841 of such Act
 7 (42 U.S.C. 1395t), \$16,000,000 for each fiscal year
 8 of the demonstration program.

9 (12) LIMITED ENGLISH PROFICIENT DE-
 10 FINED.—In this subsection, the term “limited
 11 English proficient” means individuals who self-iden-
 12 tify on the Census as speaking English less than
 13 “very well”.

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

16 (1) INCLUSION AS RURAL HEALTH CLINIC
 17 SERVICES.—Section 1861 of the Social Security Act
 18 (42 U.S.C. 1395x) is amended—

19 (A) in subsection (aa)(1)—

20 (i) in subparagraph (C), by striking
 21 “and” at the end;

22 (ii) in subparagraph (D), by inserting
 23 “and” after the comma at the end; and

24 (iii) by inserting after subparagraph
 25 (D) the following new subparagraph:

1 “(E) language assistance services as defined in
2 subsection (ooo),”; and

3 (B) by adding at the end the following new
4 subsection:

5 “Language Assistance Services and Related Terms

6 “(ooo) The term ‘language assistance services’ means
7 ‘language access’ or ‘language assistance services’ (as
8 those terms are defined in section 3400 of the Public
9 Health Service Act) furnished by a ‘qualified interpreter
10 for an individual with limited English proficiency’ or a
11 ‘qualified translator’ (as those terms are defined in such
12 section 3400) to an ‘individual with limited English pro-
13 ficiency’ (as defined in such section 3400).”.

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

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

19 (B) in subparagraph (J), by striking the
20 period at the end and inserting “; and”; and

21 (C) by adding at the end the following new
22 subparagraph:

23 “(K) language assistance services (as de-
24 fined in section 1861(ooo)).”.

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

3 (A) in paragraph (9), by striking “and” at
4 the end;

5 (B) in paragraph (10), by striking the pe-
6 riod at the end and inserting “; and”; and

7 (C) by inserting after paragraph (10) the
8 following new paragraph:

9 “(11) in the case of language assistance serv-
10 ices (as defined in section 1861(ooo)), 100 percent
11 of the reasonable charges for such services, as deter-
12 mined in consultation with the Medicare Payment
13 Advisory Commission.”.

14 (4) WAIVER OF BUDGET NEUTRALITY.—For
15 the 3-year period beginning on the date of enact-
16 ment of this section, the budget neutrality provision
17 of section 1848(c)(2)(B)(ii) of the Social Security
18 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not
19 apply with respect to language assistance services
20 (as defined in section 1861(ooo) of such Act).

21 (c) MEDICARE PARTS C AND D; MEDICARE ADVAN-
22 TAGE PLANS AND PRESCRIPTION DRUG PLANS REPORT-
23 ING REQUIREMENT.—Section 1857(e) of the Social Secu-
24 rity Act (42 U.S.C. 1395w-27(e)) is amended by adding
25 at the end the following new paragraph:

1 “(6) REPORTING REQUIREMENTS RELATING TO
2 EFFECTIVE LANGUAGE SERVICES.—A contract under
3 this part shall require a Medicare Advantage organi-
4 zation (and, through application of section 1860D–
5 12(b)(3)(D), a contract under section 1860D–12
6 shall require a PDP sponsor) to annually submit
7 (for each year of the contract) a report that contains
8 information on the internal policies and procedures
9 of the organization (or sponsor) related to recruit-
10 ment and retention efforts directed to workforce di-
11 versity and linguistically and culturally appropriate
12 provision of services in each of the following con-
13 texts:

14 “(A) The collection of data in a manner
15 that meets the requirements of title I of the
16 Health Equity and Accountability Act of 2026,
17 regarding the enrollee population.

18 “(B) Education of staff and contractors
19 who have routine contact with enrollees regard-
20 ing the various needs of the diverse enrollee
21 population.

22 “(C) Evaluation of the language services
23 programs and services offered by the organiza-
24 tion (or sponsor) with respect to the enrollee

1 population, such as through analysis of com-
 2 plaints or satisfaction survey results.

3 “(D) Methods by which the plan provides
 4 to the Secretary information regarding the eth-
 5 nic diversity of the enrollee population.

6 “(E) The periodic provision of educational
 7 information to plan enrollees on the language
 8 services and programs offered by the organiza-
 9 tion (or sponsor).”.

10 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID
 11 AND CHIP.—

12 (1) PAYMENTS TO STATES.—Section
 13 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
 14 1396b(a)(2)(E)), as amended by section 2005(h)(3),
 15 is further amended by—

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

17 (B) striking “translation or interpretation
 18 services” and inserting “language assistance
 19 services”; and

20 (C) striking “children of families” and in-
 21 serting “individuals”.

22 (2) STATE PLAN REQUIREMENTS.—Section
 23 1902(a)(10)(A) of the Social Security Act (42
 24 U.S.C. 1396a(a)(10)(A)) is amended by striking
 25 “and (30)” and inserting “(30), and (32)”.

1 (3) DEFINITION OF MEDICAL ASSISTANCE.—

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

4 (A) in paragraph (31), by striking “and”
5 at the end;

6 (B) by redesignating paragraph (32) as
7 paragraph (33); and

8 (C) by inserting after paragraph (31) the
9 following new paragraph:

10 “(32) language assistance services, as such
11 term is defined in section 1861(nnn), provided in a
12 timely manner to individuals with limited English
13 proficiency as defined in section 3400 of the Public
14 Health Service Act; and”.

15 (4) USE OF DEDUCTIONS AND COST SHAR-
16 ING.—Subsections (a)(2) and (b)(2) of section 1916
17 of the Social Security Act (42 U.S.C. 1396o) are
18 each amended—

19 (A) in subparagraph (I), by striking “or”
20 at the end;

21 (B) in subparagraph (J), by striking “;
22 and” and inserting “, or”; and

23 (C) by adding at the end the following new
24 subparagraph:

1 “(K) language assistance services described
2 in section 1905(a)(32); and”.

3 (5) CHIP COVERAGE REQUIREMENTS.—Section
4 2103 of the Social Security Act (42 U.S.C. 1397cc)
5 is amended—

6 (A) in subsection (a), in the matter before
7 paragraph (1), by striking “(5), (6), (7) and
8 (8)” and inserting “(5) through (13)”;

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

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

19 (C) in subsection (e)(2)—

20 (i) in the heading, by striking “PRE-
21 VENTIVE” and inserting “CERTAIN”;
22 and

23 (ii) by inserting “language assistance
24 services described in subsection (c)(13),”

1 before “or for pregnancy-related assist-
2 ance”.

3 (6) DEFINITION OF CHILD HEALTH ASSIST-
4 ANCE.—Section 2110(a)(27) of the Social Security
5 Act (42 U.S.C. 1397jj(a)(27)) is amended by strik-
6 ing “transportation, translation, and outreach serv-
7 ices” and inserting “transportation services, lan-
8 guage assistance services as described in section
9 2103(c)(13), and outreach services”.

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

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

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

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

25 (A) in subsection (a)(1)—

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

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

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

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

17 (1) PAYMENT OF COSTS.—

18 (A) IN GENERAL.—Subject to subpara-
 19 graph (B), the Secretary shall make payments
 20 (on a quarterly basis) directly to eligible entities
 21 to support the provision of language assistance
 22 services to individuals with limited English pro-
 23 ficiency in an amount equal to an eligible enti-
 24 ty’s eligible costs for providing such services for
 25 the quarter.

(B) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary such sums as may be necessary for each of fiscal years 2027 through 2031.

(C) RELATION TO MEDICAID DSH.—Payments under this subsection shall not offset or reduce payments under section 1923 of the Social Security Act (42 U.S.C. 1396r–4), nor shall payments under such section be considered when determining uncompensated costs associated with the provision of language assistance services for the purposes of this subsection.

(2) METHODOLOGY FOR PAYMENT OF CLAIMS.—

(A) IN GENERAL.—The Secretary shall establish a methodology to determine the average per person cost of language assistance services.

(B) DIFFERENT ENTITIES.—In establishing such methodology, the Secretary may establish different methodologies for different types of eligible entities.

(C) NO INDIVIDUAL CLAIMS.—The Secretary may not require eligible entities to sub-

1 mit individual claims for language assistance
2 services for individual patients as a requirement
3 for payment under this subsection.

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

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

15 (5) REPORTING REQUIREMENTS.—

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

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

6 (6) DEFINITIONS.—In this subsection:

7 (A) ELIGIBLE COSTS.—The term “eligible
8 costs” means, with respect to an eligible entity
9 that provides language assistance services to
10 limited English proficient individuals, the prod-
11 uct of—

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

16 (ii) the number of individuals with
17 limited English proficiency who are pro-
18 vided language assistance services by the
19 entity and for whom no reimbursement is
20 available for such services under the
21 amendments made by subsection (a), (b),
22 (c), or (d), or by private health insurance.

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

25 (i) is a Medicaid provider that is—

1 (I) a physician;

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

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

11 (IV) provider of long-term serv-
12 ices and supports;

13 (V) a hospice provider; or

14 (VI) a palliative care provider;

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

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

1 (C) LANGUAGE ASSISTANCE SERVICES.—

2 The term “language assistance services” has
3 the meaning given such term in section
4 1861(nnn) of the Social Security Act, as added
5 by subsection (b).

6 (f) APPLICATION OF CIVIL RIGHTS ACT OF 1964,
7 SECTION 1557 OF THE AFFORDABLE CARE ACT, AND
8 OTHER LAWS.—Nothing in this section shall be construed
9 to limit otherwise existing obligations of recipients of Fed-
10 eral financial assistance under title VI of the Civil Rights
11 Act of 1964 (42 U.S.C. 2000d et seq.), section 1557 of
12 the Affordable Care Act (42 U.S.C. 18116), or other laws
13 that protect the civil rights of individuals.

14 (g) EFFECTIVE DATE.—

15 (1) IN GENERAL.—Except as otherwise pro-
16 vided and subject to paragraph (2), the amendments
17 made by this section shall take effect on January 1,
18 2027.

19 (2) EXCEPTION IF STATE LEGISLATION RE-
20 QUIRED.—In the case of a State plan for medical as-
21 sistance under title XIX of the Social Security Act
22 (42 U.S.C. 1396 et seq.) or a State plan for child
23 health assistance under title XXI of such Act (42
24 U.S.C. 1397aa et seq.) which the Secretary of
25 Health and Human Services determines requires

1 State legislation (other than legislation appro-
2 priating funds) in order for the plan to meet the ad-
3 ditional requirement imposed by the amendments
4 made by this section, such State plan shall not be
5 regarded as failing to comply with the requirements
6 of such title solely on the basis of its failure to meet
7 this additional requirement before the first day of
8 the first calendar quarter beginning after the close
9 of the first regular session of the State legislature
10 that begins after the date of the enactment of this
11 Act. For purposes of the previous sentence, in the
12 case of a State that has a 2-year legislative session,
13 each year of such session shall be deemed to be a
14 separate regular session of the State legislature.

15 **SEC. 2008. INCREASING UNDERSTANDING OF AND IMPROV-**
16 **ING HEALTH LITERACY.**

17 (a) IN GENERAL.—The Secretary, in consultation
18 with the Director of the National Institute on Minority
19 Health and Health Disparities and the Deputy Assistant
20 Secretary for Minority Health, shall award grants to eligi-
21 ble entities to improve health care for patient populations
22 that have low health literacy.

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

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

4 (2) prepare and submit to the Secretary an ap-
5 plication at such time, in such manner, and con-
6 taining such information as the Secretary may rea-
7 sonably require.

8 (c) USE OF FUNDS.—

9 (1) AGENCY FOR HEALTHCARE RESEARCH AND
10 QUALITY.—A grant under subsection (a) that is
11 awarded through the Director of the Agency for
12 Healthcare Research and Quality shall be used—

13 (A) to define and increase the under-
14 standing of health literacy across all areas of
15 health care, including end of life care;

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

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

20 (D) for any other activity determined ap-
21 propriate by the Director.

22 (2) HEALTH RESOURCES AND SERVICES ADMIN-
23 ISTRATION.—A grant under subsection (a) that is
24 awarded through the Administrator of the Health
25 Resources and Services Administration shall be used

1 to conduct demonstration projects for interventions
2 for patients with low health literacy that may in-
3 clude—

4 (A) the development of new disease man-
5 agement and end of life care programs for pa-
6 tients with low health literacy;

7 (B) the tailoring of disease management
8 programs and end of life care addressing men-
9 tal, physical, oral, and behavioral health condi-
10 tions for patients with low health literacy;

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

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

15 (E) the conduct of educational campaigns
16 for patients and providers about low health lit-
17 eracy;

18 (F) the conduct of educational campaigns
19 concerning health directed specifically at pa-
20 tients with mental disabilities, including those
21 with cognitive and intellectual disabilities, de-
22 signed to reduce the incidence of low health lit-
23 eracy among these populations, which shall
24 have instructional materials in the plain lan-
25 guage standards promulgated under the Plain

1 Writing Act of 2010 (5 U.S.C. 301 note) for
2 Federal agencies; and

3 (G) other activities determined appropriate
4 by the Administrator.

5 (d) DEFINITIONS.—In this section:

6 (1) LOW HEALTH LITERACY.—The term “low
7 health literacy” means the inability of an individual
8 to obtain, process, and understand basic health in-
9 formation and services needed to make appropriate
10 health decisions, and engage with and self-advocate
11 within health care systems, including through com-
12 pleting documents and exercising patient rights.

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

15 (A) acting through the Director of the
16 Agency for Healthcare Research and Quality,
17 with respect to grants under subsection (c)(1);
18 and

19 (B) acting through the Administrator of
20 the Health Resources and Services Administra-
21 tion with respect to grants under subsection
22 (c)(2).

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

1 such sums as may be necessary for each of fiscal years
 2 2027 through 2031.

3 **SEC. 2009. REQUIREMENTS FOR HEALTH PROGRAMS OR**
 4 **ACTIVITIES RECEIVING FEDERAL FUNDS.**

5 (a) COVERED ENTITY; HEALTH PROGRAM OR ACTIV-
 6 ITY.—In this section:

7 (1) COVERED ENTITY.—The term “covered en-
 8 tity” means an entity described in clause (i) of sec-
 9 tion 3401(a)(2)(C) of the Public Health Service Act,
 10 as added by section 2004.

11 (2) HEALTH PROGRAM OR ACTIVITY.—The
 12 term “health program or activity” has the meaning
 13 given such term in clause (ii) of such section
 14 3401(a)(2)(C).

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

19 (1) ensure that appropriate clinical and support
 20 staff receive ongoing education and training in cul-
 21 turally and linguistically appropriate service delivery
 22 at least annually;

23 (2) offer and provide appropriate language as-
 24 sistance services at no additional charge to each pa-
 25 tient that is an individual with limited English pro-

1 ficiency at all points of contact, in a timely manner
2 during all hours of operation;

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

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

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

10 (1) When a patient requests the use of family,
11 friends, or other persons untrained in interpretation
12 or translation if each of the following conditions are
13 met:

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

16 (B) The covered entity informs the patient
17 in the primary language of the patient that he
18 or she has the option of having the entity pro-
19 vide to the patient an interpreter and trans-
20 lation services without charge.

21 (C) The covered entity informs the patient
22 that the entity may not require an individual
23 with a limited English proficiency to use a fam-
24 ily member or friend as an interpreter.

1 (D) The covered entity evaluates whether
2 the person the patient wishes to use as an in-
3 terpreter is competent. If the covered entity has
4 reason to believe that such person is not com-
5 petent as an interpreter, the entity provides its
6 own interpreter to protect the covered entity
7 from liability if the patient's interpreter is later
8 found not competent.

9 (E) If the covered entity has reason to be-
10 lieve that there is a conflict of interest between
11 the interpreter and patient, the covered entity
12 may not use the patient's interpreter.

13 (F) The covered entity has the patient sign
14 a waiver, witnessed by at least 1 individual not
15 related to the patient, that includes the infor-
16 mation stated in subparagraphs (A) through
17 (E) and is translated into the patient's primary
18 language.

19 (2) When a medical emergency exists and the
20 delay directly associated with obtaining competent
21 interpreter or translation services would jeopardize
22 the health of the patient, but only until a competent
23 interpreter or translation service is available.

24 (d) RULE OF CONSTRUCTION.—Subsection (c)(2)
25 shall not be construed to mean that emergency rooms or

1 similar entities that regularly provide health care services
 2 in medical emergencies are exempt from legal or regu-
 3 latory requirements related to competent interpreter serv-
 4 ices.

5 **SEC. 2010. REPORT ON FEDERAL EFFORTS TO PROVIDE**
 6 **CULTURALLY AND LINGUISTICALLY APPRO-**
 7 **PRIATE HEALTH CARE SERVICES.**

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

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

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

24 (3) recommendations on the development and
 25 implementation of policies and practices by providers

1 of health care services and health care-related serv-
 2 ices for individuals with limited English proficiency,
 3 including people with cognitive, hearing, vision, or
 4 print impairments;

5 (4) recommend guidelines or standards for
 6 health literacy and plain language, informed consent,
 7 discharge instructions, and written communications,
 8 and for improvement of health care access;

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

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

14 (b) AUTHORIZATION OF APPROPRIATIONS.—There
 15 are authorized to be appropriated to carry out this section
 16 such sums as may be necessary for each of fiscal years
 17 2027 through 2031.

18 **SEC. 2011. ENGLISH INSTRUCTION FOR INDIVIDUALS WITH**
 19 **LIMITED ENGLISH PROFICIENCY.**

20 (a) GRANTS AUTHORIZED.—The Secretary of Edu-
 21 cation is authorized to provide grants to eligible entities
 22 for the provision of English as a second language (in this
 23 section referred to as “ESL”) instruction to individuals
 24 with limited English proficiency, including health care-re-
 25 lated English instruction, and shall determine, after con-

1 sultation with appropriate stakeholders, the mechanism
2 for administering and distributing such grants.

3 (b) ELIGIBLE ENTITY.—In this section, the term “el-
4 igible entity” means—

5 (1) a State; or

6 (2) a community-based organization that pre-
7 dominantly employs and serves racial and ethnic mi-
8 nority groups (as defined in section 1707(g) of the
9 Public Health Service Act (42 U.S.C. 300u–6(g))).

10 (c) APPLICATION.—An eligible entity that desires to
11 receive a grant under this section shall apply by submit-
12 ting to the Secretary of Education an application at such
13 time, in such manner, and containing such information as
14 the Secretary may require.

15 (d) USE OF GRANT.—An eligible entity shall use
16 grant funds provided under this section to—

17 (1) develop and implement a plan for assuring
18 the availability of ESL instruction, free of charge, to
19 the community served by the eligible entity, that ef-
20 fectively integrates information about the nature of
21 the United States health care system, how to access
22 care, and any special language skills that may be re-
23 quired for individuals with limited English pro-
24 ficiency to access and regularly negotiate the health
25 care system effectively;

1 (2) develop a plan for making ESL instruction
2 available free to charge to individuals with limited
3 English proficiency in the community served by the
4 eligible entity who are seeking instruction, including,
5 where appropriate, through the use of public-private
6 partnerships; and

7 (3) provide ESL instruction to individuals with
8 limited English proficiency in the community served
9 by the eligible entity.

10 (e) SUPPLEMENT, NOT SUPPLANT.—An eligible enti-
11 ty awarded a grant under this section shall use funds
12 made available under this section to supplement, and not
13 supplant, other Federal, State, and local funds that would
14 otherwise be expended to carry out activities under this
15 section.

16 (f) DUTIES OF THE SECRETARY.—The Secretary of
17 Education shall—

18 (1) collect and make publicly available annual
19 data on how much Federal, State, and local govern-
20 ments spend annually on ESL instruction;

21 (2) collect data from eligible entities awarded a
22 grant under this section to identify the unmet needs
23 of individuals with limited English proficiency for
24 appropriate ESL instruction, including—

1 (A) the preferred written and spoken lan-
2 guage of such individuals;

3 (B) the availability of enrollment in ESL
4 instruction programs in the communities served
5 by each eligible entity awarded a grant under
6 this section, including the extent of waiting lists
7 for ESL instruction, how many programs main-
8 tain waiting lists, and, for programs that do not
9 have waiting lists, the reasons why such a list
10 is unnecessary or otherwise not maintained;

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

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

16 (E) the number of individuals with limited
17 English proficiency and the number of individ-
18 uals enrolled in ESL instruction programs in
19 the communities served by each eligible entity
20 awarded a grant under this section;

21 (F) the effectiveness of the ESL instruc-
22 tion provided through grants awarded under
23 this section in meeting the needs of individuals
24 receiving such instruction; and

1 (G) an assessment of the need for pro-
2 grams that integrate job training and ESL in-
3 struction, to assist individuals with limited
4 English proficiency in obtaining better jobs;

5 (3) determine the cost and most appropriate
6 methods of making ESL instruction available to all
7 individuals with limited English proficiency in the
8 United States who are seeking instruction; and

9 (4) not later than 1 year after the date of en-
10 actment of this Act, issue a report to Congress
11 that—

12 (A) assesses the information collected in
13 paragraphs (1), (2), and (3) and makes rec-
14 ommendations on steps that should be taken to
15 realize the goal of making ESL instruction
16 available to all individuals with limited English
17 proficiency in the United States who are seek-
18 ing instruction; and

19 (B) evaluates the impact of the grant pro-
20 gram authorized under this section on the ac-
21 cessibility of, and ability to effectively negotiate,
22 the health care system for individuals with lim-
23 ited English proficiency who have received ESL
24 instruction funded by a grant under this sec-
25 tion.

1 (g) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to the Secretary of Edu-
3 cation \$250,000,000 for each of fiscal years 2027 through
4 2031 to carry out this section.

5 **SEC. 2012. IMPLEMENTATION.**

6 (a) GENERAL PROVISIONS.—

7 (1) IMMUNITY.—A person injured by a violation
8 of this title (including an amendment made by this
9 title) by a State may bring a civil action in the ap-
10 propriate Federal court for such injury in accord-
11 ance with this section.

12 (2) REMEDIES.—In a civil action under this
13 section for a violation of this title, such remedies
14 shall be available as would be available in a civil ac-
15 tion for such violation against any party other than
16 a State.

17 (b) RULE OF CONSTRUCTION.—Nothing in this title
18 may be construed to limit otherwise existing obligations
19 of recipients of Federal financial assistance under title VI
20 of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
21 or any other Federal statute.

22 **SEC. 2013. LANGUAGE ACCESS SERVICES.**

23 (a) ESSENTIAL BENEFITS.—Section 1302(b)(1) of
24 the Patient Protection and Affordable Care Act (42

1 U.S.C. 18022(b)(1)) is amended by adding at the end the
 2 following:

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

5 (b) EMPLOYER-SPONSORED MINIMUM ESSENTIAL
 6 COVERAGE.—

7 (1) IN GENERAL.—Section 36B(e)(2)(C) of the
 8 Internal Revenue Code of 1986 is amended by redes-
 9 ignating clauses (iii) and (iv) as clauses (iv) and (v),
 10 respectively, and by inserting after clause (ii) the fol-
 11 lowing new clause:

12 “(iii) COVERAGE MUST INCLUDE LAN-
 13 GUAGE ACCESS AND SERVICES.—Except as
 14 provided in clause (iv), an employee shall
 15 not be treated as eligible for minimum es-
 16 sential coverage if such coverage consists
 17 of an eligible employer-sponsored plan (as
 18 defined in section 5000A(f)(2)) and the
 19 plan does not provide coverage for lan-
 20 guage access services, including oral inter-
 21 pretation and written translations.”.

22 (2) CONFORMING AMENDMENTS.—

23 (A) Section 36B(e)(2)(C) of such Code is
 24 amended by striking “clause (iii)” each place it

1 appears in clauses (i) and (ii) and inserting
 2 “clause (iv)”.

3 (B) Section 36B(c)(2)(C)(iv) of such Code,
 4 as redesignated by this subsection, is amended
 5 by striking “(i) and (ii)” and inserting “(i), (ii),
 6 and (iii)”.

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

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

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

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

16 “(E) reduce health disparities through the
 17 provision of language access services, including
 18 oral interpretation and written translations.”.

19 (d) REGULATIONS REGARDING INTERNAL CLAIMS
 20 AND APPEALS AND EXTERNAL REVIEW PROCESSES FOR
 21 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—
 22 The Secretary of the Treasury, the Secretary of Labor,
 23 and the Secretary of Health and Human Services shall
 24 amend the regulations in section 54.9815–2719(e) of title
 25 26, Code of Federal Regulations (or successor regula-

1 tions), section 2590.715–2719(e) of title 29, Code of Fed-
 2 eral Regulations (or successor regulations), and section
 3 147.136(e) of title 45, Code of Federal Regulations (or
 4 successor regulations), respectively, to require group
 5 health plans and health insurance issuers offering group
 6 or individual health insurance coverage to which such sec-
 7 tions apply—

8 (1) to provide oral interpretation services with-
 9 out any threshold requirements;

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

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

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

1 (1) amend the single streamlined application
2 form developed pursuant to section 1413 of the Pa-
3 tient Protection and Affordable Care Act (42 U.S.C.
4 18083) to collect the preferred spoken and written
5 language for each household member applying for
6 coverage under a qualified health plan through an
7 Exchange under title I of such Act (42 U.S.C.
8 18001 et seq.);

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

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

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

4 **SEC. 2014. MEDICALLY UNDERSERVED POPULATIONS.**

5 Section 330(b)(3) of the Public Health Service Act
 6 (42 U.S.C. 254b(b)(3)) is amended to read as follows:

7 “(3) MEDICALLY UNDERSERVED POPU-
 8 LATION.—The term ‘medically underserved popu-
 9 lation’ means—

10 “(A) the population of an urban or rural
 11 area designated by the Secretary as—

12 “(i) an area with a shortage of per-
 13 sonal health services; or

14 “(ii) a population group having a
 15 shortage of such services; or

16 “(B) a population of individuals, not con-
 17 fined to a particular urban or rural area, who
 18 are designated by the Secretary as having a
 19 shortage of personal health services due to a
 20 specific demographic trait.”.

21 **SEC. 2015. IMPROVING ACCESS TO FEDERAL SERVICES BY**
 22 **INDIVIDUALS WITH LIMITED ENGLISH PRO-**
 23 **FICIENCY.**

24 (a) ENSURING MEANINGFUL ACCESS.—

1 (1) IN GENERAL.—Not later than 1 year after
2 the date of the enactment of this Act, the head of
3 each agency shall ensure that individuals with LEP
4 can meaningfully access the federally conducted pro-
5 grams and activities of the agency, including by—

6 (A) consistent with any applicable Lan-
7 guage Access Technical Standards established
8 by the agency under subsection (c)—

9 (i) translating each vital document or
10 content created for the public into—

11 (I) any languages the agency fre-
12 quently encounters; and

13 (II) the dominant languages spo-
14 ken in the United States based on
15 current U.S. Census data; and

16 (ii) adding multilingual functionality
17 to agency digital and information tech-
18 nology systems to identify and track the
19 spoken and written language needs of peo-
20 ple who engage with the agency and to
21 provide documents and content in other
22 languages;

23 (B) providing oral interpretation, sight
24 translation, and telephonic or remote interpre-
25 tation services to such individuals;

1 (C) recognizing, as an alternative to using
2 qualified interpreters or translators, the use of
3 demonstrably bilingual staff of the agency that
4 have been assessed and are qualified to deliver
5 accurate and effective communication as an ap-
6 propriate method of providing language assist-
7 ance;

8 (D) acknowledging that, when qualified,
9 such staff may offer service that is faster, more
10 effective, and more cost-efficient than the use of
11 qualified interpreters or translators;

12 (E) notifying the public of the availability
13 of language assistance, including interpreters,
14 translated documents and digital content, and
15 bilingual staff, through the use of multilingual
16 notices, taglines, signage or demonstrably equiv-
17 alent alternatives included on documents and
18 digital content the agency creates for the public
19 and in agency buildings and offices; and

20 (F) training employees of the agency who
21 interact with the public on any policy or proce-
22 dure established by the agency to implement
23 the language access plan established by the
24 agency under subsection (b).

1 (2) PUBLIC COMPLAINT AND TRACKING SYS-
2 TEM.—

3 (A) COMPLAINTS.—The Attorney General
4 shall establish and maintain a publicly acces-
5 sible system for individuals to submit com-
6 plaints to the Attorney General regarding bar-
7 riers to receiving meaningful access, as de-
8 scribed under paragraph (1), from an agency.

9 (B) RESPONSE.—The head of the agency
10 with respect to which the complaint was made
11 shall respond to each complaint that was made
12 not later than 60 days after receipt of the com-
13 plaint from the Attorney General.

14 (C) REPORTS.—The Attorney General
15 shall publish on the website of the Department
16 of Justice an annual report summarizing the
17 complaints made under subparagraph (A),
18 disaggregated by the agency that is the subject
19 of the complaint, the language with respect to
20 which the agency failed to provide access, and
21 the program or activity to which the person is
22 guaranteed meaningful access under paragraph
23 (1).

24 (b) LANGUAGE ACCESS PLAN.—

1 (1) ESTABLISHMENT.—Not later than 1 year
2 after the date of the enactment of this Act, the head
3 of each agency shall establish a language access plan
4 to implement subsection (a) that—

5 (A) is practical and effective, readily imple-
6 mented, and responsive to the particular cir-
7 cumstances and mission of the agency;

8 (B) is consistent with the Language Access
9 Technical Standards issued under subsection
10 (c);

11 (C) is consistent with the standards set
12 forth—

13 (i) in the initial LEP Guidance of the
14 agency;

15 (ii) in the policy guidance document
16 entitled “Enforcement of Title VI of the
17 Civil Rights Act of 1964—National Origin
18 Discrimination Against Persons With Lim-
19 ited English Proficiency” 65 Fed. Reg. 50,
20 123 (Aug. 16, 2000); and

21 (iii) in the Attorney General’s memo-
22 randum to the heads of Department com-
23 ponents issued on November 21, 2022, en-
24 titled “Strengthening the Federal Govern-
25 ment’s Commitment to Language Access”;

1 (D) identifies which populations containing
2 individuals with LEP are likely to seek access
3 to the services and programs of the agency, in-
4 cluding language populations that are emerging,
5 have been historically isolated, are of lesser dif-
6 fusion, and do not have a commonly used writ-
7 ten format;

8 (E) describes how multilingual communica-
9 tions will be meaningfully provided to the popu-
10 lations identified pursuant under subparagraph
11 (D), including whether such communications
12 will be provided through oral, visual, or commu-
13 nity-based modes of communication as appro-
14 priate;

15 (F) in the case that the agency provides
16 assistance during emergency response situations
17 (such as disasters, public health crises, and
18 other urgent circumstances) specifies how mul-
19 tilingual communications will be meaningfully
20 provided to such populations during such situa-
21 tions regardless of whether an official state of
22 emergency has been declared; and

23 (G) sets procedures for the agency with re-
24 spect to monitoring, evaluating, and improving

1 the performance of the agency in implementing
2 the plan, including—

3 (i) regular assessments of the lan-
4 guage access needs of the agency and the
5 effectiveness of the language access pro-
6 vided by the agency;

7 (ii) measurable performance indicators
8 addressing timeliness, accuracy, and qual-
9 ity of language assistance services;

10 (iii) mechanisms for collecting and re-
11 viewing data on service usage, complaints,
12 and identified barriers;

13 (iv) periodic internal reviews con-
14 ducted by the civil rights office of the
15 agency; and

16 (v) processes for corrective action and
17 continuous improvement when deficiencies
18 or gaps in meaningful access are identified.

19 (2) NOTICE AND COMMENT.—The head of each
20 agency shall publish a proposal for the plan required
21 to be established under paragraph (1) in the Federal
22 Register for a 60-day public comment period to en-
23 sure that stakeholders, including individuals with
24 LEP and organizations representing such individ-
25 uals, have an adequate opportunity to provide input

1 on how the head of such agency carries out the pro-
2 visions of this section.

3 (3) FEDERAL REGISTER.—After considering
4 any comments received during the period described
5 under paragraph (2) with respect to plan published
6 under such paragraph, the head of an agency
7 shall—

8 (A) update such plan on the basis of such
9 comments as the head of the agency determines
10 appropriate; and

11 (B) publish a finalized version of the plan
12 in the Federal Register.

13 (4) SUBMISSION TO THE ATTORNEY GENERAL
14 AND TO CONGRESS.—Not later than 30 days after
15 the head of an agency establishes the language ac-
16 cess plan required by paragraph (1), the head of
17 such agency shall submit such plan to—

18 (A) the Attorney General; and

19 (B) the Chair and Ranking Minority Mem-
20 ber of—

21 (i) the Committee on the Judiciary of
22 the House of Representatives;

23 (ii) the Committee on the Judiciary of
24 the Senate;

1 (iii) the Committee on Oversight and
2 Government Reform of the House of Rep-
3 resentatives; and

4 (iv) the Committee on Homeland Se-
5 curity and Governmental Affairs of the
6 Senate.

7 (5) CENTRAL REPOSITORY.—The Department
8 of Justice shall establish and maintain a publicly
9 available website with the domain name “LEP.gov”
10 to serve as the central repository for each plan sub-
11 mitted to the Attorney General under paragraph
12 (4)(A).

13 (c) LANGUAGE ACCESS TECHNICAL STANDARDS.—

14 (1) ESTABLISHMENT OF STANDARD.—Not later
15 than 1 year after the date of the enactment of this
16 Act, the head of each agency, in consultation with
17 the Attorney General, the National Institute of
18 Standards and Technology, and stakeholders and
19 advocates from non-English-speaking communities,
20 shall establish standards to be known as Language
21 Access Technical Standards to—

22 (A) ensure meaningful access to federally
23 conducted programs and activities under sub-
24 section (a); and

1 (B) be used as a measure of progress to
2 evaluate the effectiveness and accuracy of lan-
3 guage access for federally conducted programs
4 and activities carried out by each agency.

5 (2) GENERAL ACCESSIBILITY REQUIRE-
6 MENTS.—The Language Access Technical Standards
7 shall at a minimum, with respect to the systems and
8 services of the agency—

9 (A) allow individuals with LEP to access
10 any written content provided by the agency in
11 the language of their choice among the agency's
12 supported languages;

13 (B) ensure the functionality, quality, and
14 timeliness of the system and services for all lan-
15 guages;

16 (C) implement user-friendly interfaces that
17 account for varying literacy and digital skills;
18 and

19 (D) be culturally determined.

20 (3) UNDUE BURDEN EXCEPTION.—

21 (A) WRITTEN REQUEST.—In the case that
22 the head of an agency determines that compli-
23 ance with a specific requirement included in the
24 Language Access Technical Standards estab-
25 lished under this subsection would impose an

undue burden on the agency, the head of the agency shall submit to the Attorney General a written request to waive such requirement for the agency that identifies—

(i) the specific requirement that would impose such undue burden;

(ii) the nature of the burden; and

(iii) any alternative to fulfilling the requirement and why each such alternative is not feasible.

(B) ATTORNEY GENERAL REVIEW.—

(i) IN GENERAL.—Not later than 30 days after receiving a request under subparagraph (A), the Attorney General shall grant or deny the request.

(ii) DETERMINATION CRITERIA.—In determining whether to grant or deny a request under paragraph (2), the Attorney General an agency shall consider whether—

(I) individuals with limited English proficiency are likely to interact with the agency; and

(II) a failure to provide meaningful language access is likely to result

1 in significant harm, denial of benefits,
2 or diminished civil rights protections.

3 (C) EXPIRATION.—A grant of a waiver
4 under this subsection shall expire two years
5 after such grant.

6 (D) RECORD.—The Attorney General shall
7 maintain a publicly accessible record of all writ-
8 ten requests received under subparagraph (A)
9 in the central repository established under sub-
10 section (b)(5).

11 (4) PUBLIC PARTICIPATION AND COMMENT.—
12 Before establishing Language Access Technical
13 Standards, or updating any such standards, the
14 head of an agency shall provide opportunity for pub-
15 lic comment and engage communities representing
16 individuals with LEP, including community and cul-
17 tural organizations that work with individuals with
18 LEP, and providers of professional language serv-
19 ices.

20 (5) UPDATES.—The Language Access Tech-
21 nical Standards shall be reviewed at least once every
22 3 years, and updated as necessary following such re-
23 view.

1 (6) ADOPTION.—The head of each agency shall
2 certify compliance with the Language Access Tech-
3 nical Standards annually to the Attorney General.

4 (7) SCOPE.—The Language Access Technical
5 Standards shall apply to all agency programs, activi-
6 ties, and communications, including—

7 (A) in-person, telephonic, and virtual inter-
8 actions;

9 (B) paper and digital content and docu-
10 ments;

11 (C) websites, portals, and mobile applica-
12 tions; and

13 (D) artificial intelligence-assisted and ma-
14 chine translation language assistance services,
15 including automated translation, transcription,
16 and interpretation technologies.

17 (d) AI AND AUTOMATED LANGUAGE ASSISTANCE
18 SERVICES.—

19 (1) LIMITATION.—The head of an agency—

20 (A) may not fully replace any qualified lan-
21 guage assistance services of the agency with ar-
22 tificial intelligence or machine translation serv-
23 ices; and

1 (B) shall require a qualified human trans-
2 lator or interpreter to verify any use of such
3 service or machine translation by the agency.

4 (2) REQUIREMENTS.—The head of each agency
5 shall ensure that any artificial intelligence-assisted
6 language assistance services used by the agency—

7 (A) do not replace any qualified translators
8 and interpreters;

9 (B) publicly disclose on an annual basis on
10 www.LEP.gov data sources, limitations, con-
11 fidence levels, and error rates of the service;

12 (C) comply with section 552a of title 5,
13 United States Code (commonly referred to as
14 the Privacy Act of 1974), the Federal Informa-
15 tion Security Modernization Act of 2014, and
16 the E–Government Act of 2002, and protect
17 personal and sensitive information from disclo-
18 sure;

19 (D) are tested to prevent discrimination
20 based on language, culture, ethnicity, or other
21 protected characteristics, with mitigation strate-
22 gies documented;

23 (E) are reviewed and validated by qualified
24 translators and interpreters to ensure proper

1 cultural context, idiomatic accuracy, and clarity
2 of the translation or interpretation; and

3 (F) are continuously monitored by the
4 agency for performance, with errors reported
5 and corrective actions for user-reported inac-
6 curacies in translation and interpretation imple-
7 mented.

8 (3) BEST PRACTICES.—Not later than 1 year
9 after the date of the enactment of this Act, the At-
10 torney General shall issue guidance on best practices
11 for the use of artificial intelligence in language as-
12 sistance services, including validation, monitoring,
13 and accountability measures for such artificial intel-
14 ligence.

15 (4) AUDIT REQUIREMENT.—

16 (A) IN GENERAL.—The Inspector General
17 of each agency shall conduct, at least once
18 every two years after the date of the enactment
19 of this Act, an audit of all artificial intelligence-
20 assisted language systems to assess accuracy,
21 fairness, cultural relevance, and compliance
22 with the Language Access Technical Standards
23 established under subsection (c).

24 (B) REPORT.—An Inspector General shall
25 submit to the Attorney General a report on an

1 audit conducted under subparagraph (A), not
2 later than 90 days after such audit is com-
3 pleted.

4 (C) PUBLIC TRANSPARENCY.—The Attor-
5 ney General shall make publicly available a
6 summary of the report submitted under sub-
7 paragraph (B).

8 (5) NIST.—The National Institute of Stand-
9 ards and Technology shall provide technical exper-
10 tise, validation protocols, and standardization tools
11 for artificial intelligence-assisted language assistance
12 services.

13 (e) INTERAGENCY COORDINATION.—

14 (1) INTERAGENCY LANGUAGE ACCESS STAND-
15 ARD COUNCIL.—The Administrator of General Serv-
16 ices shall convene an Interagency Language Access
17 Standards Council to coordinate updates, best prac-
18 tices, and research on emerging technologies.

19 (2) LANGUAGE ACCESS WORKING GROUP.—

20 (A) IN GENERAL.—There is established an
21 Language Access Working Group to—

22 (i) serve as a central resource for pro-
23 viding support and technical assistance to
24 agencies in implementing the language ac-
25 cess plan of the agency; and

1 (ii) directly engage with community
2 groups, individuals with LEP, and other
3 stakeholders to ensure adherence with this
4 section.

5 (B) MEMBERSHIP.—The members of the
6 Group shall be comprised of one Language Ac-
7 cess Coordinator from each agency and the At-
8 torney General.

9 (C) HEAD OF GROUP.—The Attorney Gen-
10 eral shall serve as the head of the Group.

11 (f) ESTABLISHMENT OF LANGUAGE ACCESS COORDI-
12 NATOR POSITION.—

13 (1) POSITION.—There is established in each
14 agency a position to be known as the Language Ac-
15 cess Coordinator.

16 (2) DESIGNATION.—The head of each agency
17 shall designate an officer or employee of the agency
18 to serve as the Language Access Coordinator for the
19 agency.

20 (3) DUTIES.—The Language Access Coordi-
21 nator shall—

22 (A) serve as point of contact for each lan-
23 guage access effort of the agency;

24 (B) shall ensure that each agency compo-
25 nent that frequently interacts with individuals

1 with LEP provides, if feasible, mandatory an-
2 nual training to managers, personnel who fre-
3 quently communicate with individuals with
4 LEP, and personnel who arrange for language
5 support, on this section, the language access
6 plan of the agency, and agency procedures for
7 identifying language access needs, providing
8 language assistance services, working with in-
9 terpreters and translators, requesting document
10 translations, and tracking the use of language
11 access services;

12 (C) determine annually whether additional
13 federally conducted programs and activities
14 should be made accessible for individuals with
15 LEP and notify agency components of their re-
16 sponsibility to provide such access; and

17 (D) beginning on the date that is 3 years
18 after the date of the enactment of this Act,
19 evaluate the language access plan of the agency,
20 including a review of the costs of language as-
21 sistance services, and propose changes to agen-
22 cy components, as appropriate, to refine such
23 plan.

24 (g) NONCOMPLIANCE.—Noncompliance with the re-
25 quirements of this section—

1 (1) shall be treated as discrimination under title
2 VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d
3 et seq.), thereby granting the Department of Justice
4 enforcement authority, including the authority to
5 conduct an investigation, commence an administra-
6 tive action, and seek civil remedies; and

7 (2) may trigger administrative, civil, or injunc-
8 tive remedies by aggrieved parties or the Attorney
9 General.

10 (h) DEFINITIONS.—In this section:

11 (1) AGENCY.—The term “agency” has the
12 meaning given that term in section 551 of title 5,
13 United States Code.

14 (2) INDIVIDUAL WITH LEP.—The term “indi-
15 vidual with LEP” means an individual for whom
16 English is not a primary language and who has a
17 limited ability to read, speak, write, or understand
18 the English language (including an individual who is
19 able to speak or understand the English language,
20 but has a limited ability to read or write the English
21 language).

22 (3) LANGUAGE ASSISTANCE SERVICES.—The
23 term “language assistance services” means oral and
24 written language assistance services used to provide
25 individuals with LEP meaningful access to, and an

1 equal opportunity to participate fully in, the services,
2 activities, and other programs administered by the
3 Federal Government.

4 (4) MEANINGFUL ACCESS.—The term “mean-
5 ingful access” means access that—

6 (A) results in accurate, timely, and effec-
7 tive communication at no cost to the individual
8 with LEP; and

9 (B) is comparable to the access provided to
10 individuals who are proficient in English.

11 (5) PRIMARY LANGUAGE.—The term “primary
12 language” means the language in which an indi-
13 vidual most effectively communicates.

14 (6) PROGRAM OR ACTIVITY.—The term “pro-
15 gram or activity” means all the operations of an
16 agency that involve contact with the public, the ad-
17 ministration of Federal benefits, or communication
18 with members of the public or program participants.

19 (7) QUALIFIED INTERPRETER OR TRANS-
20 LATOR.—The term “qualified interpreter or trans-
21 lator” means—

22 (A) an individual who—

23 (i) is capable of effective, accurate,
24 and impartial rendition of spoken or signed
25 communication from one language to an-

1 other between people who speak, sign,
2 read, or write in a different language, both
3 receptively and expressively, using any nec-
4 essary specialized vocabulary and with ap-
5 propriate cultural relevance, either simulta-
6 neously or consecutively;

7 (ii) demonstrates to the Language Ac-
8 cess Coordinator of the agency proficiency
9 in and ability to listen to a spoken lan-
10 guage, seeing or feeling a signed or manual
11 language, or reading something written in
12 one language and expressing what is being
13 conveyed by that language accurately and
14 with appropriate cultural relevance into an-
15 other language, either simultaneously or
16 consecutively, including with respect to any
17 specialized term, concept, or any particu-
18 larized vocabulary or phraseology par-
19 ticular to the program or service concerned
20 that is being conveyed; and

21 (iii) understands and adheres to the
22 roles of interpreters or translators, includ-
23 ing any confidentiality, ethics, and impar-
24 tiality rules.

1 (8) VITAL DOCUMENT.—The term “vital docu-
 2 ment” means any written material containing infor-
 3 mation critical for—

4 (A) accessing or understanding a Federal
 5 program or activity or required by law; or

6 (B) obtaining any aid, benefit, service, or
 7 training, such as—

8 (i) an application for a benefit or
 9 service;

10 (ii) a consent or complaint form;

11 (iii) a notice of rights and responsibil-
 12 ities; or

13 (iv) a letter or notice that requires a
 14 response from a beneficiary, applicant,
 15 participant, or employee.

16 **SEC. 2016. STOP MENTAL HEALTH STIGMA ACT.**

17 (a) DEFINITIONS.—In this section:

18 (1) AANHPI.—The term “AANHPI” means
 19 Asian American, Native Hawaiian, and Pacific Is-
 20 lander.

21 (2) SECRETARY.—Except as otherwise speci-
 22 fied, the term “Secretary” means the Secretary of
 23 Health and Human Services.

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

1 (1) The AANHPI community is among the
2 fastest growing population groups in the United
3 States. It is a diverse population representing more
4 than 70 distinct ethnicities, and speaking more than
5 100 languages and dialects.

6 (2) There is a growing mental health crisis in
7 the United States, particularly for AANHPI individ-
8 uals. AANHPI individuals with mental health chal-
9 lenges have the lowest rates of mental health service
10 utilization compared to other racial or ethnic popu-
11 lations. In 2023, only 35 percent of Asian adults
12 with a mental health challenge received treatment in
13 the past year. Although suicide is the eleventh lead-
14 ing cause of death, it is the leading cause of death
15 for AANHPI youth. From 2018 to 2023, AANHPI
16 youth between the ages of 10 to 24 years were the
17 only racial or ethnic population in this age category
18 where suicide was the leading cause of death.

19 (3) Such mental health disparities within the
20 AANHPI community may be attributed to systemic
21 barriers to accessing mental health services, includ-
22 ing stigma attached to mental health, limited avail-
23 ability of and access to culturally and linguistically
24 appropriate services, and insufficient research.

1 (4) Insufficient research on AANHPI commu-
 2 nities often leads to an inaccurate representation of
 3 their experiences and needs. It is imperative to
 4 disaggregate AANHPI population data to better un-
 5 derstand the range of mental health issues for each
 6 subpopulation so that specific culturally and linguis-
 7 tically appropriate solutions can be developed.

8 (5) Critical investments are necessary to reduce
 9 stigma and improve mental health within AANHPI
 10 communities, including increasing culturally and lin-
 11 guistically appropriate outreach education and men-
 12 tal health services, improving representation of
 13 AANHPI individuals among the behavioral health
 14 workforce, and strengthening disaggregated data col-
 15 lection in research.

16 (c) NATIONAL AANHPI BEHAVIORAL HEALTH OUT-
 17 REACH AND EDUCATION STRATEGY.—Part D of title V
 18 of the Public Health Service Act (42 U.S.C. 290dd et seq.)
 19 is amended by adding at the end the following new section:

20 **“SEC. 554. NATIONAL AANHPI BEHAVIORAL HEALTH OUT-
 21 REACH AND EDUCATION STRATEGY.**

22 “(a) IN GENERAL.—The Secretary, acting through
 23 the Assistant Secretary, shall, in coordination with the Di-
 24 rector of the Office of Minority Health, the Director of
 25 the National Institutes of Health, and the Director of the

1 Centers for Disease Control and Prevention, and in con-
2 sultation with advocacy and behavioral health organiza-
3 tions serving populations of Asian American, Native Ha-
4 waiian, and Pacific Islander individuals or communities,
5 develop and implement a national outreach and education
6 strategy to promote behavioral health and reduce stigma
7 associated with mental health and substance use disorders
8 within the Asian American, Native Hawaiian, and Pacific
9 Islander population. Such strategy shall—

10 “(1) be designed to meet the diverse cultural
11 and language needs and preferences of the various
12 Asian American, Native Hawaiian, and Pacific Is-
13 lander populations;

14 “(2) be developmentally and age appropriate;

15 “(3) increase awareness of symptoms of mental
16 illnesses common within subgroups of such popu-
17 lation, taking into account differences within sub-
18 groups, such as gender, gender identity, age, sexual
19 orientation, culture, or ethnicity;

20 “(4) provide information, in a publicly acces-
21 sible manner, on evidence-based, culturally and lin-
22 guistically appropriate, and adapted interventions
23 and treatments;

1 “(5) ensure full participation of, and engage,
2 both consumers and community members in the de-
3 velopment and implementation of materials; and

4 “(6) seek to broaden the perspective among
5 both individuals in Asian American, Native Hawai-
6 ian, and Pacific Islander communities and stake-
7 holders serving such communities to use a com-
8 prehensive public health approach to promoting be-
9 havioral health that addresses a holistic view of
10 health by focusing on the intersection between be-
11 havioral and physical health.

12 “(b) REPORTS.—Beginning not later than 1 year
13 after the date of the enactment of the Health Equity and
14 Accountability Act of 2026 and annually thereafter, the
15 Secretary, acting through the Assistant Secretary, shall
16 submit to Congress, and make publicly available, a report
17 on the extent to which the strategy developed and imple-
18 mented under subsection (a) increased awareness among
19 the Asian American, Native Hawaiian, and Pacific Is-
20 lander population of mental health and substance use dis-
21 orders.

22 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
23 is authorized to be appropriated to carry out this section
24 \$3,000,000 for each of fiscal years 2026 through 2030.”.

1 (d) SYSTEMATIC REVIEW OF AND REPORT ON THE
2 AANHPI YOUTH BEHAVIORAL HEALTH CRISIS.—

3 (1) SYSTEMATIC REVIEW.—

4 (A) IN GENERAL.—The Secretary, acting
5 through the Assistant Secretary for Mental
6 Health and Substance Use, in coordination with
7 the Director of the National Institutes of
8 Health, the Director of the Centers for Disease
9 Control and Prevention, and the Director of the
10 Office of Minority Health, shall conduct a sys-
11 tematic review of behavioral health among
12 AANHPI youth.

13 (B) ELEMENTS.—Such systematic review
14 required under subparagraph (A) shall include
15 an assessment of—

16 (i) the prevalence, risk factors, and
17 root causes of mental health challenges,
18 substance misuse, and mental health and
19 substance use disorders among AANHPI
20 youth;

21 (ii) the prevalence and methods of at-
22 tempted suicide, nonfatal substance use
23 overdose, and death by suicide or sub-
24 stance use overdose among AANHPI
25 youth; and

1 (iii) AANHPI youth that received
2 treatment for mental health and substance
3 use disorders.

4 (2) REPORT.—Not later than one year after the
5 date of the enactment of this Act, the Secretary
6 shall submit to the Committee on Health, Edu-
7 cation, Labor, and Pensions of the Senate and the
8 Committee on Energy and Commerce of the House
9 of Representatives, and make publicly available, a
10 report on the findings of the systematic review con-
11 ducted under paragraph (1), including—

12 (A) identification of the barriers to access-
13 ing behavioral health prevention, treatment, and
14 recovery services for AANHPI youth;

15 (B) identification of root causes of mental
16 health challenges and substance misuse among
17 AANHPI youth;

18 (C) recommendations for evidence-based
19 actions to be taken by the Secretary to improve
20 behavioral health among AANHPI youth;

21 (D) recommendations for legislative or ad-
22 ministrative action to improve the behavioral
23 health of AANHPI youth experiencing depres-
24 sion, suicide, and overdose, and to reduce the
25 prevalence of depression, suicide, overdose, and

1 other behavioral health conditions among
2 AANHPI youth; and

3 (E) such other recommendations as the
4 Secretary determines appropriate.

5 (3) DATA.—Any data included in the system-
6 atic review or report under this section shall be
7 disaggregated by race, ethnicity, age, sex, gender
8 identity, sexual orientation, geographic region, dis-
9 ability status, and other relevant factors, in a man-
10 ner that protects personal privacy and that is con-
11 sistent with applicable Federal and State privacy
12 law.

13 (4) AUTHORIZATION OF APPROPRIATIONS.—For
14 purposes of carrying out this subsection, there is au-
15 thorized to be appropriated \$1,500,000 for fiscal
16 year 2027.

17 (e) SYSTEMATIC REVIEW OF AND REPORT ON STRAT-
18 EGIES ON THE AANHPI BEHAVIORAL HEALTH WORK-
19 FORCE SHORTAGE.—

20 (1) SYSTEMATIC REVIEW.—

21 (A) IN GENERAL.—The Secretary, acting
22 through the Assistant Secretary for Mental
23 Health and Substance Use, in coordination with
24 the Administrator of the Health Resources and
25 Services Administration, the Secretary of

1 Labor, and the Director of the Office of Minor-
2 ity Health, shall conduct a systematic review of
3 strategies for increasing the behavioral health
4 workforce that identify as AANHPI.

5 (B) ELEMENTS.—Such systematic review
6 required under subparagraph (A) shall include
7 an assessment of—

8 (i) the total number of behavioral
9 health workers in the United States who
10 identify as AANHPI;

11 (ii) with respect to each such worker,
12 information regarding the current type of
13 license, geographic area of practice, and
14 type of employer (such as hospital, Feder-
15 ally qualified health center, school, or pri-
16 vate practice);

17 (iii) information regarding the cul-
18 tural and linguistic capabilities of such
19 workers, including languages spoken pro-
20 ficiently;

21 (iv) the relevant barriers to enrollment
22 in behavioral health professional education
23 programs and entering the behavioral
24 health workforce for AANHPI individuals;
25 and

1 (v) the total number of behavioral
2 health workers who identify as AANHPI
3 and who participate in Federal programs
4 that seek to increase, train, and support
5 the behavioral health workforce.

6 (2) REPORT.—Not later than one year after the
7 date of the enactment of this Act, the Secretary
8 shall submit to the Committee on Health, Edu-
9 cation, Labor, and Pensions of the Senate and the
10 Committee on Energy and Commerce of the House
11 of Representatives, and make publicly available, a
12 report on the findings of the systematic review con-
13 ducted under paragraph (1), including—

14 (A) identification of AANHPI behavioral
15 health workers' knowledge and awareness of the
16 barriers to quality behavioral health care serv-
17 ices faced by AANHPI individuals, including
18 stigma, limited English proficiency, and lack of
19 health insurance coverage;

20 (B) recommendations for actions to be
21 taken by the Secretary to increase the number
22 of AANHPI behavioral health workers;

23 (C) recommendations for legislative or ad-
24 ministrative action to improve the enrollment of

1 AANHPI individuals in behavioral health work-
2 force education and training programs; and

3 (D) such other recommendations as the
4 Secretary determines appropriate.

5 (3) DATA.—Any data included in the system-
6 atic review or report under this section shall be
7 disaggregated by race, ethnicity, age, sex, gender
8 identity, sexual orientation, geographic region, dis-
9 ability status, and other relevant factors, in a man-
10 ner that protects personal privacy and that is con-
11 sistent with applicable Federal and State privacy
12 law.

13 (4) DEFINITION.—In this section the term “be-
14 havioral health worker” means any individual li-
15 censed or certified to provide mental health or sub-
16 stance use disorder services, including in the profes-
17 sions of social work, psychology, psychiatry, mar-
18 riage and family therapy, mental health counseling,
19 peer support, and substance use disorder counseling.

20 (5) AUTHORIZATION OF APPROPRIATIONS.—For
21 purposes of carrying out this subsection, there is au-
22 thorized to be appropriated \$1,500,000 for fiscal
23 year 2027.

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

3 **Subtitle A—Diversifying the Health**
4 **Care Workplace**

5 **SEC. 3001. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
6 **ACT.**

7 Title XXXIV of the Public Health Service Act, as
8 added by section 2004, is amended by adding at the end
9 the following:

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

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

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

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

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

24 “(A) The Health Resources and Services
25 Administration.

1 “(B) The Department of Health and
2 Human Services Data Council.

3 “(C) The Office of Minority Health of the
4 Department of Health and Human Services.

5 “(D) The Substance Abuse and Mental
6 Health Services Administration.

7 “(E) The Bureau of Labor Statistics of
8 the Department of Labor.

9 “(F) The National Institute on Minority
10 Health and Health Disparities.

11 “(G) The Agency for Healthcare Research
12 and Quality.

13 “(H) The National Academy of Medicine.

14 “(I) The Indian Health Service.

15 “(J) The Centers for Medicare & Medicaid
16 Services.

17 “(K) The Department of Education.

18 “(L) Institutions described in section
19 371(a) of the Higher Education Act of 1965.

20 “(M) Consumer organizations.

21 “(N) Health professional associations, in-
22 cluding those that represent underrepresented
23 minority populations.

24 “(O) Researchers in the area of health
25 workforce.

1 “(P) Health workforce accreditation enti-
2 ties.

3 “(Q) Private (including nonprofit) founda-
4 tions that have sponsored workforce diversity
5 initiatives.

6 “(R) Local and State health departments.

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

11 “(T) National community-based organiza-
12 tions that serve as a national intermediary to
13 their rural or urban affiliate members and have
14 demonstrated capacity to train health care pro-
15 fessionals.

16 “(U) The Veterans Health Administration.

17 “(V) Other entities determined appropriate
18 by the Secretary.

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

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

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

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

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

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

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

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

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

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

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

4 “(10) Help with monitoring of standards for di-
5 versity, equity, and inclusion.

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

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

16 “(e) COORDINATION WITH OTHER EFFORTS.—In
17 providing for the establishment of the working group
18 under subsection (a), the Secretary shall take such steps
19 as may be necessary to ensure that the work of the work-
20 ing group does not overlap with, or otherwise duplicate,
21 other Federal Government efforts with respect to ensuring
22 health equity in data collection in public health emer-
23 gencies.

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

1 such sums as may be necessary for each of fiscal years
2 2027 through 2031.

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

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

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

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

19 “(2) Statistical information relating to rep-
20 resentation of underrepresented minority populations
21 in health and allied health professions and occupa-
22 tions.

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

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

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

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

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

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

19 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2027 through 2031.

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

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

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

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

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

18 “(B) historically Black professional or
19 graduate institutions eligible for grants under
20 section 326 of such Act;

21 “(C) Hispanic-serving health professions
22 schools;

23 “(D) Hispanic-serving institutions, as de-
24 fined in section 502 of such Act;

25 “(E) Tribal Colleges or Universities, as de-
26 fined in section 316 of such Act;

1 “(F) Asian American and Native American
2 Pacific Islander-serving institutions, as defined
3 in section 371(c) of such Act;

4 “(G) institutions that have programs to re-
5 cruit and retain underrepresented health profes-
6 sionals of minority populations, in which a sig-
7 nificant number of the enrolled participants are
8 from minority populations;

9 “(H) health professional associations,
10 which may include health professional associa-
11 tions representing underrepresented minority
12 populations; and

13 “(I) institutions, including national and re-
14 gional community-based organizations with
15 demonstrated commitment to a diversified
16 workforce—

17 “(i) located in communities with pre-
18 dominantly underrepresented minority pop-
19 ulations;

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

23 “(iii) in which at least 20 percent of
24 the enrolled participants are from under-
25 represented minority populations; and

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

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

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

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

17 “(3) postbaccalaureate programs;

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

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

24 “(6) mentoring programs;

“(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 2027 through 2031.

“(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, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Health Resources and Services Administration, shall award grants that expand existing opportunities for scientists and researchers and promote the inclu-

1 sion of underrepresented minority populations in the
2 health professions.

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

12 “(c) DATA COLLECTION.—The head of each agency
13 listed in subsection (a) shall collect data on the number
14 (expressed as an absolute number and a percentage) of
15 underrepresented applicants from minority populations,
16 and applicants from populations that are not minority
17 populations, who receive and are denied agency funding
18 at every stage of review. Such data shall be reported annu-
19 ally to the Secretary and the appropriate committees of
20 Congress.

21 “(d) STUDENT LOAN REIMBURSEMENT.—The Sec-
22 retary shall establish a student loan reimbursement pro-
23 gram to provide student loan reimbursement assistance to
24 researchers who focus on racial and ethnic disparities in
25 health. The Secretary shall promulgate regulations to de-

1 fine the scope and procedures for the program under this
2 subsection.

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

12 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2027 through 2031.

16 **“SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH**
17 **PROFESSIONALS.**

18 “(a) IN GENERAL.—The Secretary, acting through
19 the Director of the Centers for Disease Control and Pre-
20 vention, the Assistant Secretary for Mental Health and
21 Substance Use, the Administrator of the Health Resources
22 and Services Administration, and the Administrator of the
23 Centers for Medicare & Medicaid Services, shall establish
24 a program to award grants to universities and other insti-

1 tutions to enter into agreements with eligible individuals
2 under which—

3 “(1) the university or institution supports the
4 eligible individual’s career in a nonresearch-related
5 health and wellness profession; and

6 “(2) the eligible individual commits to per-
7 forming a period of obligated service in such a ca-
8 reer to serve, or to work on health issues affecting,
9 underserved communities, such as communities of
10 racial and ethnic minority groups.

11 “(b) ELIGIBLE INDIVIDUALS.—To be an eligible indi-
12 vidual for purposes of subsection (a), an individual shall
13 be a student in a health professions school, a graduate
14 of such a school who is working in a health profession,
15 an individual working in a health or wellness profession
16 (including mental and behavioral health), or a faculty
17 member of such a school.

18 “(c) APPLICATION.—To seek a grant under this sec-
19 tion, a university or other institution shall submit to the
20 Secretary an application at such time, in such manner,
21 and containing such information as the Secretary may re-
22 quire.

23 “(d) USE OF FUNDS.—A university or other institu-
24 tion receiving a grant under this section shall use the

1 grant for agreements described in subsection (a). Such
2 agreements may—

3 “(1) support an eligible individual’s health ac-
4 tivities or projects that involve underserved commu-
5 nities, including communities of racial and ethnic
6 minority groups;

7 “(2) support an eligible individual’s health-re-
8 lated career advancement activities;

9 “(3) pay, or reimburse for payment of, student
10 loans or training or credentialing costs for eligible
11 individuals who are health professionals and are fo-
12 cused on health issues affecting underserved commu-
13 nities, including communities of racial and ethnic
14 minority groups; and

15 “(4) establish and promote leadership training
16 programs for eligible individuals to decrease health
17 disparities and to increase cultural competence with
18 the goal of increasing diversity in leadership posi-
19 tions.

20 “(e) DEFINITION.—In this section, the term ‘career
21 in a nonresearch-related health and wellness profession’
22 means employment or intended employment in the field
23 of public health, health policy, health management, health
24 administration, medicine, nursing, pharmacy, psychology,
25 social work, psychiatry, other mental and behavioral

1 health, allied health, community health, social work, or
 2 other fields determined appropriate by the Secretary,
 3 other than in a position that involves research.

4 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
 5 are authorized to be appropriated to carry out this section
 6 such sums as may be necessary for each of fiscal years
 7 2027 through 2031.

8 **“SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
 9 **VERSITY ON QUALITY.**

10 “(a) IN GENERAL.—The Director of the Agency for
 11 Healthcare Research and Quality (in this section referred
 12 to as the ‘Director’), in collaboration with the Deputy As-
 13 sistant Secretary for Minority Health and the Director of
 14 the National Institute on Minority Health and Health Dis-
 15 parities, shall award grants to eligible entities to expand
 16 research on the link between health workforce diversity
 17 and quality health care.

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

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

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

1 “(c) USE OF FUNDS.—Amounts received under a
2 grant awarded under subsection (a) shall be used to sup-
3 port research that investigates the effect of health work-
4 force diversity on—

5 “(1) language access;

6 “(2) cultural competence;

7 “(3) patient satisfaction;

8 “(4) timeliness of care;

9 “(5) safety of care;

10 “(6) effectiveness of care;

11 “(7) efficiency of care;

12 “(8) patient outcomes;

13 “(9) community engagement;

14 “(10) resource allocation;

15 “(11) organizational structure;

16 “(12) compliance of care; or

17 “(13) other topics determined appropriate by
18 the Director.

19 “(d) PRIORITY.—In awarding grants under sub-
20 section (a), the Director shall give individualized consider-
21 ation to all relevant aspects of the applicant’s background.
22 Consideration of prior research experience involving the
23 health of underserved communities shall be such a relevant
24 aspect.

1 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2027 through 2031.

5 **“SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.**

6 “(a) ESTABLISHMENT.—The Secretary, acting
7 through the Office of Minority Health, in collaboration
8 with the National Institute on Minority Health and Health
9 Disparities, the Office for Civil Rights, the Centers for
10 Disease Control and Prevention, the Centers for Medicare
11 & Medicaid Services, the Health Resources and Services
12 Administration, and other appropriate public and private
13 entities, shall establish and coordinate a health and health
14 care disparities education program to support, develop,
15 and implement educational initiatives and outreach strate-
16 gies that inform health care professionals and the public
17 about the existence of and methods to reduce racial and
18 ethnic disparities in health and health care.

19 “(b) ACTIVITIES.—The Secretary, through the edu-
20 cation program established under subsection (a), shall,
21 through the use of public awareness and outreach cam-
22 paigns targeting the general public and the medical com-
23 munity at large—

24 “(1) disseminate scientific evidence for the ex-
25 istence and extent of racial and ethnic disparities in

1 health care, including disparities that are not other-
2 wise attributable to known factors such as access to
3 care, patient preferences, or appropriateness of
4 intervention, as described in the 2002 report of the
5 National Academy of Medicine (formerly the ‘Insti-
6 tute of Medicine’) entitled ‘Unequal Treatment: Con-
7 fronting Racial and Ethnic Disparities in Health
8 Care’, as well as the impact of disparities related to
9 age, disability status, socioeconomic status, sex, gen-
10 der identity, and sexual orientation on racial and
11 ethnic minority groups;

12 “(2) disseminate new research findings to
13 health care providers and patients to assist them in
14 understanding, reducing, and eliminating health and
15 health care disparities;

16 “(3) disseminate information about the impact
17 of linguistic and cultural barriers on health care
18 quality and the obligation of health providers who
19 receive Federal financial assistance to ensure that
20 individuals with limited English proficiency have ac-
21 cess to language access services;

22 “(4) disseminate information about the impor-
23 tance and legality of racial, ethnic, disability status,
24 socioeconomic status, sex, gender identity, and sex-

1 ual orientation, and primary language data collec-
2 tion, analysis, and reporting;

3 “(5) design and implement specific educational
4 initiatives to health care providers relating to health
5 and health care disparities;

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

10 “(7) design and implement specific educational
11 initiatives to educate the health care workforce relat-
12 ing to unconscious bias.

13 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to carry out this section
15 such sums as may be necessary for each of fiscal years
16 2027 through 2031.”.

1 **SEC. 3002. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
2 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
3 **HISTORICALLY BLACK PROFESSIONAL OR**
4 **GRADUATE INSTITUTIONS, ASIAN AMERICAN**
5 **AND NATIVE AMERICAN PACIFIC ISLANDER-**
6 **SERVING INSTITUTIONS, TRIBAL COLLEGES,**
7 **REGIONAL COMMUNITY-BASED ORGANIZA-**
8 **TIONS, AND NATIONAL MINORITY MEDICAL**
9 **ASSOCIATIONS.**

10 Part B of title VII of the Public Health Service Act
11 (42 U.S.C. 293 et seq.) is amended by adding at the end
12 the following:

13 **“SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
14 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
15 **HISTORICALLY BLACK PROFESSIONAL OR**
16 **GRADUATE INSTITUTIONS, ASIAN AMERICAN**
17 **AND NATIVE AMERICAN PACIFIC ISLANDER-**
18 **SERVING INSTITUTIONS, AND TRIBAL COL-**
19 **LEGES.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration and in consultation with the Secretary of
23 Education, shall award grants to Hispanic-serving institu-
24 tions, historically Black colleges and universities, histori-
25 cally Black professional or graduate institutions eligible
26 for grants under section 326 of the Higher Education Act

1 of 1965, Asian American and Native American Pacific Is-
 2 lander-serving institutions, Tribal Colleges or Universities,
 3 regional community-based organizations, and national mi-
 4 nority medical associations, for counseling, mentoring, and
 5 providing information on financial assistance to prepare
 6 underrepresented minority individuals to enroll in and
 7 graduate from health professional schools and to increase
 8 services for underrepresented minority students includ-
 9 ing—

10 “(1) mentoring with underrepresented health
 11 professionals;

12 “(2) providing financial assistance information
 13 for continued education and applications to health
 14 professional schools; and

15 “(3) retaining existing enrolled underrep-
 16 resented minority students in a health professions
 17 school.

18 “(b) DEFINITIONS.—In this section:

19 “(1) ASIAN AMERICAN AND NATIVE AMERICAN
 20 PACIFIC ISLANDER-SERVING INSTITUTION.—The
 21 term ‘Asian American and Native American Pacific
 22 Islander-serving institution’ has the meaning given
 23 such term in section 320(b) of the Higher Education
 24 Act of 1965.

1 “(2) HISPANIC-SERVING INSTITUTION.—The
2 term ‘Hispanic-serving institution’ means an entity
3 that—

4 “(A) is a school or program for which
5 there is a definition under section 799B;

6 “(B) has an enrollment of full-time equiva-
7 lent students that is made up of at least 9 per-
8 cent Hispanic students;

9 “(C) has been effective in carrying out pro-
10 grams to recruit Hispanic individuals to enroll
11 in and graduate from the school;

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

14 “(E) has a significant number of graduates
15 who are providing health services to medically
16 underserved populations or to individuals in
17 health professional shortage areas; and

18 “(F) is a Hispanic Center of Excellence in
19 Health Professions Education designated under
20 section 736(d)(2).

21 “(3) HISTORICALLY BLACK COLLEGE AND UNI-
22 VERSITY.—The term ‘historically Black college and
23 university’ has the meaning given the term ‘part B
24 institution’ as defined in section 322 of the Higher
25 Education Act of 1965.

1 “(4) TRIBAL COLLEGE OR UNIVERSITY.—The
 2 term ‘Tribal College or University’ has the meaning
 3 given such term in section 316(b) of the Higher
 4 Education Act of 1965.

5 “(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In
 6 carrying out the National Health Service Corps Loan Re-
 7 payment Program established under subpart III of part
 8 D of title III and the loan repayment program under sec-
 9 tion 317F, the Secretary shall ensure, notwithstanding
 10 such subpart or section, that loan repayments of not less
 11 than \$50,000 per year per person are awarded for repay-
 12 ment of loans incurred for enrollment or participation of
 13 underrepresented minority individuals in health profes-
 14 sional schools and other health programs described in this
 15 section.

16 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 17 are authorized to be appropriated to carry out this section
 18 such sums as may be necessary for each of fiscal years
 19 2027 through 2031.”.

20 **SEC. 3003. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
 21 **DISEASE CONTROL AND PREVENTION.**

22 Section 317F(c)(1) of the Public Health Service Act
 23 (42 U.S.C. 247b–7(c)(1)) is amended by striking
 24 “\$500,000 for fiscal year 1994, and such sums as may
 25 be necessary for each of the fiscal years 1995 through

1 2002” and inserting “such sums as may be necessary for
 2 each of fiscal years 2027 through 2031”.

3 **SEC. 3004. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
 4 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
 5 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

6 Part D of title VII of the Public Health Service Act
 7 (42 U.S.C. 294 et seq.) is amended by inserting after sec-
 8 tion 755 of such Act (42 U.S.C. 294e) the following:

9 **“SEC. 755A. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
 10 **GREE PROGRAMS.**

11 “(a) COOPERATIVE AGREEMENTS.—The Secretary,
 12 acting through the Administrator of the Health Resources
 13 and Services Administration, in consultation with the Di-
 14 rector of the Centers for Disease Control and Prevention,
 15 the Director of the Agency for Healthcare Research and
 16 Quality, and the Deputy Assistant Secretary for Minority
 17 Health, shall enter into cooperative agreements with
 18 schools of public health and schools of allied health to de-
 19 sign and implement online degree programs.

20 “(b) PRIORITY.—In entering into cooperative agree-
 21 ments under this section, the Secretary shall give priority
 22 to any school of public health or school of allied health
 23 that has an established track record of serving medically
 24 underserved communities.

1 “(c) REQUIREMENTS.—As a condition of entering
2 into a cooperative agreement with the Secretary under this
3 section, a school of public health or school of allied health
4 shall agree to design and implement an online degree pro-
5 gram that meets the following restrictions:

6 “(1) Enrollment of individuals who have ob-
7 tained a secondary school diploma or its recognized
8 equivalent.

9 “(2) Maintaining a significant enrollment of
10 underrepresented minority or disadvantaged stu-
11 dents.

12 “(3) Achieving a high completion rate of en-
13 rolled underrepresented minority or disadvantaged
14 students.

15 “(d) PERIOD OF COOPERATIVE AGREEMENTS.—The
16 period during which payments are made through a cooper-
17 ative agreement entered into under this section may not
18 exceed 3 years.

19 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2027 through 2031.”.

1 **SEC. 3005. NATIONAL HEALTH CARE WORKFORCE COMMIS-**
2 **SION.**

3 (a) SENSE OF CONGRESS.—It is the sense of Con-
4 gress that the National Health Care Workforce Commis-
5 sion established by section 5101 of the Patient Protection
6 and Affordable Care Act (42 U.S.C. 294q) should, in car-
7 rying out its assigned duties under that section, give at-
8 tention to the needs of racial and ethnic minority groups,
9 individuals with lower socioeconomic status, individuals
10 with mental, developmental, and physical disabilities, les-
11 bian, gay, bisexual, transgender, queer, and questioning
12 populations, and individuals who are members of multiple
13 minority or special population groups.

14 (b) REAUTHORIZATION.—Section 5101(h)(2) of the
15 Patient Protection and Affordable Care Act (42 U.S.C.
16 294q(h)(2)) is amended by striking “such sums as may
17 be necessary” and inserting “\$3,000,000 for each of fiscal
18 years 2027 through 2029”.

19 **SEC. 3006. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

20 Subtitle B of title XXXIV of the Public Health Serv-
21 ice Act, as added by section 3001, is further amended by
22 inserting after section 3417 the following:

23 **“SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
24 **SERVICES CORPS.**

25 “(a) IN GENERAL.—The Director of the Centers for
26 Disease Control and Prevention, in collaboration with the

1 Administrator of the Health Resources and Services Ad-
2 ministration and the Deputy Assistant Secretary for Mi-
3 nority Health, shall award grants to eligible entities to in-
4 crease awareness among secondary and postsecondary stu-
5 dents of career opportunities in the health professions.

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

8 “(1) be a clinical, public health, or health serv-
9 ices organization, community-based or nonprofit en-
10 tity, or other entity determined appropriate by the
11 Director of the Centers for Disease Control and Pre-
12 vention;

13 “(2) serve a health professional shortage area,
14 as determined by the Secretary;

15 “(3) work with students, including those from
16 racial and ethnic minority groups, that have ex-
17 pressed an interest in the health professions; and

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

21 “(c) USE OF FUNDS.—Grant awards under sub-
22 section (a) shall be used to support internships that will
23 increase awareness among students of non-research-based,
24 career opportunities in the following health professions:

25 “(1) Medicine.

1 “(2) Nursing.

2 “(3) Public health.

3 “(4) Pharmacy.

4 “(5) Health administration and management.

5 “(6) Health policy.

6 “(7) Psychology.

7 “(8) Dentistry.

8 “(9) International health.

9 “(10) Social work.

10 “(11) Allied health.

11 “(12) Psychiatry.

12 “(13) Hospice care.

13 “(14) Community health, patient navigation,
14 and peer support.

15 “(15) Other professions determined appropriate
16 by the Director of the Centers for Disease Control
17 and Prevention.

18 “(d) PRIORITY.—In awarding grants under sub-
19 section (a), the Director of the Centers for Disease Con-
20 trol and Prevention shall give priority to those entities
21 that—

22 “(1) serve a high proportion of individuals from
23 disadvantaged backgrounds;

24 “(2) have experience in health disparity elimi-
25 nation programs;

1 “(3) facilitate the entry of disadvantaged indi-
2 viduals into institutions of higher education; and

3 “(4) provide counseling or other services de-
4 signed to assist disadvantaged individuals in success-
5 fully completing their education at the postsecondary
6 level.

7 “(e) STIPENDS.—

8 “(1) IN GENERAL.—Subject to paragraph (2),
9 an entity receiving a grant under this section may
10 use the funds made available through such grant to
11 award stipends for educational and living expenses
12 to students participating in the internship supported
13 by the grant.

14 “(2) LIMITATIONS.—A stipend awarded under
15 paragraph (1) to an individual—

16 “(A) may not be provided for a period that
17 exceeds 6 months; and

18 “(B) may not exceed \$50 per day for an
19 individual (notwithstanding any other provision
20 of law regarding the amount of a stipend).

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 such sums as may be necessary for each of fiscal years
24 2027 through 2031.

1 **“SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
2 **PROGRAM.**

3 “(a) IN GENERAL.—The Director of the Centers for
4 Disease Control and Prevention, in collaboration with the
5 Deputy Assistant Secretary for Minority Health, shall
6 award scholarships to eligible individuals under subsection
7 (b) who seek a career in public health.

8 “(b) ELIGIBILITY.—To be eligible to receive a schol-
9 arship under subsection (a), an individual shall—

10 “(1) have interest, knowledge, or skill in public
11 health research or public health practice, or other
12 health professions as determined appropriate by the
13 Director of the Centers for Disease Control and Pre-
14 vention;

15 “(2) reside in a health professional shortage
16 area as determined by the Secretary;

17 “(3) demonstrate promise for becoming a leader
18 in public health;

19 “(4) secure admission to a 4-year institution of
20 higher education; and

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

24 “(c) USE OF FUNDS.—Amounts received under an
25 award under subsection (a) shall be used to support oppor-
26 tunities for students to become public health professionals.

1 “(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Director shall give priority to those stu-
3 dents that—

4 “(1) are from disadvantaged backgrounds;

5 “(2) have secured admissions to an institution
6 described in section 371(a) of the Higher Education
7 Act of 1965; and

8 “(3) have identified a health professional as a
9 mentor at their institution described in subsection
10 (b)(4) and an academic advisor to assist in the com-
11 pletion of their baccalaureate degree.

12 “(e) SCHOLARSHIPS.—The Secretary may approve
13 payment of scholarships under this section for such indi-
14 viduals for any period of education in student under-
15 graduate tenure, except that such a scholarship may not
16 be provided to an individual for more than 4 years, and
17 such a scholarship may not exceed \$20,000 per academic
18 year for an individual (notwithstanding any other provi-
19 sion of law regarding the amount of a scholarship).

20 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2027 through 2031.

1 **“SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH**
2 **FELLOWSHIP PROGRAM.**

3 “(a) IN GENERAL.—The Director of the Centers for
4 Disease Control and Prevention, in collaboration with the
5 Deputy Assistant Secretary for Minority Health, the As-
6 sistant Secretary for Mental Health and Substance Use,
7 and the Director of the Indian Health Service, shall award
8 research fellowships to eligible individuals under sub-
9 section (b) to conduct research that will examine gender
10 and health disparities and to pursue a career in the health
11 professions.

12 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
13 ship under subsection (a), an individual shall—

14 “(1) have experience in health research or pub-
15 lic health practice;

16 “(2) reside in a health professional shortage
17 area designated by the Secretary under section 332;

18 “(3) have expressed an interest in the health
19 professions;

20 “(4) demonstrate promise for becoming a leader
21 in the field of women’s sexual and reproductive
22 health, including family planning;

23 “(5) secure admission to a health professions
24 school or graduate program with an emphasis in
25 gender studies; and

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

4 “(c) USE OF FUNDS.—A fellowship awarded under
5 subsection (a) to an eligible individual under subsection
6 (b) shall be used to support an opportunity for the indi-
7 vidual to become a researcher and advance the research
8 base on the intersection between gender and health.

9 “(d) PRIORITY.—In awarding fellowships under sub-
10 section (a), the Director of the Centers for Disease Con-
11 trol and Prevention shall give priority to those applicants
12 that—

13 “(1) are from disadvantaged backgrounds; and

14 “(2) have identified a mentor and academic ad-
15 visor who will assist in the completion of their grad-
16 uate or professional degree and have secured a re-
17 search assistant position with a researcher working
18 in the area of gender and health.

19 “(e) FELLOWSHIPS.—The Director of the Centers for
20 Disease Control and Prevention may approve fellowships
21 for individuals under this section for any period of edu-
22 cation in the student’s graduate or health profession ten-
23 ure, except that such a fellowship may not be provided
24 to an individual for more than 3 years, and such a fellow-
25 ship may not exceed \$25,000 per academic year for an

1 individual (notwithstanding any other provision of law re-
2 garding the amount of a fellowship).

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2027 through 2031.

7 **“SEC. 3421. PAUL DAVID WELLSTONE INTERNATIONAL**
8 **HEALTH FELLOWSHIP PROGRAM.**

9 “(a) IN GENERAL.—The Director of the Agency for
10 Healthcare Research and Quality, in collaboration with
11 the Deputy Assistant Secretary for Minority Health, shall
12 award research fellowships to eligible individuals under
13 subsection (b) to advance their understanding of inter-
14 national health.

15 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
16 ship under subsection (a), an individual shall—

17 “(1) have educational experience in the field of
18 international health;

19 “(2) reside in a health professional shortage
20 area as determined by the Secretary;

21 “(3) demonstrate promise for becoming a leader
22 in the field of international health;

23 “(4) be in the fourth year of a 4-year institu-
24 tion of higher education or a recent graduate of a
25 4-year institution of higher education; and

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

4 “(c) USE OF FUNDS.—A fellowship awarded under
5 subsection (a) to an eligible individual under subsection
6 (b) shall be used to support an opportunity for the indi-
7 vidual to become a health professional and to advance the
8 knowledge of the individual about international issues re-
9 lating to health care access and quality.

10 “(d) PRIORITY.—In awarding fellowships under sub-
11 section (a), the Director of the Agency for Healthcare Re-
12 search and Quality shall give priority to eligible individuals
13 under subsection (b) that—

14 “(1) are from a disadvantaged background; and

15 “(2) have identified a mentor at a health pro-
16 fessions school or institution, an academic advisor to
17 assist in the completion of their graduate or profes-
18 sional degree, and an advisor from an international
19 health non-governmental organization, private volun-
20 teer organization, or other international institution
21 or program that focuses on increasing health care
22 access and quality for residents in developing coun-
23 tries.

24 “(e) FELLOWSHIPS.—A fellowship awarded under
25 this section may not—

1 “(1) be provided to an eligible individual for
2 more than a period of 6 months;

3 “(2) be awarded to a graduate of a 4-year insti-
4 tution of higher education that has not been enrolled
5 in such institution for more than 1 year; or

6 “(3) exceed \$8,000 per academic year (notwith-
7 standing any other provision of law regarding the
8 amount of a fellowship).

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section
11 such sums as may be necessary for each of fiscal years
12 2027 through 2031.

13 **“SEC. 3422. EDWARD R. ROYBAL HEALTH SCHOLAR PRO-**
14 **GRAM.**

15 “(a) IN GENERAL.—The Director of the Agency for
16 Healthcare Research and Quality, the Administrator of
17 the Centers for Medicare & Medicaid Services, and the Ad-
18 ministrators of the Health Resources and Services Admin-
19 istration, in collaboration with the Deputy Assistant Sec-
20 retary for Minority Health, shall award grants to eligible
21 entities under subsection (b) to expose entering graduate
22 students to the health professions.

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

1 “(1) be a clinical, public health, or health serv-
2 ices organization, community-based, academic, or
3 nonprofit entity, or other entity determined appro-
4 priate by the Director of the Agency for Healthcare
5 Research and Quality;

6 “(2) serve in a health professional shortage
7 area designated by the Secretary under section 332;

8 “(3) work with students obtaining a degree in
9 the health professions; and

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

13 “(c) USE OF FUNDS.—Amounts received under a
14 grant awarded under subsection (a) shall be used to sup-
15 port opportunities that expose students to non-research-
16 based health professions, including—

17 “(1) public health policy;

18 “(2) health care and pharmaceutical policy;

19 “(3) health care administration and manage-
20 ment;

21 “(4) health economics; and

22 “(5) other professions determined appropriate
23 by the Director of the Agency for Healthcare Re-
24 search and Quality, the Administrator of the Centers
25 for Medicare & Medicaid Services, or the Adminis-

1 trator of the Health Resources and Services Admin-
2 istration.

3 “(d) PRIORITY.—In awarding grants under sub-
4 section (a), the Director of the Agency for Healthcare Re-
5 search and Quality, the Administrator of the Centers for
6 Medicare & Medicaid Services, and the Administrator of
7 the Health Resources and Services Administration, in col-
8 laboration with the Deputy Assistant Secretary for Minor-
9 ity Health, shall give priority to entities that—

10 “(1) have experience with health disparity elimi-
11 nation programs;

12 “(2) facilitate training in the fields described in
13 subsection (c); and

14 “(3) provide counseling or other services de-
15 signed to assist students in successfully completing
16 their education at the postsecondary level.

17 “(e) STIPENDS.—

18 “(1) IN GENERAL.—Subject to paragraph (2),
19 an entity receiving a grant under this section may
20 use the funds made available through such grant to
21 award stipends for educational and living expenses
22 to students participating in the opportunities sup-
23 ported by the grant.

24 “(2) LIMITATIONS.—A stipend awarded under
25 paragraph (1) to an individual—

1 “(A) may not be provided for a period that
2 exceeds 2 months; and

3 “(B) may not exceed \$100 per day (not-
4 withstanding any other provision of law regard-
5 ing the amount of a stipend).

6 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2027 through 2031.

10 **“SEC. 3423. LEADERSHIP FELLOWSHIP PROGRAMS.**

11 “(a) IN GENERAL.—The Secretary shall award
12 grants to national minority medical or health professional
13 associations to develop leadership fellowship programs for
14 underrepresented health professionals in order to—

15 “(1) assist such professionals in becoming fu-
16 ture leaders in public health and health care delivery
17 institutions; and

18 “(2) increase diversity in decision-making posi-
19 tions that can improve the health of underserved
20 communities.

21 “(b) USE OF FUNDS.—A leadership fellowship pro-
22 gram supported under this section shall—

23 “(1) focus on training mid-career physicians
24 and health care executives who have documented

1 leadership experience and a commitment to public
 2 health services in underserved communities; and

3 “(2) support Federal public health policy and
 4 budget programs, and priorities that impact health
 5 equity, through activities such as didactic lectures
 6 and leader site visits.

7 “(c) PERIOD OF GRANTS.—The period during which
 8 payments are made under a grant awarded under sub-
 9 section (a) may not exceed 3 years.

10 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 11 are authorized to be appropriated to carry out this section
 12 such sums as may be necessary for each of fiscal years
 13 2027 through 2031.”.

14 **SEC. 3007. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
 15 **PROGRAM.**

16 Section 402E of the Higher Education Act of 1965
 17 (20 U.S.C. 1070a–15) is amended by striking subsection
 18 (g) and inserting the following:

19 “(g) COLLABORATION IN HEALTH PROFESSION DI-
 20 VERSITY TRAINING PROGRAMS.—The Secretary shall co-
 21 ordinate with the Secretary of Health and Human Serv-
 22 ices to ensure that there is collaboration between the goals
 23 of the program under this section and programs of the
 24 Health Resources and Services Administration that pro-
 25 mote health workforce diversity. The Secretary of Edu-

1 cation shall take such measures as may be necessary to
 2 encourage students participating in projects assisted
 3 under this section to consider health profession careers.

4 “(h) FUNDING.—From amounts appropriated pursu-
 5 ant to the authority of section 402A(g), the Secretary
 6 shall, to the extent practicable, allocate funds for projects
 7 authorized by this section in an amount that is not less
 8 than \$31,000,000 for each of the fiscal years 2027
 9 through 2031.”.

10 **SEC. 3008. RULES FOR DETERMINATION OF FULL-TIME**
 11 **EQUIVALENT RESIDENTS FOR COST-REPORT-**
 12 **ING PERIODS.**

13 (a) DGME DETERMINATIONS.—Section 1886(h)(4)
 14 of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as
 15 amended by section 2006(a), is amended—

16 (1) in subparagraph (E), by striking “Subject
 17 to subparagraphs (J) and (K), such rules” and in-
 18 serting “Subject to subparagraphs (J), (K), and
 19 (M), such rules”;

20 (2) in subparagraph (J), by striking “Such
 21 rules” and inserting “Subject to subparagraph (M),
 22 such rules”;

23 (3) in subparagraph (K), by striking “In deter-
 24 mining” and inserting “Subject to subparagraph
 25 (M), in determining”; and

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

3 “(M) TREATMENT OF CERTAIN RESIDENTS
 4 AND INTERNS.—For purposes of cost-reporting
 5 periods beginning on or after October 1, 2027,
 6 in determining the hospital’s number of full-
 7 time equivalent residents for purposes of this
 8 paragraph, all time spent by an intern or resi-
 9 dent in an approved medical residency training
 10 program shall be counted toward the determina-
 11 tion of full-time equivalency if the hospital—

12 “(i) is recognized as a subsection (d)
 13 hospital;

14 “(ii) is recognized as a subsection (d)
 15 Puerto Rico hospital;

16 “(iii) is reimbursed under a reim-
 17 bursement system authorized under section
 18 1814(b)(3); or

19 “(iv) is a provider-based hospital out-
 20 patient department.”.

21 (b) IME DETERMINATIONS.—Section
 22 1886(d)(5)(B)(xi) of the Social Security Act (42 U.S.C.
 23 1395ww(d)(5)(B)(xi)) is amended—

1 (1) in subclause (II), by striking “In deter-
 2 mining” and inserting “Subject to subclause (IV), in
 3 determining”;

4 (2) in subclause (III), by striking “In deter-
 5 mining” and inserting “Subject to subclause (IV), in
 6 determining”; and

7 (3) by inserting after subclause (III) the fol-
 8 lowing new subclause:

9 “(IV) For purposes of cost-reporting peri-
 10 ods beginning on or after October 1, 2027, the
 11 provisions of subparagraph (M) of subsection
 12 (h)(4) shall apply under this subparagraph in
 13 the same manner as they apply under such sub-
 14 section.”.

15 **SEC. 3009. DEVELOPING AND IMPLEMENTING STRATEGIES**
 16 **FOR LOCAL HEALTH EQUITY.**

17 (a) GRANTS.—The Secretary of Health and Human
 18 Services, acting jointly with the Secretary of Education
 19 and the Secretary of Labor, shall make grants to eligible
 20 institutions of higher educations for the purposes of—

21 (1) in accordance with subsection (b), devel-
 22 oping capacity—

23 (A) to build an evidence base for successful
 24 strategies for increasing local health equity; and

1 (B) to serve as national models of driving
2 local health equity; and

3 (2) in accordance with subsection (c), devel-
4 oping a strategic partnership with the community in
5 which the institution is located.

6 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
7 HEALTH EQUITY.—As a condition of receipt of a grant
8 under subsection (a), an institution of higher education
9 shall agree to use such grant to build an evidence base
10 for successful strategies for increasing local health equity,
11 and to serve as a national model of driving local health
12 equity, by supporting—

13 (1) resources to strengthen institutional metrics
14 and capacity to execute institution-wide health work-
15 force goals that can serve as models for increasing
16 health equity in communities across the United
17 States;

18 (2) collaborations among a cohort of institu-
19 tions in implementing systemic change, partnership
20 development, and programmatic efforts supportive of
21 health equity goals across disciplines and popu-
22 lations; and

23 (3) enhanced or newly developed data systems
24 and research infrastructure capable of informing
25 current and future workforce efforts and building a

1 foundation for a broader research agenda targeting
2 urban health disparities.

3 (c) STRATEGIC PARTNERSHIPS.—As a condition of
4 receipt of a grant under subsection (a), an institution of
5 higher education shall agree to use the grant to develop
6 a strategic partnership with the community in which such
7 institution is located for the purposes of—

8 (1) strengthening connections between such in-
9 stitution and the community—

10 (A) to improve evaluation of, and address,
11 the health and health workforce needs of such
12 community; and

13 (B) to engage such community in health
14 workforce development;

15 (2) developing, enhancing, or accelerating inno-
16 vative undergraduate and graduate programs in the
17 biomedical sciences and health professions; and

18 (3) strengthening pipeline programs in the bio-
19 medical sciences and health professions, including by
20 developing partnerships between institutions of high-
21 er education and elementary schools and secondary
22 schools to recruit the next generation of health pro-
23 fessionals earlier in the pipeline to a health care ca-
24 reer.

1 (d) DEFINITION OF ELIGIBLE INSTITUTION OF
2 HIGHER EDUCATION.—For purposes of this section, the
3 term “eligible institution of higher education” includes—

4 (1) a program authorized under section 317(a)
5 of the Higher Education Act of 1965 (20 U.S.C.
6 1059d(a)); and

7 (2) a professional or graduate institution de-
8 scribed in section 326 of such Act (20 U.S.C.
9 1063b).

10 (e) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section
12 such sums as may be necessary for each of fiscal years
13 2027 through 2031.

14 **SEC. 3010. HEALTH PROFESSIONS WORKFORCE FUND.**

15 (a) ESTABLISHMENT.—There is established in the
16 Health Resources and Services Administration of the De-
17 partment of Health and Human Services a Health Profes-
18 sions Workforce Fund to provide for expanded and sus-
19 tained national investment in the health professions and
20 nursing workforce development programs under titles VII
21 and title VIII of the Public Health Service Act (42 U.S.C.
22 292 et seq.; 42 U.S.C. 296 et seq.).

23 (b) FUNDING.—

24 (1) IN GENERAL.—There is authorized to be
25 appropriated, and there is appropriated, out of any

monies in the Treasury not otherwise appropriated,
to the Health Professions Workforce Fund—

(A) \$392,000,000 for fiscal year 2027;

(B) \$412,000,000 for fiscal year 2028;

(C) \$432,000,000 for fiscal year 2029;

(D) \$454,000,000 for fiscal year 2030;

(E) \$476,000,000 for fiscal year 2031;

(F) \$500,000,000 for fiscal year 2032;

(G) \$525,000,000 for fiscal year 2033; and

(H) \$552,000,000 for fiscal year 2034.

(2) HEALTH PROFESSIONS EDUCATION PROGRAMS.—For the purpose of carrying out health professions education programs authorized under title VII of the Public Health Service Act (42 U.S.C. 292 et seq.), in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated out of any monies in the Health Professions Workforce Fund, the following:

(A) \$265,000,000 for fiscal year 2027.

(B) \$278,000,000 for fiscal year 2028.

(C) \$292,000,000 for fiscal year 2029.

(D) \$307,000,000 for fiscal year 2030.

(E) \$322,000,000 for fiscal year 2031.

(F) \$338,000,000 for fiscal year 2032.

1 (G) \$355,000,000 for fiscal year 2033.

2 (H) \$373,000,000 for fiscal year 2034.

3 (3) NURSING WORKFORCE DEVELOPMENT PRO-
 4 GRAMS.—For the purpose of carrying out nursing
 5 workforce development programs authorized under
 6 title VIII of the Public Health Service Act (42
 7 U.S.C. 296 et seq.), in addition to any other
 8 amounts authorized to be appropriated for such pur-
 9 pose, there is authorized to be appropriated out of
 10 any monies in the Health Professions Workforce
 11 Fund, the following:

12 (A) \$127,000,000 for fiscal year 2027.

13 (B) \$134,000,000 for fiscal year 2028.

14 (C) \$140,000,000 for fiscal year 2029.

15 (D) \$147,000,000 for fiscal year 2030.

16 (E) \$154,000,000 for fiscal year 2031.

17 (F) \$162,000,000 for fiscal year 2032.

18 (G) \$170,000,000 for fiscal year 2033.

19 (H) \$179,000,000 for fiscal year 2034.

20 **SEC. 3011. FUTURE ADVANCEMENT OF ACADEMIC NURS-**
 21 **ING.**

22 (a) SUPPORT FOR NURSING EDUCATION AND THE
 23 FUTURE NURSING WORKFORCE.—Part D of title VIII of
 24 the Public Health Service Act (42 U.S.C. 296p et seq.)
 25 is amended by adding at the end the following:

1 **“SEC. 832. NURSING EDUCATION ENHANCEMENT AND MOD-**
2 **ERNIZATION GRANTS IN UNDERSERVED**
3 **AREAS.**

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Administrator of the Health Resources and Services
6 Administration, may award grants to schools of nursing
7 for—

8 “(1) increasing the number of faculty and stu-
9 dents at such schools in order to enhance the pre-
10 paredness of the United States for, and the ability
11 of the United States to address and quickly respond
12 to, public health emergencies declared under section
13 319 and pandemics; or

14 “(2) the enhancement and modernization of
15 nursing education programs.

16 “(b) PRIORITY.—In selecting grant recipients under
17 this section, the Secretary shall give priority to schools of
18 nursing that—

19 “(1) are located in a medically underserved
20 community;

21 “(2) are located in a health professional short-
22 age area as defined under section 332(a); or

23 “(3) are institutions of higher education listed
24 under section 371(a) of the Higher Education Act of
25 1965.

1 “(c) CONSIDERATION.—In awarding grants under
2 this section, the Secretary, to the extent practicable, may
3 ensure equitable distribution of awards among the geo-
4 graphic regions of the United States.

5 “(d) USE OF FUNDS.—A school of nursing that re-
6 ceives a grant under this section may use the funds award-
7 ed through such grant for activities that include—

8 “(1) enhancing enrollment and retention of stu-
9 dents at such school, with a priority for students
10 from disadvantaged backgrounds (including racial or
11 ethnic groups underrepresented in the nursing work-
12 force), individuals from rural and underserved areas,
13 low-income individuals, and first generation college
14 students (as defined in section 402A(h)(3) of the
15 Higher Education Act of 1965);

16 “(2) creating, supporting, or modernizing edu-
17 cational programs and curriculum at such school;

18 “(3) retaining current faculty, and hiring new
19 faculty, with an emphasis on faculty from racial or
20 ethnic groups who are underrepresented in the nurs-
21 ing workforce;

22 “(4) modernizing infrastructure at such school,
23 including audiovisual or other equipment, personal
24 protective equipment, simulation and augmented re-

1 ality resources, telehealth technologies, and virtual
2 and physical laboratories;

3 “(5) partnering with a health care facility,
4 nurse-managed health clinic, community health cen-
5 ter, or other facility that provides health care in
6 order to provide educational opportunities for the
7 purpose of establishing or expanding clinical edu-
8 cation;

9 “(6) enhancing and expanding nursing pro-
10 programs that prepare nurse researchers and scientists;

11 “(7) establishing nurse-led intradisciplinary and
12 interprofessional educational partnerships; and

13 “(8) other activities that the Secretary deter-
14 mines further the development, improvement, and
15 expansion of schools of nursing.

16 “(e) REPORTS FROM ENTITIES.—Each school of
17 nursing awarded a grant under this section shall submit
18 an annual report to the Secretary on the activities con-
19 ducted under such grant.

20 “(f) REPORT TO CONGRESS.—Not later than 5 years
21 after the date of the enactment of this section, the Sec-
22 retary shall submit to the Committee on Health, Edu-
23 cation, Labor, and Pensions of the Senate and the Com-
24 mittee on Energy and Commerce of the House of Rep-
25 resentatives a report that provides a summary of the ac-

1 tivities and outcomes associated with grants made under
 2 this section. Such report shall include—

3 “(1) a list of schools of nursing receiving grants
 4 under this section, including the primary geographic
 5 location of any school of nursing that was improved
 6 or expanded through such a grant;

7 “(2) the total number of students who are en-
 8 rolled at or who have graduated from any school of
 9 nursing that was improved or expanded through a
 10 grant under this section;

11 “(3) to the extent such information is available,
 12 the effects of the grants awarded under this section
 13 on retaining and hiring of faculty, including any in-
 14 crease in diverse faculty, the number of clinical edu-
 15 cation partnerships, the modernization of nursing
 16 education infrastructure, and other ways this section
 17 helps address and quickly respond to public health
 18 emergencies and pandemics;

19 “(4) recommendations for improving the grants
 20 awarded under this section; and

21 “(5) any other considerations as the Secretary
 22 determines appropriate.

23 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
 24 carry out this section, there is authorized to be appro-

1 priated \$1,000,000,000, to remain available until ex-
 2 pended.”.

3 (b) STRENGTHENING NURSE EDUCATION.—The
 4 heading of part D of title VIII of the Public Health Serv-
 5 ice Act (42 U.S.C. 296p et seq.) is amended by striking
 6 “**BASIC**”.

7 **SEC. 3012. SENSE OF CONGRESS RELATING TO GRADUATE**
 8 **MEDICAL EDUCATION.**

9 It is the sense of Congress that eliminating the limit
 10 of the number of residency positions that receive some
 11 level of Medicare support under section 1886(h) of the So-
 12 cial Security Act (42 U.S.C. 1395ww(h)), also referred to
 13 as the Medical graduate medical education cap, is critical
 14 to—

15 (1) ensuring an appropriate supply of physi-
 16 cians to meet the health care needs in the United
 17 States;

18 (2) facilitating equitable access for all who seek
 19 health care;

20 (3) increasing the racial and ethnic diversity of
 21 physicians in the United States; and

22 (4) mitigating disparities in health and health
 23 care.

1 **SEC. 3013. CAREER SUPPORT FOR SKILLED, INTERNATIONAL-**
2 **ALLY EDUCATED HEALTH PROFESSIONALS.**

3 (a) GRANTS TO ELIGIBLE ENTITIES.—

4 (1) AUTHORITY TO PROVIDE GRANTS.—The
5 Secretary of Health and Human Services (in this
6 section referred to as the “Secretary”), acting
7 through the Bureau of Health Workforce within the
8 Health Resources and Services Administration, the
9 National Institute on Minority Health and Health
10 Disparities, or the Office of Minority Health, may
11 award grants to eligible entities under paragraph (2)
12 to carry out activities described in subsection (b).

13 (2) ELIGIBILITY.—To be eligible to receive a
14 grant under this section, an entity shall—

15 (A) be a clinical, public health, or health
16 services organization, a community-based or
17 nonprofit entity, an academic institution, a
18 faith-based organization, a State, county, or
19 local government, an area health education cen-
20 ter, or another entity determined appropriate by
21 the Secretary; and

22 (B) submit to the Secretary an application
23 at such time, in such manner, and containing
24 such information as the Secretary may require.

25 (b) AUTHORIZED ACTIVITIES.—A grant awarded
26 under this section shall be used—

- 1 (1) to provide services to assist unemployed and
2 underemployed skilled immigrants, residing in the
3 United States, who have legal, permanent work au-
4 thorization and who are internationally educated
5 health professionals, enter into the health workforce
6 of the United States with employment matching
7 their health professional skills and education, and
8 advance in employment to positions that better
9 match their health professional education and exper-
10 tise;
- 11 (2) to provide training opportunities to reduce
12 barriers to entry and advancement in the health
13 workforce for skilled, internationally educated immi-
14 grants;
- 15 (3) to educate employers regarding the abilities
16 and capacities of internationally educated health
17 professionals;
- 18 (4) to assist in the evaluation of foreign creden-
19 tials;
- 20 (5) to support preceptorships for international
21 medical graduates in primary care training; and
- 22 (6) to facilitate access to contextualized and ac-
23 celerated courses on English as a second language.

1 **SEC. 3014. STUDY AND REPORT ON STRATEGIES FOR IN-**
2 **CREASING DIVERSITY.**

3 (a) STUDY.—The Comptroller General of the United
4 States shall conduct a study on strategies for increasing
5 the diversity of the health professional workforce. Such
6 study shall include an analysis of strategies for increasing
7 the number of health professionals from rural, lower in-
8 come, and underrepresented minority communities, includ-
9 ing which strategies are most effective for achieving such
10 goal.

11 (b) REPORT.—Not later than 2 years after the date
12 of enactment of this Act, the Comptroller General shall
13 submit to Congress a report on the study conducted under
14 subsection (a), together with recommendations for such
15 legislation and administrative action as the Comptroller
16 General determines appropriate.

17 **SEC. 3015. CONRAD STATE 30 PROGRAM; PHYSICIAN RETEN-**
18 **TION.**

19 (a) CONRAD STATE 30 PROGRAM EXTENSION.—

20 (1) IN GENERAL.—Section 220(c) of the Immi-
21 gration and Nationality Technical Corrections Act of
22 1994 (Public Law 103–416; 8 U.S.C. 1182 note) is
23 amended by striking “September 30, 2015” and in-
24 serting “the date that is 3 years after the date of
25 the enactment of the Health Equity and Account-
26 ability Act of 2026”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall take effect as if enacted on
3 September 30, 2018.

4 (b) RETAINING PHYSICIANS WHO HAVE PRACTICED
5 IN MEDICALLY UNDERSERVED COMMUNITIES.—Section
6 201(b)(1) of the Immigration and Nationality Act (8
7 U.S.C. 1151(b)(1)) is amended by adding at the end the
8 following:

9 “(F)(i) Alien physicians who have completed
10 service requirements of a waiver requested under
11 section 203(b)(2)(B)(ii), including—

12 “(I) alien physicians who completed such
13 service before the date of the enactment of the
14 Health Equity and Accountability Act of 2026;
15 and

16 “(II) the spouse or children of an alien
17 physician described in subclause (I).

18 “(ii) Nothing in this subparagraph may be con-
19 strued—

20 “(I) to prevent the filing of a petition with
21 the Secretary of Homeland Security for classi-
22 fication under section 204(a) or the filing of an
23 application for adjustment of status under sec-
24 tion 245 by an alien physician described in
25 clause (i)(I) before the date on which such alien

1 physician completed the service described in
2 section 214(l) or worked full-time as a physi-
3 cian for an aggregate of 5 years at the location
4 identified in the section 214(l) waiver or in an
5 area or areas designated by the Secretary of
6 Health and Human Services as having a short-
7 age of health care professionals; or

8 “(II) to permit the Secretary of Homeland
9 Security to grant a petition or application de-
10 scribed in subclause (I) until the alien has sat-
11 isfied all of the requirements of the waiver re-
12 ceived under section 214(l).”.

13 (c) EMPLOYMENT PROTECTIONS FOR PHYSICIANS.—

14 (1) EXCEPTIONS TO 2-YEAR FOREIGN RESI-
15 DENCY REQUIREMENT.—Section 214(l)(1) of the
16 Immigration and Nationality Act (8 U.S.C.
17 1184(l)(1)) is amended—

18 (A) in the matter preceding subparagraph
19 (A), by striking “Attorney General” and insert-
20 ing “Secretary of Homeland Security”;

21 (B) in subparagraph (A), by striking “Di-
22 rector of the United States Information Agen-
23 cy” and inserting “Secretary of State”;

1 (C) in subparagraph (B), by inserting “,
2 except as provided in paragraphs (7) and (8)”
3 before the semicolon at the end;

4 (D) in subparagraph (C), by amending
5 clauses (i) and (ii) to read as follows:

6 “(i) the alien demonstrates a bona
7 fide offer of full-time employment at a
8 health facility or health care organization,
9 which employment has been determined by
10 the Secretary of Homeland Security to be
11 in the public interest; and

12 “(ii) the alien—

13 “(I) has accepted employment
14 with the health facility or health care
15 organization in a geographic area or
16 areas which are designated by the
17 Secretary of Health and Human Serv-
18 ices as having a shortage of health
19 care professionals;

20 “(II) begins employment by the
21 later of the date that is—

22 “(aa) 120 days after receiv-
23 ing such waiver;

24 “(bb) 120 days after com-
25 pleting graduate medical edu-

1 cation or training under a pro-
2 gram approved pursuant to sec-
3 tion 212(j)(1); or

4 “(cc) 120 days after receiv-
5 ing nonimmigrant status or em-
6 ployment authorization, if the
7 alien or the alien’s employer peti-
8 tions for such nonimmigrant sta-
9 tus or employment authorization
10 not later than 120 days after the
11 date on which the alien completes
12 his or her graduate medical edu-
13 cation or training under a pro-
14 gram approved pursuant to sec-
15 tion 212(j)(1); and

16 “(III) agrees to continue to work
17 for a total of not less than 3 years in
18 the status authorized for such employ-
19 ment under this subsection, except as
20 provided in paragraph (8); and”; and

21 (E) in subparagraph (D), in the matter
22 preceding clause (i), by inserting “except as
23 provided in paragraph (8),” before “in the
24 case”.

1 (2) ALLOWABLE VISA STATUS FOR PHYSICIANS
2 FULFILLING WAIVER REQUIREMENTS IN MEDICALLY
3 UNDERSERVED AREAS.—Section 214(l)(2)(A) of
4 such Act (8 U.S.C. 1184(l)(2)(A)) is amended to
5 read as follows:

6 “(A) Upon the request of an interested
7 Federal agency or an interested State agency
8 for recommendation of a waiver under this sec-
9 tion by a physician who is maintaining valid
10 nonimmigrant status under section
11 101(a)(15)(J) and received a favorable rec-
12 ommendation by the Secretary of State, the
13 Secretary of Homeland Security may adjust the
14 status of such physician to any status author-
15 ized for employment under this Act. The nu-
16 merical limitations set forth in subsection
17 (g)(1)(A) shall not apply to any alien whose
18 status is adjusted pursuant to this subpara-
19 graph.”.

20 (3) VIOLATION OF AGREEMENTS.—Section
21 214(l)(3)(A) of such Act (8 U.S.C. 1184(l)(3)(A)) is
22 amended by inserting “substantial requirement of
23 an” before “agreement entered into”.

24 (4) PHYSICIAN EMPLOYMENT IN UNDERSERVED
25 AREAS.—Section 214(l) of such Act, as amended by

1 this subsection, is further amended by adding at the
2 end the following:

3 “(4)(A) If an interested State agency denies an
4 application for a waiver under paragraph (1)(B)
5 from a physician pursuing graduate medical edu-
6 cation or training pursuant to section 101(a)(15)(J)
7 because the State has requested the maximum num-
8 ber of waivers permitted for that fiscal year, the
9 physician’s nonimmigrant status shall be extended
10 for up to 6 months if the physician agrees to seek
11 a waiver under this subsection (except for paragraph
12 (1)(D)(ii)) to work for an employer described in
13 paragraph (1)(C) in a State that has not yet re-
14 quested the maximum number of waivers.

15 “(B) Such physician shall be authorized to
16 work only for the employer referred to in subpara-
17 graph (A) during the period beginning on the date
18 on which a new waiver application is filed with such
19 State and ending on the earlier of—

20 “(i) the date on which the Secretary of
21 Homeland Security denies such waiver; or

22 “(ii) the date on which the Secretary ap-
23 proves an application for adjustment of status
24 under paragraph (2)(A) pursuant to the ap-
25 proval of such waiver.”.

1 (5) CONTRACT REQUIREMENTS.—Section 214(l)
2 of such Act, as amended by this subsection, is fur-
3 ther amended by adding at the end the following:

4 “(5) An alien granted a waiver under para-
5 graph (1)(C) shall enter into an employment agree-
6 ment with the contracting health facility or health
7 care organization that—

8 “(A) specifies—

9 “(i) the maximum number of on-call
10 hours per week (which may be a monthly
11 average) that the alien will be expected to
12 be available; and

13 “(ii) the compensation the alien will
14 receive for on-call time;

15 “(B) specifies—

16 “(i) whether the contracting facility or
17 organization—

18 “(I) has secured medical mal-
19 practice liability protection for the
20 alien under section 224(g) of the Pub-
21 lic Health Service Act (42 U.S.C.
22 233(g)); or

23 “(II) will pay the alien’s mal-
24 practice insurance premiums; and

1 “(ii) the amount of such liability pro-
2 tection that will be provided;

3 “(C) describes all of the work locations
4 that the alien will work and includes a state-
5 ment that the contracting facility or organiza-
6 tion will not add additional work locations with-
7 out the approval of the Federal agency or State
8 agency that requested the waiver; and

9 “(D) does not include a non-compete provi-
10 sion.

11 “(6) An alien granted a waiver under this sub-
12 section whose employment relationship with a health
13 facility or health care organization terminates under
14 paragraph (1)(C)(ii) during the 3-year service period
15 required under paragraph (1) shall be considered to
16 be maintaining lawful status in an authorized period
17 of stay during the 120-day period referred to in
18 items (aa) and (bb) of subclause (III) of paragraph
19 (1)(C)(ii) or the 45-day period referred to in sub-
20 clause (III)(cc) of such paragraph.”.

21 (6) RECAPTURING WAIVER SLOTS LOST TO
22 OTHER STATES.—Section 214(l) of such Act, as
23 amended by this subsection, is further amended by
24 adding at the end the following:

1 “(7) If a recipient of a waiver under this sub-
2 section terminates the recipient’s employment with a
3 health facility or health care organization pursuant
4 to paragraph (1)(C)(ii), including termination of em-
5 ployment because of circumstances described in
6 paragraph (1)(C)(ii)(III), and accepts new employ-
7 ment with such a facility or organization in a dif-
8 ferent State, the State from which the alien is de-
9 parting may be granted an additional waiver by the
10 Secretary of State for use in the fiscal year in which
11 the alien’s employment was terminated.”.

12 (7) EXCEPTION TO 3-YEAR WORK REQUIRE-
13 MENT.—Section 214(l) of such Act, as amended by
14 this subsection, is further amended by adding at the
15 end the following:

16 “(8) The 3-year work requirement set forth in
17 subparagraphs (C) and (D) of paragraph (1) shall
18 not apply if—

19 “(A)(i) the Secretary of Homeland Secu-
20 rity determines the existence of extenuating cir-
21 cumstances, including violations by the em-
22 ployer of the employment agreement with the
23 alien or of labor and employment laws, which
24 justify a lesser period of employment at such
25 facility or organization; and

1 “(ii) the alien demonstrates, not later than
2 120 days after the employment termination
3 date (unless the Secretary determines that ex-
4 tenuating circumstances would justify an exten-
5 sion), another bona fide offer of employment at
6 a health facility or health care organization in
7 a geographic area or areas designated by the
8 Secretary of Health and Human Services as
9 having a shortage of health care professionals,
10 for the remainder of such 3-year period;

11 “(B)(i) the interested State agency that re-
12 quested the waiver attests to the existence of
13 extenuating circumstances, including violations
14 by the employer of the employment agreement
15 with the alien or of labor and employment laws,
16 which justify a lesser period of employment at
17 such facility or organization; and

18 “(ii) the alien demonstrates, not later than
19 120 days after the employment termination
20 date (unless the Secretary determines that ex-
21 tenuating circumstances would justify an exten-
22 sion), another bona fide offer of employment at
23 a health facility or health care organization in
24 a geographic area or areas designated by the
25 Secretary of Health and Human Services as

1 having a shortage of health care professionals,
2 for the remainder of such 3-year period; or

3 “(C) the alien—

4 “(i) elects not to pursue a determina-
5 tion of extenuating circumstances pursuant
6 to subparagraph (A) or (B);

7 “(ii) terminates the alien’s employ-
8 ment relationship with the health facility
9 or health care organization at which the
10 alien was employed;

11 “(iii) demonstrates, not later than 45
12 days after the employment termination
13 date, another bona fide offer of employ-
14 ment at a health facility or health care or-
15 ganization in a geographic area or areas,
16 in the State that requested the alien’s
17 waiver, which are designated by the Sec-
18 retary of Health and Human Services as
19 having a shortage of health care profes-
20 sionals; and

21 “(iv) agrees to be employed for the re-
22 mainder of such 3-year period, and 1 addi-
23 tional year for each termination under
24 clause (ii).”.

25 (d) ALLOTMENT OF CONRAD STATE 30 WAIVERS.—

1 (1) IN GENERAL.—Section 214(l) of the Immi-
2 gration and Nationality Act (8 U.S.C. 1184(l)), as
3 amended by subsection (c), is further amended by
4 adding at the end the following:

5 “(9)(A)(i) All States shall be allotted a total of 35
6 waivers under paragraph (1)(B) for a fiscal year if 90 per-
7 cent of the waivers available to the States receiving at
8 least 5 waivers were used in the previous fiscal year.

9 “(ii) When an allotment occurs under clause (i), all
10 States shall be allotted an additional 5 waivers under
11 paragraph (1)(B) for each subsequent fiscal year if 90
12 percent of the waivers available to the States receiving at
13 least 5 waivers were used in the previous fiscal year. If
14 the States are allotted 45 or more waivers for a fiscal year,
15 the States will only receive an additional increase of 5
16 waivers the following fiscal year if 95 percent of the waiv-
17 ers available to the States receiving at least 1 waiver were
18 used in the previous fiscal year.

19 “(B) Any increase in allotments under subparagraph
20 (A) shall be maintained indefinitely, unless in a fiscal year
21 the total number of such waivers granted is 5 percent
22 lower than in the last year in which there was an increase
23 in the number of waivers allotted pursuant to this para-
24 graph, in which case—

1 “(i) the number of waivers allotted shall be de-
2 creased by 5 for all States beginning in the next fis-
3 cal year; and

4 “(ii) each additional 5 percent decrease in such
5 waivers granted from the last year in which there
6 was an increase in the allotment, shall result in an
7 additional decrease of 5 waivers allotted for all
8 States, provided that the number of waivers allotted
9 for all States shall not drop below 30.”.

10 (2) ACADEMIC MEDICAL CENTERS.—Section
11 214(l)(1)(D) of such Act, as amended by subsection
12 (c)(1)(E), is further amended—

13 (A) in clause (ii), by striking “and” at the
14 end;

15 (B) in clause (iii), by striking the period at
16 the end and inserting “; and”; and

17 (C) by adding at the end the following:

18 “(iv) in the case of a request by an inter-
19 ested State agency—

20 “(I) the head of such agency deter-
21 mines that the alien is to practice medicine
22 in, or be on the faculty of a residency pro-
23 gram at, an academic medical center (as
24 defined in section 411.355(e)(2) of title 42,
25 Code of Federal Regulations, or a similar

1 successor regulation), without regard to
 2 whether such facility is located within an
 3 area designated by the Secretary of Health
 4 and Human Services as having a shortage
 5 of health care professionals; and

6 “(II) the head of such agency deter-
 7 mines that—

8 “(aa) the alien physician’s work
 9 is in the public interest; and

10 “(bb) the grant of such waiver
 11 would not cause the number of the
 12 waivers granted on behalf of aliens for
 13 such State for a fiscal year to exceed
 14 3 (within the limitation in subpara-
 15 graph (B) and subject to paragraph
 16 (6)), in accordance with the conditions
 17 of this clause.”.

18 (e) AMENDMENTS TO THE PROCEDURES, DEFINI-
 19 TIONS, AND OTHER PROVISIONS RELATED TO PHYSICIAN
 20 IMMIGRATION.—

21 (1) DUAL INTENT FOR PHYSICIANS SEEKING
 22 GRADUATE MEDICAL TRAINING.—Section 214(b) of
 23 the Immigration and Nationality Act (8 U.S.C.
 24 1184(b)) is amended by striking “and other than a
 25 nonimmigrant described in any provision of section

101(a)(15)(H)(i) except subclause (b1) of such section)” and inserting “a nonimmigrant described in any provision of section 101(a)(15)(H)(i) (except subclause (b1) of such section), and an alien coming to the United States to receive graduate medical education or training as described in section 212(j) or to take examinations required to receive graduate medical education or training as described in section 212(j))”.

(2) PHYSICIAN NATIONAL INTEREST WAIVER
CLARIFICATIONS.—

(A) PRACTICE AND GEOGRAPHIC AREA.—

Section 203(b)(2)(B)(ii)(I) of the Immigration and Nationality Act (8 U.S.C. 1153(b)(2)(B)(ii)(I)) is amended by striking items (aa) and (bb) and inserting the following:

“(aa) the alien physician agrees to work on a full-time basis practicing primary care, specialty medicine, or a combination thereof, in an area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals, or at a health care facility under the jurisdiction of the Secretary of Veterans Affairs; or

1 “(bb) the alien physician is pursuing
 2 such waiver based upon service at a facility
 3 or facilities that serve patients who reside
 4 in a geographic area or areas designated
 5 by the Secretary of Health and Human
 6 Services as having a shortage of health
 7 care professionals (without regard to
 8 whether such facility or facilities are lo-
 9 cated within such an area) and a Federal
 10 agency, or a local, county, regional, or
 11 State department of public health deter-
 12 mines the alien physician’s work was or
 13 will be in the public interest.”.

14 (B) FIVE-YEAR SERVICE REQUIREMENT.—
 15 Section 203(b)(2)(B)(ii) of such Act, as amend-
 16 ed by subparagraph (A), is further amended—

17 (i) by moving subclauses (II), (III),
 18 and (IV) 4 ems to the left; and

19 (ii) in subclause (II)—

20 (I) by inserting “(aa)” after
 21 “(II)”; and

22 (II) by adding at the end the fol-
 23 lowing:

24 “(bb) The 5-year service requirement
 25 described in item (aa) shall begin on the

1 date on which the alien physician begins
2 work in the shortage area in any legal sta-
3 tus and not on the date on which an immi-
4 grant visa petition is filed or approved.
5 Such service shall be aggregated without
6 regard to when such service began and
7 without regard to whether such service
8 began during or in conjunction with a
9 course of graduate medical education.

10 “(cc) An alien physician shall not be
11 required to submit an employment contract
12 with a term exceeding the balance of the 5-
13 year commitment yet to be served or an
14 employment contract dated within a min-
15 imum time period before filing a visa peti-
16 tion under this subsection.

17 “(dd) An alien physician shall not be
18 required to file additional immigrant visa
19 petitions upon a change of work location
20 from the location approved in the original
21 national interest immigrant petition.”.

22 (3) TECHNICAL CLARIFICATION REGARDING AD-
23 VANCED DEGREE FOR PHYSICIANS.—Section
24 203(b)(2)(A) of such Act is amended by adding at
25 the end the following: “An alien physician holding a

1 foreign medical degree that has been deemed suffi-
2 cient for acceptance by an accredited United States
3 medical residency or fellowship program is a member
4 of the professions holding an advanced degree or its
5 equivalent.”.

6 (4) SHORT-TERM WORK AUTHORIZATION FOR
7 PHYSICIANS COMPLETING THEIR RESIDENCIES.—

8 (A) IN GENERAL.—A physician completing
9 graduate medical education or training de-
10 scribed in section 212(j) of the Immigration
11 and Nationality Act (8 U.S.C. 1182(j)) as a
12 nonimmigrant described in section
13 101(a)(15)(H)(i) of such Act (8 U.S.C.
14 1101(a)(15)(H)(i))—

15 (i) shall have such nonimmigrant sta-
16 tus automatically extended until October 1
17 of the fiscal year for which a petition for
18 a continuation of such nonimmigrant sta-
19 tus has been submitted in a timely manner
20 and the employment start date for the ben-
21 eficiary of such petition is October 1 of
22 that fiscal year; and

23 (ii) shall be authorized to be employed
24 incident to status during the period be-

1 tween the filing of such petition and Octo-
2 ber 1 of such fiscal year.

3 (B) TERMINATION.—The physician’s sta-
4 tus and employment authorization shall termi-
5 nate on the date that is 30 days after the date
6 on which a petition described in clause (i)(I) is
7 rejected, denied, or revoked.

8 (C) AUTOMATIC EXTENSION.—A physi-
9 cian’s status and employment authorization will
10 automatically extend to October 1 of the next
11 fiscal year if all of the visas described in section
12 101(a)(15)(H)(i) of the Immigration and Na-
13 tionality Act (8 U.S.C. 1101(a)(15)(H)(i)) that
14 were authorized to be issued for the fiscal year
15 have been issued.

16 (5) APPLICABILITY OF SECTION 212(e) TO
17 SPOUSES AND CHILDREN OF J–1 EXCHANGE VISI-
18 TORS.—A spouse or child of an exchange visitor de-
19 scribed in section 101(a)(15)(J) of the Immigration
20 and Nationality Act (8 U.S.C. 1101(a)(15)(J)) shall
21 not be subject to the requirements under section
22 212(e) of such Act (8 U.S.C. 1182(e)).

23 (f) ANNUAL CONRAD STATE 30 J–1 VISA WAIVER
24 PROGRAM STATISTICAL REPORT.—The Director of U.S.
25 Citizenship and Immigration Service shall submit an an-

1 nual report to Congress and to the Secretary of Health
 2 and Human Services that identifies the number of aliens
 3 admitted during the most recently concluded fiscal year
 4 as a result of the Conrad State 30 J–1 Visa Waiver Pro-
 5 gram established under sections 212(e) and 214(l) of the
 6 Immigration and Nationality Act (8 U.S.C. 1182(e) and
 7 1184(l)), broken down by State.

8 **SEC. 3016. GRANTS FOR SCHOOLS OF MEDICINE AND**
 9 **SCHOOLS OF OSTEOPATHIC MEDICINE IN UN-**
 10 **DERSERVED AREAS.**

11 Subpart II of part C of title VII of the Public Health
 12 Service Act (42 U.S.C. 293m et seq.) is amended by add-
 13 ing at the end the following:

14 **“SEC. 749C. GRANTS FOR SCHOOLS OF MEDICINE AND**
 15 **SCHOOLS OF OSTEOPATHIC MEDICINE IN UN-**
 16 **DERSERVED AREAS.**

17 “(a) IN GENERAL.—The Secretary may award grants
 18 to institutions of higher education (including consortiums
 19 of such institutions) for the establishment, improvement,
 20 or expansion of a school of medicine or osteopathic medi-
 21 cine, or a branch campus of a school of medicine or osteo-
 22 pathic medicine.

23 “(b) PRIORITY.—In selecting grant recipients under
 24 this section, the Secretary shall give priority to any insti-

1 tution of higher education (or consortium of such institu-
2 tions) that—

3 “(1) proposes to use the grant for the establish-
4 ment of a school of medicine or osteopathic medi-
5 cine, or a branch campus of a school of medicine or
6 osteopathic medicine, in an area—

7 “(A) in which—

8 “(i) no other such school is based; or

9 “(ii) in the case in which the school of
10 medicine or osteopathic medicine proposed
11 to be established would be a minority-serv-
12 ing institution, no other minority-serving
13 institution that includes a school of medi-
14 cine or osteopathic medicine is based; and

15 “(B) that is a medically underserved com-
16 munity or a health professional shortage area;
17 or

18 “(2) is a minority-serving institution described
19 in section 371(a) of the Higher Education Act of
20 1965 or an institution or program described in sec-
21 tion 326(e) of such Act.

22 “(c) CONSIDERATIONS.—In awarding grants under
23 this section, the Secretary, to the extent practicable, may
24 ensure equitable distribution of awards among the geo-
25 graphical regions of the United States.

1 “(d) USE OF FUNDS.—An institution of higher edu-
2 cation (or a consortium of such institutions)—

3 “(1) shall use grant amounts received under
4 this section to—

5 “(A) recruit, enroll, and retain medical
6 students who are pursuing a degree of doctor of
7 medicine or doctor of osteopathy, including in-
8 dividuals who are from disadvantaged back-
9 grounds (including racial and ethnic groups
10 underrepresented among medical students and
11 health professions), individuals from rural and
12 underserved areas, low-income individuals, and
13 first generation college students, at a school of
14 medicine or osteopathic medicine or a branch
15 campus of a school of medicine or osteopathic
16 medicine; and

17 “(B) develop, implement, and expand cur-
18 riculum that emphasizes care for rural and un-
19 derserved populations, including accessible and
20 culturally and linguistically appropriate care
21 and services, at such school or branch campus;
22 and

23 “(2) may use grant amounts received under this
24 section to—

25 “(A) plan and construct—

1 “(i) a school of medicine or osteo-
2 pathic medicine, or a branch campus of a
3 school of medicine or osteopathic medicine,
4 in an area in which no other such school
5 is based; or

6 “(ii) a school of medicine or osteo-
7 pathic medicine, or a branch campus of a
8 school of medicine or osteopathic medicine,
9 that will be a minority-serving institution,
10 in an area in which no other such school
11 that is a minority-serving institution is
12 based;

13 “(B) plan, develop, and meet criteria for
14 accreditation for a school of medicine or osteo-
15 pathic medicine or a branch campus of a school
16 of medicine or osteopathic medicine;

17 “(C) hire faculty, including faculty from
18 racial and ethnic groups who are underrep-
19 resented among the medical and other health
20 professions, and other staff to serve at such a
21 school or branch campus;

22 “(D) support educational programs at such
23 a school or branch campus;

24 “(E) modernize and expand infrastructure
25 at such a school or branch campus; and

1 “(F) support other activities that the Sec-
2 retary determines further the establishment,
3 improvement, or expansion of a school of medi-
4 cine or osteopathic medicine or a branch cam-
5 pus of a school of medicine or osteopathic medi-
6 cine.

7 “(e) APPLICATION.—To be eligible to receive a grant
8 under subsection (a), an institution of higher education
9 (or a consortium of such institutions), shall submit an ap-
10 plication to the Secretary at such time, in such manner,
11 and containing such information as the Secretary may re-
12 quire, including a description of the institution’s or con-
13 sortium’s planned activities described in subsection (d).

14 “(f) REPORTING.—

15 “(1) REPORTS FROM ENTITIES.—Each institu-
16 tion of higher education, or consortium of such insti-
17 tutions, awarded a grant under this section shall
18 submit an annual report to the Secretary on the ac-
19 tivities conducted under such grant.

20 “(2) REPORT TO CONGRESS.—Not later than 5
21 years after the date of enactment of this section and
22 every 5 years thereafter, the Secretary shall submit
23 to the Committee on Health, Education, Labor, and
24 Pensions of the Senate and the Committee on En-
25 ergy and Commerce of the House of Representatives

1 a report that provides a summary of the activities
 2 and outcomes associated with grants made under
 3 this section. Such reports shall include a list of
 4 awardees, including their primary geographic loca-
 5 tion, and location of any school of medicine or osteo-
 6 pathic medicine, or a branch campus of a school of
 7 medicine or osteopathic medicine that was estab-
 8 lished, improved, or expanded under this program.

9 “(g) DEFINITIONS.—In this section:

10 “(1) BRANCH CAMPUS.—

11 “(A) IN GENERAL.—The term ‘branch
 12 campus’, with respect to a school of medicine or
 13 osteopathic medicine, means an additional loca-
 14 tion of such school that is geographically apart
 15 and independent of the main campus, at which
 16 the school offers at least 50 percent of the pro-
 17 gram leading to a degree of doctor of medicine
 18 or doctor of osteopathy that is offered at the
 19 main campus.

20 “(B) INDEPENDENCE FROM MAIN CAM-
 21 PUS.—For purposes of subparagraph (A), the
 22 location of a school described in such subpara-
 23 graph shall be considered to be independent of
 24 the main campus described in such subpara-
 25 graph if the location—

1 “(i) is permanent in nature;

2 “(ii) offers courses in educational pro-
3 grams leading to a degree, certificate, or
4 other recognized educational credential;

5 “(iii) has its own faculty and adminis-
6 trative or supervisory organization; and

7 “(iv) has its own budgetary and hiring
8 authority.

9 “(2) FIRST GENERATION COLLEGE STUDENT.—

10 The term ‘first generation college student’ has the
11 meaning given such term in section 402A(h)(3) of
12 the Higher Education Act of 1965.

13 “(3) HEALTH PROFESSIONAL SHORTAGE
14 AREA.—The term ‘health professional shortage area’
15 has the meaning given such term in section 332(a).

16 “(4) INSTITUTION OF HIGHER EDUCATION.—

17 The term ‘institution of higher education’ has the
18 meaning given such term in section 101 of the High-
19 er Education Act of 1965.

20 “(5) MEDICALLY UNDERSERVED COMMUNITY.—

21 The term ‘medically underserved community’ has the
22 meaning given such term in section 799B(6).

23 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated such sums as may be nec-
25 essary to carry out this section.”.

1 **Subtitle B—Substance Use Dis-**
2 **order Treatment and Behavioral**
3 **and Mental Health Workforce**

4 **SEC. 3021. SHORT TITLE.**

5 This subtitle may be cited as the “STAR Plus Schol-
6 arship Act”.

7 **SEC. 3022. SUBSTANCE USE DISORDER TREATMENT AND**
8 **BEHAVIORAL AND MENTAL HEALTH WORK-**
9 **FORCE SCHOLARSHIP PROGRAM.**

10 (a) IN GENERAL.—Part F of title VII of the Public
11 Health Service Act (42 U.S.C. 295h) is amended by add-
12 ing at the end the following:

13 **“SEC. 782. SUBSTANCE USE DISORDER TREATMENT AND**
14 **BEHAVIORAL AND MENTAL HEALTH WORK-**
15 **FORCE SCHOLARSHIP PROGRAM.**

16 “(a) ESTABLISHMENT.—The Secretary, acting
17 through the Administrator of the Health Resources and
18 Services Administration (in this section referred to as the
19 ‘Secretary’) shall establish the Substance Use Disorder
20 Treatment and Behavioral and Mental Health Workforce
21 Scholarship Program (in this section referred to as the
22 ‘Scholarship Program’) to award scholarships to assure an
23 adequate supply of individuals in covered employment.

1 “(b) ELIGIBILITY; APPLICATION; WRITTEN CON-
2 TRACT.—To be eligible to participate in the Scholarship
3 Program, an individual must—

4 “(1) be accepted for enrollment, or be enrolled,
5 as a full-time student—

6 “(A) in an accredited (as determined by
7 the Secretary) educational institution in a
8 State; and

9 “(B) in a course of study or program, of-
10 fered by such institution and approved by the
11 Secretary, leading to covered employment;

12 “(2) submit an application to participate in the
13 Scholarship Program; and

14 “(3) sign and submit to the Secretary, at the
15 time of submittal of such application, a written con-
16 tract (described in subsection (f)) to accept payment
17 of a scholarship and to serve (in accordance with
18 this section) for the applicable period of obligated
19 service in a mental health professional shortage
20 area.

21 “(c) REVIEW AND EVALUATION OF INFORMATION
22 AND FORMS BY PROSPECTIVE APPLICANT.—

23 “(1) CONTENTS OF APPLICATION AND CON-
24 TRACT FORMS.—In disseminating application forms
25 and contract forms to individuals desiring to partici-

1 pate in the Scholarship Program, the Secretary shall
2 include with such forms—

3 “(A) a fair summary of the rights and li-
4 abilities of an individual whose application is
5 approved (and whose contract is accepted) by
6 the Secretary, including in the summary a clear
7 explanation of the damages to which the United
8 States is entitled under subsection (j) in the
9 case of the individual’s breach of the contract;
10 and

11 “(B) such other information as may be
12 necessary for the individual to understand the
13 individual’s prospective participation in the
14 Scholarship Program, including a statement of
15 all factors considered in approving applications
16 for participation in the Scholarship Program
17 and in approving specific positions and employ-
18 ers that are eligible for the Scholarship Pro-
19 gram.

20 “(2) CLARITY; AVAILABILITY.—The application
21 form, contract form, and all other information fur-
22 nished by the Secretary under this section shall be
23 written in a manner calculated to be understood by
24 the average individual applying to participate in the
25 Scholarship Program. The Secretary shall make

1 such application forms, contract forms, and other in-
2 formation available to individuals desiring to partici-
3 pate in the Scholarship Program on a date suffi-
4 ciently early to ensure that such individuals have
5 adequate time to carefully review and evaluate such
6 forms and information.

7 “(3) EDUCATION AND ASSISTANCE.—

8 “(A) DISTRIBUTION OF INFORMATIONAL
9 MATERIALS.—The Secretary shall distribute to
10 health professions schools materials providing
11 information on the Scholarship Program and
12 shall encourage the schools to disseminate the
13 materials to the students of the schools.

14 “(B) END OF OBLIGATED SERVICE.—

15 “(i) ENCOURAGEMENT TO CONTINUE
16 SERVICE.—In the case of any health pro-
17 fessional whose period of obligated service
18 under the Scholarship Program is nearing
19 completion, the Secretary shall encourage
20 the individual to remain in a mental health
21 professional shortage area and to continue
22 in covered employment.

23 “(ii) ASSISTANCE IN TRANSITION.—

24 During the period in which a health pro-
25 fessional is planning and making the tran-

1 sition from obligated service under the
2 Scholarship Program, the Secretary may
3 provide assistance to the professional re-
4 garding such transition if the professional
5 is remaining in a mental health profes-
6 sional shortage area and is continuing in
7 covered employment.

8 “(d) FACTORS CONSIDERED IN PROVIDING CON-
9 TRACTS; PRIORITIES.—

10 “(1) FACTORS CONSIDERED IN PROVIDING CON-
11 TRACTS.—In providing contracts under the Scholar-
12 ship Program—

13 “(A) the Secretary shall consider the ex-
14 tent of the demonstrated interest of the appli-
15 cants for the contracts in providing substance
16 use disorder treatment and behavioral and men-
17 tal health services; and

18 “(B) may consider such other factors re-
19 garding the applicants as the Secretary deter-
20 mines to be relevant to selecting qualified indi-
21 viduals to participate in such Program.

22 “(2) PRIORITIES.—In providing contracts under
23 the Scholarship Program, the Secretary shall give
24 priority—

1 “(A) to any application for such a contract
 2 submitted by an individual who has characteris-
 3 tics that increase the probability that the indi-
 4 vidual will continue to serve in a mental health
 5 professional shortage area after the period of
 6 obligated service pursuant to subsection (f) is
 7 completed; and

8 “(B) to any application for such a contract
 9 submitted by an individual who is from a group
 10 or population that is underrepresented in the
 11 substance use disorder treatment and behav-
 12 ioral and mental health workforce.

13 “(e) COMMENCEMENT OF PARTICIPATION IN SCHOL-
 14 ARSHIP PROGRAM; NOTICE.—

15 “(1) COMMENCEMENT OF PARTICIPATION.—An
 16 individual becomes a participant in the Scholarship
 17 Program only upon the Secretary’s approval of the
 18 individual’s application submitted under subsection
 19 (b)(2) and the Secretary’s acceptance of the contract
 20 submitted by the individual under subsection (b)(3).

21 “(2) NOTICE.—The Secretary shall provide
 22 written notice to an individual promptly upon the
 23 Secretary’s approving, under paragraph (1), of the
 24 individual’s participation in the Scholarship Pro-
 25 gram.

1 “(f) WRITTEN CONTRACT; CONTENTS.—The written
2 contract (referred to in this section) between the Secretary
3 and an individual shall contain—

4 “(1) an agreement that—

5 “(A) subject to paragraph (2), the Sec-
6 retary agrees to provide the individual with a
7 scholarship (described in subsection (g)) for a
8 period of one or more school years during which
9 the individual is pursuing a course of study de-
10 scribed in subsection (b)(1)(B); and

11 “(B) subject to paragraph (2), the indi-
12 vidual agrees—

13 “(i) to accept provision of such a
14 scholarship to the individual;

15 “(ii) to maintain enrollment in a
16 course of study described in subsection
17 (b)(1)(B) until the individual completes the
18 course of study;

19 “(iii) while enrolled in such course of
20 study, to maintain an acceptable level of
21 academic standing (as determined under
22 regulations of the Secretary by the edu-
23 cational institution offering such course of
24 study); and

1 “(iv) to serve for a time period (in
 2 this section referred to as the ‘period of
 3 obligated service’) equal to one year for
 4 each school year for which the individual
 5 was provided a scholarship under the
 6 Scholarship Program, in covered employ-
 7 ment in a mental health professional short-
 8 age area (designated under section 332);

9 “(2) a provision that any financial obligation of
 10 the United States arising out of a contract entered
 11 into under this section and any obligation of the in-
 12 dividual which is conditioned thereon, is contingent
 13 upon funds being appropriated for scholarships
 14 under this section;

15 “(3) a statement of the damages to which the
 16 United States is entitled, under subsection (j), for
 17 the individual’s breach of the contract; and

18 “(4) such other statements of the rights and li-
 19 abilities of the Secretary and of the individual, not
 20 inconsistent with the provisions of this section.

21 “(g) SCHOLARSHIP PROVISIONS; CONTRACT WITH
 22 EDUCATIONAL INSTITUTION; INCREASE IN MONTHLY STI-
 23 PEND.—

24 “(1) SCHOLARSHIP PROVISIONS.—A scholarship
 25 provided to a student for a school year under a writ-

1 ten contract under the Scholarship Program shall
2 consist of payment to, or (in accordance with para-
3 graph (2)) on behalf of, the student of the amount
4 (except as provided in section 711) of—

5 “(A) the tuition of the student in such
6 school year; and

7 “(B) all other reasonable educational ex-
8 penses, including fees, books, and laboratory ex-
9 penses, incurred by the student in such school
10 year.

11 “(2) CONTRACT WITH EDUCATIONAL INSTITU-
12 TION.—The Secretary may contract with an edu-
13 cational institution, in which a participant in the
14 Scholarship Program is enrolled, for the payment to
15 the educational institution of the amounts of tuition
16 and other reasonable educational expenses described
17 in paragraph (1). Payment to such an educational
18 institution may be made without regard to section
19 3324 of title 31, United States Code.

20 “(h) EMPLOYMENT CEILING OF DEPARTMENT UN-
21 AFFECTED.—Notwithstanding any other provision of law,
22 individuals who have entered into written contracts with
23 the Secretary under this section, while undergoing aca-
24 demic training, shall not be counted against any employ-
25 ment ceiling affecting the Department.

1 “(i) OBLIGATED SERVICE.—Any individual receiving
2 payments under the Scholarship Program as required by
3 an agreement under this section shall agree to an annual
4 commitment to work full-time in covered employment,
5 with no more than 1 year passing between any 2 years
6 of covered employment, in the United States in—

7 “(1) a mental health professional shortage area,
8 as designated under section 332;

9 “(2) a county (or a municipality, if not con-
10 tained within any county) where the mean drug
11 overdose death rate per 100,000 people over the past
12 3 years for which official data is available from the
13 State, is higher than the most recent available na-
14 tional average overdose death rate per 100,000 peo-
15 ple, as reported by the Centers for Disease Control
16 and Prevention; or

17 “(3) any facility, program, center, or clinic as
18 determined appropriate by the Secretary for pur-
19 poses of this section because of a shortage of mental
20 health professionals, including private practices and
21 other medical facilities designated under section
22 332(a) as having such a shortage.

23 “(j) BREACH.—

24 “(1) LIQUIDATED DAMAGES FORMULA.—The
25 Secretary may establish a liquidated damages for-

1 mula to be used in the event of a breach of an
2 agreement entered into under this section.

3 “(2) LIMITATION.—The failure by an individual
4 to complete the full period of service obligated pur-
5 suant to such an agreement, taken alone, shall not
6 constitute a breach of the agreement, so long as the
7 individual completed in good faith the years of serv-
8 ice for which payments were made to the individual
9 under this section.

10 “(k) FUND REGARDING USE OF AMOUNTS RECOV-
11 ERED FOR CONTRACT BREACH TO REPLACE SERVICES
12 LOST AS RESULT OF BREACH.—

13 “(1) ESTABLISHMENT OF FUND.—There is es-
14 tablished in the Treasury of the United States a
15 fund to be known as the Substance Use Disorder
16 Treatment and Behavioral and Mental Health Work-
17 force Scholarship Program Replacement Fund (in
18 this subsection referred to as the ‘Fund’). The Fund
19 shall consist of such amounts as may be appro-
20 priated under paragraph (2) to the Fund. Amounts
21 appropriated for the Fund shall remain available
22 until expended.

23 “(2) AUTHORIZATION OF APPROPRIATIONS TO
24 FUND.—For each fiscal year, there is authorized to

1 be appropriated to the Fund an amount equal to the
2 sum of—

3 “(A) the amount collected during the pre-
4 ceding fiscal year by the Federal Government
5 pursuant to the liability of individuals under
6 subsection (j) for the breach of contracts en-
7 tered into under this section; and

8 “(B) the aggregate of the amount of inter-
9 est accruing during the preceding fiscal year on
10 obligations held in the Fund pursuant to para-
11 graph (4) and the amount of proceeds from the
12 sale or redemption of such obligations during
13 such fiscal year.

14 “(3) USE OF FUND.—

15 “(A) PAYMENTS TO CERTAIN HEALTH FA-
16 CILITIES.—Amounts in the Fund and available
17 pursuant to appropriations Acts may, subject to
18 subparagraph (B), be expended by the Sec-
19 retary to make payments to any entity that has
20 a need for a health professional to provide sub-
21 stance use disorder treatment and behavioral
22 and mental health services as a result of the
23 breach by an individual of a contract entered
24 into under this section.

1 “(B) PURPOSE OF PAYMENTS.—An entity
2 receiving payments pursuant to subparagraph
3 (A) may expend the payments to recruit and
4 employ a health professional to provide sub-
5 stance use disorder treatment and behavioral
6 and mental health services to patients of the
7 entity, or to enter into a contract with such a
8 professional to provide the services to the pa-
9 tients.

10 “(4) INVESTMENT.—

11 “(A) IN GENERAL.—The Secretary of the
12 Treasury shall invest such amounts of the Fund
13 as such Secretary determines are not required
14 to meet current withdrawals from the Fund.
15 Such investments may be made only in interest-
16 bearing obligations of the United States. For
17 such purpose, such obligations may be acquired
18 on original issue at the issue price, or by pur-
19 chase of outstanding obligations at the market
20 price.

21 “(B) SALE OF OBLIGATIONS.—Any obliga-
22 tion acquired by the Fund may be sold by the
23 Secretary of the Treasury at the market price.

24 “(I) COVERED EMPLOYMENT DEFINED.—In this sec-
25 tion, the term ‘covered employment’ means—

1 “(1) full-time employment (including a fellow-
 2 ship) where the primary intent and function of the
 3 position is the direct treatment or recovery support
 4 of patients with or in recovery from a substance use,
 5 behavioral health, or mental health disorder; and

6 “(2) may include employment as a physician
 7 (with a degree of doctor of medicine or doctor of os-
 8 teopathy), a psychiatric nurse, a social worker, a
 9 marriage and family therapist, a mental health coun-
 10 selor, an addiction counselor, an occupational thera-
 11 pist, a psychologist, a psychiatrist, a child and ado-
 12 lescent psychiatrist, or a neurologist.

13 “(m) AUTHORIZATION OF APPROPRIATIONS.—There
 14 is authorized to be appropriated to carry out this section
 15 \$75,000,000 for each of fiscal years 2027 through 2031.”.

16 (b) EXCLUSION OF SCHOLARSHIP FROM GROSS IN-
 17 COME OF THE RECIPIENT.—

18 (1) IN GENERAL.—Section 117(c)(2) of the In-
 19 ternal Revenue Code of 1986 is amended—

20 (A) by striking “or” at the end of subpara-
 21 graph (B);

22 (B) by striking the period at the end of
 23 subparagraph (C) and inserting “, or”; and

24 (C) by adding at the end the following new
 25 subparagraph:

1 “(D) section 782 of the Public Health
2 Service Act.”.

3 (2) EFFECTIVE DATE.—The amendments made
4 by this section shall apply to taxable years ending
5 after the date of the enactment of this Act.

6 **Subtitle C—ACCESS in Mental**
7 **Health Act**

8 **SEC. 3031. SHORT TITLE.**

9 This subtitle may be cited as the “Advancing Cul-
10 turally Competent and Equitable Supportive Services in
11 Mental Health Act” or the “ACCESS in Mental Health
12 Act”.

13 **SEC. 3032. PURPOSE.**

14 The purpose of this subtitle is to increase the num-
15 ber, size, and quality of accredited graduate training pro-
16 grams for mental and behavioral health professions at mi-
17 nority-serving institutions to address shortages in the
18 mental and behavioral health professional workforce and
19 diversify such workforce.

1 **SEC. 3033. GRANTS TO SUPPORT GRADUATE PROGRAMS IN**
 2 **MENTAL AND BEHAVIORAL HEALTH PROFES-**
 3 **SIONS AT HISTORICALLY BLACK COLLEGES**
 4 **AND UNIVERSITIES, TRIBAL COLLEGES AND**
 5 **UNIVERSITIES, AND OTHER MINORITY-SERV-**
 6 **ING INSTITUTIONS.**

7 Part A of title VII of the Higher Education Act of
 8 1965 (20 U.S.C. 1070) is amended—

9 (1) by redesignating subpart 5 as subpart 6;

10 (2) in section 731—

11 (A) in the section heading, by striking

12 “**SUBPARTS 1 THROUGH 4**” and inserting

13 “**SUBPARTS 1 THROUGH 5**”;

14 (B) in subsection (a), by striking “sub-

15 parts 1 through 4” and inserting “subparts 1

16 through 5”;

17 (C) in subsection (b), by striking “subparts

18 1 through 4” and inserting “subparts 1

19 through 5”; and

20 (D) in subsection (d), by striking “subpart

21 1, 2, 3, or 4” and inserting “subpart 1, 2, 3,

22 4, or 5”; and

23 (3) by inserting after subpart 4 the following:

1 **“Subpart 5—Grants To Support Graduate Programs**
2 **in Mental and Behavioral Health Professions at**
3 **Historically Black Colleges and Universities,**
4 **Tribal Colleges and Universities, and Other Mi-**
5 **nority-Serving Institutions**

6 **“SEC. 727. DEFINITIONS.**

7 “In this subpart:

8 “(1) COST OF ATTENDANCE.—The term ‘cost of
9 attendance’ has the meaning given that term in sec-
10 tion 472.

11 “(2) CULTURALLY RESPONSIVE CARE.—The
12 term ‘culturally responsive care’ means care that is
13 conducted or provided in a manner that is responsive
14 to the beliefs, backgrounds, customs, interpersonal
15 styles, lived experiences, language, and behaviors of
16 individuals who are receiving the care, and in a man-
17 ner that has the greatest likelihood of ensuring max-
18 imum benefit and participation in the treatment pro-
19 vided.

20 “(3) ELIGIBLE INSTITUTION.—The term ‘eligi-
21 ble institution’ means—

22 “(A) an institution of higher education
23 that is—

24 “(i) a part B institution (as defined in
25 section 322);

1 “(ii) a Hispanic-serving institution (as
2 defined in section 502);

3 “(iii) a Tribal College or University
4 (as defined in section 316);

5 “(iv) an Alaska Native-serving institu-
6 tion (as defined in section 317(b));

7 “(v) a Native Hawaiian-serving insti-
8 tution (as defined in section 317(b));

9 “(vi) a Predominantly Black Institu-
10 tion (as defined in section 318);

11 “(vii) an Asian American and Native
12 American Pacific Islander-serving institu-
13 tion (as defined in section 320(b)); or

14 “(viii) a Native American-serving,
15 nontribal institution (as defined in section
16 319);

17 “(B) a consortium of institutions described
18 in subparagraph (A); or

19 “(C) an institution described in subpara-
20 graph (A), or a consortium described in sub-
21 paragraph (B), in partnership with any other
22 institution of higher education, but only if the
23 program supported with a grant under this sub-
24 part is carried out at an institution described in
25 subparagraph (A).

1 “(4) HEALTH PROFESSIONAL SHORTAGE
2 AREA.—The term ‘health professional shortage area’
3 means an area designated as a health professional
4 shortage area by the Administrator of the Health
5 Resources and Services Administration of the De-
6 partment of Health and Human Services.

7 “(5) MENTAL OR BEHAVIORAL HEALTH PRO-
8 FESSIONAL.—The term ‘mental or behavioral health
9 professional’ means an individual with a graduate
10 degree from an institution of higher education with
11 an accredited program that prepares students for
12 State licensing or certification in fields such as psy-
13 chiatry, psychology, school psychology, behavioral pe-
14 diatrics, psychiatric nursing, social work, school so-
15 cial work, substance use disorder prevention and
16 treatment, marriage and family counseling, school
17 counseling, professional counseling, child and adoles-
18 cent psychiatry, or any other provider that is a State
19 licensed or certified mental health professional quali-
20 fied under State law to provide mental health serv-
21 ices.

22 “(6) SCHOOL-BASED MENTAL HEALTH SERV-
23 ICES PROVIDER.—The term ‘school-based mental
24 health services provider’ has the meaning given the

1 term in section 4102 of the Elementary and Sec-
 2 ondary Education Act of 1965 (20 U.S.C. 7112).

3 “(7) TRAUMA-INFORMED CARE.—The term
 4 ‘trauma-informed care’ means care received by indi-
 5 viduals who have experienced or witnessed trauma
 6 that is healing-centered and culturally responsive in
 7 accordance with professional standards of practice
 8 and accounting for patients’ experiences and that
 9 recognizes the emotional, behavioral, and develop-
 10 mental challenges that can accompany trauma expo-
 11 sure in order to eliminate or mitigate triggers that
 12 may cause re-traumatization of the patient.

13 **“SEC. 728. GRANTS TO INSTITUTIONS FOR GRADUATE**
 14 **TRAINING PROGRAMS IN MENTAL OR BEHAV-**
 15 **IORAL HEALTH PROFESSIONS.**

16 “(a) PROGRAM AUTHORIZED.—From amounts made
 17 available to carry out this section for each fiscal year and
 18 not reserved under subsection (b), the Secretary is author-
 19 ized to award grants, on a competitive basis, to eligible
 20 institutions—

21 “(1) to establish, expand, or improve graduate
 22 programs in mental and behavioral health profes-
 23 sions, including programs that train school-based
 24 mental services providers; or

1 “(2) to engage in planning activities necessary
2 for the establishment of new graduate programs in
3 mental and behavioral health professions, including
4 programs that train school-based mental health serv-
5 ices providers.

6 “(b) RESERVATION.—The Secretary may reserve not
7 more than 2 percent of the funds made available to carry
8 out this section for a fiscal year to provide technical assist-
9 ance to eligible institutions on matters relating to the
10 grant program under this section and the implementation
11 of programs supported by such grants.

12 “(c) USE OF FUNDS.—

13 “(1) REQUIRED USE OF FUNDS.—An eligible
14 institution that receives a grant under subsection
15 (a)(1) shall use not less than 5 percent of grant
16 funds to award scholarships or stipends, based on fi-
17 nancial need, to cover all or part of a student’s cost
18 of attendance for the mental or behavioral health
19 graduate program. Scholarships and stipends award-
20 ed under this subsection shall prioritize students
21 who are from health professional shortage areas.

22 “(2) ALLOWABLE USE OF FUNDS.—After ful-
23 filling the requirement in paragraph (1), an eligible
24 institution that receives a grant under subsection

1 (a)(1) shall use any remaining grant funds to carry
2 out one or more of the following activities:

3 “(A) Establish new accredited graduate
4 programs that prepare students for State li-
5 censing and certification to serve as mental or
6 behavioral health professionals or school-based
7 mental health services providers, including
8 through hiring and compensating faculty, pur-
9 chasing or developing culturally responsive
10 course materials, or other activities necessary to
11 establish such programs.

12 “(B) Ensure that graduate programs in
13 mental or behavioral health professions offered
14 by the institution are preparing professionals
15 who are highly qualified, are able to provide
16 culturally responsive care and trauma-informed
17 care, and are equipped to serve in health pro-
18 fessional shortage areas or other high-need
19 areas or schools, which may include—

20 “(i) recruiting, training, retraining, or
21 retaining faculty for such programs;

22 “(ii) designing or redesigning such
23 programs—

24 “(I) to prepare mental or behav-
25 ioral health professionals to serve in

1 health professional shortage areas or
 2 other high-need areas or schools, pro-
 3 vide culturally responsive care and
 4 trauma-informed care to diverse pa-
 5 tients, and meet the needs of the
 6 whole child or person;

7 “(II) to incorporate rigorous aca-
 8 demic content and scientifically valid
 9 research; and

10 “(III) to adequately prepare stu-
 11 dents to meet State licensure and cer-
 12 tification standards; and

13 “(iii) developing or implementing high
 14 quality course materials, which may in-
 15 clude purchasing necessary educational
 16 materials or other academic resources, to
 17 support the design or redesign of the pro-
 18 gram as described in clause (ii).

19 “(C) Provide students with sustained and
 20 high-quality preservice and clinical experience
 21 that is aligned with graduate education stand-
 22 ards for their respective fields, which may in-
 23 clude—

24 “(i) arranging for exemplary mental
 25 or behavioral health professionals in rel-

1 evant fields or work settings to mentor stu-
2 dents who are prospective mental or behav-
3 ioral health professionals; or

4 “(ii) substantially increasing the level
5 of interaction between faculty at institu-
6 tions of higher education and new and ex-
7 perienced mental or behavioral health pro-
8 fessionals, and providing support, including
9 preparation time, for such interactions.

10 “(D) Establish partnerships with other in-
11 stitutions of higher education with accredited
12 programs that prepare students for State li-
13 censing or certification in mental or behavioral
14 health fields to allow cross registration or other
15 forms of program collaboration determined eli-
16 gible by the Secretary for the purposes of ex-
17 panding access to classes, certificate programs,
18 or degree programs in mental or behavioral
19 health fields for students from racial or ethnic
20 minority communities.

21 “(E) Develop and implement supportive
22 services for former students of the institution
23 who work as mental or behavioral health profes-
24 sionals or partnerships with school districts,
25 State or local agencies, or other places of em-

1 ployment for former students to promote reten-
2 tion in those professions, including services
3 such as—

4 “(i) mental or behavioral health pro-
5 fessional mentoring from exemplary mental
6 or behavioral health professionals in rel-
7 evant fields or work settings, including
8 those working in schools or home-based
9 care settings;

10 “(ii) materials, resources, and support
11 for mental or behavioral health profes-
12 sionals during their first 3 years of em-
13 ployment in such profession; or

14 “(iii) services to prevent or mitigate
15 secondary trauma or burnout associated
16 with working in mental health professional
17 shortage areas or other high-need areas or
18 schools.

19 “(F) Disseminate information on effective
20 practices for the preparation of mental or be-
21 havioral health professionals, including prac-
22 tices for obtaining any certifications or licenses
23 needed to practice as a mental or behavioral
24 health professional or a school-based mental
25 health services provider in a State.

1 “(G) Develop strategies to increase aware-
2 ness, interest, and experiential learning oppor-
3 tunities in mental and behavioral health ca-
4 reers, especially among racial and ethnic minor-
5 ity communities, including through partnerships
6 with State educational agencies, local edu-
7 cational agencies, or other institutions of higher
8 education to increase awareness of and interest
9 in such careers among elementary school stu-
10 dents, secondary school students, or under-
11 graduate students.

12 “(3) PLANNING GRANTS.—An eligible institu-
13 tion that receives a grant under subsection (a)(2)
14 shall use the grant to engage in planning activities
15 necessary for the establishment of at least 1 new
16 graduate program in mental or behavioral health
17 professions.

18 “(d) APPLICATION.—To be eligible to receive a grant
19 under this section, an eligible institution shall submit an
20 application to the Secretary at such time, in such manner,
21 and containing such information as the Secretary may re-
22 quire. An eligible institution applying for a grant under
23 subsection (a)(2) shall include in the institution’s applica-
24 tion for such grant information demonstrating evidence
25 of—

1 “(1) an institutional commitment to opening
2 and sustaining a graduate program that prepares
3 students to work as a mental or behavioral health
4 professional; and

5 “(2) a relationship with the relevant profes-
6 sional organization, accreditation agency or associa-
7 tion, or regulatory body to ensure that planning
8 aligns with professional standards and State
9 credentialing requirements.

10 “(e) GRANT AMOUNT.—

11 “(1) IN GENERAL.—The minimum amount of
12 each grant under subsection (a)(1) shall be
13 \$500,000.

14 “(2) PLANNING GRANTS.—The amount of each
15 grant under subsection (a)(2) shall be an amount
16 determined by the Secretary.

17 “(f) LIMITATION ON ADMINISTRATIVE EXPENSES.—

18 An eligible institution that receives a grant under this sec-
19 tion may use not more than 3 percent of funds provided
20 to administer the grant, not including salary and benefits
21 for faculty and staff.

22 “(g) REGULATIONS.—The Secretary shall prescribe
23 such regulations as may be necessary to carry out this
24 section.

1 “(h) REPORT.—Not later than 2 years after the date
2 of enactment of this section, and not less frequently than
3 once every 2 years thereafter, the Secretary shall submit
4 to the authorizing committees a report on the grant pro-
5 gram under this section. Each report shall include—

6 “(1) descriptions of the programs supported
7 with grants under this section;

8 “(2) demographic information about the stu-
9 dents served by such programs; and

10 “(3) such other information as the Secretary
11 determines appropriate.

12 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary for each fiscal year.

15 **“SEC. 729. GRANTS TO STUDENTS FOR GRADUATE STUDY IN**
16 **MENTAL OR BEHAVIORAL HEALTH PROFES-**
17 **SIONS.**

18 “(a) IN GENERAL.—The Secretary is authorized to
19 carry out a program under which the Secretary shall pay
20 to an eligible institution such sums as may be necessary
21 to enable the institution to provide each eligible student
22 with a grant in the amount of \$10,000 for each year dur-
23 ing which the student attends an eligible graduate pro-
24 gram at the institution.

1 “(b) APPLICATION.—To be eligible to receive a grant
2 under this section, a student shall submit to the institution
3 an application at such time, in such manner, and con-
4 taining such information as the Secretary, in consultation
5 with the institution, may require.

6 “(c) DISTRIBUTION TO STUDENTS.—Subject to sub-
7 section (d), grants to students under this section shall be
8 made in accordance with a process determined by the Sec-
9 retary for such purpose, in such manner as will best ac-
10 complish the purpose of this section.

11 “(d) LIMITATION ON SECRETARIAL AND INSTITU-
12 TIONAL AUTHORITY.—In carrying out the grant program
13 under this section, the Secretary and any institution par-
14 ticipating in the program may not—

15 “(1) convert a grant into a loan or otherwise
16 require a student to repay any portion of the grant
17 amount; or

18 “(2) require a student to complete a service ob-
19 ligation as a condition of receiving such a grant.

20 “(e) REPORT.—Not later than 2 years after the date
21 of enactment of this section, and not less frequently than
22 once every 2 years thereafter, the Secretary shall submit
23 to the authorizing committees a report on the grant pro-
24 gram under this section. Each report shall include infor-
25 mation on the following:

1 “(1) The number and demographic information
2 of students who received grants under this section.

3 “(2) The degrees obtained by such recipients.

4 “(3) Such other information as the Secretary
5 determines appropriate.

6 “(f) DEFINITIONS.—In this section:

7 “(1) ELIGIBLE GRADUATE PROGRAM.—The
8 term ‘eligible graduate program’ means a graduate
9 degree program in a mental or behavioral health
10 profession, including school-based mental health
11 services, offered by an eligible institution.

12 “(2) ELIGIBLE STUDENT.—The term ‘eligible
13 student’ means a student who—

14 “(A) is enrolled in an eligible graduate
15 program at a eligible institution participating in
16 the program under this section;

17 “(B) is in good academic standing, as de-
18 termined by the institution; and

19 “(C) has submitted an application to the
20 institution in accordance with subsection (b).

21 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 such sums as may be necessary for each fiscal year.”.

1 **Subtitle D—Developing the**
2 **Community Health Workforce Act**

3 **SEC. 3041. IMPROVING RECRUITMENT AND RETENTION OF**
4 **FEDERAL QUALIFIED HEALTH CENTER**
5 **STAFF.**

6 (a) PRIORITY TO FQHCs AND RURAL HEALTH CLIN-
7 ICS.—Section 333(a) of the Public Health Service Act (42
8 U.S.C. 254f(a)) is amended by adding at the end the fol-
9 lowing:

10 “(4) In approving applications for assignment of
11 members of the Corps, the Secretary shall, notwith-
12 standing paragraph (3), give priority to applications with
13 respect to health professional shortage areas that are Fed-
14 erally qualified health centers and rural health clinics, as
15 defined in section 1861(aa) of the Social Security Act.”.

16 (b) LOAN REPAYMENT PROGRAM.—

17 (1) IN GENERAL.—The Secretary of Health and
18 Human Services shall award grants to Federally
19 qualified health centers (as defined in section
20 1861(aa) of the Social Security Act (42 U.S.C.
21 1395x(aa))) for the purpose of addressing health
22 professional workforce shortages by making loan re-
23 payments on behalf of health care professionals serv-
24 ing at such centers.

1 (2) APPLICATIONS.—To seek a grant under
 2 paragraph (1), a Federally qualified health center
 3 shall submit an application to the Secretary of
 4 Health and Human Services at such time, in such
 5 manner, and containing such information as the Sec-
 6 retary may require. At a minimum, such an applica-
 7 tion shall include—

8 (A) a description of the center’s capacity
 9 to address specific regional workforce shortages,
 10 supported by data;

11 (B) a plan for making loan repayments as
 12 described in paragraph (1); and

13 (C) a description of the center’s use of an
 14 interdisciplinary approach to care (such as
 15 through the use of teams to provide care that
 16 include physicians, nurses, social workers, com-
 17 munity health workers, pharmacists, and other
 18 health care professionals).

19 **SEC. 3042. COMMUNITY HEALTH CENTER WORKFORCE**
 20 **PIPELINE PROGRAM.**

21 (a) GRANTS TO RECRUIT, TRAIN, AND RETAIN A
 22 COMMUNITY-BASED HEALTH CENTER WORKFORCE.—

23 (1) IN GENERAL.—Section 330 of the Public
 24 Health Service Act (42 U.S.C. 254b) is amended—

1 (A) by redesignating subsection (r) as sub-
 2 section (u); and

3 (B) by inserting after subsection (q) the
 4 following new subsection:

5 “(r) RECRUITING, TRAINING, AND RETAINING A
 6 COMMUNITY-BASED WORKFORCE.—The Secretary may
 7 award grants to health centers for the purpose of assisting
 8 such centers in—

9 “(1) recruiting and hiring staff with the skills
 10 and experience necessary to effectively serve health
 11 center patient populations in rural and underserved
 12 areas; and

13 “(2) supporting career advancement and work-
 14 force development opportunities for such staff.”.

15 (b) FQHCs DEEMED ELIGIBLE TO REGISTER AS
 16 APPRENTICESHIP PROGRAM.—Not later than 180 days
 17 after the date of the enactment of this Act, the Secretary
 18 of Labor shall revise the regulations under part 29 of title
 19 29, Code of Federal Regulations, as in effect on the date
 20 of the enactment of this Act, so that Federally qualified
 21 health centers (as defined in section 1861(aa) of the Social
 22 Security Act (42 U.S.C. 1395x(aa))) are eligible to reg-
 23 ister as apprenticeship programs under such part.

24 (c) HEALTH CENTERS CAREER OPPORTUNITIES.—
 25 Section 330 of the Public Health Service Act (42 U.S.C.

1 254b), as amended by subsection (a), is further amended
2 by inserting after subsection (r) the following:

3 “(s) HEALTH CENTERS CAREER OPPORTUNITIES.—

4 “(1) IN GENERAL.—The Secretary may award
5 grants to institutions of higher education, including
6 community colleges and minority-serving institu-
7 tions, to establish partnerships with one or more
8 health centers funded under this section for training
9 students in health professions.

10 “(2) USE OF FUNDS.—

11 “(A) COSTS.—An institution of higher
12 education receiving a grant under this sub-
13 section may use the grant to pay the costs of
14 training, including the salary of the clinicians
15 or other educators who provide the training.

16 “(B) TRAINING SUPPORTED.—The train-
17 ing supported pursuant to a grant under this
18 subsection may include formal training and
19 mentorships.

20 “(C) TYPES OF TRAINING.—The types of
21 training supported pursuant to a grant under
22 this subsection may include clinical, information
23 technology, operations, finance, or other train-
24 ing for students of health professions, as deter-
25 mined by the institution of higher education re-

1 ceiving the grant in partnership with the health
2 center involved.

3 “(3) DEFINITIONS.—In this subsection:

4 “(A) The term ‘institution of higher edu-
5 cation’ means an institution of higher education
6 described in subsection (a) or (b) of section 101
7 of the Higher Education Act of 1965.

8 “(B) The term ‘minority-serving institu-
9 tion’ means an institution of higher education
10 described in section 371(a) of the Higher Edu-
11 cation Act of 1965.”.

12 (d) BEHAVIORAL HEALTH SPECIALISTS.—Section
13 330 of the Public Health Service Act (42 U.S.C. 254b),
14 as amended by subsection (c), is further amended by in-
15 serting after subsection (s) the following:

16 “(t) BEHAVIORAL HEALTH SPECIALISTS.—

17 “(1) IN GENERAL.—The Secretary may award
18 grants to health centers to establish, operate, or ex-
19 pand training programs for behavioral health spe-
20 cialists.

21 “(2) USE OF FUNDS.—The training programs
22 for behavioral health specialists supported pursuant
23 to a grant under this subsection may include—

24 “(A) stipends for personnel to operate the
25 training programs;

1 “(B) apprenticeship programs; and

2 “(C) other recruitment and retention ac-
3 tivities for behavioral health specialists.”.

4 **SEC. 3043. EXPANDING HOSPITAL AND FQHC PARTNER-**
5 **SHIPS FOR GRADUATE MEDICAL EDUCATION.**

6 (a) PAYMENTS TO TEACHING HEALTH CENTERS.—

7 (1) IN GENERAL.—Section 340H of the Public
8 Health Service Act (42 U.S.C. 256h) is amended—

9 (A) in subsection (a)(1), in the matter pre-
10 ceeding subparagraph (A), by inserting “, or
11 that have in effect a covered agreement with a
12 sponsoring institution so listed,” after “relevant
13 accrediting body”; and

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

16 “(5) COVERED AGREEMENT.—The term ‘cov-
17 ered agreement’ means a written contract, memo-
18 randum of understanding, or other written agree-
19 ment entered into for a period of not less than 2
20 years for the purpose of conducting an approved
21 graduate medical residency training program.”.

22 (2) EFFECTIVE DATE.—The amendments made
23 by paragraph (1) shall apply with respect to ex-
24 penses incurred on or after October 1, 2027.

1 (b) MEDICARE GME CAP.—Section 1886(h) of the
2 Social Security Act (42 U.S.C. 1395ww(h)) is amended—

3 (1) in paragraph (4)(F)(i), by striking “and
4 (10)” and inserting “(10), and (11)”; and

5 (2) by adding at the end the following new
6 paragraph:

7 “(11) TRAINING PROGRAMS AT FEDERALLY
8 QUALIFIED HEALTH CENTERS.—

9 “(A) IN GENERAL.—For cost reporting pe-
10 riods beginning on or after October 1, 2027, in
11 the case of a hospital that has an approved
12 medical residency training program where a sig-
13 nificant portion of such program occurs at a
14 Federally qualified health center (as determined
15 by the Secretary), the Secretary shall increase
16 the otherwise applicable resident limit for such
17 hospital by 3 full-time equivalent residency posi-
18 tions.

19 “(B) DEFINITIONS.—In this paragraph:

20 “(i) OTHERWISE APPLICABLE RESI-
21 DENT LIMIT.—The term ‘otherwise appli-
22 cable resident limit’ means, with respect to
23 a hospital, the limit otherwise applicable
24 under subparagraphs (F)(i) and (H) of
25 paragraph (4) on the resident level for the

1 hospital determined without regard to this
 2 paragraph but taking into account sub-
 3 paragraphs (A) and (B) of paragraph (7),
 4 subparagraphs (A) and (B) of paragraph
 5 (8), and paragraphs (9)(A) and (10)(A).

6 “(ii) RESIDENT LEVEL.—The term
 7 ‘resident level’ has the meaning given such
 8 term in paragraph (7)(C)(i).”.

9 **SEC. 3044. EXPANDING FQHC SERVICES.**

10 (a) BEHAVIORAL HEALTH PROFESSIONAL AND CASE
 11 MANAGER SERVICES.—

12 (1) MEDICARE.—Section 1861(aa) of the Social
 13 Security Act (42 U.S.C. 1395x(aa)) is amended—

14 (A) in paragraph (1)—

15 (i) in subparagraph (B), by inserting
 16 “such services furnished on or after Octo-
 17 ber 1, 2026, by a behavioral health con-
 18 sultant, peer support specialist, or other
 19 behavioral health professional (as such
 20 terms are defined by the Secretary),” be-
 21 fore “and such services”;

22 (ii) in subparagraph (C), by striking
 23 “and” at the end;

1 (iii) in subparagraph (D), by striking
2 the comma at the end and inserting “,
3 and”; and

4 (iv) by inserting after subparagraph
5 (D) the following new subparagraph:

6 “(E) case management services furnished on or
7 after October 1, 2026, by a case manager (as de-
8 fined by the Secretary),”; and

9 (B) in paragraph (3)(A), by striking “(D)”
10 and inserting “(E)”.

11 (2) MEDICAID.—Section 1905(l)(2)(A) of the
12 Social Security Act (42 U.S.C. 1396d(l)(2)(A)) is
13 amended by inserting “and (E)” before “of section”.

14 (b) GUIDANCE ON STATE MEDICAID PAYMENTS TO
15 FQHCs.—Section 1902(bb) of the Social Security Act (42
16 U.S.C. 1396a(bb)) is amended by adding at the end the
17 following new paragraph:

18 “(7) STUDY AND GUIDANCE ON PAYMENT AD-
19 JUSTMENTS.—Not later than October 1, 2027, and
20 not less frequently than annually thereafter, the Sec-
21 retary shall—

22 “(A) conduct a study on any differences in
23 the methods by which State plans adjust the
24 payment amount under paragraph (3) for serv-
25 ices furnished during a fiscal year; and

1 “(B) based on the results of the study con-
2 ducted under subparagraph (A), issue guidance
3 to State plans on best practices for adjusting
4 the payment amount under paragraph (3) for
5 services furnished during a fiscal year.”.

6 **TITLE IV—IMPROVING HEALTH**
7 **CARE ACCESS AND QUALITY**

8 **SEC. 4000. DEFINITION.**

9 In this title and the amendments made by this title,
10 the term “health care” includes all health care needed
11 throughout the life cycle and the end of life.

12 **Subtitle A—Reducing Barriers to**
13 **Accessing Care**

14 **SEC. 4001. THE PROTECTING SENSITIVE LOCATIONS ACT.**

15 (a) IN GENERAL.—Section 287 of the Immigration
16 and Nationality Act (8 U.S.C. 1357) is amended by add-
17 ing at the end the following:

18 “(i)(1) In order to ensure individuals’ access to sen-
19 sitive locations, this subsection shall apply to any enforce-
20 ment action by—

21 “(A) officers or agents of the Department of
22 Homeland Security, including officers and agents of
23 U.S. Immigration and Customs Enforcement and
24 U.S. Customs and Border Protection; and

1 “(B) any individual designated to perform im-
2 migration enforcement functions pursuant to a writ-
3 ten agreement described in subsection (g).

4 “(2)(A) Except as provided in subparagraphs (C) and
5 (D) of paragraph (3), an enforcement action may not take
6 place, be focused on a location, or occur, within 1,000 feet
7 of a sensitive location, except under exigent circumstances.

8 “(B) If an immigration enforcement action is taking
9 place under exigent circumstances, and the exigent cir-
10 cumstances permitting the enforcement action cease, the
11 enforcement action shall be discontinued until such exi-
12 gent circumstances reemerge.

13 “(C) If an individual referred to in subparagraph (A)
14 or (B) of paragraph (1) is not certain that exigent cir-
15 cumstances exist, the individual—

16 “(i) shall cease the enforcement action imme-
17 diately;

18 “(ii) shall consult with his or her supervisor in
19 real time regarding the existence of exigent cir-
20 cumstances; and

21 “(iii) may not continue the enforcement action
22 until the individual’s supervisor affirmatively con-
23 firms the existence of exigent circumstances.

24 “(3)(A) When proceeding with an enforcement action
25 at or near a sensitive location, individuals referred to in

1 subparagraph (A) or (B) of paragraph (1) shall make
2 every effort—

3 “(i) to conduct themselves as discreetly as pos-
4 sible, consistent with officer and public safety;

5 “(ii) to limit the time spent at the sensitive lo-
6 cation; and

7 “(iii) to limit the enforcement action to the per-
8 son or persons for whom prior approval was ob-
9 tained.

10 “(B) If, in the course of an enforcement action that
11 is not initiated at, or focused on, a sensitive location, indi-
12 viduals referred to in subparagraph (A) or (B) of para-
13 graph (1) are led to or near a sensitive location, and no
14 clear exigent circumstance with respect to the sensitive lo-
15 cation exists, such individuals shall—

16 “(i) cease taking any further enforcement ac-
17 tion;

18 “(ii) conduct themselves in a discreet manner;

19 “(iii) maintain surveillance; and

20 “(iv) in the event that uncertainty exists about
21 the existence of exigent circumstances, immediately
22 consult their supervisor in order to determine wheth-
23 er such enforcement action should be discontinued
24 pursuant to paragraph (2)(C).

1 “(C) This subsection shall not apply to the transpor-
2 tation of an individual apprehended at or near a land or
3 sea border to a hospital or health care provider for the
4 purpose of providing such individual medical care.

5 “(D) This subsection shall not apply to a rare pre-
6 meditated arrest operation, undertaken with the prior
7 written approval of an appropriate authorizing official, in-
8 volving the targeted arrest of a terrorist suspect, an indi-
9 vidual who poses a clear threat to national security, or
10 an individual who poses an extraordinary danger to public
11 safety.

12 “(4) If an enforcement action is carried out in viola-
13 tion of this subsection—

14 “(A) no information resulting from the enforce-
15 ment action may be entered into the record or re-
16 ceived into evidence in a removal proceeding result-
17 ing from the enforcement action; and

18 “(B) the alien who is the subject of such re-
19 moval proceeding may file a motion for the imme-
20 diate termination of the removal proceeding.

21 “(5)(A) Each official specified in subparagraph (B)
22 shall ensure the employees under the supervision of such
23 official receive annual training in compliance with the re-
24 quirements of this subsection, section 239, and section

1 384 of the Illegal Immigration Reform and Immigrant Re-
2 sponsibility Act of 1996 (8 U.S.C. 1367).

3 “(B) The officials specified in this subparagraph are
4 the following:

5 “(i) The Chief Counsel of U.S. Immigration
6 and Customs Enforcement.

7 “(ii) The Field Office Directors of U.S. Immi-
8 gration and Customs Enforcement.

9 “(iii) Each Special Agent in Charge of U.S. Im-
10 migration and Customs Enforcement.

11 “(iv) Each Chief Patrol Agent of U.S. Customs
12 and Border Protection.

13 “(v) The Director of Field Operations of U.S.
14 Customs and Border Protection.

15 “(vi) The Director of Air and Marine Oper-
16 ations of U.S. Customs and Border Protection.

17 “(vii) The Internal Affairs Special Agent in
18 Charge of U.S. Customs and Border Protection.

19 “(6)(A) Not later than 30 days after any enforcement
20 action is taken at a sensitive location by any individual
21 referred to in subparagraph (A) or (B) of paragraph (1),
22 the Secretary of Homeland Security shall provide a report
23 to the Office of the Inspector General of the Department
24 of Homeland Security and the Office for Civil Rights and
25 Civil Liberties of the Department of Homeland Security

1 with respect to each such enforcement action, which shall
2 contain—

3 “(i) the date, State, and local political subdivi-
4 sion (such as city, town, or county) in which each
5 enforcement action occurred;

6 “(ii) the specific sensitive location site where
7 the enforcement action occurred;

8 “(iii) the type of enforcement action that oc-
9 curred;

10 “(iv) the specific department, agency, and offi-
11 cers responsible for the enforcement action;

12 “(v) a thorough description of the cir-
13 cumstances which purportedly justified the enforce-
14 ment action, including—

15 “(I) a clear description of the exigent cir-
16 cumstances involved; or

17 “(II) a certified copy of the written ap-
18 proval for the immigration arrest that was
19 signed by an appropriate authorizing officer,
20 along with a clear description of the specific
21 and rare threat which justified the premeditated
22 arrest at such sensitive location;

23 “(vi) a description of the intended target of the
24 enforcement action;

1 “(vii) the number of individuals, if any, ar-
2 rested or taken into custody through the enforce-
3 ment action;

4 “(viii) the number of collateral arrests, if any,
5 from the enforcement action and the reasons for
6 each such arrest; and

7 “(ix) a certification of whether a supervisor was
8 contacted before, during, or after each such enforce-
9 ment action.

10 “(B) An appropriate committee of Congress may, at
11 any time, request and successfully receive a confidential
12 or redacted copy of any of the individual reports described
13 in subparagraph (A).

14 “(7)(A) The Director of U.S. Immigration and Cus-
15 toms Enforcement and the Commissioner for U.S. Cus-
16 toms and Border Protection shall each submit an annual
17 report to the appropriate committees of Congress that de-
18 scribes the enforcement actions covered by this subsection
19 that were undertaken by U.S. Immigration and Customs
20 Enforcement or U.S. Customs and Border Protection, as
21 applicable, during the preceding fiscal year.

22 “(B) Each report submitted pursuant to subpara-
23 graph (A) shall include—

24 “(i) the number of enforcement actions at or fo-
25 cused on a sensitive location;

1 “(ii) the number of enforcement actions where
2 officers or agents were subsequently led to or near
3 a sensitive location;

4 “(iii) the date, site, State, and local political
5 subdivision (such as city, town, or county) in which
6 each enforcement action covered by clause (i) or (ii)
7 occurred;

8 “(iv) the component of the agency responsible
9 for each such enforcement action;

10 “(v) a description of the intended target of each
11 such enforcement action;

12 “(vi) the number of individuals, if any, arrested
13 or taken into custody through each such enforce-
14 ment action;

15 “(vii) the number of collateral arrests, if any,
16 from each such enforcement action and the reasons
17 for each such arrest; and

18 “(viii) a certification of whether the location ad-
19 ministrator was contacted prior to, during, or after
20 each such enforcement action.

21 “(8)(A) The Office of Inspector General of the De-
22 partment of Homeland Security shall submit an annual
23 report to the appropriate committees of Congress regard-
24 ing the complaints of enforcement actions covered by this
25 subsection that were taken in sensitive locations by U.S.

1 Immigration and Customs Enforcement and U.S. Customs
2 and Border Protection during the preceding year.

3 “(B) Each report submitted pursuant to subpara-
4 graph (A) shall include—

5 “(i) the number of complaints of enforcement
6 actions reported at, or focused on, a sensitive loca-
7 tion;

8 “(ii) the reported date, site, State, and local po-
9 litical subdivision (such as city, town, or county) in
10 which each enforcement action referred to in clause
11 (i) occurred;

12 “(iii) the reported agency responsible for each
13 such enforcement action;

14 “(iv) a description of the intended target of
15 each such enforcement action;

16 “(v) the reported number of individuals, if any,
17 arrested or taken into custody through each such en-
18 forcement action;

19 “(vi) the reported number of collateral arrests,
20 if any, from each such enforcement action, and the
21 reasons for each such arrest; and

22 “(vii) if available, a certification of whether the
23 location administrator was contacted prior to, dur-
24 ing, or after each such enforcement action.

25 “(9) In this subsection:

1 “(A) The term ‘appropriate authorizing official’
2 means—

3 “(i) in the case of officers and agents of
4 U.S. Immigration and Customs Enforcement—

5 “(I) in the case of officers and agents
6 of U.S. Immigration and Customs Enforce-
7 ment—

8 “(II) the Executive Associate Director
9 of Homeland Security Investigations;

10 “(III) the Assistant Director for Field
11 Operations, Enforcement, and Removal
12 Operations;

13 “(IV) the Executive Associate Direc-
14 tor for Field Operations, Enforcement, and
15 Removal Operations; or

16 “(V) any other individual who is de-
17 termined to be an appropriate authorizing
18 official by the Secretary of Homeland Se-
19 curity; and

20 “(ii) in the case of officers and agents of
21 U.S. Customs and Border Protection—

22 “(I) a Chief Patrol Agent;

23 “(II) the Director of Field Operations;

24 “(III) the Director of Air and Marine
25 Operations;

1 “(IV) the Internal Affairs Special
2 Agent in Charge; or

3 “(V) any other individual who is de-
4 termined to be an appropriate authorizing
5 official by the Secretary of Homeland Se-
6 curity; and

7 “(iii) in the case of all other individuals re-
8 ferred to in subparagraph (A) or (B) of para-
9 graph (1), an official determined under rules
10 promulgated by the Secretary of Homeland Se-
11 curity not later than 90 days after the date of
12 the enactment of the Protecting Sensitive Loca-
13 tions Act.

14 “(B) The term ‘appropriate committees of Con-
15 gress’ means—

16 “(i) the Committee on Homeland Security
17 and Governmental Affairs of the Senate;

18 “(ii) the Committee on the Judiciary of the
19 Senate;

20 “(iii) the Committee on Appropriations of
21 the Senate;

22 “(iv) the Committee on Homeland Security
23 of the House of Representatives;

24 “(v) the Committee on the Judiciary of the
25 House of Representatives; and

1 “(vi) the Committee on Appropriations of
2 the House of Representatives.

3 “(C) The term ‘early childhood education pro-
4 gram’ has the meaning given such term in section
5 103(8) of the Higher Education Act of 1965 (20
6 U.S.C. 1003(8)).

7 “(D) The term ‘enforcement action’—

8 “(i) means an apprehension, arrest, inter-
9 view, request for identification, search, or sur-
10 veillance for the purposes of immigration en-
11 forcement; and

12 “(ii) includes an enforcement action at, or
13 focused on, a sensitive location that is part of
14 a joint case led by another law enforcement
15 agency.

16 “(E) The term ‘exigent circumstances’ means a
17 situation involving—

18 “(i) the imminent risk of death, violence,
19 or physical harm to any person, including a sit-
20 uation implicating terrorism or the national se-
21 curity of the United States in some other man-
22 ner;

23 “(ii) the immediate arrest or hot pursuit of
24 an individual presenting an imminent danger to

1 public safety, including the imminent risk of
2 death, violence, or physical harm to a person;

3 “(iii) a rare, premeditated arrest operation
4 described in paragraph (3)(D), undertaken with
5 the prior written approval of an appropriate au-
6 thorizing official, involving the targeted arrest
7 of a terrorist suspect, an individual who poses
8 a clear threat to national security, or an indi-
9 vidual who poses an extraordinary danger to
10 public safety;

11 “(iv) a direct threat to national security; or

12 “(v) the imminent risk of destruction of
13 evidence that is material to an ongoing criminal
14 case.

15 “(F) The term ‘sensitive location’ includes all of
16 the physical space located within 1,000 feet of—

17 “(i) any medical or mental healthcare facil-
18 ity, including any hospital, health care practi-
19 tioner’s office, accredited health clinic, vaccina-
20 tion or testing site, or emergent or urgent care
21 facility, or community health center;

22 “(ii) any public or private school (including
23 preschools, primary schools, secondary schools,
24 and postsecondary schools (including colleges
25 and), any site of an early childhood education

1 program, any other institution of learning, such
2 as vocational or trade schools, and any other
3 site where individuals who are unemployed or
4 underemployed may apply for or receive work-
5 force training;

6 “(iii) any scholastic or education-related
7 activity or event, including field trips and inter-
8 scholastic events;

9 “(iv) any school bus or school bus stop
10 during periods when school children are present
11 on the bus or at the stop;

12 “(v) any recreational facility for children,
13 such as playgrounds and formal recreational fa-
14 cilities;

15 “(vi) any child care focused facility, includ-
16 ing child care centers, before or after school
17 care centers, foster care facilities, and group
18 homes for children;

19 “(vii) any location where disaster or emer-
20 gency response and relief is being provided by
21 Federal, State, or local entities, such as the dis-
22 tribution of emergency supplies, food, and
23 water; any place of temporary shelter; any place
24 along an evacuation route; and any site where

1 registration for disaster-related assistance or
2 family reunification is taking place;

3 “(viii) any location of any organization
4 that—

5 “(I) assists children, pregnant women,
6 victims of crime or abuse, or individuals
7 with significant mental or physical disabili-
8 ties, including domestic violence shelters,
9 child advocacy centers, facilities that serve
10 disabled persons, drug or alcohol coun-
11 seling and treatment facilities, rape crisis
12 centers, supervised visitation centers, fam-
13 ily justice centers, victims’ services pro-
14 viders, and community-based organizations
15 providing social services; or

16 “(II) provides disaster or emergency
17 social services and assistance, or services
18 for individuals experiencing homelessness,
19 including food banks, pantries, or other es-
20 tablishments distributing food, and shel-
21 ters;

22 “(ix) any church, synagogue, mosque, or
23 other place of worship or religious study, such
24 as buildings rented for the purpose of religious

1 services, or a temporary facility or location
2 where such activities are taking place;

3 “(x) any sites of a funeral, graveside cere-
4 mony, wedding, or any site where other reli-
5 gious or civil ceremonies or observances are oc-
6 ccurring;

7 “(xi) any site during the occurrence of a
8 public demonstration, such as a march, rally, or
9 parade;

10 “(xii) any Federal, State, or local court-
11 house, including the office of an individual’s
12 legal counsel or representative, and a probation
13 office;

14 “(xiii) any congressional district office;

15 “(xiv) any Social Security office;

16 “(xv) any public assistance offices, includ-
17 ing locations where individuals may apply for or
18 receive unemployment compensation or report
19 violations of labor and employment laws;

20 “(xvi) the indoor or outdoor premises of a
21 department of motor vehicles;

22 “(xvii) a polling place, including any build-
23 ing or infrastructure where voting takes place
24 during an election;

1 “(xviii) a labor union hall or any other
 2 union- operated building or office where reg-
 3 istered applicants are referred in rotation to
 4 jobs;

5 “(xix) any public library; or

6 “(xx) any other location specified by the
 7 Secretary of Homeland Security for purposes of
 8 this subsection.

9 “(G) The term ‘supervisor’ means an official
 10 determined under rules promulgated by the Sec-
 11 retary of Homeland Security pursuant to section
 12 2(c) of the Protecting Sensitive Locations Act.”.

13 (b) EFFECTIVE DATE.—The amendment made by
 14 subsection (a) shall take effect on the date that is 90 days
 15 after the date of the enactment of this Act.

16 (c) RULEMAKING.—Not later than 90 days after the
 17 date of the enactment of this Act, the Secretary of Home-
 18 land Security shall promulgate regulations to carry out the
 19 amendment made by subsection (a).

20 **SEC. 4002. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
 21 **TION EVIDENCING CITIZENSHIP OR NATION-**
 22 **ALITY UNDER THE MEDICAID PROGRAM.**

23 (a) REPEAL.—Subsections (i)(22) and (x) of section
 24 1903 of the Social Security Act (42 U.S.C. 1396b) are
 25 each repealed.

1 (b) CONFORMING AMENDMENTS.—

2 (1) STATE PAYMENTS FOR MEDICAL ASSIST-
3 ANCE.—Section 1902 of the Social Security Act (42
4 U.S.C. 1396a) is amended—

5 (A) by amending paragraph (46) of sub-
6 section (a) to read as follows:

7 “(46) provide that information is requested and
8 exchanged for purposes of income and eligibility
9 verification in accordance with a State system which
10 meets the requirements of section 1137 of this
11 Act;”;

12 (B) in subsection (e)(13)(A)(i)—

13 (i) in the matter preceding subclause
14 (I), by striking “sections 1902(a)(46)(B)
15 and 1137(d)” and inserting “section
16 1137(d)”; and

17 (ii) by striking subclause (IV) and re-
18 designating subclause (V) as subclause
19 (IV); and

20 (C) by striking subsection (ee).

21 (2) REPEAL.—Subsection (c) of section 6036 of
22 the Deficit Reduction Act of 2005 (42 U.S.C. 1396b
23 note) is repealed.

1 (3) CHIP REPEAL.—Section 2105(c)(9) of the
 2 Social Security Act (42 U.S.C. 1397ee(c)(9)) is re-
 3 pealed.

4 (c) EFFECTIVE DATE.—The amendments made by
 5 this section shall take effect on the date of enactment of
 6 this Act.

7 **SEC. 4003. REMOVING BARRIERS TO HEALTH CARE AND NU-**
 8 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
 9 **NANT PERSONS, AND LAWFULLY PRESENT IN-**
 10 **DIVIDUALS.**

11 (a) MEDICAID.—Section 1903(v) of the Social Secu-
 12 rity Act (42 U.S.C. 1396b(v)) is amended by striking
 13 paragraphs (4) and (5) and inserting the following new
 14 paragraph:

15 “(4)(A) Notwithstanding sections 401(a), 402(b),
 16 403, and 421 of the Personal Responsibility and Work Op-
 17 portunity Reconciliation Act of 1996 and paragraph (1),
 18 payment shall be made to a State under this section for
 19 medical assistance furnished to an alien under this title
 20 (including an alien described in such paragraph) who
 21 meets any of the following conditions:

22 “(i) The alien is otherwise eligible for such as-
 23 sistance under the State plan approved under this
 24 title (other than the requirement of the receipt of
 25 aid or assistance under title IV, supplemental secu-

1 rity income benefits under title XVI, or a State sup-
2 plementary payment) within either or both of the
3 following eligibility categories:

4 “(I) Children under 21 years of age, in-
5 cluding any optional targeted low-income child
6 (as such term is defined in section
7 1905(u)(2)(B)).

8 “(II) Pregnant persons during pregnancy
9 and during the 12-month period beginning on
10 the last day of the pregnancy.

11 “(ii) The alien is lawfully present in the United
12 States.

13 “(B) No debt shall accrue under an affidavit of sup-
14 port against any sponsor of an alien who meets the condi-
15 tions specified in subparagraph (A) on the basis of the
16 provision of medical assistance to such alien under this
17 paragraph and the cost of such assistance shall not be con-
18 sidered as an unreimbursed cost.”.

19 (b) CHIP.—Subparagraph (Q) of section 2107(e)(1)
20 of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is
21 amended to read as follows:

22 “(Q) Paragraph (4) of section 1903(v) (re-
23 lating to coverage of categories of children,
24 pregnant persons, and other lawfully present in-
25 dividuals).”.

1 (c) SUPPLEMENTAL NUTRITION ASSISTANCE PRO-
2 GRAM BENEFITS.—

3 (1) PERSONAL RESPONSIBILITY AND WORK OP-
4 PORTUNITY RECONCILIATION ACT OF 1996.—

5 (A) FEDERAL PUBLIC BENEFITS.—Section
6 401(b) of the Personal Responsibility and Work
7 Opportunity Reconciliation Act of 1996 (8
8 U.S.C. 1611(b)) is amended by adding at the
9 end the following:

10 “(6) Subsection (a) shall not apply to benefits
11 under the supplemental nutrition assistance program
12 established under the Food and Nutrition Act of
13 2008 (7 U.S.C. 2011 et seq.) for an individual who
14 is lawfully present in the United States, regardless
15 of—

16 “(A) the immigration status of the indi-
17 vidual; or

18 “(B) the date of entry by the individual
19 into the United States.”.

20 (B) OTHER SPECIFIED FEDERAL PRO-
21 GRAMS.—Section 402(a) of the Personal Re-
22 sponsibility and Work Opportunity Reconcili-
23 ation Act of 1996 (8 U.S.C. 1612(a)) is amend-
24 ed—

25 (i) in paragraph (2)—

1 (I) in subparagraph (D)(ii)—

2 (aa) in the clause heading,
3 by striking “FOOD STAMPS” and
4 inserting “SUPPLEMENTAL NU-
5 TRITION ASSISTANCE PROGRAM”;
6 and

7 (bb) in subclause (I), in the
8 first sentence, by striking “Food
9 Stamp Act of 1977” and insert-
10 ing “Food and Nutrition Act of
11 2008 (7 U.S.C. 2011 et seq.)”;

12 (II) in subparagraph (F)(ii), by
13 striking “(within” and all that follows
14 through the end of the clause and in-
15 serting “(within the meaning of sec-
16 tion 3(j) of the Food and Nutrition
17 Act of 2008 (7 U.S.C. 2012(j))).”;

18 (III) in subparagraph (G)(ii), by
19 striking “section 4(e) of the Indian
20 Self-Determination and Education As-
21 sistance Act (25 U.S.C. 450b(e)))”
22 and inserting “section 4 of the Indian
23 Self-Determination and Education As-
24 sistance Act (25 U.S.C. 5304))”;

1 (IV) in subparagraph (I), in the
2 subparagraph heading, by striking
3 “FOOD STAMP” and inserting “SUP-
4 PLEMENTAL NUTRITION ASSISTANCE
5 PROGRAM”;

6 (V) in subparagraph (J), in the
7 subparagraph heading, by striking
8 “FOOD STAMP” and inserting “SUP-
9 PLEMENTAL NUTRITION ASSISTANCE
10 PROGRAM”;

11 (VI) in subparagraph (K)—

12 (aa) in the subparagraph
13 heading, by striking “FOOD
14 STAMP” and inserting “SUPPLE-
15 MENTAL NUTRITION ASSISTANCE
16 PROGRAM”; and

17 (bb) in clause (i), by striking
18 subclause (I) and inserting the
19 following:

20 “(I) is lawfully present in the
21 United States, regardless of the immi-
22 gration status of the individual or the
23 date of entry by the individual into
24 the United States; and”; and

1 (VII) by striking subparagraph
2 (L) and inserting the following:

3 “(L) SUPPLEMENTAL NUTRITION ASSIST-
4 ANCE PROGRAM BENEFITS GENERALLY.—With
5 respect to eligibility for benefits for the speci-
6 fied Federal program described in paragraph
7 (3)(B), paragraph (1) shall not apply to any in-
8 dividual who is lawfully present in the United
9 States, regardless of—

10 “(i) the immigration status of the in-
11 dividual; or

12 “(ii) the date of entry by the indi-
13 vidual into the United States.”; and

14 (ii) in paragraph (3)—

15 (I) in the matter preceding sub-
16 paragraph (A), by striking “For pur-
17 poses of” and inserting “In”; and

18 (II) by striking subparagraph (B)
19 and inserting the following:

20 “(B) SNAP.—The supplemental nutrition
21 assistance program established under the Food
22 and Nutrition Act of 2008 (7 U.S.C. 2011 et
23 seq.).”.

24 (C) CERTAIN LIMITED ELIGIBILITY.—Sec-
25 tion 403 of the Personal Responsibility and

1 Work Opportunity Reconciliation Act of 1996
2 (8 U.S.C. 1613) is amended—

3 (i) in subsection (b)—

4 (I) in the matter preceding para-
5 graph (1), by striking “aliens”;

6 (II) in paragraph (2)(C), by
7 striking “an individual described in
8 clause (i) or (ii)” and inserting “such
9 an individual”; and

10 (III) by adding at the end the
11 following:

12 “(4) SUPPLEMENTAL NUTRITION ASSISTANCE
13 PROGRAM BENEFITS.—Benefits under the supple-
14 mental nutrition assistance program established
15 under the Food and Nutrition Act of 2008 (7 U.S.C.
16 2011 et seq.) for an individual who is lawfully
17 present in the United States, regardless of—

18 “(A) the immigration status of the indi-
19 vidual; or

20 “(B) the date of entry by the individual
21 into the United States.”; and

22 (ii) in subsection (c)(2)(L), by strik-
23 ing “the Food Stamp Act of 1977 (7
24 U.S.C. 2011 et seq.)” and inserting “the
25 supplemental nutrition assistance program

1 established under the Food and Nutrition
2 Act of 2008 (7 U.S.C. 2011 et seq.)”.

3 (2) FOOD AND NUTRITION ACT OF 2008.—

4 (A) IN GENERAL.—Section 6(f) of the
5 Food and Nutrition Act of 2008 (7 U.S.C.
6 2015(f)) is amended—

7 (i) in paragraph (2)—

8 (I) by redesignating subpara-
9 graphs (B), (C), and (D) as clauses
10 (ii), (iii), and (iv), respectively;

11 (II) by striking the paragraph
12 designation and all that follows
13 through “a citizen” in subparagraph
14 (A) and inserting the following:

15 “(B)(i) a citizen”; and

16 (III) in the undesignated matter
17 following clause (iv) of subparagraph
18 (B) (as so redesignated)—

19 (aa) by striking “the indi-
20 vidual” and inserting “an indi-
21 vidual”; and

22 (bb) by striking “The in-
23 come” and inserting the fol-
24 lowing:

1 “(2) FACTOR FOR CONSIDERATION.—The in-
2 come”;

3 (ii) by redesignating paragraph (1) as
4 subparagraph (A) and indenting the sub-
5 paragraph appropriately;

6 (iii) by striking “(f) No individual”
7 and inserting the following:

8 “(f) ALIENS.—

9 “(1) IN GENERAL.—Subject to paragraph (3),
10 no individual”; and

11 (iv) by adding at the end the fol-
12 lowing:

13 “(3) CLARIFICATION OF APPLICABILITY.—Not-
14 withstanding paragraph (1), an individual who is
15 lawfully present in the United States shall not be
16 considered to be ineligible for benefits under that
17 paragraph on the basis of—

18 “(A) the immigration status of the indi-
19 vidual; or

20 “(B) the date of entry by the individual
21 into the United States.”.

22 (B) CONFORMING AMENDMENT.—Section
23 5(i)(1) of the Food and Nutrition Act of 2008
24 (7 U.S.C. 2014(i)(1)) is amended, in the first

1 sentence, by striking “section 6(f)(2)(B) of this
2 Act” and inserting “section 6(f)(1)(B)(ii)”.

3 (d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—
4 Section 421(d) of the Personal Responsibility and Work
5 Opportunity Reconciliation Act of 1996 (8 U.S.C.
6 1631(d)) is amended by striking paragraph (3) and insert-
7 ing the following:

8 “(3) SUPPLEMENTAL NUTRITION ASSISTANCE
9 PROGRAM.—This section shall not apply to benefits
10 under the supplemental nutrition assistance program
11 established under the Food and Nutrition Act of
12 2008 (7 U.S.C. 2011 et seq.), to the extent that a
13 child is a member of a household under that pro-
14 gram.”.

15 (e) ENSURING PROPER SCREENING.—Section
16 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7
17 U.S.C. 2020(e)(2)(B)) is amended—

18 (1) by redesignating clauses (vi) and (vii) as
19 clauses (vii) and (viii), respectively; and

20 (2) by inserting after clause (v) the following:

21 “(vi) shall provide a method for imple-
22 menting section 421 of the Personal Responsi-
23 bility and Work Opportunity Reconciliation Act
24 of 1996 (8 U.S.C. 1631) that does not require

1 any unnecessary information from an individual
 2 who may be exempt from that provision;”.

3 **SEC. 4004. IMPROVE AFFORDABILITY AND REDUCE PRE-**
 4 **MIUM COSTS OF HEALTH INSURANCE FOR**
 5 **CONSUMERS.**

6 (a) IN GENERAL.—Section 36B(b)(3)(A) of the In-
 7 ternal Revenue Code of 1986 is amended to read as fol-
 8 lows:

9 “(A) APPLICABLE PERCENTAGE.—The ap-
 10 plicable percentage for any taxable year shall be
 11 the percentage such that the applicable percent-
 12 age for any taxpayer whose household income is
 13 within an income tier specified in the following
 14 table shall increase, on a sliding scale in a lin-
 15 ear manner, from the initial premium percent-
 16 age to the final premium percentage specified in
 17 such table for such income tier:

“In the case of household income (expressed as a percent of poverty line) within the following in- come tier:	The initial premium percentage is—	The final premium percentage is—
Up to 150 percent	0.0	0.0
150 percent up to 200 percent	0.0	3.0
200 percent up to 250 percent	3.0	4.0
250 percent up to 300 percent	4.0	6.0
300 percent up to 400 percent	6.0	8.5
400 percent and higher	8.5	8.5.”.

18 (b) CONFORMING AMENDMENTS.—Section 36B(c)(1)
 19 of the Internal Revenue Code of 1986 is amended—

1 (1) by striking “but does not exceed 400 per-
2 cent” in subparagraph (A), and

3 (2) by striking subparagraph (E).

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 2026.

7 **SEC. 4005. REMOVING CITIZENSHIP AND IMMIGRATION**
8 **BARRIERS TO ACCESS TO AFFORDABLE**
9 **HEALTH CARE UNDER THE ACA.**

10 (a) IN GENERAL.—

11 (1) PREMIUM TAX CREDITS.—Section 36B of
12 the Internal Revenue Code of 1986 is amended—

13 (A) in subsection (c)(1), by inserting after
14 subparagraph (A) the following:

15 “(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS
16 INELIGIBLE FOR MEDICAID DUE TO
17 STATUS.—If—

18 “(i) a taxpayer has a household in-
19 come which is not greater than 100 per-
20 cent of an amount equal to the poverty line
21 for a family of the size involved,

22 “(ii) the taxpayer is a noncitizen who
23 is not eligible for the Medicaid program
24 under title XIX of the Social Security Act

1 by reason of the individual's immigration
2 status,

3 “(iii) the taxpayer is ineligible for
4 minimum essential coverage under section
5 5000A(f)(1)(A)(ii), and

6 “(iv) under the Medicaid eligibility
7 criteria for noncitizens in effect on Decem-
8 ber 26, 2020, the taxpayer would be ineli-
9 gible for such minimum essential coverage
10 by reason of the taxpayer's immigration
11 status,

12 the taxpayer shall, for purposes of the credit
13 under this section, be treated as an applicable
14 taxpayer with a household income which is
15 equal to 100 percent of the poverty line for a
16 family of the size involved.”, and

17 (B) by striking subsection (e).

18 (2) COST-SHARING REDUCTIONS.—Section 1402
19 of the Patient Protection and Affordable Care Act
20 (42 U.S.C. 18071) is amended—

21 (A) by striking subsection (e); and

22 (B) by redesignating subsections (f) and
23 (g) as subsections (e) and (f), respectively.

24 (3) BASIC HEALTH PROGRAM ELIGIBILITY.—
25 Section 1331(e)(1)(B) of the Patient Protection and

1 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
2 amended by striking “lawfully present in the United
3 States,”.

4 (4) RESTRICTIONS ON FEDERAL PAYMENTS.—
5 Section 1412 of the Patient Protection and Afford-
6 able Care Act (42 U.S.C. 18082) is amended—

7 (A) by striking subsection (d); and

8 (B) by redesignating subsection (e) as sub-
9 section (d).

10 (5) REQUIREMENT TO MAINTAIN MINIMUM ES-
11 SENTIAL COVERAGE.—Section 5000A(d) of the In-
12 ternal Revenue Code of 1986 is amended—

13 (A) by striking paragraph (3); and

14 (B) by redesignating paragraph (4) as
15 paragraph (3).

16 (b) CONFORMING AMENDMENTS.—

17 (1) ESTABLISHMENT OF PROGRAM.—Section
18 1411(a) of the Patient Protection and Affordable
19 Care Act (42 U.S.C. 18081(a)) is amended—

20 (A) by striking paragraph (1); and

21 (B) by redesignating paragraphs (2), (3),
22 and (4) as paragraphs (1), (2), and (3), respec-
23 tively.

1 (2) QUALIFIED INDIVIDUALS.—Section 1312(f)
 2 of the Patient Protection and Affordable Care Act
 3 (42 U.S.C. 18032(f)) is amended—

4 (A) in the heading, by striking “; ACCESS
 5 LIMITED TO CITIZENS AND LAWFUL RESI-
 6 DENTS”; and

7 (B) by striking paragraph (3).

8 (c) EFFECTIVE DATE.—The amendments made by
 9 this section shall apply to years, plan years, and taxable
 10 years, as applicable, beginning after December 31, 2026.

11 **SEC. 4006. HEAL FOR IMMIGRANT FAMILIES ACT.**

12 (a) CONSISTENCY IN HEALTH INSURANCE COV-
 13 ERAGE FOR INDIVIDUALS WITH FEDERALLY AUTHOR-
 14 IZED PRESENCE, INCLUDING DEFERRED ACTION.—

15 (1) IN GENERAL.—For purposes of eligibility
 16 under any of the provisions described in paragraph
 17 (2), all individuals granted federally authorized pres-
 18 ence in the United States shall be considered to be
 19 lawfully present in the United States.

20 (2) PROVISIONS DESCRIBED.—The provisions
 21 described in this paragraph are the following:

22 (A) EXCHANGE ELIGIBILITY.—Section
 23 1411 of the Patient Protection and Affordable
 24 Care Act (42 U.S.C. 18031).

1 (B) REDUCED COST-SHARING ELIGI-
 2 BILITY.—Section 1402 of the Patient Protec-
 3 tion and Affordable Care Act (42 U.S.C.
 4 18071).

5 (C) PREMIUM SUBSIDY ELIGIBILITY.—Sec-
 6 tion 36B of the Internal Revenue Code of 1986
 7 (26 U.S.C. 36B).

8 (D) MEDICAID AND CHIP ELIGIBILITY.—
 9 Titles XIX and XXI of the Social Security Act,
 10 including under section 1903(v) of such Act (42
 11 U.S.C. 1396b(v)).

12 (3) EFFECTIVE DATE.—

13 (A) IN GENERAL.—Paragraph (1) shall
 14 take effect on the date of enactment of this Act.

15 (B) TRANSITION THROUGH SPECIAL EN-
 16 ROLLMENT PERIOD.—In the case of an indi-
 17 vidual described in paragraph (1) who, before
 18 the first day of the first annual open enrollment
 19 period under subparagraph (B) of section
 20 1311(c)(6) of the Patient Protection and Af-
 21 fordable Care Act (42 U.S.C. 18031(c)(6)) be-
 22 ginning after the date of enactment of this Act,
 23 is granted federally authorized presence in the
 24 United States and who, as a result of such sub-
 25 section, qualifies for a subsidy under a provi-

sion described in subparagraph (B) or (C) of paragraph (2), the Secretary of Health and Human Services shall establish a special enrollment period under subparagraph (C) of such section 1311(c)(6) during which such individual may enroll in qualified health plans through Exchanges under title I of the Patient Protection and Affordable Care Act and qualify for such a subsidy. For such an individual who has been granted federally authorized presence in the United States as of the date of enactment of this Act, such special enrollment period shall begin not later than 90 days after such date of enactment. Nothing in this paragraph shall be construed as affecting the authority of the Secretary to establish additional special enrollment periods under such subparagraph (C).

(b) STATE OPTION TO EXPAND MEDICAID AND CHIP TO INDIVIDUALS WITHOUT LAWFUL PRESENCE.—

(1) MEDICAID.—

(A) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(i) in subclause (XXII), by striking “or” at the end;

1 (ii) in subclause (XXIII), by striking
2 the semicolon and inserting “; or”; and

3 (iii) by adding at the end the fol-
4 lowing new subclause:

5 “(XXIV) who would be eligible
6 under the State plan (or waiver of
7 such plan) under this title if they were
8 citizens of the United States;”.

9 (B) CONFORMING AMENDMENT.—Section
10 1905(a) of the Social Security Act (42 U.S.C.
11 1396d(a)) is amended, in the matter preceding
12 paragraph (1)—

13 (i) in the matter designated as clause
14 (xvii), by striking “or” at the end;

15 (ii) in the matter designated as clause
16 (xviii), by adding “or” at the end; and

17 (iii) by inserting after the matter des-
18 ignated as clause (xviii) the following:

19 “(xix) individuals described in section
20 1902(a)(10)(A)(ii)(XXIV),”.

21 (2) CHIP.—Title XXI of the Social Security
22 Act (42 U.S.C. 1397aa et seq.) is amended by in-
23 serting after section 2112 the following new section:

1 **“SEC. 2112A. STATE OPTION TO PROVIDE COVERAGE FOR**
 2 **INDIVIDUALS WITHOUT LAWFUL PRESENCE.**

3 “A State may elect through an amendment to its
 4 State child health plan under section 2102 to treat an in-
 5 dividual as a targeted low-income child or a targeted low-
 6 income pregnant woman for purposes of this title if such
 7 individual would otherwise be included as such a child or
 8 such a pregnant woman (as applicable) under such plan
 9 if the individual were a citizen of the United States.”.

10 (3) NONAPPLICATION OF ELIGIBILITY PROHIBI-
 11 TION.—Section 401(a) of the Personal Responsi-
 12 bility and Work Opportunity Reconciliation Act of
 13 1996 (42 U.S.C. 1611(a)) is amended by adding at
 14 the end the following new sentence: “The preceding
 15 sentence shall not apply with respect to a nonciti-
 16 zen’s eligibility under a State plan (or waiver of such
 17 plan) under title XIX of the Social Security Act or
 18 under a State child health plan (or waiver of such
 19 plan) under title XXI of such Act to the extent that
 20 such State has elected to make such individual so el-
 21 igible pursuant to section 1902(a)(10)(A)(ii)(XXIV)
 22 or 2112A of such Act, respectively.”.

23 (c) PRESERVING ACCESS TO COVERAGE.—

24 (1) IN GENERAL.—Nothing in this section, in-
 25 cluding the amendments made by this section, shall
 26 prevent lawfully present noncitizens who are ineli-

1 gible for full benefits under the Medicaid program
 2 under title XIX of the Social Security Act from se-
 3 curing a credit for which such lawfully present non-
 4 citizens would be eligible under section 36B(c)(1)(B)
 5 of the Internal Revenue Code of 1986 and under the
 6 Medicaid provisions for lawfully present noncitizens,
 7 as in effect on the date prior to the date of enact-
 8 ment of this Act.

9 (2) DEFINITION.—For purposes of paragraph
 10 (1), the term “full benefits” means, with respect to
 11 an individual and State, medical assistance for all
 12 services covered under the State plan under title
 13 XIX of the Social Security Act that is not less in
 14 amount, duration, or scope, or is determined by the
 15 Secretary of Health and Human Services to be sub-
 16 stantially equivalent to the medical assistance avail-
 17 able for an individual described in section
 18 1902(a)(10)(A)(i) of the Social Security Act (42
 19 U.S.C. 1396a(a)(10)(A)(i)).

20 **SEC. 4007. STUDY ON THE UNINSURED.**

21 (a) IN GENERAL.—The Secretary of Health and
 22 Human Services (in this section referred to as the “Sec-
 23 retary”) shall—

24 (1) conduct a study, in accordance with the
 25 standards under section 3101 of the Public Health

1 Service Act (42 U.S.C. 300kk), on the demographic
2 characteristics of the population of individuals who
3 do not have health insurance or oral health coverage;
4 and

5 (2) predict, based on such study, the demo-
6 graphic characteristics of the population of individ-
7 uals who would remain without health insurance
8 after the end of any annual open enrollment or any
9 special enrollment period or upon enactment and im-
10 plementation of any legislative changes to the Pa-
11 tient Protection and Affordable Care Act (Public
12 Law 111–148) that affect the number of persons eli-
13 gible for health insurance.

14 (b) REPORTING REQUIREMENTS.—

15 (1) IN GENERAL.—Not later than 12 months
16 after the date of the enactment of this Act, the Sec-
17 retary shall submit to the Congress the results of
18 the study under subsection (a)(1) and the prediction
19 made under subsection (a)(2).

20 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
21 ISTICS.—The Secretary shall—

22 (A) report the demographic characteristics
23 under paragraphs (1) and (2) of subsection (a)
24 on the basis of racial and ethnic minority group
25 (as defined in section 1707(g)(1) of the Public

1 Health Service Act), and stratify the reporting
2 on each racial and ethnic minority group by
3 other demographic characteristics that can im-
4 pact access to health insurance, such as sexual
5 orientation, gender identity, primary language,
6 disability status, sex, socioeconomic status, age
7 group, citizenship, and immigration status, in a
8 manner consistent with title I of this Act, in-
9 cluding the amendments made by such title;
10 and

11 (B) not use such report, or any informa-
12 tion gathered in preparing such report—

13 (i) to share information on any indi-
14 vidual with the Department of Homeland
15 Security or any other agency that engages
16 in immigration enforcement actions; or

17 (ii) for the exploitation of, or discrimi-
18 nation against, communities of color or the
19 LGBTQ+ population.

20 **SEC. 4008. MEDICAID FALLBACK COVERAGE PROGRAM FOR**
21 **LOW-INCOME ADULTS IN NON-EXPANSION**
22 **STATES.**

23 (a) IN GENERAL.—As soon as possible after the date
24 of enactment of this Act the Secretary of Health and

1 Human Services (in this section referred to as the “Sec-
2 retary”) shall—

3 (1) directly or by contract, establish a program
4 that offers eligible individuals the opportunity to en-
5 roll in health benefits coverage that meets the re-
6 quirements described in subsection (c) and any re-
7 quirements applicable to such coverage pursuant to
8 subsection (d); and

9 (2) ensure that such program is administered
10 consistent with the requirements of section
11 431.10(c)(2) of title 42, Code of Federal Regula-
12 tions.

13 (b) DEFINITION OF ELIGIBLE INDIVIDUAL.—In this
14 section, the term “eligible individual” means an individual
15 who—

16 (1) is described in section
17 1902(a)(10)(A)(i)(VIII) of the Social Security Act
18 (42 U.S.C. 1396a(a)(10)(A)(i)(VIII));

19 (2) resides in a State that—

20 (A) does not expend amounts for medical
21 assistance under title XIX of the Social Secu-
22 rity Act (42 U.S.C. 1396 et seq.) for all individ-
23 uals described in such section; and

24 (B) did not expend amounts for medical
25 assistance under such title for all such individ-

1 uals as of the date of enactment of this Act;
2 and

3 (3) would not be eligible for medical assistance
4 under such State's plan for medical assistance under
5 title XIX of the Social Security Act (42 U.S.C. 1396
6 et seq.), or a waiver of such plan, as such plan or
7 waiver was in effect on such date.

8 (c) HEALTH BENEFITS COVERAGE REQUIRE-
9 MENTS.—The requirements described in this subsection
10 with respect to health benefits coverage are the following:

11 (1) ESSENTIAL HEALTH BENEFITS.—At a min-
12 imum, the coverage meets the minimum standards
13 required under paragraph (5) of section 1937(b) of
14 the Social Security Act (42 U.S.C. 1396u–7(b)) for
15 benchmark coverage described in paragraph (1) of
16 such section or benchmark equivalent coverage de-
17 scribed in paragraph (2) of such section.

18 (2) PREMIUMS AND COST-SHARING.—No pre-
19 miums are imposed for the coverage, and
20 deductibles, cost-sharing, or similar charges may
21 only be imposed in accordance with the requirements
22 imposed on State Medicaid plans under section 1916
23 of the Social Security Act (42 U.S.C. 1396o).

1 (d) APPLICATION OF REQUIREMENTS AND PROVI-
2 SIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT.—

3 The Secretary shall specify that—

4 (1) any requirement applicable to the furnishing
5 of medical assistance under title XIX of the Social
6 Security Act (42 U.S.C. 1396 et seq.) by States that
7 have elected to make medical assistance available to
8 individuals described in section
9 1902(a)(10)(A)(i)(VIII) of such title (42 U.S.C.
10 1396a(a)(10)(A)(i)(VIII)) that does not conflict with
11 the requirements specified in subsection (c) applies
12 to the program established under this section; and

13 (2) other provisions of such title apply to such
14 program.

15 (e) NO STATE MANDATE.—Nothing in this section
16 shall be construed as requiring a State to make expendi-
17 tures related to the program established under this section
18 and the Secretary shall not impose any such requirement.

19 (f) FUNDING.—There are appropriated to the Sec-
20 retary for each fiscal year beginning with fiscal year 2027
21 from any funds in the Treasury not otherwise appro-
22 priated, such sums as are necessary to carry out this sec-
23 tion.

1 **SEC. 4009. INCREASE AND EXTENSION OF TEMPORARY EN-**
 2 **HANCED FMAP FOR STATES WHICH BEGIN TO**
 3 **EXPEND AMOUNTS FOR CERTAIN MANDA-**
 4 **TORY INDIVIDUALS.**

5 (a) IN GENERAL.—Section 1905(ii)(1) of the Social
 6 Security Act (42 U.S.C. 1396d(ii)(1)) is amended—

7 (1) by striking “8-quarter period” and inserting
 8 “40-quarter period”; and

9 (2) by striking “5 percentage points” and in-
 10 serting “10 percentage points”.

11 (b) EFFECTIVE DATE.—The amendments made by
 12 this section shall take effect as if included in the enact-
 13 ment of section 9814 of the American Rescue Plan Act
 14 of 2021 (Public Law 117–2).

15 **Subtitle B—Improvement of**
 16 **Coverage**

17 **SEC. 4101. MEDICAID IN THE TERRITORIES.**

18 (a) ELIMINATION OF GENERAL MEDICAID FUNDING
 19 LIMITATIONS (“CAP”) FOR TERRITORIES.—

20 (1) IN GENERAL.—Section 1108 of the Social
 21 Security Act (42 U.S.C. 1308) is amended—

22 (A) in subsection (f), in the matter pre-
 23 ceding paragraph (1), by striking “subsections
 24 (g) and (h)” and inserting “subsections (g),
 25 (h), and (j)”;

1 (B) in subsection (g)(2), in the matter pre-
 2 ceding subparagraph (A), by inserting “sub-
 3 section (j) and” after “subject to”;

4 (C) in subsection (i)—

5 (i) by striking paragraph (4); and

6 (ii) by redesignating paragraph (5) as
 7 paragraph (4); and

8 (D) by adding at the end the following new
 9 subsection:

10 “(j) SUNSET OF MEDICAID FUNDING LIMITATIONS
 11 FOR PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE
 12 NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—
 13 Subsections (f) and (g) shall not apply to Puerto Rico,
 14 the Virgin Islands, Guam, the Northern Mariana Islands,
 15 and American Samoa beginning with fiscal year 2027.”.

16 (2) CONFORMING AMENDMENTS.—

17 (A) Section 1902(j) of the Social Security
 18 Act (42 U.S.C. 1396a(j)) is amended by strik-
 19 ing “, the limitation in section 1108(f),”.

20 (B) Section 1903(u) of the Social Security
 21 Act (42 U.S.C. 1396b(u)) is amended by strik-
 22 ing paragraph (4).

23 (3) EFFECTIVE DATE.—The amendments made
 24 by this subsection shall apply beginning with fiscal
 25 year 2027.

1 (b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL
 2 ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR
 3 PUERTO RICO.—Section 1905 of the Social Security Act
 4 (42 U.S.C. 1396d) is amended—

5 (1) in subsection (b), in the first sentence, by
 6 inserting “for fiscal years before fiscal year 2027”
 7 after “American Samoa”; and

8 (2) in subsection (ff)(2), by striking “2027”
 9 and inserting “2026”.

10 (c) PERMITTING MEDICAID DSH ALLOTMENTS FOR
 11 TERRITORIES.—Section 1923(f) of the Social Security Act
 12 (42 U.S.C. 1396r–4(f)) is amended—

13 (1) in paragraph (6), by adding at the end the
 14 following new subparagraph:

15 “(C) TERRITORIES.—

16 “(i) FISCAL YEAR 2027.—For fiscal
 17 year 2027, the DSH allotment for Puerto
 18 Rico, the Virgin Islands, Guam, the North-
 19 ern Mariana Islands, and American Samoa
 20 shall bear the same ratio to \$300,000,000
 21 as the ratio of the number of individuals
 22 who are low-income or uninsured and re-
 23 siding in such respective territory (as esti-
 24 mated from time to time by the Secretary)

1 bears to the sums of the number of such
 2 individuals residing in all of the territories.

3 “(ii) SUBSEQUENT FISCAL YEAR.—
 4 For each subsequent fiscal year, the DSH
 5 allotment for each such territory is subject
 6 to an increase in accordance with para-
 7 graph (3).”; and

8 (2) in paragraph (9), by inserting before the pe-
 9 riod at the end the following: “, and includes, begin-
 10 ning with fiscal year 2027, Puerto Rico, the Virgin
 11 Islands, Guam, the Northern Mariana Islands, and
 12 American Samoa”.

13 **SEC. 4102. EXTENSION OF THE SUPPLEMENTAL SECURITY**
 14 **INCOME PROGRAM TO PUERTO RICO, THE**
 15 **UNITED STATES VIRGIN ISLANDS, GUAM, AND**
 16 **AMERICAN SAMOA.**

17 (a) IN GENERAL.—Section 303 of the Social Security
 18 Amendments of 1972 (86 Stat. 1484) is amended by strik-
 19 ing subsection (b).

20 (b) CONFORMING AMENDMENTS.—

21 (1) DEFINITION OF STATE.—Section
 22 1101(a)(1) of the Social Security Act (42 U.S.C.
 23 1301(a)(1)) is amended by striking the 5th sentence
 24 and inserting the following: “Such term when used

in title XVI includes Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.”.

(2) **ELIMINATION OF LIMIT ON TOTAL PAYMENTS TO THE TERRITORIES.**—Section 1108 of such Act (42 U.S.C. 1308) is amended—

(A) in the section heading, by striking “;

LIMITATION ON TOTAL PAYMENTS”;

(B) by striking subsection (a); and

(C) in subsection (c), by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (4), respectively.

(3) **UNITED STATES NATIONALS TREATED THE SAME AS CITIZENS.**—Section 1614(a)(1)(B) of such Act (42 U.S.C. 1382c(a)(1)(B)) is amended—

(A) in clause (i)(I), by inserting “or national,” after “citizen”;

(B) in clause (i)(II), by adding “; or” at the end; and

(C) in clause (ii), by inserting “or national” after “citizen”.

(4) **TERRITORIES INCLUDED IN GEOGRAPHIC MEANING OF UNITED STATES.**—Section 1614(e) of such Act (42 U.S.C. 1382c(e)) is amended by striking “and the District of Columbia” and inserting “,

1 the District of Columbia, Puerto Rico, the United
 2 States Virgin Islands, Guam, and American
 3 Samoa”.

4 (c) WAIVER AUTHORITY.—The Commissioner of So-
 5 cial Security may waive or modify any statutory require-
 6 ment relating to the provision of benefits under the Sup-
 7 plemental Security Income Program under title XVI of the
 8 Social Security Act in Puerto Rico, the United States Vir-
 9 gin Islands, Guam, or American Samoa, to the extent that
 10 the Commissioner deems it necessary in order to adapt
 11 the program to the needs of the territory involved.

12 (d) EFFECTIVE DATE.—This section and the amend-
 13 ments made by this section shall take effect on the 1st
 14 day of the 1st Federal fiscal year that begins 1 year or
 15 more after the date of the enactment of this Act.

16 **SEC. 4103. EXTENSION OF MEDICARE SECONDARY PAYER.**

17 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
 18 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
 19 ed—

20 (1) in the last sentence, by inserting “, and be-
 21 fore January 1, 2027” after “prior to such date”;
 22 and

23 (2) by adding at the end the following new sen-
 24 tence: “Effective for items and services furnished on
 25 or after January 1, 2027 (with respect to periods

1 beginning on or after the date that is 42 months
 2 prior to such date), clauses (i) and (ii) shall be ap-
 3 plied by substituting ‘42-month’ for ‘12-month’ each
 4 place it appears.”.

5 (b) **EFFECTIVE DATE.**—The amendments made by
 6 this section shall take effect on the date of enactment of
 7 this Act. For purposes of determining an individual’s sta-
 8 tus under section 1862(b)(1)(C) of the Social Security Act
 9 (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection
 10 (a), an individual who is within the coordinating period
 11 as of the date of enactment of this Act shall have that
 12 period extended to the full 42 months described in the last
 13 sentence of such section, as added by the amendment
 14 made by subsection (a)(2).

15 **SEC. 4104. INDIAN DEFINED IN TITLE I OF THE PATIENT**
 16 **PROTECTION AND AFFORDABLE CARE ACT.**

17 (a) **DEFINITION OF INDIAN.**—Section 1304 of the
 18 Patient Protection and Affordable Care Act (42 U.S.C.
 19 18024) is amended by adding at the end the following:

20 “(f) **INDIAN.**—In this title:

21 “(1) **IN GENERAL.**—The term ‘Indian’ means—

22 “(A) an Indian, a California Indian, or an
 23 Urban Indian (as those terms are defined in
 24 section 4 of the Indian Health Care Improve-
 25 ment Act (25 U.S.C. 1603)); or

1 “(B) an individual who is of Indian de-
2 scend and a member of an Indian community
3 served by a local facility or program of the In-
4 dian Health Service.

5 “(2) INCLUSIONS.—The term ‘Indian’ includes
6 the following individuals:

7 “(A) A member of a federally recognized
8 Indian Tribe.

9 “(B) A resident of an urban center who
10 meets 1 or more of the following criteria:

11 “(i) A member of a Tribe, band, or
12 other organized group of Indians, including
13 those Tribes, bands, or groups terminated
14 since 1940 and those recognized as of the
15 date of enactment of the Health Equity
16 and Accountability Act of 2026 or later by
17 the State in which they reside, or being a
18 descendant, in the first or second degree,
19 of any such member.

20 “(ii) An Eskimo or Aleut or other
21 Alaska Native.

22 “(iii) An individual who is determined
23 to be an Indian under regulations promul-
24 gated by the Secretary.

1 “(C) An individual who is considered by
2 the Secretary of the Interior to be an Indian for
3 any purpose.

4 “(D) An individual who is considered by
5 the Secretary to be an Indian for purposes of
6 eligibility for services provided by the Indian
7 Health Service, including as a California In-
8 dian, Eskimo, Aleut, or other Alaska Native.”.

9 (b) CONFORMING AMENDMENTS.—

10 (1) AFFORDABLE CHOICES OF HEALTH BEN-
11 EFIT PLANS.—Section 1311(c)(6)(D) of the Patient
12 Protection and Affordable Care Act (42 U.S.C.
13 18031(c)(6)(D)) is amended by striking “(as defined
14 in section 4 of the Indian Health Care Improvement
15 Act)”.

16 (2) REDUCED COST-SHARING FOR INDIVIDUALS
17 ENROLLING IN QUALIFIED HEALTH PLANS.—Section
18 1402(d) of the Patient Protection and Affordable
19 Care Act (42 U.S.C. 18071(d)) is amended—

20 (A) in paragraph (1), in the matter pre-
21 ceding subparagraph (A), by striking “(as de-
22 fined in section 4(d) of the Indian Self-Deter-
23 mination and Education Assistance Act (25
24 U.S.C. 450b(d)))”; and

1 (B) in paragraph (2), in the matter pre-
 2 ceding subparagraph (A), by striking “(as so
 3 defined)”.

4 (3) EXEMPTION FROM PENALTY FOR NOT
 5 MAINTAINING MINIMUM ESSENTIAL COVERAGE.—
 6 Section 5000A(e) of the Internal Revenue Code of
 7 1986 is amended by striking paragraph (3) and in-
 8 serting the following:

9 “(3) INDIANS.—Any applicable individual who
 10 is an Indian (as defined in section 1304(f) of the
 11 Patient Protection and Affordable Care Act).”.

12 (c) EFFECTIVE DATE OF IRC AMENDMENT.—The
 13 amendment made by subsection (b)(3) shall apply to tax-
 14 able years beginning after the date of the enactment of
 15 this Act.

16 **SEC. 4105. REMOVING MEDICARE BARRIER TO HEALTH**
 17 **CARE.**

18 (a) PART A.—Section 1818(a)(3)(B) of the Social
 19 Security Act (42 U.S.C. 1395i–2(a)(3)(B)) is amended by
 20 striking “an alien” and all that follows through “under
 21 this section” and inserting “an individual who is lawfully
 22 present in the United States”.

23 (b) PART B.—Section 1836(a)(2)(B) of the Social
 24 Security Act (42 U.S.C. 1395o(a)(2)(B)) is amended by
 25 striking “an alien” and all that follows through “under

1 this part” and inserting “an individual who is lawfully
2 present in the United States”.

3 **SEC. 4106. LOWERING MEDICARE PREMIUMS AND PRE-**
4 **SCRIPTION DRUG COSTS.**

5 (a) MEDICARE COST ASSISTANCE PROGRAM.—

6 (1) IN GENERAL.—Title XVIII of the Social Se-
7 curity Act (42 U.S.C. 1395 et seq.) is amended by
8 adding at the end the following new section:

9 **“SEC. 1899D. MEDICARE COST ASSISTANCE PROGRAM.**

10 “(a) IN GENERAL.—Effective beginning January 1,
11 2027, in the case of a Medicare Cost Assistance Program
12 eligible individual (as defined in subsection (b)(1)), the
13 Secretary shall provide Medicare cost assistance for the
14 following costs incurred with respect to the individual:

15 “(1) Premiums under section 1818.

16 “(2) Premiums under section 1839.

17 “(3) Coinsurance under this title (including co-
18 insurance described in section 1813).

19 “(4) Deductibles established under this title (in-
20 cluding those described in section 1813 and section
21 1833(b)).

22 “(5) The difference between the amount that is
23 paid under section 1833(a) and the amount that
24 would be paid under such section if any reference to

1 a percent less than 100 percent therein were deemed
2 a reference to ‘100 percent’.

3 “(b) DETERMINATION OF ELIGIBILITY.—

4 “(1) MEDICARE COST ASSISTANCE PROGRAM
5 ELIGIBLE INDIVIDUAL DEFINED.—The term ‘Medi-
6 care Cost Assistance Program eligible individual’
7 means an individual who—

8 “(A) is eligible for, and is receiving, med-
9 ical assistance for the payment of medicare
10 cost-sharing under a State Medicaid program
11 pursuant to clause (i), (iii), or (iv) of section
12 1902(a)(10)(E) as of December 31, 2026; or

13 “(B)(i) is entitled to hospital insurance
14 benefits under part A (including an individual
15 entitled to such benefits pursuant to an enroll-
16 ment under section 1818); and

17 “(ii) has income at or below 200 percent of
18 the poverty line applicable to a family of the
19 size involved.

20 “(2) JOINT DETERMINATION BY COMMISSIONER
21 OF SOCIAL SECURITY FOR LIS AND MEDICARE COST
22 ASSISTANCE.—

23 “(A) IN GENERAL.—The determination of
24 whether an individual is a Medicare Cost As-
25 sistance Program eligible individual shall be de-

1 terminated by the Commissioner of Social Secu-
2 rity (referred to in this section as the ‘Commis-
3 sioner’) jointly with the determination of wheth-
4 er an individual is a subsidy eligible individual
5 described in section 1860D–14(a)(3). Such de-
6 termination shall be made with respect to eligi-
7 bility for Medicare cost assistance under this
8 section and premium and cost-sharing subsidies
9 under section 1860D–14 upon application of an
10 individual for a determination with respect to
11 eligibility for either such assistance or such sub-
12 sidies. There are authorized to be appropriated
13 to the Social Security Administration such
14 sums as may be necessary for the determination
15 of eligibility under this paragraph.

16 “(B) EFFECTIVE PERIOD.—Determina-
17 tions under this paragraph with respect to eligi-
18 bility for each of such assistance or such sub-
19 sidies shall be effective beginning with the
20 month in which the individual applies for a de-
21 termination described in subparagraph (A) and
22 shall remain in effect until such time as the
23 Secretary determines the individual is no longer
24 eligible as determined under subparagraph
25 (C)(ii).

1 “(C) REDETERMINATIONS.—With respect
2 to eligibility determinations under this para-
3 graph—

4 “(i) redeterminations shall be made at
5 the same time with respect to eligibility for
6 Medicare cost assistance under this section
7 and cost-sharing subsidies under section
8 1860D–14, but not more frequently than
9 once every 12 months;

10 “(ii) a redetermination shall automati-
11 cally determine that an individual remains
12 eligible for such assistance or subsidies un-
13 less—

14 “(I) the Commissioner has infor-
15 mation indicating that the individual’s
16 circumstances have changed such that
17 the individual is no longer eligible for
18 such assistance or subsidies;

19 “(II) the Commissioner sends no-
20 tice to the individual regarding such
21 information that requests a response
22 either confirming or correcting such
23 information; and

24 “(III) the individual either con-
25 firms such information or fails to pro-

1 vide documentation indicating that
2 such circumstances have not changed
3 within 60 days of receiving the notice
4 described in subclause (II);

5 “(iii) the Commissioner shall establish
6 procedures for appeals of such determina-
7 tions that are similar to the procedures de-
8 scribed in the third sentence of section
9 1631(c)(1)(A); and

10 “(iv) judicial review of the final deci-
11 sion of the Commissioner made after a
12 hearing shall be available to the same ex-
13 tent, and with the same limitations, as pro-
14 vided in subsections (g) and (h) of section
15 205.

16 “(D) TREATMENT OF MEDICAID BENE-
17 FICIARIES.—The Secretary shall provide that
18 individuals who are full-benefit dual eligible in-
19 dividuals (as defined in section 1935(c)(6)) or
20 who are recipients of supplemental security in-
21 come benefits under title XVI shall be treated
22 as a Medicare Cost Assistance Program eligible
23 individual and, in the case of such individual
24 who is a part D eligible individual, a subsidy el-

1 igible individual described in section 1860D–
2 14(a)(3).

3 “(E) SIMPLIFIED APPLICATION FORM.—

4 “(i) IN GENERAL.—The Secretary
5 shall develop and distribute a simplified
6 application form for use by individuals in
7 applying for Medicare cost assistance
8 under this section and premium and cost-
9 sharing subsidies under section 1860D–14.
10 Such form shall be easily readable based
11 on culturally fluid language for all demo-
12 graphics beyond just the various languages
13 offered. An audio version, digital version,
14 and photo-voice option should also be pro-
15 vided for all learners. The Secretary shall
16 provide for the translation of such applica-
17 tion form into at least the 10 languages
18 (other than English) that are most often
19 used by individuals applying for hospital
20 insurance benefits under section 226 or
21 226A and shall make the translated forms
22 available to the Commissioner of Social Se-
23 curity.

1 “(ii) CONSULTATION.—In developing
2 the form under clause (i), the Secretary
3 shall consult with beneficiary groups.

4 “(3) INCOME DETERMINATIONS.—For purposes
5 of applying this section—

6 “(A) in the case of an individual who is
7 not treated as a Medicare Cost Assistance Pro-
8 gram eligible individual or a subsidy eligible in-
9 dividual under paragraph (2)(D), income shall
10 be determined in the manner described under
11 section 1612 for purposes of the supplemental
12 security income program, except that support
13 and maintenance furnished in kind shall not be
14 counted as income; and

15 “(B) the term ‘poverty line’ has the mean-
16 ing given such term in section 673(2) of the
17 Community Services Block Grant Act (42
18 U.S.C. 9902(2)), including any revision re-
19 quired by such section.

20 “(c) BENEFICIARY PROTECTIONS.—

21 “(1) IN GENERAL.—In the case in which the
22 payment for Medicare cost assistance for a Medicare
23 Cost Assistance Program eligible individual with re-
24 spect to an item or service is reduced or eliminated,
25 the individual shall not have any legal liability to

1 make payment to a provider of services (as defined
2 in section 1861(u)), a supplier (as defined in section
3 1861(d)), or to an organization described in section
4 1903(m)(1)(A) for the service, and any lawful sanc-
5 tion that may be imposed upon a provider of serv-
6 ices, a supplier, or such an organization for excess
7 charges under this title or title XIX shall apply to
8 the imposition of any charge imposed upon the indi-
9 vidual in such case.

10 “(2) CLARIFICATION.—This paragraph shall
11 not be construed as preventing payment of any
12 medicare cost assistance by a medicare supplemental
13 policy or an employer retiree health plan on behalf
14 of an individual.

15 “(d) ADMINISTRATION.—

16 “(1) IN GENERAL.—The Secretary shall estab-
17 lish procedures for the administration of the pro-
18 gram under this section.

19 “(2) FUNDING.—For purposes of carrying out
20 this section, the Secretary shall make payments from
21 the Federal Hospital Insurance Trust Fund under
22 section 1817 and the Federal Supplementary Med-
23 ical Insurance Trust Fund under section 1841, in
24 such proportion as the Secretary determines appro-
25 priate, of such amounts as the Secretary determines

1 necessary to provide Medicare cost assistance under
2 this section.

3 “(e) REFERENCES TO MEDICARE COST-SHARING.—
4 Effective beginning January 1, 2027, any reference to
5 medicare cost-sharing described in section 1905(p) shall
6 be deemed a reference to Medicare cost assistance under
7 this section.

8 “(f) OUTREACH EFFORTS.—For provisions relating
9 to outreach efforts to increase awareness of the availability
10 of Medicare cost assistance, see section 1144.”.

11 (2) SPECIAL ENROLLMENT PERIOD.—

12 (A) NO PREMIUM PENALTY.—Section
13 1839(b) of the Social Security Act (42 U.S.C.
14 1395r(b)) is amended, in the last sentence, by
15 inserting the following before the period: “or,
16 effective beginning January 1, 2027, for indi-
17 viduals who are Medicare Cost Assistance Pro-
18 gram eligible individuals (as defined in section
19 1899D(b)(1)).”.

20 (B) SPECIAL ENROLLMENT PERIOD.—Sec-
21 tion 1837 of the Social Security Act (42 U.S.C.
22 1395p) is amended by adding at the end the
23 following new subsection:

24 “(p) SPECIAL ENROLLMENT PERIOD FOR MEDICARE
25 COST ASSISTANCE PROGRAM ELIGIBLE INDIVIDUAL.—

1 “(1) IN GENERAL.—Effective beginning Janu-
 2 ary 1, 2027, the Secretary shall establish special en-
 3 rollment periods for Medicare Cost Assistance Pro-
 4 gram eligible individuals (as defined in section
 5 1899D(b)(1)).

6 “(2) COVERAGE PERIOD.—In the case of an in-
 7 dividual who enrolls during the special enrollment
 8 period provided under paragraph (1), the coverage
 9 period under this part shall—

10 “(A) begin on the first day of the first
 11 month in which the individual applies for a de-
 12 termination under section 1899D(b)(2)(A); and

13 “(B) remain in effect until such time as
 14 the Secretary determines the individual is no
 15 longer eligible as determined under section
 16 1899D(b)(2)(C)(ii).”.

17 (C) CONFORMING SUNSET OF STATE
 18 AGREEMENTS RELATING TO ENROLLMENT OF
 19 QUALIFIED MEDICARE BENEFICIARIES.—

20 (i) PART A.—Section 1818(g) of the
 21 Social Security Act (42 U.S.C. 1395i–2(g))
 22 is amended by adding at the end the fol-
 23 lowing new paragraph:

24 “(3) SUNSET.—This subsection shall not apply on or
 25 after January 1, 2027.”.

1 (ii) PART B.—Section 1843(h) of the
2 Social Security Act (42 U.S.C. 1395v(h))
3 is amended by adding at the end the fol-
4 lowing new paragraph:

5 “(4) SUNSET WITH RESPECT TO QUALIFIED MEDI-
6 CARE BENEFICIARIES.—This subsection shall not apply
7 with respect to qualified medicare beneficiaries on or after
8 January 1, 2027.”.

9 (3) PUBLIC AWARENESS CAMPAIGN.—Section
10 1144 of the Social Security Act (42 U.S.C. 1320b–
11 14) is amended by adding at the end the following
12 new subsection:

13 “(d) PUBLIC AWARENESS CAMPAIGN.—

14 “(1) IN GENERAL.—The Commissioner shall
15 conduct a public awareness campaign to educate
16 Medicare beneficiaries on the availability of Medicare
17 cost assistance for low-income individuals under sec-
18 tion 1899D.

19 “(2) COORDINATION.—In carrying out the pub-
20 lic awareness campaign under paragraph (1), the
21 Commissioner shall coordinate with State health in-
22 surance assistance programs described in subsection
23 (a)(1)(A) of section 119 of the Medicare Improve-
24 ments for Patients and Providers Act of 2008 (42
25 U.S.C. 1395b–3 note), the Administrator of the Ad-

1 ministration for Community Living, and the Admin-
 2 istrator of the Centers for Medicare & Medicaid
 3 Services.

4 “(3) FUNDING.—There is appropriated to the
 5 Commissioner, out of any funds in the Treasury not
 6 otherwise appropriated, \$10,000,000 for each of fis-
 7 cal years 2027 through 2031, to provide grants to
 8 State health insurance assistance programs to carry
 9 out outreach and education activities under the pub-
 10 lic awareness campaign pursuant to this sub-
 11 section.”.

12 (b) MOVING MEDICARE COST-SHARING BENEFITS
 13 FROM MEDICAID TO MEDICARE.—

14 (1) ENDING MOST MEDICARE COST-SHARING
 15 BENEFITS UNDER MEDICAID.—Section 1902(a)(10)
 16 of the Social Security Act (42 U.S.C. 1396a(a)(10))
 17 is amended—

18 (A) by inserting “for calendar quarters be-
 19 ginning before January 1, 2027,” before “for
 20 making” each place it appears in clauses (i),
 21 (iii), and (iv) of subparagraph (E); and

22 (B) in the matter following subparagraph
 23 (G)—

24 (i) by inserting “furnished during cal-
 25 endar quarters beginning before January

1, 2027” after “(described in section 1905(p)(3))”;

(ii) by striking “(XV)” and inserting “, (XV)”;

(iii) by striking “and (XVIII)” and inserting “(XVIII)”;

(iv) by striking “and (XIX)” and inserting “(XIX)”;

(v) by inserting “, and (XX) no medical assistance for medicare cost-sharing, other than medical assistance for medicare cost-sharing for qualified disabled and working individuals described in section 1905(s), shall be made available after January 1, 2027” before the semicolon at the end.

(2) CONFORMING AMENDMENTS.—

(A) TITLE XIX.—

(i) Section 1903(i) of such Act (42 U.S.C. 1396b(i)), as amended by section 4002, is further amended—

(I) in paragraph (26), by striking “or” at the end;

1 (II) in paragraph (27), by strik-
2 ing the period at the end and insert-
3 ing “; or”; and

4 (III) by inserting after paragraph
5 (27) the following new paragraph:

6 “(28) with respect to any amount expended for
7 medical assistance for medicare cost-sharing (other
8 than medical assistance for medicare cost-sharing
9 for qualified disabled and working individuals de-
10 scribed in section 1905(s)) furnished during cal-
11 endar quarters beginning on or after January 1,
12 2027.”.

13 (ii) Section 1905(a) of such Act (42
14 U.S.C. 1396d(a)) is amended, in the first
15 sentence, by inserting “furnished during
16 calendar quarters beginning before Janu-
17 ary 1, 2027” after “medicare cost-shar-
18 ing”.

19 (iii) Section 1933(g) of such Act (42
20 U.S.C. 1396u-3(g)) is amended—

21 (I) in paragraph (2)(Q), by strik-
22 ing “paragraph (4), for each subse-
23 quent year” and inserting “para-
24 graphs (4) and (5), for each subse-
25 quent year before 2027”; and

1 (II) by adding at the end the fol-
 2 lowing:

3 “(5) SUNSET.—No individual shall be selected
 4 to be a qualifying individual for any calendar year
 5 or period under this section beginning on or after
 6 January 1, 2027, and no State allocation shall be
 7 made for any fiscal year or period under this section
 8 beginning on or after January 1, 2027.”.

9 (iv) Section 1935(a) of such Act (42
 10 U.S.C. 1396u–5(a)) is amended—

11 (I) in paragraph (2)(A), by strik-
 12 ing “make determinations” and in-
 13 serting “prior to January 1, 2027,
 14 make determinations”; and

15 (II) in paragraph (3), by insert-
 16 ing “prior to January 1, 2027,” be-
 17 fore “the State shall”.

18 (B) TITLE XI.—Section 1144 of the Social
 19 Security Act (42 U.S.C. 1320b–14) is amend-
 20 ed—

21 (i) in subsection (a)—

22 (I) in paragraph (1)(A)—

23 (aa) by striking “sections
 24 1902(a)(10)(E) and 1933” and
 25 inserting “section

1 1902(a)(10)(E) and (prior to
2 January 1, 2027) section 1933”;

3 (bb) by striking “for the
4 transitional assistance under sec-
5 tion 1860D–31(f), or” and in-
6 serting a comma; and

7 (cc) by inserting “, or for
8 Medicare premium and cost-shar-
9 ing assistance under section
10 1899D (in the case of months be-
11 ginning on or after January 1,
12 2027)” before the semicolon; and

13 (II) by striking paragraph (2)
14 and inserting the following:

15 “(2) CONTENT OF NOTICE.—Any notice fur-
16 nished under paragraph (1) shall state that eligi-
17 bility for such medical assistance, subsidies, or pro-
18 gram is conditioned upon meeting the applicable eli-
19 gibility criteria.”;

20 (ii) in subsection (b)(1)(A)—

21 (I) by striking “sections
22 1902(a)(10)(E) and 1933” and in-
23 serting “section 1902(a)(10)(E) and
24 (prior to January 1, 2027) section
25 1933”;

1 (II) by striking “for transitional
 2 assistance under section 1860D–31(f),
 3 or”; and

4 (III) by inserting “, or for Medi-
 5 care premium and cost-sharing assist-
 6 ance under section 1899D” before the
 7 semicolon; and

8 (iii) in subsection (c)—

9 (I) in paragraph (1)(B), by in-
 10 serting “, and (beginning January 1,
 11 2027) provide an application for en-
 12 rollment under the Medicare Savings
 13 Program” before the period;

14 (II) in paragraph (2), in the
 15 paragraph header, by inserting
 16 “MEDICARE SAVINGS PROGRAM APPLI-
 17 CATION AND” before “LIS APPLICA-
 18 TION”; and

19 (III) in paragraph (7), by strik-
 20 ing “means the program of medical
 21 assistance” and all that follows
 22 through the period and inserting
 23 “means—

24 “(A) prior to January 1, 2027, the pro-
 25 gram of medical assistance for payment of the

1 cost of medicare cost-sharing under the Med-
 2 icaid program pursuant to sections
 3 1902(a)(10)(E) and 1933; and

4 “(B) beginning January 1, 2027, the pro-
 5 gram for medical assistance for payment of the
 6 cost of medicare cost-sharing for qualified dis-
 7 abled and working individuals described in sec-
 8 tion 1905(s) pursuant to section
 9 1902(a)(10)(E)(ii) and medicare premium and
 10 cost-sharing assistance provided under section
 11 1899D.”.

12 (3) ENSURING THAT MEDICARE COST-SHARING
 13 BENEFICIARIES UNDER MEDICAID RECEIVE MEDI-
 14 CARE COST ASSISTANCE.—Not later than January 1,
 15 2027, the Secretary of Health and Human Services
 16 and the Commissioner of Social Security shall jointly
 17 develop and implement a transition plan to ensure
 18 that all individuals who are eligible for and are re-
 19 ceiving medical assistance for the payment of medi-
 20 care cost-sharing under a State Medicaid program
 21 pursuant to clauses (i), (iii), and (iv) of section
 22 1902(a)(10)(E) of the Social Security Act (42
 23 U.S.C. 1396a(a)(10)(E)) as of December 31, 2022,
 24 receive Medicare cost assistance under section

1 1899D of such Act, as added by subsection (a), as
 2 of January 1, 2027.

3 (c) ENHANCING PRESCRIPTION DRUG AFFORD-
 4 ABILITY BY EXPANDING ACCESS TO ASSISTANCE WITH
 5 OUT-OF-POCKET COSTS UNDER MEDICARE PART D FOR
 6 LOW-INCOME SENIORS AND INDIVIDUALS WITH DISABIL-
 7 ITIES.—

8 (1) EXPANDING ACCESS.—Section 1860D–14 of
 9 the Social Security Act (42 U.S.C. 1395w–114) is
 10 amended—

11 (A) in subsection (a)—

12 (i) in paragraph (1), in the matter
 13 preceding subparagraph (A)—

14 (I) by striking “150 percent” and
 15 inserting “200 percent”; and

16 (II) by striking “and who meets
 17 the resources requirement described in
 18 paragraph (3)(D) (or, with respect to
 19 a plan year beginning on or after Jan-
 20 uary 1, 2024, paragraph (3)(E)) or
 21 who is covered under this paragraph
 22 under paragraph (3)(B)(i)”;

23 (ii) by striking paragraph (2);

24 (iii) in paragraph (3)—

25 (I) in subparagraph (A)—

1 (aa) in clause (i), by adding
 2 “and” at the end;

3 (bb) in clause (ii)—
 4 (AA) by striking “150
 5 percent” and inserting “200
 6 percent”; and

7 (BB) by striking “;
 8 and” at the end and insert-
 9 ing a period; and
 10 (cc) by striking clause (iii);

11 (II) by striking subparagraphs
 12 (B) and (C) and inserting the fol-
 13 lowing:

14 “(B) DETERMINATIONS.—For provisions
 15 relating to joint determinations with respect to
 16 eligibility for Medicare cost assistance under
 17 section 1899D and premium and cost-sharing
 18 subsidies under this section, see section
 19 1899D(b)(2).

20 “(C) INCOME DETERMINATIONS.—For pur-
 21 poses of applying this section—

22 “(i) in the case of an individual who
 23 is not treated as a Medicare cost-sharing
 24 assistance eligible individual and a subsidy
 25 eligible individual under section

1 1899D(b)(2)(D), income shall be deter-
 2 mined in the manner described under sec-
 3 tion 1612 for purposes of the supplemental
 4 security income program, except that sup-
 5 port and maintenance furnished in kind
 6 shall not be counted as income; and

7 “(ii) the term ‘poverty line’ has the
 8 meaning given such term in section 673(2)
 9 of the Community Services Block Grant
 10 Act (42 U.S.C. 9902(2)), including any re-
 11 vision required by such section.”; and

12 (III) by striking subparagraphs
 13 (D), (E), and (G); and

14 (iv) in paragraph (4)—

15 (I) in subparagraph (A)—

16 (aa) by striking “(A) Co-
 17 PAYMENT FOR LOWEST INCOME
 18 DUAL ELIGIBLE INDIVIDUALS.—
 19 ”;

20 (bb) by redesignating
 21 clauses (i) and (ii) as subpara-
 22 graphs (A) and (B), respectively
 23 and indenting appropriately; and

24 (cc) by moving the flush text
 25 at the end 2 ems to the left; and

1 (II) by striking subparagraph
2 (B); and

3 (B) in subsection (c)(1), in the second sen-
4 tence, by striking “subsections (a)(1)(D) and
5 (a)(2)(E)” and inserting “subsection
6 (a)(1)(D)”.

7 (2) TREATMENT OF REDUCTION OF COST-SHAR-
8 ING FOR INDIVIDUALS RECEIVING HOME AND COM-
9 MUNITY-BASED SERVICES.—Section 1860D-
10 14(a)(1)(D)(i) of the Social Security Act (42 U.S.C.
11 1395w-114(a)(1)(D)(i)) is amended—

12 (A) by striking “who would be such an in-
13 stitutionalized individual or couple, if the full-
14 benefit dual eligible individual were not”; and

15 (B) by striking “or subsection (c) or (d) of
16 section 1915 or under a State plan amendment
17 under subsection (i) of such section” and in-
18 serting “, section 1115A, section 1915, or
19 under a State plan amendment”.

20 (3) EFFECTIVE DATE.—The amendments made
21 by this subsection shall apply to plan year 2027 and
22 subsequent plan years.

1 **SEC. 4107. REDUCING COST-SHARING, ALIGNING INCOME**
 2 **AND RESOURCE ELIGIBILITY TESTS, SIMPLI-**
 3 **FYING ENROLLMENT, AND OTHER PROGRAM**
 4 **IMPROVEMENTS FOR LOW-INCOME BENE-**
 5 **FICIARIES.**

6 (a) INCREASE IN INCOME ELIGIBILITY TO 135 PER-
 7 CENT OF FPL FOR QUALIFIED MEDICARE BENE-
 8 FICIARIES.—

9 (1) IN GENERAL.—Section 1905(p)(2)(A) of the
 10 Social Security Act (42 U.S.C. 1396d(p)(2)(A)) is
 11 amended by striking “shall be at least the percent
 12 provided under subparagraph (B) (but not more
 13 than 100 percent) of the official poverty line” and
 14 all that follows through the period at the end and
 15 inserting the following: “shall be—

16 “(i) before January 1, 2027, at least
 17 the percent provided under subparagraph
 18 (B) (but not more than 100 percent) of
 19 the official poverty line (as defined by the
 20 Office of Management and Budget, and re-
 21 vised annually in accordance with section
 22 673(2) of the Community Services Block
 23 Grant Act (42 U.S.C. 9902(2))) applicable
 24 to a family of the size involved; and

25 “(ii) on or after January 1, 2027,
 26 equal to 135 percent of the official poverty

1 line (as so defined and revised) applicable
 2 to a family of the size involved.”.

3 (2) NOT COUNTING IN-KIND SUPPORT AND
 4 MAINTENANCE AS INCOME.—Section 1905(p)(2)(D)
 5 of the Social Security Act (42 U.S.C.
 6 1396d(p)(2)(D)) is amended by adding at the end
 7 the following new clause:

8 “(iii) In determining income under this sub-
 9 section, support and maintenance furnished in kind
 10 shall not be counted as income.”.

11 (b) INCREASE IN INCOME ELIGIBILITY TO 200 PER-
 12 CENT OF FPL FOR SPECIFIED LOW-INCOME MEDICARE
 13 BENEFICIARIES.—

14 (1) ELIGIBILITY OF INDIVIDUALS WITH IN-
 15 COMES BELOW 150 PERCENT OF FPL.—Section
 16 1902(a)(10)(E) of the Social Security Act (42
 17 U.S.C. 1396a(a)(10)(E)) is amended—

18 (A) by adding “and” at the end of clause

19 (ii);

20 (B) in clause (iii)—

21 (i) by striking “and 120 percent in
 22 1995 and years thereafter” and inserting
 23 “120 percent in 1995 and years thereafter
 24 before 2027, and 200 percent in 2027 and
 25 years thereafter”; and

1 (ii) by striking “and” at the end; and
 2 (C) by striking clause (iv).

3 (2) REFERENCES.—Section 1905(p)(1) of the
 4 Social Security Act (42 U.S.C. 1396d(p)(1)) is
 5 amended by adding at and below subparagraph (C)
 6 the following flush sentence:

7 “The term ‘specified low-income medicare beneficiary’
 8 means an individual described in section
 9 1902(a)(10)(E)(iii).”.

10 (3) CONFORMING AMENDMENTS.—

11 (A) The first sentence of section 1905(b)
 12 of such Act (42 U.S.C. 1396d(b)) is amended
 13 by striking “and section 1933(d)”.

14 (B) Section 1933 of such Act (42 U.S.C.
 15 1396u–3) is repealed.

16 (c) 100 PERCENT FMAP.—Section 1905 of the So-
 17 cial Security Act (42 U.S.C. 1396d) is amended—

18 (1) in subsection (b), by striking “and (ii)” and
 19 inserting “(ii), and (ll)”;

20 (2) amended by adding at the end the following
 21 new subsection:

22 “(ll) INCREASED FMAP FOR EXPANDED MEDICARE
 23 COST-SHARING POPULATIONS.—

24 “(1) IN GENERAL.—Notwithstanding subsection
 25 (b), with respect to expenditures described in para-

graph (2) the Federal medical assistance percentage shall be equal to 100 percent.

“(2) EXPENDITURES DESCRIBED.—The expenditures described in this paragraph are expenditures made on or after January 1, 2027, for medical assistance for medicare cost-sharing provided to any individual under clause (i), (ii), or (iii) of section 1902(a)(10)(E) who would not have been eligible for medicare cost-sharing under any such clause under the income or resource eligibility standards in effect on October 1, 2018.”.

(d) CONSOLIDATION OF LOW-INCOME SUBSIDY RESOURCE ELIGIBILITY TESTS.—

(1) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)) is amended—

(A) by striking subparagraph (D);

(B) by redesignating subparagraphs (E) through (G) as subparagraphs (D) through (F), respectively; and

(C) in the heading of subparagraph (D), as so redesignated, by striking “ALTERNATIVE RESOURCE” and inserting “RESOURCE”.

(2) CLARIFICATION OF CERTAIN RULES RELATING TO INCOME AND RESOURCE DETERMINA-

1 TIONS.—Section 1860D–14(a)(3) of the Social Secu-
 2 rity Act (42 U.S.C. 1395w–114(a)(3)), as amended
 3 by paragraph (1), is amended by striking subpara-
 4 graph (F) and inserting the following new subpara-
 5 graphs:

6 “(F) RESOURCE EXCLUSIONS.—In deter-
 7 mining the resources of an individual (and the
 8 eligible spouse of the individual, if any) under
 9 section 1613 for purposes of subparagraph
 10 (D)—

11 “(i) no part of the value of any life in-
 12 surance policy shall be taken into account;

13 “(ii) no part of the value of any vehi-
 14 cle shall be taken into account;

15 “(iii) there shall be excluded an
 16 amount equal to \$1,500 each with respect
 17 to any individual or eligible spouse of an
 18 individual who attests that some of the re-
 19 sources of such individual or spouse will be
 20 used to meet the burial and related ex-
 21 penses of such individual or spouse; and

22 “(iv) no balance in, or benefits re-
 23 ceived under, an employee pension benefit
 24 plan (as defined in section 3 of the Em-
 25 ployee Retirement Income Security Act of

1 1974 (29 U.S.C. 1002)) shall be taken into
2 account.

3 “(G) FAMILY SIZE.—In determining the
4 size of the family of an individual for purposes
5 of determining the income eligibility of such in-
6 dividual under this section, an individual’s fam-
7 ily shall consist of—

8 “(i) the individual;

9 “(ii) the individual’s spouse who lives
10 in the same household as the individual (if
11 any); and

12 “(iii) any other individuals who—

13 “(I) are related to the individual
14 whose income eligibility is in question
15 or such individual’s spouse who lives
16 in the same household;

17 “(II) are living in the same
18 household as such individual; and

19 “(III) are dependent on such in-
20 dividual or such individual’s spouse
21 who is living in the same household
22 for at least one-half of their financial
23 support.”.

1 (3) CONFORMING AMENDMENTS.—Section
2 1860D–14(a) of the Social Security Act (42 U.S.C.
3 1395w–114(a)) is amended—

4 (A) in paragraph (1), in the matter pre-
5 ceding subparagraph (A), by inserting “(as de-
6 termined under paragraph (3)(G))” after “fam-
7 ily of the size involved”; and

8 (B) in paragraph (3), as amended by para-
9 graphs (1) and (2)—

10 (i) in subparagraph (A), in the matter
11 preceding clause (i), by striking “subpara-
12 graph (F)” and inserting “subparagraph
13 (E)”;

14 (ii) in subparagraph (A)(ii), by insert-
15 ing “(as determined under subparagraph
16 (G))” after “family of the size involved”;

17 (iii) in subparagraph (A)(iii), by strik-
18 ing “or (E)”;

19 (iv) in subparagraph (B)(v), in the
20 matter preceding subclause (I), by striking
21 “subparagraph (F)” and inserting “sub-
22 paragraph (E)”;

23 (v) in subparagraph (D)(i), in the
24 matter preceding subclause (I), by striking
25 “subject to the life insurance policy exclu-

1 sion provided under subparagraph (G)”
 2 and inserting “subject to the resource ex-
 3 clusions provided under subparagraph
 4 (F)”.

5 (e) ALIGNMENT OF LOW-INCOME SUBSIDY AND
 6 MEDICARE SAVINGS PROGRAM INCOME AND RESOURCE
 7 ELIGIBILITY TESTS.—

8 (1) APPLICATION OF MEDICAID SPOUSAL IM-
 9 POVERISHMENT RESOURCE ALLOWANCE TO MSP AND
 10 LIS RESOURCE ELIGIBILITY.—Section 1905(p)(1)(C)
 11 of the Social Security Act (42 U.S.C.
 12 1396d(p)(1)(C)) is amended to read as follows:

13 “(C) whose resources (as determined under sec-
 14 tion 1613 for purposes of the supplemental security
 15 income program subject to the resource exclusions
 16 under subparagraph (F) of section 1860D–14(a)(3))
 17 do not exceed—

18 “(i) in the case of an individual with a
 19 spouse, an amount equal to the sum of the first
 20 amount specified in subsection (f)(2)(A)(i) of
 21 section 1924 (as adjusted under subsection (g)
 22 of such section) and the amount specified in
 23 subsection (f)(2)(A)(ii)(II) of such section (as
 24 so adjusted); or

1 “(ii) in the case of an individual who does
 2 not have a spouse, an amount equal to $\frac{1}{2}$ of
 3 the amount described in clause (i).”.

4 (2) APPLICATION TO QDWIS.—Section
 5 1905(s)(3) of the Social Security Act (42 U.S.C.
 6 1396d(s)(3)) is amended to read as follows:

7 “(3) whose resources (as determined under sec-
 8 tion 1613 for purposes of the supplemental security
 9 income program subject to the resource exclusions
 10 under subparagraph (F) of section 1860D–14(a)(3))
 11 do not exceed—

12 “(A) in the case of an individual with a
 13 spouse, the amount in effect for the year under
 14 clause (i) of subsection (p)(1)(C); and

15 “(B) in the case of an individual who does
 16 not have a spouse, the amount in effect for the
 17 year under clause (ii) of subsection (p)(1)(C);
 18 and”.

19 (3) APPLICATION TO LIS.—Clause (i) of section
 20 1860D–14(a)(3)(D) of the Social Security Act (42
 21 U.S.C. 1395w–114(a)(3)(D)), as redesignated and
 22 amended by subsection (d), is amended to read as
 23 follows:

24 “(i) IN GENERAL.—The resources re-
 25 quirement of this subparagraph is that an

individual's resources (as determined under section 1613 for purposes of the supplemental security income program subject to the resource exclusions provided under subparagraph (F)) do not exceed the amount in effect for the year under section 1905(p)(1)(C)(ii).”.

(f) ENROLLMENT SIMPLIFICATIONS.—

(1) APPLICATION OF 3-MONTH RETROACTIVE ELIGIBILITY TO QMBS.—

(A) IN GENERAL.—Section 1902(e)(8) of the Social Security Act (42 U.S.C. 1396a(e)(8)) is amended by striking “after the end of the month in which the determination first occurs” and inserting “in or after the third month before the month in which the individual makes application for assistance”.

(B) PROCESS FOR SUBMITTING CLAIMS DURING RETROACTIVE ELIGIBILITY PERIOD.—Section 1902(e)(8) of the Social Security Act (42 U.S.C. 1396a(e)(8)) is further amended by adding at the end the following: “The Secretary shall provide for a process under which claims for medical assistance under the State plan may be submitted for services furnished to such an

1 individual during such 3-month period before
 2 the month in which the individual made appli-
 3 cation for assistance.”.

4 (C) CONFORMING AMENDMENT.—Section
 5 1905(a) of the Social Security Act (42 U.S.C.
 6 1396d(a)) is amended, in the matter preceding
 7 paragraph (1), by striking “or, in the case of
 8 medicare cost-sharing with respect to a quali-
 9 fied medicare beneficiary described in sub-
 10 section (p)(1), if provided after the month in
 11 which the individual becomes such a bene-
 12 ficiary”.

13 (2) STATE OPTION FOR 12-MONTH CONTINUOUS
 14 ELIGIBILITY FOR SLMBS AND QWDIS.—Section
 15 1902(e)(12) of the Social Security Act (42 U.S.C.
 16 1396a(e)(12)) is amended—

17 (A) by redesignating subparagraphs (A),
 18 (B), and (C) as clauses (i), (ii), and (iii) respec-
 19 tively;

20 (B) by inserting “(A)” after “(12)”; and

21 (C) by adding at the end the following:

22 “(B) At the option of the State, the plan may provide
 23 that an individual who is determined to be eligible for ben-
 24 efits under a State plan approved under this title under
 25 any of the following eligibility categories, or who is rede-

1 terminated to be eligible for such benefits under any of such
 2 categories, shall be considered to meet the eligibility re-
 3 quirements met on the date of application and shall re-
 4 main eligible for those benefits until the end of the 12-
 5 month period following the date of the determination or
 6 redetermination of eligibility, except that a State may pro-
 7 vide for such determinations more frequently, but not
 8 more frequently than once every 6 months for an indi-
 9 vidual:

10 “(i) A specified low-income medicare beneficiary
 11 described in subsection (a)(10)(E)(iii) of this section
 12 who is determined eligible for medicare cost-sharing
 13 described in section 1905(p)(3)(A)(ii).

14 “(ii) A qualified disabled and working indi-
 15 vidual described in section 1905(s) who is deter-
 16 mined eligible for medicare cost-sharing described in
 17 section 1905(p)(3)(A)(i).”.

18 (3) STATE OPTION TO USE EXPRESS LANE ELI-
 19 GIBILITY FOR THE MEDICARE SAVINGS PROGRAM.—
 20 Section 1902(e)(13)(A) of the Social Security Act
 21 (42 U.S.C. 1396a(e)(13)(A)) is amended by adding
 22 at the end the following new clause:

23 “(iii) STATE OPTION TO EXTEND EXPRESS
 24 LANE ELIGIBILITY TO OTHER POPULATIONS.—

1 “(I) IN GENERAL.—At the option of
 2 the State, the State may apply the provi-
 3 sions of this paragraph with respect to de-
 4 termining eligibility under this title for an
 5 eligible individual (as defined in subclause
 6 (II)). In applying this paragraph in the
 7 case of a State making such an option, any
 8 reference in this paragraph to a child with
 9 respect to this title (other than a reference
 10 to child health assistance) shall be deemed
 11 to be a reference to an eligible individual.

12 “(II) ELIGIBLE INDIVIDUAL DE-
 13 FINED.—In this clause, the term ‘eligible
 14 individual’ means any of the following:

15 “(aa) A qualified medicare bene-
 16 ficiary described in section 1905(p)(1)
 17 for purposes of determining eligibility
 18 for medicare cost-sharing (as defined
 19 in section 1905(p)(3)).

20 “(bb) A specified low-income
 21 medicare beneficiary described in sub-
 22 section (a)(10)(E)(iii) of this section
 23 for purposes of determining eligibility
 24 for medicare cost-sharing described in
 25 section 1905(p)(3)(A)(ii).

1 “(cc) A qualified disabled and
 2 working individual described in sec-
 3 tion 1905(s) for purposes of deter-
 4 mining eligibility for medicare cost-
 5 sharing described in section
 6 1905(p)(3)(A)(i).”.

7 (g) MEDICAID TREATMENT OF CERTAIN MEDICARE
 8 PROVIDERS.—Section 1902(n) of the Social Security Act
 9 (42 U.S.C. 1396a(n)) is amended by inserting after para-
 10 graph (3)(C) the following new paragraph:

11 “(4) A State plan shall not deny a claim from a pro-
 12 vider or supplier with respect to medicare cost-sharing de-
 13 scribed in subparagraph (B), (C), or (D) of section
 14 1905(p)(3) for an item or service which is eligible for pay-
 15 ment under title XVIII on the basis that the provider or
 16 supplier does not have a provider agreement in effect
 17 under this title or does not otherwise serve all individuals
 18 entitled to medical assistance under this title. The State
 19 shall create a mechanism through which providers or sup-
 20 pliers that do not otherwise have provider agreements with
 21 the State can bill the State for medicare cost-sharing for
 22 qualified medicare beneficiaries.”.

23 (h) ELIGIBILITY FOR OTHER PROGRAMS.—Section
 24 1905(p) of the Social Security Act (42 U.S.C. 1396d(p))

1 is amended by adding at the end the following new para-
 2 graph:

3 “(7) Notwithstanding any other provision of law, any
 4 medical assistance for some or all medicare cost-sharing
 5 under this title shall not be considered income or resources
 6 in determining eligibility for, or the amount of assistance
 7 or benefits provided under, any other public benefit pro-
 8 vided under Federal law or the law of any State or polit-
 9 ical subdivision thereof.”.

10 (i) TREATMENT OF QUALIFIED MEDICARE BENE-
 11 FICIARIES, SPECIFIED LOW-INCOME MEDICARE BENE-
 12 FICIARIES, AND OTHER DUAL ELIGIBLES AS MEDICARE
 13 BENEFICIARIES.—Section 1862 of the Social Security Act
 14 (42 U.S.C. 1395y) is amended by adding at the end the
 15 following new subsection:

16 “(p) TREATMENT OF QUALIFIED MEDICARE BENE-
 17 FICIARIES (QMBS), SPECIFIED LOW-INCOME MEDICARE
 18 BENEFICIARIES (SLMBS), AND OTHER DUAL ELIGI-
 19 BLES.—Nothing in this title shall be construed as author-
 20 izing a provider of services or supplier to discriminate
 21 (through a private contractual arrangement or otherwise)
 22 against an individual who is otherwise entitled to services
 23 under this title on the basis that the individual is a quali-
 24 fied medicare beneficiary (as defined in section
 25 1905(p)(1)), a specified low-income medicare beneficiary,

1 or is otherwise eligible for medical assistance for medicare
2 cost-sharing or other benefits under title XIX.”.

3 (j) ADDITIONAL FUNDING FOR STATE HEALTH IN-
4 SURANCE ASSISTANCE PROGRAMS.—

5 (1) GRANTS.—

6 (A) IN GENERAL.—The Secretary of
7 Health and Human Services (in this subsection
8 referred to as the “Secretary”) shall use
9 amounts made available under subparagraph
10 (B) to make grants to States for State health
11 insurance assistance programs receiving assist-
12 ance under section 4360 of the Omnibus Budg-
13 et Reconciliation Act of 1990 (42 U.S.C.
14 1395b–4).

15 (B) FUNDING.—For purposes of making
16 grants under this subsection, the Secretary
17 shall provide for the transfer, from the Federal
18 Hospital Insurance Trust Fund under section
19 1817 of the Social Security Act (42 U.S.C.
20 1395i) and the Federal Supplementary Medical
21 Insurance Trust Fund under section 1841 of
22 such Act (42 U.S.C. 1395t), in the same pro-
23 portion as the Secretary determines under sec-
24 tion 1853(f) of such Act (42 U.S.C. 1395w–
25 23(f)), of \$50,000,000 to the Centers for Medi-

1 care & Medicaid Services Program Management
2 Account for each of the fiscal years 2027
3 through 2031, to remain available until ex-
4 pended.

5 (2) AMOUNT OF GRANTS.—The amount of a
6 grant to a State under this subsection from the total
7 amount made available under paragraph (1) shall be
8 equal to the sum of the amount allocated to the
9 State under paragraph (3)(A) and the amount allo-
10 cated to the State under subparagraph (3)(B).

11 (3) ALLOCATION TO STATES.—

12 (A) ALLOCATION BASED ON PERCENTAGE
13 OF LOW-INCOME BENEFICIARIES.—The amount
14 allocated to a State under this subparagraph
15 from $\frac{2}{3}$ of the total amount made available
16 under paragraph (1) shall be based on the num-
17 ber of individuals who meet the requirement
18 under subsection (a)(3)(A)(ii) of section
19 1860D–14 of the Social Security Act (42
20 U.S.C. 1395w–114) but who have not enrolled
21 to receive a subsidy under such section 1860D–
22 14 relative to the total number of individuals
23 who meet the requirement under such sub-
24 section (a)(3)(A)(ii) in each State, as estimated
25 by the Secretary.

1 (B) ALLOCATION BASED ON PERCENTAGE
 2 OF RURAL BENEFICIARIES.—The amount allo-
 3 cated to a State under this subparagraph from
 4 $\frac{1}{3}$ of the total amount made available under
 5 paragraph (1) shall be based on the number of
 6 part D eligible individuals (as defined in section
 7 1860D–1(a)(3)(A) of such Act (42 U.S.C.
 8 1395w–101(a)(3)(A))) residing in a rural area
 9 relative to the total number of such individuals
 10 in each State, as estimated by the Secretary.

11 (4) PORTION OF GRANT BASED ON PERCENT-
 12 AGE OF LOW-INCOME BENEFICIARIES TO BE USED
 13 TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY
 14 BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE
 15 FOR THE MEDICARE SAVINGS PROGRAM.—Each
 16 grant awarded under this subsection with respect to
 17 amounts allocated under paragraph (3)(A) shall be
 18 used to provide outreach to individuals who may be
 19 subsidy eligible individuals (as defined in section
 20 1860D–14(a)(3)(A) of the Social Security Act (42
 21 U.S.C. 1395w–114(a)(3)(A))) or eligible for the pro-
 22 gram of medical assistance for payment of the cost
 23 of medicare cost-sharing under the Medicaid pro-
 24 gram pursuant to section 1902(a)(10)(E) of such
 25 Act (42 U.S.C. 1396a(a)(10)(E), 1396u–3).

1 (k) EFFECTIVE DATE.—

2 (1) IN GENERAL.—Except as provided in para-
3 graph (2), the amendments and repeal made by this
4 section take effect on January 1, 2027, and, with re-
5 spect to title XIX of the Social Security Act, apply
6 to calendar quarters beginning on or after January
7 1, 2027.

8 (2) EXCEPTION FOR STATE LEGISLATION.—In
9 the case of a State plan for medical assistance under
10 title XIX of the Social Security Act which the Sec-
11 retary of Health and Human Services determines re-
12 quires State legislation (other than legislation appro-
13 priating funds) in order for the plan to meet the ad-
14 ditional requirements imposed by the amendments
15 and repeal made by this section, the State plan shall
16 not be regarded as failing to comply with the re-
17 quirements of such title solely on the basis of its
18 failure to meet these additional requirements before
19 the first day of the first calendar quarter beginning
20 after the close of the first regular session of the
21 State legislature that begins after the date of the en-
22 actment of this Act. For purposes of the previous
23 sentence, in the case of a State that has a 2-year
24 legislative session, each year of such session shall be

1 deemed to be a separate regular session of the State
2 legislature.

3 **SEC. 4108. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
4 **PROVIDED BY URBAN INDIAN ORGANIZA-**
5 **TIONS.**

6 (a) IN GENERAL.—The third sentence of section
7 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))
8 is amended by striking “for the 8 fiscal year quarters be-
9 ginning with the first fiscal year quarter beginning after
10 the date of the enactment of the American Rescue Plan
11 Act of 2021,” and inserting “and”.

12 (b) EFFECTIVE DATE.—The amendment made by
13 this section shall apply to medical assistance provided on
14 or after the date of enactment of this Act.

15 **SEC. 4109. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
16 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
17 **A FEDERALLY QUALIFIED HEALTH CENTER**
18 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
19 **TEM UNDER THE MEDICAID PROGRAM.**

20 (a) IN GENERAL.—The third sentence of section
21 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))
22 is amended by striking “, for such 8 fiscal year quarters”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 this section shall apply to medical assistance provided on
25 or after the date of enactment of this Act.

1 **SEC. 4110. REPEAL OF REQUIREMENT FOR ESTATE RECOV-**
 2 **ERY UNDER THE MEDICAID PROGRAM.**

3 Section 1917 of the Social Security Act (42 U.S.C.
 4 1396p) is amended—

5 (1) in subsection (a)—

6 (A) by amending paragraph (1) to read as
 7 follows:

8 “(1) No lien may be imposed against the prop-
 9 erty of any individual prior to his death on account
 10 of medical assistance paid or to be paid on his behalf
 11 under the State plan, except pursuant to the judg-
 12 ment of a court on account of benefits incorrectly
 13 paid on behalf of such individual.”;

14 (B) by striking paragraph (2);

15 (C) in paragraph (3), by striking “(1)(B)”
 16 and inserting “(1)”; and

17 (D) by redesignating paragraph (3) as
 18 paragraph (2); and

19 (2) by amending subsection (b) to read as fol-
 20 lows:

21 “(b) ADJUSTMENT OR RECOVERY OF MEDICAL AS-
 22 SISTANCE CORRECTLY PAID UNDER A STATE PLAN.—No
 23 adjustment or recovery of any medical assistance correctly
 24 paid on behalf of an individual under the State plan may
 25 be made.”.

1 **SEC. 4111. ALLOW FOR SUSPENSION OF MEDICARE BENE-**
 2 **FITS AND PREMIUM LIABILITY FOR INDIVID-**
 3 **UALS WHO ARE INCARCERATED AND PRO-**
 4 **VIDE A SPECIAL ENROLLMENT PERIOD**
 5 **AROUND THE DATE OF RELEASE.**

6 (a) SPECIAL ENROLLMENT PERIOD FOR INDIVID-
 7 UALS INCARCERATED AT TIME OF MEDICARE ELIGI-
 8 BILITY.—Section 1837(i) of the Social Security Act (42
 9 U.S.C. 1395p(i)) is amended by adding at the end the fol-
 10 lowing new paragraph:

11 “(5)(A) In the case of an individual who—

12 “(i) at the time the individual first satis-
 13 fies paragraph (1) or (2) of section 1836(a), is
 14 incarcerated; or

15 “(ii) has elected not to enroll (or to be
 16 deemed enrolled) under this section during the
 17 individual’s initial enrollment period;
 18 there shall be a special enrollment period de-
 19 scribed in subparagraph (B).

20 “(B) The special enrollment period re-
 21 ferred to in subparagraph (A) is the 6-month
 22 period beginning on the first day after which
 23 the individual is no longer incarcerated.”.

24 (b) PREMIUM AMOUNT.—Section 1839(a) of the So-
 25 cial Security Act (42 U.S.C. 1395r(a)) is amended—

1 (1) in paragraph (1), in the second sentence, by
 2 striking “and (7),” and inserting “(7), and (8),”;
 3 and

4 (2) by adding at the end the following new
 5 paragraph:

6 “(8) In the case of an individual whose coverage pe-
 7 riod includes months in which by reason of custody under
 8 penal authority coverage is excluded pursuant to section
 9 1862(a)(3), the premium amount for such months such
 10 individual is in custody under penal authority shall be 0.”.

11 (c) CONFORMING AMENDMENT.—Section 1818(d)(5)
 12 of the Social Security Act (42 U.S.C. 1395i–2(d)(5)) is
 13 amended by adding at the end the following:

14 “(D) In the case of an individual who is a
 15 person who is excluded from coverage pursuant
 16 to section 1862(a)(3) by reason of custody
 17 under penal authority, the amount of the
 18 monthly premium for such individual shall be 0
 19 for any month in which such individual is in
 20 custody under penal authority.”.

21 **SEC. 4112. FEDERAL EMPLOYEE HEALTH BENEFITS PLANS.**

22 (a) COVERAGE OF PREGNANCY.—The Director of the
 23 Office of Personnel Management shall issue such regula-
 24 tions as are necessary to ensure that pregnancy is consid-
 25 ered a change in family status and a qualifying life event

1 for an individual who is eligible to enroll, but is not en-
 2 rolled, in a health benefits plan under chapter 89 of title
 3 5, United States Code.

4 (b) EFFECTIVE DATE.—The requirement in para-
 5 graph (1) shall apply with respect to any contract entered
 6 into under section 8902 of title 5, United States Code,
 7 on or after the date that is 1 year after the date of enact-
 8 ment of this Act.

9 **SEC. 4113. CONTINUATION OF MEDICAID INCOME ELIGI-**
 10 **BILITY STANDARD FOR PREGNANT INDIVID-**
 11 **UALS AND INFANTS.**

12 Section 1902(l)(2)(A) of the Social Security Act (42
 13 U.S.C. 1396a(l)(2)(A)) is amended—

14 (1) in clause (i), by striking “and not more
 15 than 185 percent”;

16 (2) in clause (ii)—

17 (A) in subclause (I), by striking “and”
 18 after the comma;

19 (B) in subclause (II), by striking the pe-
 20 riod at the end and inserting “, and”; and

21 (C) by adding at the end the following:

22 “(III) January 1, 2027, is the
 23 percentage provided under clause
 24 (v).”; and

1 (3) by adding at the end the following new
2 clause:

3 “(v) The percentage provided under
4 clause (ii) for medical assistance provided
5 on or after January 1, 2027, with respect
6 to individuals described in subparagraph
7 (A) or (B) of paragraph (1) shall not be
8 less than—

9 “(I) the percentage specified for
10 such individuals by the State in an
11 amendment to its State plan (whether
12 approved or not) as of January 1,
13 2014; or

14 “(II) if no such percentage is
15 specified as of January 1, 2014, the
16 percentage established for such indi-
17 viduals under the State’s authorizing
18 legislation or provided for under the
19 State’s appropriations as of that
20 date.”.

1 **Subtitle C—Expansion of Access**

2 **PART 1—GENERAL PROVISIONS**

3 **SEC. 4201. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

4 **ACT.**

5 Title XXXIV of the Public Health Service Act, as
6 amended by titles I, II, and III of this Act, is further
7 amended by inserting after subtitle C the following:

8 **“Subtitle D—Reconstruction and**
9 **Improvement Grants for Public**
10 **Health Care Facilities Serving**
11 **Pacific Islanders and the Insu-**
12 **lar Areas**

13 **“SEC. 3441. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
14 **INITIATIVES.**

15 “(a) IN GENERAL.—The Secretary, in collaboration
16 with the Administrator of the Health Resources and Serv-
17 ices Administration, the Director of the Agency for
18 Healthcare Research and Quality, and the Administrator
19 of the Centers for Medicare & Medicaid Services, shall
20 award grants to eligible entities for the conduct of dem-
21 onstration projects to improve the quality of and access
22 to health care.

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

1 “(1) be a health center, hospital, health plan,
2 health system, community clinic, hospice or palliative
3 care provider, or other health entity determined ap-
4 propriate by the Secretary—

5 “(A) that, by legal mandate or explicitly
6 adopted mission, provides patients with access
7 to services regardless of their ability to pay;

8 “(B) that provides care or treatment for a
9 substantial number of patients who are unin-
10 sured, are receiving assistance under a State
11 plan under title XIX of the Social Security Act
12 (or under a waiver of such plan), or are mem-
13 bers of vulnerable populations, as determined
14 by the Secretary; and

15 “(C)(i) with respect to which, not less than
16 50 percent of the entity’s patient population is
17 made up of racial and ethnic minority groups;
18 or

19 “(ii) that—

20 “(I) serves a disproportionate percent-
21 age of local patients who are from a racial
22 and ethnic minority group, or has a patient
23 population at least 50 percent of which is
24 composed of individuals with limited
25 English proficiency; and

1 “(II) provides an assurance that
 2 amounts received under the grant will be
 3 used only to support quality improvement
 4 activities in the racial and ethnic minority
 5 group served; and

6 “(2) prepare and submit to the Secretary an
 7 application at such time, in such manner, and con-
 8 taining such information as the Secretary may re-
 9 quire.

10 “(c) PRIORITY.—In awarding grants under sub-
 11 section (a), the Secretary shall give priority to eligible enti-
 12 ties that—

13 “(1) demonstrate an intent to operate as part
 14 of a health care partnership, network, collaborative,
 15 coalition, or alliance where each member entity con-
 16 tributes to the design, implementation, and evalua-
 17 tion of the proposed intervention; or

18 “(2) intend to use funds to carry out system-
 19 wide changes with respect to health care quality im-
 20 provement, including—

21 “(A) improved systems for data collection
 22 and reporting;

23 “(B) innovative collaborative or similar
 24 processes;

1 “(C) group programs with behavioral or
2 self-management interventions;

3 “(D) case management services;

4 “(E) physician or patient reminder sys-
5 tems;

6 “(F) educational interventions;

7 “(G) comprehensive and patient-centric
8 health care;

9 “(H) creation and distribution of education
10 materials on available health care options; or

11 “(I) other activities determined appropriate
12 by the Secretary.

13 “(d) USE OF FUNDS.—An entity shall use amounts
14 received under a grant under subsection (a) to support
15 the implementation and evaluation of health care quality
16 improvement activities or minority health and health care
17 disparity reduction activities that include—

18 “(1) with respect to health care systems, activi-
19 ties relating to improving—

20 “(A) patient safety;

21 “(B) timeliness of care;

22 “(C) effectiveness of care;

23 “(D) efficiency of care;

24 “(E) patient centeredness;

25 “(F) health information technology;

1 “(G) accessibility and availability of infor-
2 mation on health care;

3 “(H) comprehensiveness of health care;
4 and

5 “(I) patient involvement and choice in
6 health care; and

7 “(2) with respect to patients, activities relating
8 to—

9 “(A) staying healthy;

10 “(B) getting well, mentally and physically;

11 “(C) living effectively with illness or dis-
12 ability;

13 “(D) preparing for end of life and ensuring
14 that end-of-life care is accessible and available,
15 as well as coping with end-of-life issues; and

16 “(E) shared decision making.

17 “(e) COMMON DATA SYSTEMS.—The Secretary shall
18 provide financial and other technical assistance to grant-
19 ees under this section for the development of common data
20 systems.

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 such sums as may be necessary for each of fiscal years
24 2027 through 2034.

1 **“SEC. 3442. CENTERS OF EXCELLENCE.**

2 “(a) IN GENERAL.—The Secretary, acting through
3 the Administrator of the Health Resources and Services
4 Administration, shall designate centers of excellence at
5 public hospitals, and other health systems serving large
6 numbers of patients from minority populations, that—

7 “(1) meet the requirements of section
8 3441(b)(1);

9 “(2) demonstrate excellence in providing care to
10 minority populations; and

11 “(3) demonstrate excellence in reducing dispari-
12 ties in health and health care.

13 “(b) REQUIREMENTS.—A hospital or health system
14 that serves as a center of excellence under subsection (a)
15 shall—

16 “(1) design, implement, and evaluate programs
17 and policies relating to the delivery of care in ra-
18 cially, ethnically, and linguistically diverse popu-
19 lations;

20 “(2) provide training and technical assistance
21 to other hospitals and health systems relating to the
22 provision of high-quality health care to minority pop-
23 ulations; and

24 “(3) develop activities for graduate or con-
25 tinuing medical education that institutionalize a

1 focus on cultural competence training for health care
2 providers.

3 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section,
5 such sums as may be necessary for each of fiscal years
6 2027 through 2034.

7 **“SEC. 3443. RECONSTRUCTION AND IMPROVEMENT GRANTS**
8 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
9 **ING PACIFIC ISLANDERS AND THE INSULAR**
10 **AREAS.**

11 “(a) IN GENERAL.—The Secretary shall provide di-
12 rect financial assistance to designated health care pro-
13 viders and community health centers in American Samoa,
14 Guam, the Commonwealth of the Northern Mariana Is-
15 lands, the United States Virgin Islands, Puerto Rico, and
16 Hawaii for the purposes of reconstructing and improving
17 health care facilities and services in a culturally competent
18 and sustainable manner.

19 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
20 nancial assistance under subsection (a), an entity shall be
21 a public health facility or community health center located
22 in American Samoa, Guam, the Commonwealth of the
23 Northern Mariana Islands, the United States Virgin Is-
24 lands, Puerto Rico, or Hawaii that—

25 “(1) is owned or operated by—

1 “(A) the Government of American Samoa,
2 Guam, the Commonwealth of the Northern
3 Mariana Islands, the United States Virgin Is-
4 lands, Puerto Rico, or Hawaii or a unit of local
5 government; or

6 “(B) a nonprofit organization; and

7 “(2)(A) provides care or treatment for a sub-
8 stantial number of patients who are uninsured, are
9 receiving assistance under title XVIII of the Social
10 Security Act or under a State plan under title XIX
11 of such Act (or under a waiver of such plan), or are
12 members of a vulnerable population, as determined
13 by the Secretary; or

14 “(B) serves a disproportionate percentage of
15 local patients that are from a racial and ethnic mi-
16 nority group.

17 “(c) REPORT.—Not later than 180 days after the
18 date of enactment of this title and annually thereafter, the
19 Secretary shall submit to the Congress and the President
20 a report that includes an assessment of health resources
21 and facilities serving populations in American Samoa,
22 Guam, the Commonwealth of the Northern Mariana Is-
23 lands, the United States Virgin Islands, Puerto Rico, and
24 Hawaii. In preparing such report, the Secretary shall—

1 “(1) consult with and obtain information on all
2 health care facilities needs from the entities receiv-
3 ing direct financial assistance under subsection (a);

4 “(2) include all amounts of Federal assistance
5 received by each such entity in the preceding fiscal
6 year;

7 “(3) review the total unmet needs of health care
8 facilities serving American Samoa, Guam, the Com-
9 monwealth of the Northern Mariana Islands, the
10 United States Virgin Islands, Puerto Rico, and Ha-
11 waii, including needs for renovation and expansion
12 of existing facilities;

13 “(4) include a strategic plan for addressing the
14 needs of each such population identified in the re-
15 port; and

16 “(5) evaluate the effectiveness of the care pro-
17 vided by measuring patient outcomes and cost meas-
18 ures.

19 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated such sums as necessary
21 to carry out this section.”.

22 **SEC. 4202. BORDER HEALTH GRANTS.**

23 (a) DEFINITIONS.—In this section:

24 (1) BORDER AREA.—The term “border area”
25 means the United States-Mexico Border Area, as de-

1 fined in section 8 of the United States-Mexico Bor-
2 der Health Commission Act (22 U.S.C. 290n-6).

3 (2) ELIGIBLE ENTITY.—The term “eligible enti-
4 ty” means an entity that is located in the border
5 area and is any of the following:

6 (A) A State, local government, or Tribal
7 government.

8 (B) A public institution of higher edu-
9 cation.

10 (C) A nonprofit health organization.

11 (D) A community health center.

12 (E) A community clinic that is a health
13 center receiving assistance under section 330 of
14 the Public Health Service Act (42 U.S.C.
15 254b).

16 (F) A nonprofit organization serving immi-
17 grants.

18 (b) AUTHORIZATION.—From funds appropriated pur-
19 suant to subsection (f), the Secretary of Health and
20 Human Services (in this section referred to as the “Sec-
21 retary”), in consultation with the United States members
22 of the United States-Mexico Border Health Commission,
23 shall award grants to eligible entities to address priorities
24 and recommendations to improve the health of border area
25 residents that are established by—

1 (1) the United States members of the United
2 States-Mexico Border Health Commission;

3 (2) the State border health offices; and

4 (3) the Secretary.

5 (c) APPLICATION.—An eligible entity that desires a
6 grant under subsection (b) shall submit an application to
7 the Secretary at such time, in such manner, and con-
8 taining such information as the Secretary may require and
9 demonstrating the entity's capacity to provide culturally
10 and linguistically appropriate services to border area resi-
11 dents.

12 (d) USE OF FUNDS.—An eligible entity that receives
13 a grant under subsection (b) shall use the grant funds
14 for—

15 (1) programs relating to—

16 (A) maternal and child health;

17 (B) primary care and preventative health;

18 (C) public health and public health infra-
19 structure;

20 (D) musculoskeletal health and obesity;

21 (E) health education and promotion;

22 (F) oral health;

23 (G) mental and behavioral health;

24 (H) substance use disorders;

1 (I) health conditions that have a high prev-
2 alence in the border area;

3 (J) medical and health services research;

4 (K) workforce training and development;

5 (L) community health workers, patient
6 navigators, and promotores;

7 (M) health care infrastructure problems in
8 the border area (including planning and con-
9 struction grants);

10 (N) health disparities in the border area;

11 (O) environmental health;

12 (P) outreach and enrollment services with
13 respect to Federal programs (including pro-
14 grams authorized under titles XIX and XXI of
15 the Social Security Act (42 U.S.C. 1396 et seq.;
16 42 U.S.C. 1397aa et seq.));

17 (Q) end-of-life care; and

18 (R) addressing social determinants of
19 health; and

20 (2) other programs determined appropriate by
21 the Secretary.

22 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
23 vided to an eligible entity awarded a grant under sub-
24 section (b) shall be used to supplement and not supplant

1 other funds available to the eligible entity to carry out the
 2 activities described in subsection (d).

3 (f) AUTHORIZATION OF APPROPRIATIONS.—There
 4 are authorized to be appropriated to carry out this section,
 5 \$200,000,000 for fiscal year 2027, and such sums as may
 6 be necessary for each succeeding fiscal year.

7 **SEC. 4203. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

8 (a) ELIMINATION OF ISOLATION TEST FOR COST-
 9 BASED AMBULANCE REIMBURSEMENT.—

10 (1) IN GENERAL.—Section 1834(l)(8) of the
 11 Social Security Act (42 U.S.C. 1395m(l)(8)) is
 12 amended—

13 (A) in subparagraph (B)—

14 (i) by striking “owned and”; and

15 (ii) by inserting “(including when
 16 such services are provided by the entity
 17 under an arrangement with the hospital)”
 18 after “hospital”; and

19 (B) by striking the comma at the end of
 20 subparagraph (B) and all that follows and in-
 21 serting a period.

22 (2) EFFECTIVE DATE.—The amendments made
 23 by this subsection shall apply to services furnished
 24 on or after January 1, 2027.

1 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
 2 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
 3 REQUIREMENT.—

4 (1) IN GENERAL.—Section 1820(c)(2) of the
 5 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
 6 amended—

7 (A) in subparagraph (B)(iii), by striking
 8 “provides not more than” and inserting “sub-
 9 ject to subparagraph (F), provides not more
 10 than”; and

11 (B) by adding at the end the following new
 12 subparagraph:

13 “(F) ALTERNATIVE TO 25 INPATIENT BED
 14 LIMIT REQUIREMENT.—

15 “(i) IN GENERAL.—A State may elect
 16 to treat a facility, with respect to the des-
 17 ignation of the facility for a cost reporting
 18 period, as satisfying the requirement of
 19 subparagraph (B)(iii) relating to a max-
 20 imum number of acute care inpatient beds
 21 if the facility elects, in accordance with a
 22 method specified by the Secretary and be-
 23 fore the beginning of the cost reporting pe-
 24 riod, to meet the requirement under clause
 25 (ii).

1 “(ii) ALTERNATE REQUIREMENT.—

2 The requirement under this clause, with
3 respect to a facility and a cost reporting
4 period, is that the total number of inpa-
5 tient bed days described in subparagraph
6 (B)(iii) during such period will not exceed
7 7,300. For purposes of this subparagraph,
8 an individual who is an inpatient in a bed
9 in the facility for a single day shall be
10 counted as one inpatient bed day.

11 “(iii) WITHDRAWAL OF ELECTION.—

12 The option described in clause (i) shall not
13 apply to a facility for a cost reporting pe-
14 riod if the facility (for any two consecutive
15 cost reporting periods during the previous
16 5 cost-reporting periods) was treated under
17 such option and had a total number of in-
18 patient bed days for each of such two cost
19 reporting periods that exceeded the num-
20 ber specified in such clause.”.

21 (2) EFFECTIVE DATE.—The amendments made
22 by paragraph (1) shall apply to cost reporting peri-
23 ods beginning on or after the date of the enactment
24 of this Act.

1 **SEC. 4204. MEDICARE REMOTE MONITORING PILOT**
2 **PROJECTS.**

3 (a) PILOT PROJECTS.—

4 (1) IN GENERAL.—Not later than 9 months
5 after the date of enactment of this Act, the Sec-
6 retary of Health and Human Services (in this sec-
7 tion referred to as the “Secretary”) shall conduct
8 pilot projects under title XVIII of the Social Secu-
9 rity Act (42 U.S.C. 1395 et seq.) for the purpose of
10 providing incentives to home health agencies to uti-
11 lize home monitoring and communications tech-
12 nologies that—

13 (A) enhance health and health care out-
14 comes for Medicare beneficiaries; and

15 (B) reduce expenditures under such title.

16 (2) SITE REQUIREMENTS.—

17 (A) URBAN AND RURAL.—The Secretary
18 shall conduct the pilot projects under this sec-
19 tion in both urban and rural areas.

20 (B) SITE IN A SMALL STATE.—The Sec-
21 retary shall conduct at least 3 of the pilot
22 projects in a State with a population of less
23 than 1,000,000.

24 (3) DEFINITION OF HOME HEALTH AGENCY.—

25 In this section, the term “home health agency” has

1 the meaning given that term in section 1861(o) of
2 the Social Security Act (42 U.S.C. 1395x(o)).

3 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
4 OF PROJECTS.—The Secretary shall specify the criteria
5 for identifying those Medicare beneficiaries who shall be
6 considered within the scope of the pilot projects under this
7 section for purposes of the application of subsection (c)
8 and for the assessment of the effectiveness of the home
9 health agency in achieving the objectives of this section.
10 Such criteria may provide for the inclusion in the projects
11 of Medicare beneficiaries who begin receiving home health
12 services under title XVIII of the Social Security Act (42
13 U.S.C. 1395 et seq.) after the date of the implementation
14 of the projects.

15 (c) INCENTIVES.—

16 (1) PERFORMANCE TARGETS.—The Secretary
17 shall establish for each home health agency partici-
18 pating in a pilot project under this section a per-
19 formance target using one of the following meth-
20 odologies, as determined appropriate by the Sec-
21 retary:

22 (A) ADJUSTED HISTORICAL PERFORMANCE
23 TARGET.—The Secretary shall establish for the
24 agency—

1 (i) a base expenditure amount equal
2 to the average total payments made to the
3 agency under parts A and B of title XVIII
4 of the Social Security Act (42 U.S.C. 1395
5 et seq.) for Medicare beneficiaries deter-
6 mined to be within the scope of the pilot
7 project in a base period determined by the
8 Secretary; and

9 (ii) an annual per capita expenditure
10 target for such beneficiaries, reflecting the
11 base expenditure amount adjusted for risk
12 and adjusted growth rates.

13 (B) COMPARATIVE PERFORMANCE TAR-
14 GET.—The Secretary shall establish for the
15 agency a comparative performance target equal
16 to the average total payments under such parts
17 A and B during the pilot project for comparable
18 individuals in the same geographic area that
19 are not determined to be within the scope of the
20 pilot project.

21 (2) INCENTIVE.—Subject to paragraph (3), the
22 Secretary shall pay to each participating home care
23 agency an incentive payment for each year under the
24 pilot project equal to a portion of the Medicare sav-

1 ings realized for such year relative to the perform-
2 ance target under paragraph (1).

3 (3) LIMITATION ON EXPENDITURES.—The Sec-
4 retary shall limit incentive payments under this sec-
5 tion in order to ensure that the aggregate expendi-
6 tures under title XVIII of the Social Security Act
7 (42 U.S.C. 1395 et seq.) (including incentive pay-
8 ments under this subsection) do not exceed the
9 amount that the Secretary estimates would have
10 been expended if the pilot projects under this section
11 had not been implemented.

12 (d) WAIVER AUTHORITY.—The Secretary may waive
13 such provisions of titles XI and XVIII of the Social Secu-
14 rity Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.)
15 as the Secretary determines to be appropriate for the con-
16 duct of the pilot projects under this section.

17 (e) REPORT TO CONGRESS.—Not later than 5 years
18 after the date that the first pilot project under this section
19 is implemented, the Secretary shall submit to Congress a
20 report on the pilot projects. Such report shall contain a
21 detailed description of issues related to the expansion of
22 the projects under subsection (f) and recommendations for
23 such legislation and administrative actions as the Sec-
24 retary considers appropriate.

1 (f) EXPANSION.—If the Secretary determines that
 2 any of the pilot projects under this section enhance health
 3 outcomes for Medicare beneficiaries and reduce expendi-
 4 tures under title XVIII of the Social Security Act (42
 5 U.S.C. 1395 et seq.), the Secretary may initiate com-
 6 parable projects in additional areas.

7 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
 8 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
 9 tive payment under this section—

10 (1) shall be in addition to the payments that a
 11 home health agency would otherwise receive under
 12 title XVIII of the Social Security Act for the provi-
 13 sion of home health services; and

14 (2) shall have no effect on the amount of such
 15 payments.

16 **SEC. 4205. COMMUNITY HEALTH CENTER COLLABORATIVE**
 17 **ACCESS EXPANSION.**

18 Section 330(r)(4) of the Public Health Service Act
 19 (42 U.S.C. 254b(r)(4)) is amended—

20 (1) in subparagraph (A), by striking “primary
 21 health care services” each place it appears and in-
 22 serting “primary health care and other mental, den-
 23 tal, and physical health services”; and

24 (2) in subparagraph (B)—

1 (A) in clause (i), by striking “and” at the
2 end;

3 (B) in clause (ii), by striking the period at
4 the end and inserting “; and”; and

5 (C) by adding at the end the following:

6 “(iii) in the case of a rural health
7 clinic described in such subparagraph—

8 “(I) that such clinic provides, to
9 the extent possible, enabling services,
10 such as transportation and language
11 assistance (including translation and
12 interpretation); and

13 “(II) that the primary health
14 care and other services described in
15 such subparagraph are subject to full
16 reimbursement according to the pro-
17 spective payment system for Federally
18 qualified health center services under
19 section 1834(o) of the Social Security
20 Act.”.

21 **SEC. 4206. FACILITATING THE PROVISION OF TELEHEALTH**
22 **SERVICES ACROSS STATE LINES.**

23 (a) IN GENERAL.—For purposes of expediting the
24 provision of telehealth services, for which payment is made
25 under the Medicare Program established under title XVIII

1 of the Social Security Act (42 U.S.C. 1395 et seq.). across
 2 State lines, the Secretary of Health and Human Services
 3 shall, in consultation with representatives of States, physi-
 4 cians, health care practitioners, and patient advocates, en-
 5 courage and facilitate the adoption of provisions allowing
 6 for multistate practitioner practice across State lines.

7 (b) DEFINITIONS.—In subsection (a):

8 (1) TELEHEALTH SERVICE.—The term “tele-
 9 health service” has the meaning given that term in
 10 subparagraph (F) of section 1834(m)(4) of the So-
 11 cial Security Act (42 U.S.C. 1395m(m)(4)).

12 (2) PHYSICIAN, PRACTITIONER.—The terms
 13 “physician” and “practitioner” have the meaning
 14 given those terms in subparagraphs (D) and (E), re-
 15 spectively, of section 1834(m)(4) of the Social Secu-
 16 rity Act (42 U.S.C. 1395m(m)(4)).

17 (3) MEDICARE PROGRAM.—The term “Medicare
 18 Program” means the program of health insurance
 19 administered by the Secretary of Health and Human
 20 Services under title XVIII of the Social Security Act
 21 (42 U.S.C. 1395 et seq.).

22 **SEC. 4207. SCORING OF PREVENTIVE HEALTH SAVINGS.**

23 Section 202 of the Congressional Budget and Im-
 24 poundment Control Act of 1974 (2 U.S.C. 602) is amend-
 25 ed by adding at the end the following:

1 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

2 “(1) DETERMINATION BY THE DIRECTOR.—

3 Upon a request by the chairman or ranking minority
4 member of the Committee on the Budget of the Sen-
5 ate, or by the chairman or ranking minority member
6 of the Committee on the Budget of the House of
7 Representatives, the Director shall determine if a
8 proposed measure would result in reductions in
9 budget outlays in budgetary outyears through the
10 use of preventive health and preventive health serv-
11 ices.

12 “(2) PROJECTIONS.—If the Director determines
13 that a measure would result in substantial reduc-
14 tions in budget outlays as described in paragraph
15 (1), the Director—

16 “(A) shall include, in any projection pre-
17 pared by the Director, a description and esti-
18 mate of the reductions in budget outlays in the
19 budgetary outyears and a description of the
20 basis for such conclusions; and

21 “(B) may prepare a budget projection that
22 includes some or all of the budgetary outyears,
23 notwithstanding the time periods for projections
24 described in subsection (e) and sections 308,
25 402, and 424.

1 “(3) DEFINITIONS.—As used in this sub-
2 section—

3 “(A) the term ‘budgetary outyears’ means
4 the 2 consecutive 10-fiscal-year periods begin-
5 ning with the first fiscal year that is 10 years
6 after the budget year provided for in the most
7 recently agreed to concurrent resolution on the
8 budget; and

9 “(B) the term ‘preventive health’ means an
10 action that focuses on the health of the public,
11 individuals, and defined populations in order to
12 protect, promote, and maintain health, wellness,
13 and functional ability, and prevent disease, dis-
14 ability, and premature death that is dem-
15 onstrated by credible and publicly available epi-
16 demiological projection models, incorporating
17 clinical trials or observational studies in hu-
18 mans, to avoid future health care costs.”.

19 **SEC. 4208. SENSE OF CONGRESS ON MAINTENANCE OF EF-**
20 **FORT PROVISIONS REGARDING CHILDREN’S**
21 **HEALTH.**

22 It is the sense of the Congress that—

23 (1) the maintenance of effort provisions added
24 to sections 1902 and 2105(d) of the Social Security
25 Act (42 U.S.C. 1396a; 42 U.S.C. 1397ee(d)) by sec-

1 tions 2001(b) and 2101(b) of the Patient Protection
2 and Affordable Care Act were intended to maintain
3 the eligibility standards for the Medicaid program
4 under title XIX of the Social Security Act (42
5 U.S.C. 1396 et seq.) and Children’s Health Insur-
6 ance Program under title XXI of such Act (42
7 U.S.C. 1397aa et seq.) to protect vulnerable and dis-
8 abled adults, children, and senior citizens, many of
9 whom are also members of communities of color;

10 (2) the maintenance of effort provisions for
11 children’s coverage have been extended by the Con-
12 gress through September 30, 2029;

13 (3) the maintenance of effort provisions ensure
14 the continued success of the Medicaid program and
15 Children’s Health Insurance Program and were in-
16 tended to specifically protect vulnerable and disabled
17 children, many of whom are also members of com-
18 munities of color; and

19 (4) the maintenance of effort provisions must
20 be strictly enforced and proposals to weaken or
21 waive the maintenance of effort provisions must not
22 be considered.

1 **SEC. 4209. PROTECTION OF THE HHS OFFICES OF MINOR-**
2 **ITY HEALTH.**

3 (a) IN GENERAL.—Pursuant to section 1707A of the
4 Public Health Service Act (42 U.S.C. 300u–6a), the Of-
5 fices of Minority Health established within the Centers for
6 Disease Control and Prevention, the Health Resources
7 and Services Administration, the Substance Abuse and
8 Mental Health Services Administration, the Agency for
9 Healthcare Research and Quality, the Food and Drug Ad-
10 ministration, and the Centers for Medicare & Medicaid
11 Services, are offices that, regardless of change in the
12 structure of the Department of Health and Human Serv-
13 ices, shall report to the Secretary of Health and Human
14 Services.

15 (b) SENSE OF CONGRESS.—It is the sense of the
16 Congress that the Offices of Minority Health referred to
17 in subsection (a) play a critical role in addressing health
18 disparities and should be adequately funded and given a
19 prominent role in evaluating and establishing health poli-
20 cies and programs.

21 **SEC. 4210. OFFICE OF MINORITY HEALTH IN VETERANS**
22 **HEALTH ADMINISTRATION OF DEPARTMENT**
23 **OF VETERANS AFFAIRS.**

24 (a) ESTABLISHMENT AND FUNCTIONS.—Subchapter
25 I of chapter 73 of title 38, United States Code, is amended
26 by inserting after section 7308 the following new section:

1 **“§ 7308A. Office of Minority Health**

2 “(a) ESTABLISHMENT.—There is established in the
3 Department within the Office of the Under Secretary for
4 Health an office to be known as the ‘Office of Minority
5 Health’ (in this section referred to as the ‘Office’).

6 “(b) HEAD.—

7 “(1) IN GENERAL.—The Director of the Office
8 of Minority Health shall be the head of the Office.

9 “(2) APPOINTMENT.—The Director of the Of-
10 fice of Minority Health shall be appointed by the
11 Under Secretary for Health from among individuals
12 qualified to perform the duties of the position.

13 “(c) FUNCTIONS.—The functions of the Office are as
14 follows:

15 “(1) To establish short-range and long-range
16 goals and objectives and coordinate all other activi-
17 ties within the Veterans Health Administration that
18 relate to disease prevention, health promotion, health
19 care services delivery, health and health care edu-
20 cation, health care quality, and health care research
21 concerning veterans who are members of a racial or
22 ethnic minority group.

23 “(2) To support research, demonstrations, and
24 evaluations to test new and innovative models for
25 the discharge of activities described in paragraph
26 (1).

1 “(3) To increase knowledge and understanding
2 of health risk factors for veterans who are members
3 of a racial or ethnic minority group.

4 “(4) To develop mechanisms that support bet-
5 ter health care information dissemination, education,
6 prevention, and services delivery to veterans from
7 disadvantaged backgrounds, including veterans who
8 are members of a racial or ethnic minority group.

9 “(5) To enter into contracts or agreements with
10 appropriate public and nonprofit private entities to
11 develop and carry out programs to provide bilingual
12 or interpretive services to assist veterans who are
13 members of a racial or ethnic minority group and
14 who lack proficiency in speaking the English lan-
15 guage in accessing and receiving health care services
16 through the Veterans Health Administration.

17 “(6) To carry out programs to improve access
18 to health care services through the Veterans Health
19 Administration for veterans with limited proficiency
20 in speaking the English language, including the de-
21 velopment and evaluation of demonstration and pilot
22 projects for that purpose.

23 “(7) To advise the Under Secretary for Health
24 on matters relating to the development, implementa-
25 tion, and evaluation of health professions education

1 in decreasing disparities in health care outcomes be-
 2 tween veterans who are members of a racial or eth-
 3 nic minority group and other veterans, including cul-
 4 tural competency as a method of eliminating such
 5 health disparities.

6 “(8) To perform such other functions and du-
 7 ties as the Secretary or the Under Secretary for
 8 Health considers appropriate.

9 “(d) DEFINITIONS.—In this section:

10 “(1) The term ‘racial or ethnic minority group’
 11 means any of the following:

12 “(A) American Indians (including Alaska
 13 Natives, Eskimos, and Aleuts).

14 “(B) Asian Americans.

15 “(C) Native Hawaiians and Pacific Island-
 16 ers.

17 “(D) Blacks.

18 “(E) Hispanics.

19 “(2) The term ‘Hispanic’ means individuals
 20 whose origin is from Mexico, Puerto Rico, Cuba,
 21 Central or South America, or any other Spanish-
 22 speaking country.”.

23 (b) CLERICAL AMENDMENT.—The table of sections
 24 at the beginning of such chapter is amended by inserting

1 after the item relating to section 7308 the following new
 2 item:

“7308A. Office of Minority Health.”.

3 **SEC. 4211. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
 4 **ACCESS FOR LOW-INCOME PATIENTS.**

5 (a) IN GENERAL.—Not later than January 1, 2027,
 6 the Comptroller General of the United States shall con-
 7 duct a study on how amendments made by the Patient
 8 Protection and Affordable Care Act (Public Law 111–
 9 148) and the Health Care and Education Reconciliation
 10 Act of 2010 (Public Law 111–152) to titles XVIII and
 11 XIX of the Social Security Act (42 U.S.C. 1395 et seq.;
 12 42 U.S.C. 1396 et seq.) relating to disproportionate share
 13 hospital adjustment payments under Medicare and Med-
 14 icaid (and subsequent amendments made with respect to
 15 such payments) affect the timely access to health care
 16 services for low-income patients. Such study shall—

17 (1) evaluate and examine whether States elect-
 18 ing to make medical assistance available under sec-
 19 tion 1902(a)(10)(A)(i)(VIII) of the Social Security
 20 Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including
 21 States making such an election through a waiver of
 22 the State plan) to individuals described in such sec-
 23 tion mitigate the need for payments to dispropor-
 24 tionate share hospitals under section 1886(d)(5)(F)
 25 of the Social Security Act (42 U.S.C.

1 1395ww(d)(5)(F)) and section 1923 of such Act (42
2 U.S.C. 1396r-4), including the impact of such
3 States electing to make medical assistance available
4 to such individuals on—

5 (A) the number of individuals in the
6 United States who are without health insurance
7 and the distribution of such individuals in rela-
8 tion to areas primarily served by dispropor-
9 tionate share hospitals; and

10 (B) the low-income utilization rate of such
11 hospitals and the resulting fiscal sustainability
12 of such hospitals;

13 (2) evaluate the appropriate level and distribu-
14 tion of such payments among such disproportionate
15 share hospitals for purposes of—

16 (A) sufficiently accounting for the level of
17 uncompensated care provided by such hospitals
18 to low-income patients; and

19 (B) providing timely access to health care
20 services for individuals in medically underserved
21 areas; and

22 (3) assess, with respect to such disproportionate
23 share hospitals—

24 (A) the role played by such hospitals in
25 providing critical access to emergency, inpa-

1 tient, and outpatient health services, including
 2 end-of-life services, as well as the location of
 3 such hospitals in relation to medically under-
 4 served areas; and

5 (B) the extent to which such hospitals sat-
 6 isfy the requirements established for charitable
 7 hospital organizations under section 501(r) of
 8 the Internal Revenue Code of 1986 with respect
 9 to community health needs assessments, finan-
 10 cial assistance policy requirements, limitations
 11 on charges, and billing and collection require-
 12 ments.

13 (b) REPORTS.—

14 (1) REPORT TO CONGRESS.—Not later than
 15 180 days after the date on which the study under
 16 subsection (a) is completed, the Comptroller General
 17 of the United States shall submit to the Committee
 18 on Finance of the Senate and the Committee on En-
 19 ergy and Commerce of the House of Representatives
 20 a report that contains—

21 (A) the results of such study; and

22 (B) recommendations to Congress for any
 23 legislative changes to the payments to dis-
 24 proportionate share hospitals under section
 25 1886(d)(5)(F) of the Social Security Act (42

1 U.S.C. 1395ww(d)(5)(F)) and section 1923 of
2 such Act (42 U.S.C. 1396r-4) that are needed
3 to ensure access to health services for low-in-
4 come patients that—

5 (i) are based on the number of indi-
6 viduals without health insurance, the
7 amount of uncompensated care provided by
8 such hospitals, and the impact of reduced
9 payment levels on low-income communities;
10 and

11 (ii) takes into account any reports
12 submitted by the Secretary of the Treas-
13 ury, in consultation with the Secretary of
14 Health and Human Services, to congres-
15 sional committees regarding the costs in-
16 curred by charitable hospital organizations
17 for charity care, bad debt, nonreimbursed
18 expenses for services provided to individ-
19 uals under the Medicare program under
20 title XVIII of the Social Security Act and
21 the Medicaid program under title XIX of
22 such Act (42 U.S.C. 1395 et seq.; 42
23 U.S.C. 1396 et seq.), and any community
24 benefit activities provided by such organi-
25 zations.

1 (2) REPORT TO THE SECRETARY OF HEALTH
 2 AND HUMAN SERVICES.—Not later than 180 days
 3 after the date on which the study under subsection
 4 (a) is completed, the Comptroller General of the
 5 United States shall submit to the Secretary of
 6 Health and Human Services a report that con-
 7 tains—

8 (A) the results of such study; and

9 (B) any recommendations for purposes of
 10 assisting in the development of the methodology
 11 for the adjustment of payments to dispropor-
 12 tionate share hospitals, as required under sec-
 13 tion 1886(r) of the Social Security Act (42
 14 U.S.C. 1395ww(r)) and the reduction of such
 15 payments under section 1923(f)(7) of such Act
 16 (42 U.S.C. 1396r–4(f)(7)), taking into account
 17 the reports referred to in paragraph (1)(B)(ii).

18 **SEC. 4212. REAUTHORIZATION OF PROGRAMS UNDER THE**
 19 **NATIVE HAWAIIAN HEALTH CARE IMPROVE-**
 20 **MENT ACT.**

21 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
 22 Section 6(h)(1) of the Native Hawaiian Health Care Im-
 23 provement Act (42 U.S.C. 11705(h)(1)) is amended by
 24 striking “may be necessary for fiscal years 1993 through
 25 2019” and inserting “are necessary”.

1 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
 2 LOKAHI.—Section 7(b) of the Native Hawaiian Health
 3 Care Improvement Act (42 U.S.C. 11706(b)) is amended
 4 by striking “may be necessary for fiscal years 1993
 5 through 2019” and inserting “are necessary”.

6 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
 7 Section 10(c) of the Native Hawaiian Health Care Im-
 8 provement Act (42 U.S.C. 11709(c)) is amended by strik-
 9 ing “may be necessary for fiscal years 1993 through
 10 2019” and inserting “are necessary”.

11 **PART 2—RURAL**

12 **SEC. 4221. ESTABLISHMENT OF RURAL COMMUNITY HOS-** 13 **PITAL (RCH) PROGRAM.**

14 (a) IN GENERAL.—Section 1861 of the Social Secu-
 15 rity Act (42 U.S.C. 1395x), as amended by section
 16 2007(b)(1), is amended by adding at the end of the fol-
 17 lowing new subsection:

18 “Rural Community Hospital; Rural Community Hospital
 19 Services

20 “(ppp)(1) The term ‘rural community hospital’
 21 means a hospital (as defined in subsection (e)) that—

22 “(A) is located in a rural area (as defined in
 23 section 1886(d)(2)(D)) or treated as being so lo-
 24 cated pursuant to section 1886(d)(8)(E);

1 “(B) subject to paragraph (2), has less than 51
2 acute care inpatient beds, as reported in its most re-
3 cent cost report;

4 “(C) makes available 24-hour emergency care
5 services;

6 “(D) subject to paragraph (3), has a provider
7 agreement in effect with the Secretary and is open
8 to the public as of January 1, 2010; and

9 “(E) applies to the Secretary for such designa-
10 tion.

11 “(2) For purposes of paragraph (1)(B), beds in a
12 psychiatric or rehabilitation unit of the hospital which is
13 a distinct part of the hospital shall not be counted.

14 “(3) Paragraph (1)(D) shall not be construed to pro-
15 hibit any of the following from qualifying as a rural com-
16 munity hospital:

17 “(A) A replacement facility (as defined by the
18 Secretary in regulations in effect on January 1,
19 2012) with the same service area (as defined by the
20 Secretary in regulations in effect on such date).

21 “(B) A facility obtaining a new provider num-
22 ber pursuant to a change of ownership.

23 “(C) A facility which has a binding written
24 agreement with an outside, unrelated party for the

1 construction, reconstruction, lease, rental, or financ-
 2 ing of a building as of January 1, 2012.

3 “(4) Nothing in this subsection shall be construed as
 4 prohibiting a critical access hospital from qualifying as a
 5 rural community hospital if the critical access hospital
 6 meets the conditions otherwise applicable to hospitals
 7 under subsection (e) and section 1866.

8 “(5) Nothing in this subsection shall be construed as
 9 prohibiting a rural community hospital participating in
 10 the demonstration program under section 410A of the
 11 Medicare Prescription Drug, Improvement, and Mod-
 12 ernization Act of 2003 (42 U.S.C. 1395ww note; Public
 13 Law 108–173) from qualifying as a rural community hos-
 14 pital if the rural community hospital meets the conditions
 15 otherwise applicable to hospitals under subsection (e) and
 16 section 1866.”.

17 (b) PAYMENT.—

18 (1) INPATIENT HOSPITAL SERVICES.—Section
 19 1814 of the Social Security Act (42 U.S.C. 1395f)
 20 is amended by adding at the end the following new
 21 subsection:

22 “Payment for Inpatient Services Furnished in Rural
 23 Community Hospitals

24 “(m) The amount of payment under this part for in-
 25 patient hospital services furnished in a rural community

1 hospital, other than such services furnished in a psy-
 2 chiatric or rehabilitation unit of the hospital which is a
 3 distinct part, is, at the election of the hospital in the appli-
 4 cation referred to in section 1861(ppp)(1)(E)—

5 “(1) 101 percent of the reasonable costs of pro-
 6 viding such services, without regard to the amount
 7 of the customary or other charge, or

8 “(2) the amount of payment provided for under
 9 the prospective payment system for inpatient hos-
 10 pital services under section 1886(d).”.

11 (2) OUTPATIENT SERVICES.—Section 1834 of
 12 the Social Security Act (42 U.S.C. 1395m) is
 13 amended by adding at the end the following new
 14 subsection:

15 “(bb) PAYMENT FOR OUTPATIENT SERVICES FUR-
 16 NISHED IN RURAL COMMUNITY HOSPITALS.—The
 17 amount of payment under this part for outpatient services
 18 furnished in a rural community hospital is, at the election
 19 of the hospital in the application referred to in section
 20 1861(ppp)(1)(E)—

21 “(1) 101 percent of the reasonable costs of pro-
 22 viding such services, without regard to the amount
 23 of the customary or other charge and any limitation
 24 under section 1861(v)(1)(U), or

1 “(2) the amount of payment provided for under
2 the prospective payment system for covered OPD
3 services under section 1833(t).”.

4 (3) EXEMPTION FROM 30-PERCENT REDUCTION
5 IN REIMBURSEMENT FOR BAD DEBT.—Section
6 1861(v)(1)(T) of the Social Security Act (42 U.S.C.
7 1395x(v)(1)(T)) is amended in the matter preceding
8 clause (i) by inserting “(other than for a rural com-
9 munity hospital)” after “In determining such rea-
10 sonable costs for hospitals”.

11 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
12 SERVICES.—Section 1834(bb) of the Social Security Act
13 (as added by subsection (b)(2)) is amended—

14 (1) by redesignating paragraphs (1) and (2) as
15 subparagraphs (A) and (B), respectively;

16 (2) by inserting “(1)” after “(bb)”; and

17 (3) by adding at the end the following:

18 “(2) The amounts of beneficiary cost-sharing for out-
19 patient services furnished in a rural community hospital
20 under this part shall be as follows:

21 “(A) For items and services that would have
22 been paid under section 1833(t) if furnished by a
23 hospital, the amount of cost-sharing determined
24 under paragraph (8) of such section.

1 “(B) For items and services that would have
2 been paid under section 1833(h) if furnished by a
3 provider of services or supplier, no cost-sharing shall
4 apply.

5 “(C) For all other items and services, the
6 amount of cost-sharing that would apply to the item
7 or service under the methodology that would be used
8 to determine payment for such item or service if pro-
9 vided by a physician, provider of services, or sup-
10 plier, as the case may be.”.

11 (d) CONFORMING AMENDMENTS.—

12 (1) PART A PAYMENT.—Section 1814(b) of the
13 Social Security Act (42 U.S.C. 1395f(b)) is amended
14 in the matter preceding paragraph (1) by inserting
15 “other than inpatient hospital services furnished by
16 a rural community hospital,” after “critical access
17 hospital services,”.

18 (2) PART B PAYMENT.—Section 1833(a) of the
19 Social Security Act (42 U.S.C. 1395l(a)), as amend-
20 ed by section 2207(b)(3), is amended—

21 (A) by striking “and” at the end of para-
22 graph (10);

23 (B) by striking the period at the end of
24 paragraph (11) and inserting “; and”; and

25 (C) by adding at the end the following:

1 “(12) in the case of outpatient services fur-
 2 nished by a rural community hospital, the amounts
 3 described in section 1834(bb).”.

4 (3) TECHNICAL AMENDMENTS.—

5 (A) CONSULTATION WITH STATE AGEN-
 6 CIES.—Section 1863 of the Social Security Act
 7 (42 U.S.C. 1395z) is amended by striking “and
 8 (dd)(2)” and inserting “(dd)(2), and (ppp)(1)”.

9 (B) PROVIDER AGREEMENTS.—Section
 10 1866(a)(2)(A) of the Social Security Act (42
 11 U.S.C. 1395cc(a)(2)(A)) is amended by insert-
 12 ing “section 1834(bb)(2),” after “section
 13 1833(b),”.

14 (e) EFFECTIVE DATE.—The amendments made by
 15 this section shall apply to items and services furnished on
 16 or after the date that is 30 days after the date of the
 17 enactment of this Act.

18 **SEC. 4222. RURAL HEALTH QUALITY ADVISORY COMMIS-**
 19 **SION AND DEMONSTRATION PROJECTS.**

20 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
 21 SION.—

22 (1) ESTABLISHMENT.—Not later than 6
 23 months after the date of the enactment of this sec-
 24 tion, the Secretary of Health and Human Services
 25 (in this section referred to as the “Secretary”) shall

1 establish a commission to be known as the “Rural
2 Health Quality Advisory Commission” (in this sec-
3 tion referred to as the “Commission”).

4 (2) DUTIES OF COMMISSION.—

5 (A) NATIONAL PLAN.—The Commission
6 shall develop, coordinate, and facilitate imple-
7 mentation of a national plan for rural health
8 quality improvement. The national plan shall—

9 (i) identify objectives for rural health
10 quality improvement;

11 (ii) identify strategies to eliminate
12 known gaps in rural health system capacity
13 and improve rural health quality; and

14 (iii) provide recommendations for
15 Federal programs to identify opportunities
16 for strengthening and aligning policies and
17 programs to improve rural health quality.

18 (B) DEMONSTRATION PROJECTS.—The
19 Commission shall design demonstration projects
20 to recommend to the Secretary to test alter-
21 native models for rural health quality improve-
22 ment, including with respect to both personal
23 and population health.

1 (C) MONITORING.—The Commission shall
2 monitor progress toward the objectives identi-
3 fied pursuant to subparagraph (A)(i).

4 (3) MEMBERSHIP.—

5 (A) NUMBER.—The Commission shall be
6 composed of 11 members appointed by the Sec-
7 retary.

8 (B) SELECTION.—The Secretary shall se-
9 lect the members of the Commission from
10 among individuals with significant rural health
11 care and health care quality expertise, including
12 expertise in clinical health care, health care
13 quality research, end-of-life care, population or
14 public health, or purchaser organizations.

15 (4) CONTRACTING AUTHORITY.—Subject to the
16 availability of funds, the Commission may enter into
17 contracts and make other arrangements, as may be
18 necessary to carry out the duties described in para-
19 graph (2).

20 (5) STAFF.—Upon the request of the Commis-
21 sion, the Secretary may detail, on a reimbursable
22 basis, any of the personnel of the Office of Rural
23 Health Policy of the Health Resources and Services
24 Administration, the Agency for Healthcare Research
25 and Quality, or the Centers for Medicare & Medicaid

1 Services to the Commission to assist in carrying out
2 this subsection.

3 (6) REPORTS TO CONGRESS.—Not later than 1
4 year after the establishment of the Commission, and
5 annually thereafter, the Commission shall submit a
6 report to the Congress on rural health quality. Each
7 such report shall include the following:

8 (A) An inventory of relevant programs and
9 recommendations for improved coordination and
10 integration of policy and programs.

11 (B) An assessment of achievement of the
12 objectives identified in the national plan devel-
13 oped under paragraph (2) and recommenda-
14 tions for realizing such objectives.

15 (C) Recommendations on Federal legisla-
16 tion, regulations, or administrative policies to
17 enhance rural health quality and outcomes.

18 (b) RURAL HEALTH QUALITY DEMONSTRATION
19 PROJECTS.—

20 (1) IN GENERAL.—Not later than 270 days
21 after the date of the enactment of this section, the
22 Secretary, in consultation with the Rural Health
23 Quality Advisory Commission, the Office of Rural
24 Health Policy of the Health Resources and Services
25 Administration, the Agency for Healthcare Research

1 and Quality, and the Centers for Medicare & Med-
2 icaid Services, shall make grants to eligible entities
3 for a total of 5 demonstration projects to implement
4 and evaluate methods for improving the quality of
5 health care in rural communities. Each such dem-
6 onstration project shall include—

7 (A) alternative community models that—

8 (i) will achieve greater integration of
9 personal and population health services;
10 and

11 (ii) address safety, effectiveness,
12 patient- or community-centeredness, timeli-
13 ness, efficiency, and equity (the 6 aims
14 identified by the National Academy of
15 Medicine (formerly known as the “Institute
16 of Medicine”) in its report entitled “Cross-
17 ing the Quality Chasm: A New Health Sys-
18 tem for the 21st Century” released on
19 March 1, 2001);

20 (B) innovative approaches to the financing
21 and delivery of health care services to achieve
22 rural health quality and accessibility goals for
23 patients; and

24 (C) development of quality improvement
25 support structures to assist rural health sys-

1 tems and professionals in the provision of
2 health care (such as workforce support struc-
3 tures, quality monitoring and reporting, clinical
4 care protocols, and information technology ap-
5 plications).

6 (2) ELIGIBLE ENTITIES.—In this subsection,
7 the term “eligible entity” means a consortium
8 that—

9 (A) shall include—

10 (i) at least one health care provider or
11 health care delivery system located in a
12 rural area; and

13 (ii) at least one organization rep-
14 resenting multiple community stakeholders;
15 and

16 (B) may include other partners such as
17 rural research centers.

18 (3) CONSULTATION.—In developing the pro-
19 gram for awarding grants under this subsection, the
20 Secretary shall consult with the Administrator of the
21 Agency for Healthcare Research and Quality, rural
22 health care providers, rural health care researchers,
23 and private and nonprofit groups (including national
24 associations) which are undertaking similar efforts.

1 (4) EXPEDITED WAIVERS.—The Secretary shall
2 expedite the processing of any waiver that—

3 (A) is authorized under title XVIII or XIX
4 of the Social Security Act (42 U.S.C. 1395 et
5 seq.; 42 U.S.C. 1396 et seq.); and

6 (B) is necessary to carry out a demonstra-
7 tion project under this subsection.

8 (5) DEMONSTRATION PROJECT SITES.—The
9 Secretary shall ensure that the 5 demonstration
10 projects funded under this subsection are conducted
11 at a variety of sites representing the diversity of
12 rural communities in the United States.

13 (6) DURATION.—Each demonstration project
14 under this subsection shall be for a period of 4
15 years.

16 (7) INDEPENDENT EVALUATION.—The Sec-
17 retary shall enter into an arrangement with an enti-
18 ty that has experience working directly with rural
19 health systems for the conduct of an independent
20 evaluation of the program carried out under this
21 subsection.

22 (8) REPORT.—Not later than 1 year after the
23 conclusion of all of the demonstration projects fund-
24 ed under this subsection, the Secretary shall submit

1 a report to the Congress on the results of such
2 projects. The report shall include—

3 (A) an evaluation of patient access to care,
4 patient outcomes, and an analysis of the cost-
5 effectiveness of each such project; and

6 (B) recommendations on Federal legisla-
7 tion, regulations, or administrative policies to
8 enhance rural health quality and outcomes.

9 (c) APPROPRIATIONS.—

10 (1) IN GENERAL.—Out of funds in the Treas-
11 ury not otherwise appropriated, there are appro-
12 priated to the Secretary to carry out this section
13 \$30,000,000 for the period of fiscal years 2027
14 through 2031.

15 (2) AVAILABILITY.—

16 (A) IN GENERAL.—Except as provided in
17 subparagraph (B), funds appropriated under
18 paragraph (1) shall remain available for ex-
19 penditure through fiscal year 2030.

20 (B) REPORT.—For purposes of carrying
21 out subsection (b)(8), funds appropriated under
22 paragraph (1) shall remain available for ex-
23 penditure through fiscal year 2031.

1 (3) RESERVATION.—Of the amount appro-
 2 priated under paragraph (1), the Secretary shall re-
 3 serve—

4 (A) \$5,000,000 to carry out subsection (a);
 5 and

6 (B) \$25,000,000 to carry out subsection
 7 (b), of which—

8 (i) 2 percent shall be for the provision
 9 of technical assistance to grant recipients;
 10 and

11 (ii) 5 percent shall be for the inde-
 12 pendent evaluation under subsection
 13 (b)(7).

14 **SEC. 4223. RURAL HEALTH CARE SERVICES.**

15 Section 330A of the Public Health Service Act (42
 16 U.S.C. 254c) is amended to read as follows:

17 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
 18 **RURAL HEALTH NETWORK DEVELOPMENT,**
 19 **DELTA RURAL DISPARITIES AND HEALTH**
 20 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
 21 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
 22 **MENT GRANT PROGRAMS.**

23 “(a) PURPOSE.—The purpose of this section is to
 24 provide for grants—

1 “(1) under subsection (b), to promote rural
2 health care services outreach;

3 “(2) under subsection (c), to provide for the
4 planning and implementation of integrated health
5 care networks in rural areas;

6 “(3) under subsection (d), to assist rural com-
7 munities in the Delta Region to reduce health dis-
8 parities and to promote and enhance health system
9 development; and

10 “(4) under subsection (e), to provide for the
11 planning and implementation of small rural health
12 care provider quality improvement activities.

13 “(b) RURAL HEALTH CARE SERVICES OUTREACH
14 GRANTS.—

15 “(1) GRANTS.—The Director of the Office of
16 Rural Health Policy of the Health Resources and
17 Services Administration (referred to in this section
18 as the ‘Director’) may award grants to eligible enti-
19 ties to promote rural health care services outreach
20 by expanding the delivery of health care services to
21 include new and enhanced services in rural areas.
22 The Director may award the grants for periods of
23 not more than 3 years.

1 “(2) ELIGIBILITY.—To be eligible to receive a
2 grant under this subsection for a project, an enti-
3 ty—

4 “(A) shall be a rural public or rural non-
5 profit private entity, a facility that qualifies as
6 a rural health clinic under title XVIII of the
7 Social Security Act, a public or nonprofit entity
8 existing exclusively to provide services to mi-
9 grant and seasonal farm workers in rural areas,
10 or a Tribal government whose grant-funded ac-
11 tivities will be conducted within federally recog-
12 nized Tribal areas;

13 “(B) shall represent a consortium com-
14 posed of members—

15 “(i) that include 3 or more independ-
16 ently owned health care entities; and

17 “(ii) that may be nonprofit or for-
18 profit entities; and

19 “(C) shall not previously have received a
20 grant under this subsection for the same or a
21 similar project, unless the entity is proposing to
22 expand the scope of the project or the area that
23 will be served through the project.

24 “(3) APPLICATIONS.—To be eligible to receive a
25 grant under this subsection, an eligible entity shall

1 prepare and submit to the Director an application at
2 such time, in such manner, and containing such in-
3 formation as the Director may require, including—

4 “(A) a description of the project that the
5 eligible entity will carry out using the funds
6 provided under the grant;

7 “(B) a description of the manner in which
8 the project funded under the grant will meet
9 the health care needs of rural populations in
10 the local community or region to be served;

11 “(C) a plan for quantifying how health
12 care needs will be met through identification of
13 the target population and benchmarks of service
14 delivery or health status, such as—

15 “(i) quantifiable measurements of
16 health and health care status improvement
17 for projects focusing on health promotion;
18 or

19 “(ii) benchmarks of increased access
20 to primary and end-of-life care, including
21 tracking factors such as the number and
22 type of primary and end-of-life care visits,
23 identification of a medical home, or other
24 general measures of such access;

1 “(D) a description of how the local com-
 2 munity or region to be served will be involved
 3 in the development and ongoing operations of
 4 the project;

5 “(E) a plan for sustaining the project after
 6 Federal support for the project has ended;

7 “(F) a description of how the project will
 8 be evaluated;

9 “(G) the administrative capacity to submit
 10 annual performance data electronically as speci-
 11 fied by the Director; and

12 “(H) other such information as the Direc-
 13 tor determines to be appropriate.

14 “(c) RURAL HEALTH NETWORK DEVELOPMENT
 15 GRANTS.—

16 “(1) GRANTS.—

17 “(A) IN GENERAL.—The Director may
 18 award rural health network development grants
 19 to eligible entities to promote, through planning
 20 and implementation, the development of inte-
 21 grated health care networks that have combined
 22 the functions of the entities participating in the
 23 networks in order to—

24 “(i) achieve efficiencies and economies
 25 of scale;

1 “(ii) expand access to, coordinate, and
 2 improve the quality of the health care de-
 3 livery system through development of orga-
 4 nizational efficiencies;

5 “(iii) implement health information
 6 technology to achieve efficiencies, reduce
 7 medical errors, and improve quality;

8 “(iv) coordinate care and manage
 9 chronic and terminal illness; and

10 “(v) strengthen the rural health care
 11 system as a whole and across all facets of
 12 the health care delivery system, including
 13 end-of-life care, in such a manner as to
 14 show a quantifiable return on investment
 15 to the participants in the network.

16 “(B) GRANT PERIODS.—The Director may
 17 award such a rural health network development
 18 grant—

19 “(i) for a period of 3 years for imple-
 20 mentation activities; or

21 “(ii) for a period of 1 year for plan-
 22 ning activities to assist in the initial devel-
 23 opment of an integrated health care net-
 24 work, if the proposed participants in the
 25 network do not have a history of collabo-

1 rative efforts and a 3-year grant would be
2 inappropriate.

3 “(2) ELIGIBILITY.—To be eligible to receive a
4 grant under this subsection, an entity—

5 “(A) shall be a rural public or rural non-
6 profit private entity, a facility that qualifies as
7 a rural health clinic under title XVIII of the
8 Social Security Act, a public or nonprofit entity
9 existing exclusively to provide services to mi-
10 grant and seasonal farm workers in rural areas,
11 or a Tribal government whose grant-funded ac-
12 tivities will be conducted within federally recog-
13 nized Tribal areas;

14 “(B) shall represent a network composed
15 of participants—

16 “(i) that include 3 or more independ-
17 ently owned health care entities; and

18 “(ii) that may be nonprofit or for-
19 profit entities; and

20 “(C) shall not previously have received a
21 grant under this subsection (other than a 1-
22 year grant for planning activities) for the same
23 or a similar project.

24 “(3) APPLICATIONS.—To be eligible to receive a
25 grant under this subsection, an eligible entity, in

1 consultation with the appropriate State office of
2 rural health or another appropriate State entity,
3 shall prepare and submit to the Director an applica-
4 tion at such time, in such manner, and containing
5 such information as the Director may require, in-
6 cluding—

7 “(A) a description of the project that the
8 eligible entity will carry out using the funds
9 provided under the grant;

10 “(B) an explanation of the reasons why
11 Federal assistance is required to carry out the
12 project;

13 “(C) a description of—

14 “(i) the history of collaborative activi-
15 ties carried out by the participants in the
16 network;

17 “(ii) the degree to which the partici-
18 pants are ready to integrate their func-
19 tions; and

20 “(iii) how the local community or re-
21 gion to be served will benefit from and be
22 involved in the activities carried out by the
23 network;

24 “(D) a description of how the local com-
25 munity or region to be served will experience in-

1 creased access to quality health care services
 2 across the continuum of care as a result of the
 3 integration activities carried out by the net-
 4 work, including a description of—

5 “(i) return on investment for the com-
 6 munity and the network members; and

7 “(ii) other quantifiable performance
 8 measures that show the benefit of the net-
 9 work activities;

10 “(E) a plan for sustaining the project after
 11 Federal support for the project has ended;

12 “(F) a description of how the project will
 13 be evaluated;

14 “(G) the administrative capacity to submit
 15 annual performance data electronically as speci-
 16 fied by the Director; and

17 “(H) other such information as the Direc-
 18 tor determines to be appropriate.

19 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
 20 TEMS DEVELOPMENT GRANTS.—

21 “(1) GRANTS.—The Director may award grants
 22 to eligible entities to support reduction of health dis-
 23 parities, improve access to health care, and enhance
 24 rural health system development in the Delta Re-
 25 gion.

1 “(2) ELIGIBILITY.—To be eligible to receive a
2 grant under this subsection, an entity shall be a
3 rural public or rural nonprofit private entity, a facil-
4 ity that qualifies as a rural health clinic under title
5 XVIII of the Social Security Act, a public or non-
6 profit entity existing exclusively to provide services
7 to migrant and seasonal farm workers in rural
8 areas, or a Tribal government whose grant-funded
9 activities will be conducted within federally recog-
10 nized Tribal areas.

11 “(3) APPLICATIONS.—To be eligible to receive a
12 grant under this subsection, an eligible entity shall
13 prepare and submit to the Director an application at
14 such time, in such manner, and containing such in-
15 formation as the Director may require, including—

16 “(A) a description of the project that the
17 eligible entity will carry out using the funds
18 provided under the grant;

19 “(B) an explanation of the reasons why
20 Federal assistance is required to carry out the
21 project;

22 “(C) a description of the manner in which
23 the project funded under the grant will meet
24 the health care needs of the Delta Region;

1 “(D) a description of how the local com-
 2 munity or region to be served will experience in-
 3 creased access to quality health care services as
 4 a result of the activities carried out by the enti-
 5 ty;

6 “(E) a description of how health dispari-
 7 ties will be reduced or the health system will be
 8 improved;

9 “(F) a plan for sustaining the project after
 10 Federal support for the project has ended;

11 “(G) a description of how the project will
 12 be evaluated including process and outcome
 13 measures related to the quality of care provided
 14 or how the health care system improves its per-
 15 formance;

16 “(H) a description of how the grantee will
 17 develop an advisory group made up of rep-
 18 resentatives of the communities to be served to
 19 provide guidance to the grantee to best meet
 20 community need; and

21 “(I) other such information as the Director
 22 determines to be appropriate.

23 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
 24 ITY IMPROVEMENT GRANTS.—

1 “(1) GRANTS.—The Director may award grants
2 to provide for the planning and implementation of
3 small rural health care provider quality improvement
4 activities. The Director may award the grants for
5 periods of 1 to 3 years.

6 “(2) ELIGIBILITY.—To be eligible for a grant
7 under this subsection, an entity—

8 “(A) shall be—

9 “(i) a rural public or rural nonprofit
10 private health care provider or provider of
11 health care services, such as a rural health
12 clinic; or

13 “(ii) another rural provider or net-
14 work of small rural providers identified by
15 the Director as a key source of local care;
16 and

17 “(B) shall not previously have received a
18 grant under this subsection for the same or a
19 similar project.

20 “(3) PREFERENCE.—In awarding grants under
21 this subsection, the Director shall give preference to
22 facilities that qualify as rural health clinics under
23 title XVIII of the Social Security Act.

24 “(4) APPLICATIONS.—To be eligible to receive a
25 grant under this subsection, an eligible entity shall

1 prepare and submit to the Director an application at
2 such time, in such manner, and containing such in-
3 formation as the Director may require, including—

4 “(A) a description of the project that the
5 eligible entity will carry out using the funds
6 provided under the grant;

7 “(B) an explanation of the reasons why
8 Federal assistance is required to carry out the
9 project;

10 “(C) a description of the manner in which
11 the project funded under the grant will assure
12 continuous quality improvement in the provision
13 of services by the entity;

14 “(D) a description of how the local com-
15 munity or region to be served will experience in-
16 creased access to quality health care services as
17 a result of the activities carried out by the enti-
18 ty;

19 “(E) a plan for sustaining the project after
20 Federal support for the project has ended;

21 “(F) a description of how the project will
22 be evaluated including process and outcome
23 measures related to the quality of care pro-
24 vided; and

1 “(G) other such information as the Direc-
2 tor determines to be appropriate.

3 “(f) GENERAL REQUIREMENTS.—

4 “(1) PROHIBITED USES OF FUNDS.—An entity
5 that receives a grant under this section may not use
6 funds provided through the grant—

7 “(A) to build or acquire real property; or

8 “(B) for construction.

9 “(2) COORDINATION WITH OTHER AGENCIES.—

10 The Director shall coordinate activities carried out
11 under grant programs described in this section, to
12 the extent practicable, with Federal and State agen-
13 cies and nonprofit organizations that are operating
14 similar grant programs, to maximize the effect of
15 public dollars in funding meritorious proposals.

16 “(g) REPORT.—Not later than September 30, 2027,
17 the Secretary shall prepare and submit to the appropriate
18 committees of Congress a report on the progress and ac-
19 complishments of the grant programs described in sub-
20 sections (b), (c), (d), and (e).

21 “(h) DEFINITION OF DELTA REGION.—In this sec-
22 tion, the term ‘Delta Region’ has the meaning given to
23 the term ‘region’ in section 382A of the Consolidated
24 Farm and Rural Development Act (7 U.S.C. 2009aa).

1 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2027 through 2030.”.

5 **PART 3—INDIAN COMMUNITIES**

6 **SEC. 4231. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
7 **SERVICE.**

8 (a) REFERENCES.—Any reference in a law, regula-
9 tion, document, paper, or other record of the United
10 States to the Director of the Indian Health Service shall
11 be deemed to be a reference to the Assistant Secretary
12 of the Indian Health Service.

13 (b) EXECUTIVE SCHEDULE.—Section 5315 of title 5,
14 United States Code, is amended, in the matter relating
15 to the Assistant Secretaries of Health and Human Serv-
16 ices, by striking “(6)” and inserting “(7), one of whom
17 shall be the Assistant Secretary of the Indian Health Serv-
18 ice”.

19 (c) CONFORMING AMENDMENT.—Section 5316 of
20 title 5, United States Code, is amended by striking “Direc-
21 tor, Indian Health Service, Department of Health and
22 Human Services.”.

1 **SEC. 4232. EXTENSION OF FULL FEDERAL MEDICAL ASSIST-**
2 **ANCE PERCENTAGE TO INDIAN HEALTH**
3 **CARE PROVIDERS.**

4 Section 1905(a)(9) of the Social Security Act (42
5 U.S.C. 1396d(a)(9)) is amended to read as follows:

6 “(9) clinic services furnished by or under the
7 direction of a physician, without regard to whether
8 the clinic itself is administered by a physician, in-
9 cluding—

10 “(A) such services furnished outside the
11 clinic by clinic personnel to an eligible indi-
12 vidual who does not reside in a permanent
13 dwelling or does not have a fixed home or mail-
14 ing address; and

15 “(B) such services furnished outside the
16 clinic by any Indian Health Service facility, a
17 health program or facility operated by a tribe or
18 tribal organization under the Indian Self-Deter-
19 mination Act (Public Law 93–638), or an
20 urban Indian organization receiving funds
21 under title V of the Indian Health Care Im-
22 provement Act;”.

1 **SEC. 4233. CONFERRING WITH URBAN INDIAN ORGANIZA-**
 2 **TIONS.**

3 Section 514 of the Indian Health Care Improvement
 4 Act (25 U.S.C. 1660d) is amended by striking subsection
 5 (b) and inserting the following:

6 “(b) REQUIREMENT.—The Secretary and the Sec-
 7 retary of Veterans Affairs shall ensure that the Service,
 8 other agencies and offices of the Department, and the De-
 9 partment of Veterans Affairs confer, to the maximum ex-
 10 tent practicable, with urban Indian organizations in car-
 11 rying out—

12 “(1) this Act; and

13 “(2) other provisions of law relating to Indian
 14 health care.”.

15 **PART 4—PROVIDERS**

16 **SEC. 4241. AVAILABILITY OF NON-ENGLISH LANGUAGE**
 17 **SPEAKING PROVIDERS.**

18 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
 19 tient Protection and Affordable Care Act (42 U.S.C.
 20 18031(c)(1)(B)) is amended by inserting before the semi-
 21 colon the following: “and the ability of such provider to
 22 provide care in a language other than English either
 23 through the provider speaking such language or by the
 24 provider having a qualified interpreter for an individual
 25 with limited English proficiency (as defined in section

1 3400 of such Act) who speaks such language available
 2 during office hours”.

3 (b) EFFECTIVE DATE.—The amendment made by
 4 subsection (a) shall not apply to any plan beginning on
 5 or prior to the date that is 1 year after the date of the
 6 enactment of this Act.

7 **SEC. 4242. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.**

8 (a) ESSENTIAL COMMUNITY PROVIDERS.—Section
 9 1311(c)(1)(C) of the Patient Protection and Affordable
 10 Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

11 (1) by inserting “(i)” after “(C)”; and

12 (2) by adding at the end the following new
 13 clauses:

14 “(ii) not later than January 1, 2027, in-
 15 crease the percentage of essential community
 16 providers as described in clause (i) included in
 17 its network by 10 percent annually (based on
 18 the level in the plan for 2023) until 90 percent
 19 of all federally qualified health centers and 75
 20 percent of all other such essential community
 21 providers in the contract service area are in-net-
 22 work; and

23 “(iii) include at least one essential commu-
 24 nity provider in each of the essential community
 25 provider categories described in section

1 156.235(a)(2)(ii)(B) of title 45, Code of Fed-
 2 eral Regulations (as in effect on the date of en-
 3 actment of the Health Equity and Account-
 4 ability Act of 2026), in each county in the serv-
 5 ice area, where available;”.

6 (b) REPORTING REQUIREMENTS.—Section
 7 1311(e)(3) of the Patient Protection and Affordable Care
 8 Act (42 U.S.C. 18031(e)(3)) is amended by adding at the
 9 end the following new subparagraph:

10 “(E) DATA ON ESSENTIAL COMMUNITY
 11 PROVIDERS.—The Secretary shall require quali-
 12 fied health plans to submit annually to the Sec-
 13 retary data on the percentage of essential com-
 14 munity providers as described in clause (ii) of
 15 subsection (c)(1)(C), by county, that contract
 16 with each qualified health plan offered in that
 17 county and the percentage of such essential
 18 community providers, by category as described
 19 in clause (iii) of such subsection, that contract
 20 with each qualified health plan offered in that
 21 county. Such data shall be made available to
 22 the general public.”.

23 (c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS
 24 APPLIED UNDER MEDICARE AND MEDICAID.—

1 (1) MEDICARE.—Section 1852(d)(1) of the So-
2 cial Security Act (42 U.S.C. 1395w–22(d)(1)) is
3 amended—

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

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

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

10 “(F) the plan meets the requirements of
11 clauses (ii) and (iii) of section 1311(c)(1)(C) of
12 the Patient Protection and Affordable Care Act
13 (relating to inclusion in networks of essential
14 community providers).”.

15 (2) MEDICAID.—Section 1932(b)(5) of the So-
16 cial Security Act (42 U.S.C. 1396u–2(b)(5)) is
17 amended—

18 (A) by striking “, and” at the end of sub-
19 paragraph (A) and inserting a semicolon;

20 (B) by striking the period at the end of
21 subparagraph (B) and inserting “; and”; and

22 (C) by adding at the end the following new
23 subparagraph:

24 “(C) meets the requirements of clauses (ii)
25 and (iii) of section 1311(c)(1)(C) of the Patient

1 Protection and Affordable Care Act (relating to
2 inclusion in networks of essential community
3 providers) with respect to services offered in the
4 service area involved.”.

5 **SEC. 4243. PROVIDER NETWORK ADEQUACY IN COMMU-**
6 **NITIES OF COLOR.**

7 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
8 tient Protection and Affordable Care Act (42 U.S.C.
9 18031(c)(1)(B)), as amended by section 4241(a), is fur-
10 ther amended—

11 (1) by inserting “(i)” after “(B)”; and

12 (2) by adding at the end the following new
13 clauses:

14 “(ii) meet such network adequacy stand-
15 ards as the Secretary may establish with regard
16 to—

17 “(I) appointment wait time;

18 “(II) travel time and distance to
19 health care provider facilities and providers
20 by public and private transit;

21 “(III) hours of operation to accommo-
22 date individuals who cannot come to pro-
23 vider appointments during standard busi-
24 ness hours;

1 “(IV) availability of health care op-
 2 tions for patients; and

3 “(V) other network adequacy stand-
 4 ards to ensure that care through these
 5 plans is accessible to diverse communities,
 6 including individuals with limited English
 7 proficiency as defined in section 3400 of
 8 such Act; and

9 “(iii) provide coverage for services for en-
 10 rollees through out-of-network providers at no
 11 additional cost to the enrollees in cases where
 12 in-network providers are unable to comply with
 13 the standards established under subclause (III)
 14 or (IV) of clause (ii) for such services and the
 15 out-of-network providers can deliver such serv-
 16 ices in compliance with such standards;”.

17 (b) EFFECTIVE DATE.—The amendments made by
 18 subsection (a) shall not apply to plans beginning on or
 19 prior to the date that is 1 year after the date of the enact-
 20 ment of the Health Equity and Accountability Act of
 21 2026.

22 **PART 5—DENTAL**

23 **SEC. 4251. IMPROVING ACCESS TO DENTAL CARE.**

24 (a) REPORTS TO CONGRESS.—

1 (1) GAO REPORTS.—Not later than 1 year
2 after the date of the enactment of this Act, the
3 Comptroller General of the United States shall sub-
4 mit to Congress—

5 (A) a report on the Alaska Dental Health
6 Aide Therapists program and the Dental Ther-
7 apist and Advanced Dental Therapist programs
8 in Minnesota, to assess the effectiveness of den-
9 tal therapists in—

10 (i) improving access to timely dental
11 care among communities of color;

12 (ii) providing high-quality care;

13 (iii) providing culturally competent
14 care; and

15 (iv) providing accessible care to people
16 with disabilities;

17 (B) a report on State variations in the use
18 of dental hygienists and the effectiveness of ex-
19 panding the scope of practice for dental hygien-
20 ists in—

21 (i) improving access to timely dental
22 care among communities of color;

23 (ii) providing high-quality care;

24 (iii) providing culturally competent
25 care; and

1 (iv) providing accessible care to people
2 with disabilities; and

3 (C) a report on the use of telehealth serv-
4 ices to enhance services provided by dental hy-
5 gienists and therapists, including recommenda-
6 tions for any modifications to the Medicare pro-
7 gram under title XVIII of the Social Security
8 Act (42 U.S.C. 1395 et seq.) and the Medicaid
9 program under title XIX of such Act (42
10 U.S.C. 1396 et seq.) to better provide for tele-
11 health consultations in conjunction with thera-
12 pists' and hygienists' care.

13 (2) HRSA REPORT ON DENTAL SHORTAGE
14 AREAS.—Not later than 1 year after the date of the
15 enactment of this Act, the Secretary of Health and
16 Human Services, acting through the Administrator
17 of the Health Resources and Services Administra-
18 tion, shall submit to Congress a report which details
19 geographic dental access shortages and the pre-
20 paredness of dental providers to offer culturally and
21 linguistically appropriate, affordable, accessible, and
22 timely services.

23 (b) EXPANSION OF DENTAL HEALTH AID THERA-
24 PISTS IN TRIBAL AND URBAN INDIAN COMMUNITIES.—

1 Section 119 of the Indian Health Care Improvement Act
2 (25 U.S.C. 1616l) is amended—

3 (1) in subsection (d)—

4 (A) by striking paragraph (2) and insert-
5 ing the following:

6 “(2) REQUIREMENTS; EXCLUSION.—Subject to
7 paragraphs (3) and (4), in establishing a national
8 program under paragraph (1), the Secretary—

9 “(A) shall not reduce the amounts pro-
10 vided for the Community Health Aide Program
11 described in subsections (a) and (b);

12 “(B) shall exclude dental health aide thera-
13 pist services from services covered under that
14 Program; and

15 “(C) shall include urban Indian organiza-
16 tions.”; and

17 (B) in paragraph (3)—

18 (i) in the paragraph heading, by strik-
19 ing “OR TRIBAL ORGANIZATION” and in-
20 serting “, TRIBAL ORGANIZATION, OR
21 URBAN INDIAN ORGANIZATION”; and

22 (ii) in each of subparagraphs (A) and
23 (B), by striking “or tribal organization”
24 and inserting “, tribal organization, or
25 urban Indian organization”; and

1 (2) in subsection (e), by striking “or a tribal or-
 2 ganization” and inserting “a tribal organization, or
 3 an urban Indian organization”.

4 (c) COVERAGE OF DENTAL SERVICES UNDER THE
 5 MEDICARE PROGRAM.—

6 (1) COVERAGE.—Section 1861(s)(2) of the So-
 7 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
 8 ed—

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

11 (B) in subparagraph (KK), by inserting
 12 “and” at the end; and

13 (C) by adding at the end the following new
 14 subparagraph:

15 “(LL) dental and oral health services (as de-
 16 fined in subsection (qqq));”.

17 (2) DENTAL AND ORAL HEALTH SERVICES DE-
 18 FINED.—Section 1861 of the Social Security Act (42
 19 U.S.C. 1395x), as amended by sections 2007(b) and
 20 4221(a), is amended by adding at the end the fol-
 21 lowing new subsection:

22 “Dental and Oral Health Services
 23 “(qqq)(1) The term ‘dental and oral health services’
 24 means services (as defined by the Secretary) that are nec-
 25 essary to prevent disease and promote oral health, restore

1 oral structures to health and function, and treat emer-
2 gency conditions, including—

3 “(A) routine diagnostic and preventive care
4 such as dental cleanings, exams, and x-rays;

5 “(B) basic dental services such as fillings and
6 extractions;

7 “(C) major dental services such as root canals,
8 crowns, and dentures;

9 “(D) emergency dental care; and

10 “(E) other necessary services related to dental
11 and oral health (as defined by the Secretary).

12 “(2) For purposes of paragraph (1), such term shall
13 include mobile and portable oral health services (as de-
14 fined by the Secretary) that—

15 “(A) are provided for the purpose of over-
16 coming mobility, transportation, and access barriers
17 for individuals; and

18 “(B) satisfy the standards and certification re-
19 quirements established under section 1902(a)(82)
20 for the State in which the services are provided.”.

21 (3) PAYMENT AND COINSURANCE.—Section
22 1833(a)(1) of the Social Security Act (42 U.S.C.
23 1395l(a)(1)) is amended—

24 (A) by striking “and” before “(HH)”; and

1 (B) by inserting before the semicolon at
 2 the end the following: “and (II) with respect to
 3 dental and oral health services (as defined in
 4 section 1861(qqq)), the amount paid shall be (i)
 5 in the case of such services that are preventive,
 6 100 percent of the lesser of the actual charge
 7 for the services or the amount determined
 8 under the payment basis determined under sec-
 9 tion 1848, and (ii) in the case of all other such
 10 services, 80 percent of the lesser of the actual
 11 charge for the services or the amount deter-
 12 mined under the payment basis determined
 13 under section 1848”.

14 (4) PAYMENT UNDER PHYSICIAN FEE SCHED-
 15 ULE.—Section 1848(j)(3) of the Social Security Act
 16 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
 17 “, (2)(LL),” after “(including administration of the
 18 health risk assessment)”.

19 (5) DENTURES.—Section 1861(s)(8) of the So-
 20 cial Security Act (42 U.S.C. 1395x(s)(8)) is amend-
 21 ed—

22 (A) by striking “(other than dental)” and
 23 inserting “(including dentures)”; and

24 (B) by striking “internal body”.

1 (6) REPEAL OF GROUND FOR EXCLUSION.—
 2 Section 1862(a) of the Social Security Act (42
 3 U.S.C. 1395y) is amended by striking paragraph
 4 (12).

5 (7) EFFECTIVE DATE.—The amendments made
 6 by this section shall apply to services furnished on
 7 or after January 1, 2028.

8 (d) REQUIRING MEDICAID COVERAGE OF DENTAL
 9 AND ORAL HEALTH SERVICES FOR ADULTS.—

10 (1) IN GENERAL.—

11 (A) MANDATORY COVERAGE.—

12 (i) IN GENERAL.—

13 (I) REQUIREMENT.—Section
 14 1902(a)(10)(A) of the Social Security
 15 Act (42 U.S.C. 1396a(a)(10)(A)) is
 16 amended by inserting “(10),” before
 17 “(13)(B),”.

18 (II) MEDICALLY NEEDY.—

19 (aa) IN GENERAL.—Section
 20 1902(a)(10)(C)(iv) of such Act
 21 (42 U.S.C. 1396a(a)(10)(C)(iv))
 22 is amended by inserting “(10),”
 23 before “(13)(B)”.

24 (bb) RULE OF CONSTRU-
 25 TION.—Nothing in this section or

1 the amendments made by this
2 section shall be construed to limit
3 the access of an individual resid-
4 ing in an institutional setting to
5 dental and oral health services
6 (as such term is defined in sec-
7 tion 1905(mm) of the Social Se-
8 curity Act, as added by para-
9 graph (2)(B)).

10 (III) EFFECTIVE DATE.—The
11 amendments made by subclauses (I)
12 and (II) shall apply with respect to
13 expenditures for medical assistance in
14 calendar quarters beginning on or
15 after January 1, 2028.

16 (ii) BENCHMARK COVERAGE.—Section
17 1937(b)(5) of the Social Security Act (42
18 U.S.C. 1396u–7(b)(5)) is amended by
19 striking the period at the end and inserting
20 “, and beginning January 1, 2028, cov-
21 erage of dental and oral health services (as
22 such term is defined in section
23 1905(mm)).”.

24 (iii) OPTIONAL APPLICATION TO TER-
25 RITORIES.—Section 1902(j) of the Social

1 Security Act (42 U.S.C. 1396a(j)) is
2 amended—

3 (I) by striking “this title, the
4 Secretary” and inserting “this title—

5 “(1) in the case of a State other than the 50
6 States and the District of Columbia, the requirement
7 under subsection (a)(10)(A) to provide the care and
8 services listed in paragraph (10) of section 1905(a)
9 shall be optional; and

10 “(2) the Secretary”; and

11 (II) by striking the second
12 comma after “section 1108(f)”.

13 (B) DEFINITION OF DENTAL AND ORAL
14 HEALTH SERVICES.—Section 1905 of the Social
15 Security Act (42 U.S.C. 1396d), as amended by
16 section 4107(c), is further amended—

17 (i) in subsection (a)(10), by inserting
18 “and dental and oral health services (as
19 defined in subsection (mm))” after “dental
20 services”; and

21 (ii) by adding at the end the following
22 new subsection:

23 “(mm) DENTAL AND ORAL HEALTH SERVICES.—
24 For purposes of subsection (a)(10), the term ‘dental and
25 oral health services’ means dentures and denture services,

1 implants and implant services, and services necessary to
 2 prevent oral disease and promote oral health, restore oral
 3 structures to health and function, reduce oral pain, and
 4 treat emergency oral conditions, that are furnished by a
 5 provider who is legally authorized to furnish such items
 6 and services under State law (or the State regulatory
 7 mechanism provided by State law).”.

8 (C) CONFORMING AMENDMENT.—

9 (i) IN GENERAL.—Section
 10 1905(a)(10) of the Social Security Act (42
 11 U.S.C. 1396d(a)(10)), as amended by
 12 paragraph (2), is further amended by
 13 striking “dental services and”.

14 (ii) EFFECTIVE DATE.—The amend-
 15 ment made by clause (i) shall take effect
 16 on January 1, 2028.

17 (2) STATE OPTION FOR ADDITIONAL DENTAL
 18 AND ORAL HEALTH BENEFITS.—Section
 19 1905(a)(13) of the Social Security Act (42 U.S.C.
 20 1396d(a)(13)) is amended—

21 (A) in subparagraph (B), by striking “;
 22 and” and inserting a semicolon;

23 (B) in subparagraph (C), by striking the
 24 semicolon at the end and inserting “; and”; and

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

3 “(D) at State option, such items and serv-
 4 ices related to dental and oral health services
 5 (as defined in subsection (mm)) that are in ad-
 6 dition to those identified in such subsection
 7 (mm) as the State may specify;”.

8 (3) INCREASED FMAP.—

9 (A) MEDICAID.—Section 1905 of the So-
 10 cial Security Act (42 U.S.C. 1396d), as amend-
 11 ed by paragraphs (1) and (2), is further amend-
 12 ed—

13 (i) in subsection (b), by striking “and
 14 (ll)” and inserting “(ll), and (nn)”;

15 (ii) in subsection (ff), by striking
 16 “and (ii)” and inserting “, (ii), and (nn)”;
 17 and

18 (iii) by adding at the end the fol-
 19 lowing new subsection:

20 “(nn) INCREASED FMAP FOR EXPENDITURES RE-
 21 LATED TO DENTAL AND ORAL HEALTH SERVICES.—

22 “(1) IN GENERAL.—

23 “(A) 50 STATES AND DC.—Notwith-
 24 standing subsection (b), in the case of a State
 25 that is 1 of the 50 States or the District of Co-

1 lumbia, during the 12-quarter period that be-
2 gins on January 1, 2028, the Federal medical
3 assistance percentage shall be equal to 100 per-
4 cent with respect to amounts expended by the
5 State for medical assistance for dental and oral
6 health services authorized under paragraph (10)
7 of subsection (a). In no case may the applica-
8 tion of this subparagraph result in the Federal
9 medical assistance percentage determined for a
10 State with respect to expenditures described in
11 this subparagraph exceeding 100 percent.

12 “(B) TERRITORIES.—

13 “(i) IN GENERAL.—Notwithstanding
14 subsection (b), in the case of a State that
15 is Puerto Rico, the Virgin Islands, Guam,
16 the Northern Mariana Islands, or Amer-
17 ican Samoa, during a period described in
18 clause (ii), the Federal medical assistance
19 percentage shall be equal to 100 percent
20 with respect to amounts expended by the
21 State for medical assistance for any item
22 or service that is included in dental and
23 oral health services authorized under para-
24 graph (10) of subsection (a). In no case
25 may the application of this clause result in

1 the Federal medical assistance percentage
2 determined for a State with respect to ex-
3 penditures described in this clause exceed-
4 ing 100 percent.

5 “(ii) PERIOD DESCRIBED.—A period
6 described in this clause is, with respect to
7 an item or service described in clause (i)
8 and a State described in such clause, the
9 12-quarter period that begins with the first
10 quarter beginning on or after January 1,
11 2028, in which such item or service is first
12 covered under the State plan or under a
13 waiver of such plan.

14 “(2) EXCLUSIONS.—The Federal medical as-
15 sistance percentage specified in paragraph (1) shall
16 not apply to amounts expended for medical assist-
17 ance during any period for—

18 “(A) additional items and services author-
19 ized under paragraph (13)(D) of subsection (a);
20 or

21 “(B) items and services furnished to an in-
22 dividual if, as of the date of enactment of this
23 subsection, medical assistance was available to
24 such individual for such items and services or

1 medicare cost-sharing under the State plan or
 2 a waiver of such plan.”.

3 (B) EXCLUSION OF AMOUNTS ATTRIB-
 4 UTABLE TO INCREASED FMAP FROM TERRI-
 5 TORIAL CAPS.—Section 1108 of the Social Se-
 6 curity Act (42 U.S.C. 1308), as amended by
 7 section 4101, is amended—

8 (i) in subsection (f), in the matter
 9 preceding paragraph (1), by striking “(h),
 10 and (j)” and inserting “(h), (j), and (k)”;
 11 and

12 (ii) by adding at the end the fol-
 13 lowing:

14 “(k) EXCLUSION FROM CAPS OF AMOUNTS ATTRIB-
 15 UTABLE TO INCREASED FMAP FOR COVERAGE OF DEN-
 16 TAL AND ORAL HEALTH SERVICES.—Any additional
 17 amount paid to Puerto Rico, the Virgin Islands, Guam,
 18 the Northern Mariana Islands, and American Samoa for
 19 expenditures for medical assistance that is attributable to
 20 an increase in the Federal medical assistance percentage
 21 applicable to such expenditures under section 1905(nn)
 22 shall not be taken into account for purposes of applying
 23 payment limits under subsections (f) and (g).”.

24 (e) ORAL HEALTH SERVICES AS AN ESSENTIAL
 25 HEALTH BENEFIT.—Section 1302(b) of the Patient Pro-

1 tecton and Affordable Care Act (42 U.S.C. 18022(b)), as
2 amended by section 2013(a), is further amended—

3 (1) in paragraph (1)—

4 (A) in subparagraph (J), by striking “oral
5 and”; and

6 (B) by adding at the end the following:

7 “(L) Oral health services for children and
8 adults.”; and

9 (2) by adding at the end the following:

10 “(6) ORAL HEALTH SERVICES.—For purposes
11 of paragraph (1)(L), the term ‘oral health services’
12 means services (as defined by the Secretary) that
13 are necessary to prevent any oral disease and pro-
14 mote oral health, restore oral structures to health
15 and function, and treat emergency oral conditions.”.

16 (f) DEMONSTRATION PROGRAM ON TRAINING AND
17 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
18 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
19 VETERANS IN RURAL AND OTHER UNDERSERVED COM-
20 MUNITIES.—

21 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

22 The Secretary of Veterans Affairs may carry out a
23 demonstration program to establish programs to
24 train and employ alternative dental health care pro-
25 viders in order to increase access to dental health

1 care services for veterans who are entitled to such
2 services from the Department of Veterans Affairs
3 and reside in rural and other underserved commu-
4 nities.

5 (2) TELEHEALTH.—For purposes of alternative
6 dental health care providers and other dental care
7 providers who are licensed to provide clinical care,
8 dental services provided under the demonstration
9 program under this subsection may be administered
10 by such providers through telehealth-enabled collabo-
11 ration and supervision when appropriate and fea-
12 sible.

13 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
14 VIDERS DEFINED.—In this subsection, the term “al-
15 ternative dental health care providers” has the
16 meaning given that term in section 340G–1(a)(2) of
17 the Public Health Service Act (42 U.S.C. 256g–
18 1(a)(2)).

19 (4) AUTHORIZATION OF APPROPRIATIONS.—
20 There are authorized to be appropriated such sums
21 as are necessary to carry out the demonstration pro-
22 gram under this subsection.

23 (g) DEMONSTRATION PROGRAM ON TRAINING AND
24 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
25 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR

1 MEMBERS OF THE ARMED FORCES AND DEPENDENTS
2 LACKING READY ACCESS TO SUCH SERVICES.—

3 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

4 The Secretary of Defense may carry out a dem-
5 onstration program to establish programs to train
6 and employ alternative dental health care providers
7 in order to increase access to dental health care
8 services for members of the Armed Forces and their
9 dependents who lack ready access to such services,
10 including the following individuals:

11 (A) Members and dependents who reside in
12 rural areas or areas otherwise underserved by
13 dental health care providers.

14 (B) Members of a reserve component of
15 the Armed Forces in active status who are po-
16 tentially deployable.

17 (2) TELEHEALTH.—For purposes of alternative
18 dental health care providers and other dental care
19 providers who are licensed to provide clinical care,
20 dental services provided under the demonstration
21 program under this subsection may be administered
22 by such providers through telehealth-enabled collabo-
23 ration and supervision when appropriate and fea-
24 sible.

25 (3) DEFINITIONS.—In this subsection:

1 (A) ACTIVE STATUS.—The term “active
2 status” has the meaning given that term in sec-
3 tion 101(d) of title 10, United States Code.

4 (B) ALTERNATIVE DENTAL HEALTH CARE
5 PROVIDERS.—The term “alternative dental
6 health care providers” has the meaning given
7 that term in section 340G–1(a)(2) of the Public
8 Health Service Act (42 U.S.C. 256g–1(a)(2)).

9 (4) AUTHORIZATION OF APPROPRIATIONS.—
10 There are authorized to be appropriated such sums
11 as are necessary to carry out the demonstration pro-
12 gram under this subsection.

13 (h) DEMONSTRATION PROGRAM ON TRAINING AND
14 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
15 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
16 PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF
17 PRISONS.—

18 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
19 The Attorney General, acting through the Director
20 of the Bureau of Prisons, may carry out a dem-
21 onstration program to establish programs to train
22 and employ alternative dental health care providers
23 in order to increase access to dental health services
24 for prisoners within the custody of the Bureau of
25 Prisons.

1 (2) TELEHEALTH.—For purposes of alternative
 2 dental health care providers and other dental care
 3 providers who are licensed to provide clinical care,
 4 dental services provided under the demonstration
 5 program under this subsection may be administered
 6 by such providers through telehealth-enabled collabo-
 7 ration and supervision when appropriate and fea-
 8 sible.

9 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
 10 VIDERS DEFINED.—In this subsection, the term “al-
 11 ternative dental health care providers” has the
 12 meaning given that term in section 340G–1(a)(2) of
 13 the Public Health Service Act (42 U.S.C. 256g–
 14 1(a)(2)).

15 (4) AUTHORIZATION OF APPROPRIATIONS.—
 16 There are authorized to be appropriated such sums
 17 as are necessary to carry out the demonstration pro-
 18 gram under this subsection.

19 (i) DEMONSTRATION PROGRAM ON TRAINING AND
 20 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
 21 PROVIDERS FOR DENTAL HEALTH CARE SERVICES
 22 UNDER THE INDIAN HEALTH SERVICE.—

23 (1) DEFINITIONS.—In this subsection:

24 (A) ALTERNATIVE DENTAL HEALTH CARE
 25 PROVIDERS DEFINED.—The term “alternative

1 dental health care providers” has the meaning
2 given the term in section 340G–1(a)(2) of the
3 Public Health Service Act (42 U.S.C. 256g–
4 1(a)(2)).

5 (B) INDIAN HEALTH CARE IMPROVEMENT
6 ACT TERMS.—The terms “Indian tribe”, “tribal
7 organization”, and “Urban Indian organiza-
8 tion” have the meaning given those terms in
9 section 4 of the Indian Health Care Improve-
10 ment Act (25 U.S.C. 1603).

11 (2) DEMONSTRATION PROGRAM AUTHORIZED.—

12 The Secretary of Health and Human Services, act-
13 ing through the Indian Health Service, may carry
14 out a demonstration program to establish programs
15 to train and employ alternative dental health care
16 providers in order to help eliminate oral health dis-
17 parities and increase access to dental services
18 through health programs operated by the Indian
19 Health Service, Indian tribes, tribal organizations,
20 and Urban Indian organizations.

21 (3) TELEHEALTH.—For purposes of alternative
22 dental health care providers and other dental care
23 providers who are licensed to provide clinical care,
24 dental services provided under the demonstration
25 program under this subsection may be administered

1 by such providers through telehealth-enabled collabo-
 2 ration and supervision when appropriate and fea-
 3 sible.

4 (4) AUTHORIZATION OF APPROPRIATIONS.—

5 There are authorized to be appropriated such sums
 6 as are necessary to carry out the demonstration pro-
 7 gram under this subsection.

8 **SEC. 4252. ORAL HEALTH LITERACY AND AWARENESS CAM-**
 9 **PAIGN.**

10 The Public Health Service Act is amended by insert-
 11 ing after section 340G–1 of such Act (42 U.S.C. 256g–
 12 1) the following:

13 **“SEC. 340G–2. ORAL HEALTH LITERACY AND AWARENESS.**

14 “(a) CAMPAIGN.—The Secretary, acting through the
 15 Administrator of the Health Resources and Services Ad-
 16 ministration, shall establish a public education campaign
 17 (referred to in this subsection as the ‘campaign’) across
 18 all relevant programs of the Health Resources and Serv-
 19 ices Administration (including the health center program,
 20 oral health workforce programs, maternal and child health
 21 programs, the Ryan White HIV/AIDS Program, and rural
 22 health programs) to increase oral health literacy and
 23 awareness.

24 “(b) STRATEGIES.—In carrying out the campaign,
 25 the Secretary shall identify oral health literacy and aware-

1 ness strategies that are evidence based and focused on oral
2 health care education, including education on prevention
3 of oral disease such as early childhood and other caries,
4 periodontal disease, and oral cancer.

5 “(c) FOCUS.—The Secretary shall design the cam-
6 paign to communicate directly with specific populations,
7 including children, pregnant women, parents, the elderly,
8 individuals with disabilities, and ethnic and racial minority
9 populations, including Indians, Alaska Natives, and Na-
10 tive Hawaiians, in a culturally and linguistically appro-
11 priate manner.

12 “(d) OUTCOMES.—In carrying out the campaign, the
13 Secretary shall include a process for measuring outcomes
14 and effectiveness.

15 “(e) REPORT TO CONGRESS.—Not later than 3 years
16 after the date of enactment of this section, the Secretary
17 shall submit to the Committee on Energy and Commerce
18 of the House of Representatives and the Committee on
19 Health, Education, Labor, and Pensions of the Senate a
20 report on the outcomes and effectiveness of the campaign.

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this section, there is authorized to be appro-
23 priated \$750,000 for each of fiscal years 2027 through
24 2031.”.

1 **SEC. 4253. ENSURING KIDS HAVE ACCESS TO MEDICALLY**
2 **NECESSARY DENTAL CARE ACT.**

3 (a) PROHIBITION OF LIFETIME OR ANNUAL LIMITS
4 ON DENTAL BENEFITS UNDER THE CHILDREN'S
5 HEALTH INSURANCE PROGRAM.—

6 (1) IN GENERAL.—Section 2103(c)(6) of the
7 Social Security Act (42 U.S.C. 1397cc(c)(6)) is
8 amended—

9 (A) in subparagraph (A), by inserting “,
10 subject to subparagraph (D),” after “shall in-
11 clude”;

12 (B) in subparagraph (B), by striking “A
13 State” and inserting “Subject to subparagraph
14 (D), a State”; and

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

17 “(D) NO LIFETIME OR ANNUAL LIMITS ON
18 DENTAL BENEFITS.—A State shall not establish
19 lifetime or annual limits on the dollar value of
20 benefits for dental services provided under the
21 State child health plan to a targeted low-income
22 child, and, in the case that the State elects to
23 provide pregnancy-related assistance pursuant
24 to section 2112, to a targeted low-income preg-
25 nant woman (as defined in section 2112(d)), in-
26 cluding benefits for such services that are pro-

1 vided through dental coverage that is otherwise
 2 equivalent to a benchmark dental package de-
 3 scribed in subparagraph (C).”.

4 (2) EFFECTIVE DATE.—The amendments made
 5 by this subsection shall take effect on the date that
 6 is 6 months after the date of enactment of this Act.

7 (b) REQUIRING WRAPAROUND COVERAGE OF DEN-
 8 TAL SERVICES FOR CERTAIN CHILDREN UNDER CHIP.—

9 (1) IN GENERAL.—Section 2110(b)(5) of the
 10 Social Security Act (42 U.S.C. 1397jj(b)(5)) is
 11 amended—

12 (A) in the paragraph header, by striking
 13 “OPTION” and inserting “REQUIREMENT”;

14 (B) in subparagraph (A), by striking “may
 15 waive” and inserting “shall waive”; and

16 (C) in subparagraph (C), to read as fol-
 17 lows:

18 “(C) REQUIREMENT.—A State child health
 19 plan may not provide more favorable dental cov-
 20 erage or cost-sharing protection for dental cov-
 21 erage to children provided dental-only supple-
 22 mental coverage under this paragraph than the
 23 dental coverage and cost-sharing protection for
 24 dental coverage provided to targeted low-income
 25 children who are eligible for the full range of

1 child health assistance provided under the State
2 child health plan.”.

3 (2) EFFECTIVE DATE.—The amendments made
4 by this subsection shall take effect on the date that
5 is 6 months after the date of enactment of this Act.

6 **Subtitle D—Advancing Health Eq-**
7 **uity Through Payment and De-**
8 **livery Reform**

9 **SEC. 4301. CENTERS FOR MEDICARE & MEDICAID SERVICES**
10 **REPORTING AND VALUE-BASED PROGRAMS.**

11 (a) ADVANCING HEALTH EQUITY IN REPORTING AND
12 VALUE-BASED PAYMENT PROGRAMS.—

13 (1) IN GENERAL.—The Administrator of the
14 Centers for Medicare & Medicaid Services (in this
15 section referred to as the “Administrator”) shall re-
16 quire that a clinician or other professional partici-
17 pating in any pay-for-reporting or value-based pay-
18 ment program stratify clinical quality measures by
19 disparity variables, including race, ethnicity, sex, pri-
20 mary language, disability status, sexual orientation,
21 gender identity, and socioeconomic status.

22 (2) USE OF EXISTING DEMOGRAPHIC DATA
23 COLLECTION FIELDS.—A clinician or other profes-
24 sional described in paragraph (1) may use existing
25 demographic data collection fields in certified EHR

1 technology (as defined in section 1848(o)(4) of the
2 Social Security Act (42 U.S.C. 1395w-4(o)(4))) to
3 carry out such data stratification under such para-
4 graph. Such stratified data will assist clinicians and
5 other professionals in the identification of disparities
6 obscured in aggregated data and assist with the pro-
7 vision of interventions that target reducing those
8 disparities.

9 (3) CLINICIAN.—In assessing performance in
10 any value-based payment program, the Adminis-
11 trator shall incorporate a clinician or other profes-
12 sional's performance in reducing disparities across
13 race, ethnicity, sex, primary language, disability sta-
14 tus, sexual orientation, gender identity, and socio-
15 economic status. Linking performance payments to
16 the reduction of health care disparities across such
17 variables will assist in holding clinicians and other
18 professionals accountable for providing quality care
19 that can lead to decreased health inequities.

20 (4) REQUIREMENT OF ADOPTION OF CERT.—All
21 entities, clinicians, or other professionals partici-
22 pating in the Quality Payment Program of the Cen-
23 ters for Medicare & Medicaid Services shall be re-
24 quired to adopt certified EHR technology (as so de-

1 fined) as a condition of participating in such pro-
2 gram.

3 (b) QUALITY IMPROVEMENT ACTIVITIES.—The Ad-
4 ministrator, upon yearly review of the Quality Payment
5 Program, shall add quality improvement activities that im-
6 plement the Culturally and Linguistically Accessible
7 Standards (CLAS) as Improvement Activities under the
8 Quality Payment Program.

9 **SEC. 4302. DEVELOPMENT AND TESTING OF DISPARITY RE-**
10 **DUCING DELIVERY AND PAYMENT MODELS.**

11 (a) IN GENERAL.—The Center for Medicare and
12 Medicaid Innovation established under section 1115A of
13 the Social Security Act (42 U.S.C. 1315a) (in this section
14 referred to as the “CMI”) shall establish a dedicated fund
15 to identify, test, evaluate, and scale delivery and payment
16 models under the applicable titles (as defined in subsection
17 (a)(4)(B) of such section) that target health disparities
18 among racial and ethnic minorities, including models that
19 support high-value nonmedical services that address so-
20 cially determined barriers to health in all stages of the
21 life cycle through end-of-life, including English proficiency
22 status, low health and health care literacy, lack of access
23 to health care planning, including end-of-life care plan-
24 ning, case management, transportation, enrollment assist-
25 ance needs, stable and affordable housing, utility assist-

1 ance, employment and career development, and nutrition
 2 and food security which will help to reduce disparities and
 3 impact the overall cost of care.

4 (b) AMENDMENT TO SOCIAL SECURITY ACT.—The
 5 second sentence of section 1115A(a)(1) of the Social Secu-
 6 rity Act (42 U.S.C. 1315a(a)(1)) is amended by inserting
 7 “and improve health equity” after “expenditures”.

8 (c) PILOT PROGRAMS.—The CMI shall prioritize the
 9 testing of models under such section 1115A that include
 10 partnerships with entities, including community-based or-
 11 ganizations or other nonprofit entities, to help address so-
 12 cially determined barriers to health and health care.

13 (d) ALTERNATIVES.—Any model tested by the CMI
 14 under such 1115A shall include measures to assess and
 15 track the impact of the model on health disparities, using
 16 existing measures such as the Healthcare Disparities and
 17 Cultural Competency Measures endorsed by the entity
 18 with a contract under section 1890(a) of the Social Secu-
 19 rity Act (42 U.S.C. 1395aaa(a)), and stratified by race,
 20 ethnicity, English proficiency, gender identity, sexual ori-
 21 entation, and disability status.

22 **SEC. 4303. DIVERSITY IN CENTERS FOR MEDICARE AND**
 23 **MEDICAID CONSULTATION.**

24 (a) IN GENERAL.—In carrying out the duties under
 25 this subtitle, the Center for Medicare and Medicaid Inno-

1 vation established under section 1115A of the Social Secu-
 2 rity Act (42 U.S.C. 1315a) (in this section referred to as
 3 the “CMI”) shall consult clinical and analytical experts
 4 with expertise in medicine and health care management,
 5 specifically such experts with expertise in—

6 (1) the health care needs of minority, rural, and
 7 underserved populations; and

8 (2) the financial needs of safety net, commu-
 9 nity-based, rural, and critical access providers, in-
 10 cluding federally qualified health centers.

11 (b) OPEN DOOR FORUMS.—The CMI shall use open
 12 door forums or other mechanisms to seek external feed-
 13 back from interested parties and incorporate that feedback
 14 into the development of models.

15 **SEC. 4304. SUPPORTING SAFETY NET AND COMMUNITY-**
 16 **BASED PROVIDERS TO COMPETE IN VALUE-**
 17 **BASED PAYMENT SYSTEMS.**

18 (a) IN GENERAL.—Any pay-for-performance or alter-
 19 native payment model that is developed and tested by the
 20 Center for Medicare and Medicaid Innovation established
 21 under section 1115A of the Social Security Act (42 U.S.C.
 22 1315a), or any other agency of the Department of Health
 23 and Human Services with respect to the programs under
 24 titles XVIII, XIX, or XXI of such Act, shall be assessed
 25 for potential impact on safety net, community-based, and

1 critical access providers, including Federally qualified
 2 health centers.

3 (b) NEW MODELS.—The rollout of any such models
 4 shall include training and additional up front resources for
 5 community-based and safety net providers to enable those
 6 providers to participate in the model.

7 **SEC. 4305. IMPROVING ACCESS TO CARE FOR MEDICARE**
 8 **AND MEDICAID BENEFICIARIES.**

9 Section 1115A of the Social Security Act (42 U.S.C.
 10 1315a) is amended—

11 (1) in subsection (a)—

12 (A) in the last sentence of paragraph (1),
 13 by inserting “advance health equity and” before
 14 “improve the coordination”; and

15 (B) in the first sentence of paragraph
 16 (3)—

17 (i) by inserting “(including the Office
 18 of Minority Health of the Centers for
 19 Medicare & Medicaid Services, the Office
 20 of Rural Health Policy of the Health Re-
 21 sources and Services Administration, and
 22 the Office on Women’s Health of the De-
 23 partment of Health and Human Services)”
 24 after “relevant Federal agencies”; and

1 (ii) by striking “experts with expertise
2 in medicine” and inserting “experts with
3 expertise in medicine, the causes of health
4 disparities and the social determinants of
5 health, and”;

6 (2) in subsection (b)—

7 (A) in paragraph (2)—

8 (i) in subparagraph (A)—

9 (I) by inserting the following
10 after the first sentence: “Prior to se-
11 lecting a model under this paragraph,
12 the Secretary shall consult with the
13 Office of Minority Health of the Cen-
14 ters for Medicare & Medicaid Services,
15 the Office of Rural Health Policy of
16 the Health Resources and Services
17 Administration, and the Office on
18 Women’s Health of the Department of
19 Health and Human Services to ensure
20 that models under consideration ad-
21 dress health disparities and social de-
22 terminants of health as appropriate
23 for populations to be cared for under
24 the model.”;

1 (II) by inserting “and, for models
2 for which testing begins on or after
3 January 1, 2027, address health eq-
4 uity as well as improving access to
5 care received by individuals receiving
6 benefits under such title” after “appli-
7 cable title”; and

8 (III) by adding at the end the
9 following: “The models selected under
10 this subparagraph shall include the
11 social determinants of health payment
12 model described in subsection (h), the
13 testing of which shall begin not later
14 than December 31, 2027.”; and

15 (ii) in subparagraph (C), by adding at
16 the end the following new clauses:

17 “(ix) Whether the model will affect
18 access to care from providers and suppliers
19 caring for high risk patients or operating
20 in underserved areas.

21 “(x) Whether the model has the po-
22 tential to reduce health disparities, includ-
23 ing minority and rural health disparities.”;
24 (B) in paragraph (3)(B)—

1 (i) in clause (i), by inserting “or
2 health equity” after “quality of care”;

3 (ii) in clause (ii), by inserting “or in-
4 creasing health inequities” after “quality
5 of care”; and

6 (iii) in clause (iii), by inserting “or
7 health equity” after “quality of care”; and
8 (C) in paragraph (4)(A)—

9 (i) in clause (i), by striking “; and”
10 and inserting a semicolon;

11 (ii) in clause (ii), by striking the pe-
12 riod and inserting “; and”; and

13 (iii) by adding at the end the fol-
14 lowing new clause:

15 “(iii) for models for which testing be-
16 gins on or after January 1, 2027, the ex-
17 tent to which the model improves health
18 equity.”;

19 (3) in subsection (c)—

20 (A) in paragraph (1)—

21 (i) in subparagraph (A), by inserting
22 “or, beginning on or after January 1,
23 2027, increasing health inequities” before
24 the semicolon; and

1 (ii) in subparagraph (B), by inserting
2 “or, beginning on or after January 1,
3 2027, health equity” after “patient care”;
4 and

5 (B) in paragraph (3), by inserting “or in-
6 crease health disparities experienced by bene-
7 ficiaries, including low-income, minority, or
8 rural beneficiaries, or that such expansion
9 would improve health equity” before the period;
10 (4) in subsection (g), by adding at the end the
11 following: “For reports submitted after the date of
12 enactment of the Health Equity and Accountability
13 Act of 2026, each such report shall include informa-
14 tion on the following:

15 “(1) The interventions that address social de-
16 terminants of health, health disparities, or health eq-
17 uity in payment models selected by the CMI for test-
18 ing under this section.

19 “(2) Estimated Federal savings achieved
20 through reducing disparities, including rural and mi-
21 nority health disparities, improving health equity, or
22 addressing social determinants of health.

23 “(3) The effectiveness of interventions in miti-
24 gating negative health outcomes and higher costs as-
25 sociated with social determinants of health within

1 models selected by the Center for Medicare and
2 Medicaid Innovation for testing.

3 “(4) Other areas determined appropriate by the
4 Secretary.”; and

5 (5) by adding at the end the following new sub-
6 section:

7 “(h) SOCIAL DETERMINANTS OF HEALTH PAYMENT
8 MODEL.—

9 “(1) IN GENERAL.—The social determinants of
10 health payment model described in this subsection is
11 a payment model that tests each of the payment and
12 service delivery innovations described in paragraph
13 (2) in a region determined appropriate by the Sec-
14 retary.

15 “(2) PAYMENT AND SERVICE DELIVERY INNO-
16 VATIONS DESCRIBED.—For purposes of paragraph
17 (1), the payment and service delivery innovations de-
18 scribed in this clause are the following:

19 “(A) Payment and service delivery innova-
20 tions for behavioral health services, focusing on
21 gathering actionable data to address the higher
22 costs associated with beneficiaries with diag-
23 nosed behavioral conditions.

24 “(B) Payment and service delivery innova-
25 tions targeting conditions or comorbidities of

1 individuals entitled or enrolled under the Medi-
 2 care program under title XVIII and enrolled
 3 under a State plan under the Medicaid program
 4 under title XIX to increase capacity in under-
 5 served areas.

6 “(C) Payment and service delivery innova-
 7 tions targeting conditions or comorbidities of
 8 applicable individuals to increase capacity in
 9 underserved areas.

10 “(D) Payment and service delivery innova-
 11 tions targeted on Medicaid eligible pregnant
 12 and postpartum women, up to 1 year after de-
 13 livery.”.

14 **Subtitle E—Health Empowerment** 15 **Zones**

16 **SEC. 4401. DESIGNATION OF HEALTH EMPOWERMENT** 17 **ZONES.**

18 (a) IN GENERAL.—The Secretary may, at the request
 19 of an eligible community partnership described in sub-
 20 section (b)(1), designate an eligible area described in sub-
 21 section (b)(2) as a health empowerment zone for the pur-
 22 pose of eligibility for a grant under section 4402.

23 (b) ELIGIBILITY CRITERIA.—

1 (1) ELIGIBLE COMMUNITY PARTNERSHIP.—A
2 community partnership is eligible to submit a re-
3 quest under this section if the partnership—

4 (A) demonstrates widespread public sup-
5 port from key individuals and entities in the eli-
6 gible area, including members of the target
7 community, State and local governments, non-
8 profit organizations including national and re-
9 gional intermediaries with demonstrated capac-
10 ity to serve low-income urban communities, and
11 community and industry leaders, for designa-
12 tion of the eligible area as a health empower-
13 ment zone; and

14 (B) includes representatives of—

15 (i) a broad cross-section of stake-
16 holders and residents from communities in
17 the eligible area experiencing dispropor-
18 tionate disparities in health status and
19 health care; and

20 (ii) organizations, facilities, and insti-
21 tutions that have a history of working
22 within and serving such communities.

23 (2) ELIGIBLE AREA.—An area is eligible to be
24 designated as a health empowerment zone under this
25 section if one or more communities in the area expe-

1 rience disproportionate disparities in health status
2 and health care. In determining whether a commu-
3 nity experiences such disparities, the Secretary shall
4 consider data collected by the Department of Health
5 and Human Services focusing on the following areas:

6 (A) Access to affordable, high-quality
7 health care services.

8 (B) The prevalence of disproportionate
9 rates of certain illnesses or diseases including
10 the following:

11 (i) Arthritis, osteoporosis, chronic
12 back conditions, and other musculoskeletal
13 diseases.

14 (ii) Cancer.

15 (iii) Chronic kidney disease.

16 (iv) Diabetes.

17 (v) Injury (intentional and uninten-
18 tional).

19 (vi) Violence (intimate and non-
20 intimate).

21 (vii) Maternal and paternal illnesses
22 and diseases.

23 (viii) Infant mortality.

24 (ix) Mental illness and other disabil-
25 ities.

1 (x) Substance use disorder treatment
2 and prevention, including underage drink-
3 ing.

4 (xi) Nutrition, obesity, and overweight
5 conditions.

6 (xii) Heart disease.

7 (xiii) Hypertension.

8 (xiv) Cerebrovascular disease or
9 stroke.

10 (xv) Tuberculosis.

11 (xvi) HIV/AIDS and other sexually
12 transmitted infections.

13 (xvii) Viral hepatitis.

14 (xviii) Asthma.

15 (xix) Tooth decay and other oral
16 health issues.

17 (C) Within the community, the historical
18 and persistent presence of conditions that have
19 been found to contribute to health disparities
20 including any such conditions respecting any of
21 the following:

22 (i) Poverty.

23 (ii) Educational status and the quality
24 of community schools.

25 (iii) Income.

1 (iv) Access to high-quality affordable
2 health care.

3 (v) Work and work environment.

4 (vi) Environmental conditions in the
5 community, including with respect to clean
6 water, clean air, and the presence or ab-
7 sence of pollutants.

8 (vii) Language and English pro-
9 ficiency.

10 (viii) Access to affordable healthy
11 food.

12 (ix) Access to ethnically and culturally
13 diverse health and human service providers
14 and practitioners.

15 (x) Access to culturally and linguis-
16 tically competent health and human serv-
17 ices and health and human service pro-
18 viders.

19 (xi) Health-supporting infrastructure.

20 (xii) Health insurance that is ade-
21 quate and affordable.

22 (xiii) Race, racism, and bigotry (con-
23 scious and unconscious).

24 (xiv) Sexual orientation.

25 (xv) Health and health care literacy.

1 (xvi) Place of residence (such as
2 urban areas, rural areas, and reservations
3 of Indian Tribes).

4 (xvii) Stress.

5 (c) PROCEDURE.—

6 (1) REQUEST.—A request under subsection (a)
7 shall—

8 (A) describe the bounds of the area to be
9 designated as a health empowerment zone and
10 the process used to select those bounds;

11 (B) demonstrate that the partnership sub-
12 mitting the request is an eligible community
13 partnership described in subsection (b)(1);

14 (C) demonstrate that the area is an eligible
15 area described in subsection (b)(2);

16 (D) include a comprehensive assessment of
17 disparities in health status and health care ex-
18 perience by one or more communities in the
19 area;

20 (E) set forth—

21 (i) a vision and a set of values for the
22 area; and

23 (ii) a comprehensive and holistic set of
24 goals to be achieved in the area through

1 designation as a health empowerment zone;

2 and

3 (F) include a strategic plan and an action
4 plan for achieving the goals described in sub-
5 paragraph (E)(ii).

6 (2) APPROVAL.—Not later than 60 days after
7 the receipt of a request for designation of an area
8 as a health empowerment zone under this section,
9 the Secretary shall approve or disapprove the re-
10 quest.

11 (d) MINIMUM NUMBER.—The Secretary—

12 (1) shall designate not more than 110 health
13 empowerment zones under this section; and

14 (2) of such zones designated under paragraph
15 (1), shall designate at least one health empowerment
16 zone in each of the several States, the District of
17 Columbia, and each territory or possession of the
18 United States.

19 **SEC. 4402. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

20 At the request of any organization or entity seeking
21 to submit a request under section 4401(a), the Secretary
22 shall provide technical assistance, and may award a grant,
23 to assist such organization or entity—

24 (1) to form an eligible community partnership
25 described in section 4401(b)(1);

1 (2) to complete a health assessment, including
2 an assessment of health disparities under section
3 4401(c)(1)(D); or

4 (3) to prepare and submit a request, including
5 a strategic plan, in accordance with section 4401.

6 **SEC. 4403. BENEFITS OF DESIGNATION.**

7 (a) **PRIORITY.**—In awarding a grant under sub-
8 section (b), the Secretary shall give priority to any appli-
9 cant that—

10 (1) meets the eligibility criteria for the grant;

11 (2) proposes to use the grant for activities in a
12 health empowerment zone; and

13 (3) demonstrates that such activities will di-
14 rectly and significantly further the goals of the stra-
15 tegic plan approved for such zone under section
16 4401.

17 (b) **GRANTS FOR INITIAL IMPLEMENTATION OF**
18 **STRATEGIC PLAN.**—

19 (1) **IN GENERAL.**—Upon designating an eligible
20 area as a health empowerment zone at the request
21 of an eligible community partnership, the Secretary
22 shall, subject to the availability of appropriations,
23 make a grant to the community partnership for im-
24 plementation of the strategic plan for such zone.

1 (2) GRANT PERIOD.—A grant under paragraph
 2 (1) for a health empowerment zone shall be for a pe-
 3 riod of 2 years and may be renewed, except that the
 4 total period of grants under paragraph (1) for such
 5 zone may not exceed 10 years.

6 (3) LIMITATION.—In awarding grants under
 7 this subsection, the Secretary shall not give less pri-
 8 ority to an applicant or reduce the amount of a
 9 grant because the Secretary rendered technical as-
 10 sistance or made a grant to the same applicant
 11 under section 4401.

12 (4) REPORTING.—The Secretary shall establish
 13 metrics for measuring the progress of grantees
 14 under this subsection and, based on such metrics,
 15 require each such grantee to report to the Secretary
 16 not less than every 6 months on the progress in im-
 17 plementing the strategic plan for the health em-
 18 powerment zone.

19 **SEC. 4404. DEFINITION OF SECRETARY.**

20 In this subtitle, the term “Secretary” means the Sec-
 21 retary of Health and Human Services, acting through the
 22 Administrator of the Health Resources and Services Ad-
 23 ministration and the Deputy Assistant Secretary for Mi-
 24 nority Health, and in cooperation with the Director of the
 25 Office of Community Services and the Director of the Na-

1 tional Institute on Minority Health and Health Dispari-
2 ties.

3 **SEC. 4405. AUTHORIZATION OF APPROPRIATIONS.**

4 To carry out this subtitle, there is authorized to be
5 appropriated \$100,000,000 for fiscal year 2027.

6 **Subtitle F—Equitable Health Care**
7 **for All**

8 **SEC. 4501. DATA COLLECTION AND REPORTING.**

9 (a) REQUIRED REPORTING.—

10 (1) IN GENERAL.—The Secretary of Health and
11 Human Services, in consultation with the Director
12 for Civil Rights and Health Equity, the Director of
13 the National Institutes of Health, the Administrator
14 of the Centers for Medicare & Medicaid Services, the
15 Director of the Agency for Healthcare Research and
16 Quality, the Deputy Assistant Secretary for Minority
17 Health, and the Director of the Centers for Disease
18 Control and Prevention, shall by regulation require
19 all health care providers and facilities that are re-
20 quired under other provisions of law to report data
21 on specific health outcomes to the Department of
22 Health and Human Services in aggregate form, to
23 disaggregate such data by demographic characteris-
24 tics, including by race, national origin, sex (including
25 sexual orientation and gender identity), disability,

1 and age, as well as any other factor that the Sec-
 2 retary of Health and Human Services determines
 3 would be useful for determining a pattern of provi-
 4 sion of inequitable health care.

5 (2) PROPOSED REGULATIONS.—Not later than
 6 90 days after the date of enactment of this Act, the
 7 Secretary of Health and Human Services shall issue
 8 proposed regulations to carry out paragraph (1).

9 (b) REPOSITORY.—The Secretary of Health and
 10 Human Services shall—

11 (1) not later than 1 year after the date of en-
 12 actment of this Act, establish a repository of the
 13 disaggregated data reported pursuant to subsection
 14 (a);

15 (2) subject to paragraph (3), make the data in
 16 such repository publicly available; and

17 (3) ensure that such repository does not contain
 18 any data that is individually identifiable.

19 **SEC. 4502. REQUIRING EQUITABLE HEALTH CARE IN THE**
 20 **HOSPITAL VALUE-BASED PURCHASING PRO-**
 21 **GRAM.**

22 (a) EQUITABLE HEALTH CARE AS VALUE MEASURE-
 23 MENT.—Section 1886(b)(3)(B)(viii) of the Social Security
 24 Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended by
 25 adding at the end the following new subclause:

1 “(XIII)(aa) Effective for payments beginning with
2 fiscal year 2027, in expanding the number of measures
3 under subclause (III), the Secretary shall adopt measures
4 that relate to equitable health care furnished by hospitals
5 in inpatient settings.

6 “(bb) In carrying out this subclause, the Secretary
7 shall solicit input and recommendations from individuals
8 and groups representing communities of color and other
9 protected classes and ensure measures adopted pursuant
10 to this subclause account for social determinants of health,
11 as defined in section 4505(e)(10) of the Health Equity
12 and Accountability Act of 2026.

13 “(cc) For purposes of this subclause, the term ‘equi-
14 table health care’ refers to the principle that high-quality
15 care should be provided to all individuals and health care
16 treatment and services should not vary on account of the
17 real or perceived race, national origin, sex (including sex-
18 ual orientation and gender identity), disability, or age of
19 an individual, as well as any other factor that the Sec-
20 retary determines would be useful for determining a pat-
21 tern of provision of inequitable health care.”.

22 (b) INCLUSION OF EQUITABLE HEALTH CARE MEAS-
23 URES.—Section 1886(o)(2)(B) of the Social Security Act
24 (42 U.S.C. 1395ww(o)(2)(B)) is amended by adding at the
25 end the following new clause:

1 “(iv) INCLUSION OF EQUITABLE
 2 HEALTH CARE MEASURES.—Beginning in
 3 fiscal year 2027, measures selected under
 4 subparagraph (A) shall include the equi-
 5 table health care measures described in
 6 subsection (b)(3)(B)(viii)(XIII).”.

7 **SEC. 4503. PROVISION OF INEQUITABLE HEALTH CARE AS A**
 8 **BASIS FOR PERMISSIVE EXCLUSION FROM**
 9 **MEDICARE AND STATE HEALTH CARE PRO-**
 10 **GRAMS.**

11 Section 1128(b) of the Social Security Act (42 U.S.C.
 12 1320a–7(b)) is amended by adding at the end the fol-
 13 lowing new paragraph:

14 “(18) PROVISION OF INEQUITABLE HEALTH
 15 CARE.—

16 “(A) IN GENERAL.—Subject to subpara-
 17 graph (B), any health care provider that the
 18 Secretary determines has engaged in a pattern
 19 of providing inequitable health care (as defined
 20 in section 4505(e)(7) of the Health Equity and
 21 Accountability Act of 2026) on the basis of
 22 race, national origin, sex (including sexual ori-
 23 entation and gender identity), disability, or age
 24 of an individual.

1 “(B) EXCEPTION.—For purposes of car-
2 rying out subparagraph (A), the Secretary shall
3 not exclude any health care provider from par-
4 ticipation in the Medicare program under title
5 XVIII or the Medicaid program under title XIX
6 if the exclusion of such health care provider
7 would result in increased difficulty in access to
8 health care services for underserved or low-in-
9 come communities.”.

10 **SEC. 4504. OFFICE FOR CIVIL RIGHTS AND HEALTH EQUITY**
11 **OF THE DEPARTMENT OF HEALTH AND**
12 **HUMAN SERVICES.**

13 (a) NAME OF OFFICE.—Beginning on the date of en-
14 actment of this Act, the Office for Civil Rights of the De-
15 partment of Health and Human Services shall be known
16 as the “Office for Civil Rights and Health Equity” of the
17 Department of Health and Human Services. Any ref-
18 erence to the Office for Civil Rights of the Department
19 of Health and Human Services in any law, regulation,
20 map, document, record, or other paper of the United
21 States shall be deemed to be a reference to the Office for
22 Civil Rights and Health Equity.

23 (b) HEAD OF OFFICE.—The head of the Office for
24 Civil Rights and Health Equity shall be the Director for
25 Civil Rights and Health Equity, to be appointed by the

1 President, by and with the advice and consent of the Sen-
2 ate. Any reference to the Director of the Office for Civil
3 Rights of the Department of Health and Human Services
4 in any law, regulation, map, document, record, or other
5 paper of the United States shall be deemed to be a ref-
6 erence to the Director for Civil Rights and Health Equity.

7 **SEC. 4505. PROHIBITING DISCRIMINATION IN HEALTH**
8 **CARE.**

9 (a) PROHIBITING DISCRIMINATION.—

10 (1) IN GENERAL.—No health care provider, in
11 or affecting commerce, may on the basis, in whole
12 or in part, of race, sex (including sexual orientation
13 and gender identity), disability, age, or religion, sub-
14 ject an individual to the provision of inequitable
15 health care.

16 (2) NOTICE OF PATIENT RIGHTS.—The Sec-
17 retary shall provide to each patient a notice of a pa-
18 tient's rights under this section.

19 (b) ADMINISTRATIVE COMPLAINT AND CONCILIATION
20 PROCESS.—

21 (1) COMPLAINTS AND ANSWERS.—

22 (A) IN GENERAL.—An aggrieved person
23 may, not later than 1 year after an alleged vio-
24 lation of subsection (a) has occurred or con-
25 cluded, file a complaint with the Director alleg-

1 ing provision of inequitable health care by a
2 provider described in subsection (a).

3 (B) COMPLAINT.—A complaint submitted
4 pursuant to subparagraph (A) shall be in writ-
5 ing and shall contain such information and be
6 in such form as the Director requires.

7 (C) OATH OR AFFIRMATION.—The com-
8 plaint and any answer made under this sub-
9 section shall be made under oath or affirmation,
10 and may be reasonably and fairly modified at
11 any time.

12 (2) RESPONSE TO COMPLAINTS.—

13 (A) IN GENERAL.—Upon the filing of a
14 complaint under this subsection, the following
15 procedures shall apply:

16 (i) COMPLAINANT NOTICE.—The Di-
17 rector shall serve notice upon the com-
18 plainant acknowledging receipt of such fil-
19 ing and advising the complainant of the
20 time limits and procedures provided under
21 this section.

22 (ii) RESPONDENT NOTICE.—The Di-
23 rector shall, not later than 30 days after
24 receipt of such filing—

1 (I) serve on the respondent a no-
 2 tice of the complaint, together with a
 3 copy of the original complaint; and

4 (II) advise the respondent of the
 5 procedural rights and obligations of
 6 respondents under this section.

7 (iii) ANSWER.—The respondent may
 8 file, not later than 60 days after receipt of
 9 the notice from the Director, an answer to
 10 such complaint.

11 (iv) INVESTIGATIVE DUTIES.—The Di-
 12 rector shall—

13 (I) make an investigation of the
 14 alleged provision of inequitable health
 15 care; and

16 (II) complete such investigation
 17 within 180 days (unless it is impracti-
 18 cable to complete such investigation
 19 within 180 days) after the filing of
 20 the complaint.

21 (B) INVESTIGATIONS.—

22 (i) PATTERN OR PRACTICE.—In the
 23 course of investigating the complaint, the
 24 Director may seek records of care provided
 25 to patients other than the complainant if

1 necessary to demonstrate or disprove an
2 allegation of provision of inequitable health
3 care or to determine whether there is a
4 pattern or practice of such care.

5 (ii) ACCOUNTING FOR SOCIAL DETER-
6 MINANTS OF HEALTH.—In investigating
7 the complaint and reaching a determina-
8 tion on the validity of the complaint, the
9 Director shall account for social deter-
10 minants of health and the effect of such
11 social determinants on health care out-
12 comes.

13 (iii) INABILITY TO COMPLETE INVES-
14 TIGATION.—If the Director is unable to
15 complete (or finds it is impracticable to
16 complete) the investigation within 180
17 days after the filing of the complaint (or,
18 if the Director makes a certification under
19 paragraph (6)(B) with respect to a com-
20 plaint, within 180 days after the com-
21 mencement of such further action), the Di-
22 rector shall notify the complainant and re-
23 spondent in writing of the reasons in-
24 volved.

1 (iv) REPORT TO STATE LICENSING
2 AUTHORITIES.—On completing each inves-
3 tigation under this subparagraph, the Di-
4 rector shall provide to the appropriate
5 State licensing authorities information
6 specifying the results of the investigation.

7 (C) REPORT.—

8 (i) FINAL REPORT.—On completing
9 each investigation under this paragraph,
10 the Director shall prepare a final investiga-
11 tive report.

12 (ii) MODIFICATION OF REPORT.—A
13 final report under this subparagraph may
14 be modified if additional evidence is later
15 discovered.

16 (3) CONCILIATION.—

17 (A) IN GENERAL.—During the period be-
18 ginning on the date on which a complaint is
19 filed under this subsection and ending on the
20 date of final disposition of such complaint (in-
21 cluding during an investigation under para-
22 graph (2)(B)), the Director shall, to the extent
23 feasible, engage in conciliation with respect to
24 such complaint.

1 (B) CONCILIATION AGREEMENT.—A con-
2 ciliation agreement arising out of such concilia-
3 tion shall be an agreement between the re-
4 spondent and the complainant, and shall be
5 subject to approval by the Director.

6 (C) RIGHTS PROTECTED.—The Director
7 shall approve a conciliation agreement only if
8 the agreement protects the rights of the com-
9 plainant and other persons similarly situated.

10 (D) PUBLICLY AVAILABLE AGREEMENT.—

11 (i) IN GENERAL.—Subject to clause
12 (ii), the Secretary shall make available to
13 the public a copy of a conciliation agree-
14 ment entered into pursuant to this sub-
15 section unless the complainant and re-
16 spondent otherwise agree, and the Sec-
17 retary determines, that disclosure is not re-
18 quired to further the purposes of this sub-
19 section.

20 (ii) LIMITATION.—A conciliation
21 agreement that is made available to the
22 public pursuant to clause (i) may not dis-
23 close individually identifiable health infor-
24 mation.

1 (4) FAILURE TO COMPLY WITH CONCILIATION
2 AGREEMENT.—Whenever the Director has reason-
3 able cause to believe that a respondent has breached
4 a conciliation agreement, the Director shall refer the
5 matter to the Attorney General to consider filing a
6 civil action to enforce such agreement.

7 (5) WRITTEN CONSENT FOR DISCLOSURE OF
8 INFORMATION.—Nothing said or done in the course
9 of conciliation under this subsection may be made
10 public, or used as evidence in a subsequent pro-
11 ceeding under this subsection, without the written
12 consent of the parties to the conciliation.

13 (6) PROMPT JUDICIAL ACTION.—

14 (A) IN GENERAL.—If the Director deter-
15 mines at any time following the filing of a com-
16 plaint under this subsection that prompt judi-
17 cial action is necessary to carry out the pur-
18 poses of this subsection, the Director may rec-
19 ommend that the Attorney General promptly
20 commence a civil action under subsection (d).

21 (B) IMMEDIATE SUIT.—If the Director de-
22 termines at any time following the filing of a
23 complaint under this subsection that the public
24 interest would be served by allowing the com-
25 plainant to bring a civil action under subsection

1 (c) in a State or Federal court immediately, the
2 Director shall certify that the administrative
3 process has concluded and that the complainant
4 may file such an action immediately.

5 (7) ANNUAL REPORT.—Not later than 1 year
6 after the date of enactment of this Act, and annually
7 thereafter, the Director shall make publicly available
8 a report detailing the activities of the Office for Civil
9 Rights and Health Equity under this subsection, in-
10 cluding—

11 (A) the number of complaints filed and the
12 basis on which the complaints were filed;

13 (B) the number of investigations under-
14 taken as a result of such complaints; and

15 (C) the disposition of all such investiga-
16 tions.

17 (c) ENFORCEMENT BY PRIVATE PERSONS.—

18 (1) IN GENERAL.—

19 (A) CIVIL ACTION.—

20 (i) IN SUIT.—A complainant under
21 subsection (b) may commence a civil action
22 to obtain appropriate relief with respect to
23 an alleged violation of subsection (a), or
24 for breach of a conciliation agreement
25 under subsection (b), in an appropriate

1 district court of the United States or State
2 court—

3 (I) not sooner than the earliest
4 of—

5 (aa) the date a conciliation
6 agreement is reached under sub-
7 section (b);

8 (bb) the date on which the
9 Director makes a certification
10 under subsection (b)(6)(B); or

11 (cc) 180 days after the first
12 day of the alleged violation; and

13 (II) not later than 2 years after
14 the final day of the alleged violation.

15 (ii) STATUTE OF LIMITATIONS.—The
16 computation of such 2-year period shall
17 not include any time during which an ad-
18 ministrative proceeding (including inves-
19 tigation or conciliation) under subsection
20 (b) was pending with respect to a com-
21 plaint under such subsection.

22 (B) BARRING SUIT.—If the Director has
23 obtained a conciliation agreement under sub-
24 section (b) regarding an alleged violation of
25 subsection (a), no action may be commenced

1 under this paragraph by the complainant in-
2 volved with respect to the alleged violation ex-
3 cept for the purpose of enforcing the terms of
4 such an agreement.

5 (2) RELIEF WHICH MAY BE GRANTED.—

6 (A) IN GENERAL.—In a civil action under
7 paragraph (1), if the court finds that a viola-
8 tion of subsection (a) or breach of a conciliation
9 agreement has occurred, the court may award
10 to the plaintiff actual and punitive damages,
11 and may grant as relief, as the court deter-
12 mines to be appropriate, any permanent or tem-
13 porary injunction, temporary restraining order,
14 or other order (including an order enjoining the
15 defendant from engaging in a practice violating
16 subsection (a) or ordering such affirmative ac-
17 tion as may be appropriate).

18 (B) FEES AND COSTS.—In a civil action
19 under paragraph (1), the court, in its discre-
20 tion, may allow the prevailing party, other than
21 the United States, a reasonable attorney's fee
22 and costs. The United States shall be liable for
23 such fees and costs to the same extent as a pri-
24 vate person.

1 (3) INTERVENTION BY ATTORNEY GENERAL.—

2 Upon timely application, the Attorney General may
 3 intervene in a civil action under paragraph (1), if
 4 the Attorney General certifies that the case involves
 5 a pattern or practice or an issue described in sub-
 6 section (d)(1)(A).

7 (d) ENFORCEMENT BY THE ATTORNEY GENERAL.—

8 (1) COMMENCEMENT OF ACTIONS.—

9 (A) PATTERN OR PRACTICE CASES.—The
 10 Attorney General may commence a civil action
 11 in any appropriate district court of the United
 12 States if the Attorney General has reasonable
 13 cause to believe that any health care provider
 14 covered by subsection (a)—

15 (i) is engaged in a pattern or practice
 16 that violates such subsection; or

17 (ii) is engaged in a violation of such
 18 subsection that raises an issue of signifi-
 19 cant public importance.

20 (B) CASES BY REFERRAL.—The Director
 21 may determine, based on a pattern of com-
 22 plaints, a pattern of violations, a review of data
 23 reported by a health care provider covered by
 24 subsection (a), or any other means, that there
 25 is reasonable cause to believe a health care pro-

1 vider is engaged in a pattern or practice that
2 violates subsection (a). The Director may deter-
3 mine, based on a review of data reported by a
4 health care provider covered by subsection (a),
5 or any other means, that there is reasonable
6 cause to believe that a health care provider is
7 engaged in a violation of subsection (a) de-
8 scribed in subparagraph (A)(ii). If the Director
9 makes a determination under this subpara-
10 graph, the Director shall refer the related find-
11 ings to the Attorney General. If the Attorney
12 General finds that corresponding reasonable
13 cause exists, the Attorney General may com-
14 mence a civil action in any appropriate district
15 court of the United States.

16 (2) ENFORCEMENT OF SUBPOENAS.—The At-
17 torney General, on behalf of the Director, or another
18 party at whose request a subpoena is issued under
19 this subsection, may enforce such subpoena in ap-
20 propriate proceedings in the district court of the
21 United States for the district in which the person to
22 whom the subpoena was addressed resides, was
23 served, or transacts business.

24 (3) RELIEF WHICH MAY BE GRANTED IN CIVIL
25 ACTIONS.—

1 (A) IN GENERAL.—In a civil action under
2 paragraph (1), the court—

3 (i) may award such preventive relief,
4 including a permanent or temporary in-
5 junction, temporary restraining order, or
6 other order against the person responsible
7 for a violation of subsection (a) as is nec-
8 essary to assure the full enjoyment of the
9 rights granted by this subsection;

10 (ii) may award such other relief as the
11 court determines to be appropriate, includ-
12 ing monetary damages, to aggrieved per-
13 sons; and

14 (iii) may, to vindicate the public inter-
15 est, assess punitive damages against the
16 respondent—

17 (I) in an amount not exceeding
18 \$500,000, for a first violation; and

19 (II) in an amount not exceeding
20 \$1,000,000, for any subsequent viola-
21 tion.

22 (B) FEES AND COSTS.—In a civil action
23 under this subsection, the court, in its discre-
24 tion, may allow the prevailing party, other than
25 the United States, a reasonable attorney's fee

1 and costs. The United States shall be liable for
2 such fees and costs to the extent provided by
3 section 2412 of title 28, United States Code.

4 (4) INTERVENTION IN CIVIL ACTIONS.—Upon
5 timely application, any person may intervene in a
6 civil action commenced by the Attorney General
7 under paragraphs (1) and (2) if the action involves
8 an alleged violation of subsection (a) with respect to
9 which such person is an aggrieved person (including
10 a person who is a complainant under subsection (b))
11 or a conciliation agreement to which such person is
12 a party.

13 (e) DEFINITIONS.—In this section:

14 (1) AGGRIEVED PERSON.—The term “aggrieved
15 person” means—

16 (A) a person who believes that the person
17 was or will be injured in violation of subsection
18 (a); or

19 (B) the personal representative or estate of
20 a deceased person who was injured in violation
21 of subsection (a).

22 (2) DIRECTOR.—The term “Director” means
23 the Director for Civil Rights and Health Equity of
24 the Department of Health and Human Services.

1 (3) DISABILITY.—The term “disability” has the
2 meaning given such term in section 3 of the Ameri-
3 cans with Disabilities Act of 1990 (42 U.S.C.
4 12102).

5 (4) CONCILIATION.—The term “conciliation”
6 means the attempted resolution of issues raised by
7 a complaint, or by the investigation of such com-
8 plaint, through informal negotiations involving the
9 complainant, the respondent, and the Secretary.

10 (5) CONCILIATION AGREEMENT.—The term
11 “conciliation agreement” means a written agreement
12 setting forth the resolution of the issues in concilia-
13 tion.

14 (6) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
15 FORMATION.—The term “individually identifiable
16 health information” means any information, includ-
17 ing demographic information collected from an indi-
18 vidual—

19 (A) that is created or received by a health
20 care provider covered by subsection (a), health
21 plan, employer, or health care clearinghouse;

22 (B) that relates to the past, present, or fu-
23 ture physical or mental health or condition of,
24 the provision of health care to, or the past,

1 present, or future payment for the provision of
2 health care to, the individual; and

3 (C)(i) that identifies the individual; or

4 (ii) with respect to which there is a reason-
5 able basis to believe that the information can be
6 used to identify the individual.

7 (7) PROVISION OF INEQUITABLE HEALTH
8 CARE.—The term “provision of inequitable health
9 care” means the provision of any health care service,
10 by a health care provider covered by subsection (a)
11 in a manner that—

12 (A) fails to meet a high-quality care stand-
13 ard, meaning the health care provider fails to—

14 (i) avoid harm to patients as a result
15 of the health services that are intended to
16 help the patient;

17 (ii) refrain from providing services to
18 patients not likely to benefit;

19 (iii) provide care that is responsive to
20 patient preferences, needs, and values; and

21 (iv) avoids waits or delays in care; and

22 (B) is discriminatory in intent or effect
23 based at least in part on a basis specified in
24 subsection (a).

1 (8) RESPONDENT.—The term “respondent”
 2 means the person or other entity accused in a com-
 3 plaint of a violation of subsection (a).

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

6 (10) SOCIAL DETERMINANTS OF HEALTH.—The
 7 term “social determinants of health” means condi-
 8 tions in the environments in which individuals live,
 9 work, attend school, and worship, that affect a wide
 10 range of health, functioning, and quality-of-life out-
 11 comes and risks.

12 (f) RULE OF CONSTRUCTION.—Nothing in this sec-
 13 tion shall be construed as repealing or limiting the effect
 14 of title VI of the Civil Rights Act of 1964 (42 U.S.C.
 15 2000d et seq.), section 1557 of the Patient Protection and
 16 Affordable Care Act (42 U.S.C. 18116), section 504 of
 17 the Rehabilitation Act of 1973 (29 U.S.C. 794), title II
 18 or III of the Americans with Disabilities Act of 1990 (42
 19 U.S.C. 12131 et seq, 12181 et seq.), or the Age Discrimi-
 20 nation Act of 1975 (42 U.S.C. 6101 et seq.).

21 **SEC. 4506. FEDERAL HEALTH EQUITY COMMISSION.**

22 (a) ESTABLISHMENT OF COMMISSION.—

23 (1) IN GENERAL.—There is established the
 24 Federal Health Equity Commission (in this section
 25 referred to as the “Commission”).

1 (2) MEMBERSHIP.—

2 (A) IN GENERAL.—The Commission shall
3 be composed of—

4 (i) 8 voting members appointed under
5 subparagraph (B); and

6 (ii) the nonvoting, ex officio members
7 listed in subparagraph (C).

8 (B) VOTING MEMBERS.—Not more than 4
9 of the members described in subparagraph
10 (A)(i) shall at any one time be of the same po-
11 litical party. Such members shall have recog-
12 nized expertise in and personal experience with
13 racial and ethnic health inequities, health care
14 needs of vulnerable and marginalized popu-
15 lations, and health equity as a vehicle for im-
16 proving health status and health outcomes.
17 Such members shall be appointed to the Com-
18 mission as follows:

19 (i) 4 members of the Commission
20 shall be appointed by the President.

21 (ii) 2 members of the Commission
22 shall be appointed by the President pro
23 tempore of the Senate, upon the rec-
24 ommendations of the majority leader and
25 the minority leader of the Senate. Each

1 member appointed to the Commission
2 under this clause shall be appointed from
3 a different political party.

4 (iii) 2 members of the Commission
5 shall be appointed by the Speaker of the
6 House of Representatives upon the rec-
7 ommendations of the majority leader and
8 the minority leader of the House of Rep-
9 resentatives. Each member appointed to
10 the Commission under this clause shall be
11 appointed from a different political party.

12 (C) EX OFFICIO MEMBER.—The Commis-
13 sion shall have the following nonvoting, ex offi-
14 cio members:

15 (i) The Director for Civil Rights and
16 Health Equity of the Department of
17 Health and Human Services.

18 (ii) The Deputy Assistant Secretary
19 for Minority Health of the Department of
20 Health and Human Services.

21 (iii) The Director of the National In-
22 stitute on Minority Health and Health Dis-
23 parities.

24 (iv) The Chairperson of the Advisory
25 Committee on Minority Health established

1 under section 1707(c) of the Public Health
2 Service Act (42 U.S.C. 300u-6(c)).

3 (3) TERMS.—The term of office of each mem-
4 ber appointed under paragraph (2)(B) of the Com-
5 mission shall be 6 years.

6 (4) CHAIRPERSON; VICE CHAIRPERSON.—

7 (A) CHAIRPERSON.—The President shall,
8 with the concurrence of a majority of the mem-
9 bers of the Commission appointed under para-
10 graph (2)(B), designate a Chairperson from
11 among the members of the Commission ap-
12 pointed under such paragraph.

13 (B) VICE CHAIRPERSON.—

14 (i) DESIGNATION.—The Speaker of
15 the House of Representatives shall, in con-
16 sultation with the majority leaders and the
17 minority leaders of the Senate and the
18 House of Representatives and with the
19 concurrence of a majority of the members
20 of the Commission appointed under para-
21 graph (2)(B), designate a Vice Chairperson
22 from among the members of the Commis-
23 sion appointed under such paragraph. The
24 Vice Chairperson may not be a member of

1 the same political party as the Chair-
2 person.

3 (ii) DUTY.—The Vice Chairperson
4 shall act in place of the Chairperson in the
5 absence of the Chairperson.

6 (5) REMOVAL OF MEMBERS.—The President
7 may remove a member of the Commission only for
8 neglect of duty or malfeasance in office.

9 (6) QUORUM.—A majority of members of the
10 Commission appointed under paragraph (2)(B) shall
11 constitute a quorum of the Commission, but a lesser
12 number of members may hold hearings.

13 (b) DUTIES OF THE COMMISSION.—

14 (1) IN GENERAL.—The Commission shall—

15 (A) monitor and report on the implementa-
16 tion of this Act; and

17 (B) investigate, monitor, and report on
18 progress towards health equity and the elimi-
19 nation of health disparities.

20 (2) ANNUAL REPORT.—The Commission
21 shall—

22 (A) submit to the President and Congress
23 at least one report annually on health equity
24 and health disparities; and

25 (B) include in such report—

1 (i) a description of actions taken by
2 the Department of Health and Human
3 Services and any other Federal agency re-
4 lated to health equity or health disparities;
5 and

6 (ii) recommendations on ensuring eq-
7 uitable health care and eliminating health
8 disparities.

9 (c) POWERS.—

10 (1) HEARINGS.—

11 (A) IN GENERAL.—The Commission or, at
12 the direction of the Commission, any sub-
13 committee or member of the Commission, may,
14 for the purpose of carrying out this section, as
15 the Commission or the subcommittee or mem-
16 ber considers advisable—

17 (i) hold such hearings, meet and act
18 at such times and places, take such testi-
19 mony, receive such evidence, and admin-
20 ister such oaths; and

21 (ii) require, by subpoena or otherwise,
22 the attendance and testimony of such wit-
23 nesses and the production of such books,
24 records, correspondence, memoranda, pa-
25 pers, documents, tapes, and materials.

1 (B) LIMITATION ON HEARINGS.—The
2 Commission may hold a hearing under subpara-
3 graph (A)(i) only if the hearing is approved—

4 (i) by a majority of the members of
5 the Commission appointed under sub-
6 section (a)(2)(B); or

7 (ii) by a majority of such members
8 present at a meeting when a quorum is
9 present.

10 (2) ISSUANCE AND ENFORCEMENT OF SUB-
11 POENAS.—

12 (A) ISSUANCE.—A subpoena issued under
13 paragraph (1) shall—

14 (i) bear the signature of the Chair-
15 person of the Commission; and

16 (ii) be served by any person or class
17 of persons designated by the Chairperson
18 for that purpose.

19 (B) ENFORCEMENT.—In the case of contu-
20 macy or failure to obey a subpoena issued
21 under paragraph (1), the United States district
22 court for the district in which the subpoenaed
23 person resides, is served, or may be found may
24 issue an order requiring the person to appear at

1 any designated place to testify or to produce
2 documentary or other evidence.

3 (C) NONCOMPLIANCE.—Any failure to
4 obey the order of the court may be punished by
5 the court as a contempt of court.

6 (3) WITNESS ALLOWANCES AND FEES.—

7 (A) IN GENERAL.—Section 1821 of title
8 28, United States Code, shall apply to a witness
9 requested or subpoenaed to appear at a hearing
10 of the Commission.

11 (B) EXPENSES.—The per diem and mile-
12 age allowances for a witness shall be paid from
13 funds available to pay the expenses of the Com-
14 mission.

15 (4) POSTAL SERVICES.—The Commission may
16 use the United States mails in the same manner and
17 under the same conditions as other agencies of the
18 Federal Government.

19 (5) GIFTS.—The Commission may accept, use,
20 and dispose of gifts or donations of services or prop-
21 erty.

22 (d) ADMINISTRATIVE PROVISIONS.—

23 (1) STAFF.—

24 (A) DIRECTOR.—There shall be a full-time
25 staff director for the Commission who shall—

1 (i) serve as the administrative head of
2 the Commission; and

3 (ii) be appointed by the Chairperson
4 with the concurrence of the Vice Chair-
5 person.

6 (B) OTHER PERSONNEL.—The Commis-
7 sion may—

8 (i) appoint such other personnel as it
9 considers advisable, subject to the provi-
10 sions of title 5, United States Code, gov-
11 erning appointments in the competitive
12 service, and the provisions of chapter 51
13 and subchapter III of chapter 53 of that
14 title relating to classification and General
15 Schedule pay rates; and

16 (ii) may procure temporary and inter-
17 mittent services under section 3109(b) of
18 title 5, United States Code, at rates for in-
19 dividuals not in excess of the daily equiva-
20 lent paid for positions at the maximum
21 rate for GS-15 of the General Schedule
22 under section 5332 of title 5, United
23 States Code.

24 (2) COMPENSATION OF MEMBERS.—

1 (A) NON-FEDERAL EMPLOYEES.—Each
2 member of the Commission who is not an offi-
3 cer or employee of the Federal Government
4 shall be compensated at a rate equal to the
5 daily equivalent of the annual rate of basic pay
6 prescribed for level IV of the Executive Sched-
7 ule under section 5315 of title 5, United States
8 Code, for each day (including travel time) dur-
9 ing which the member is engaged in the per-
10 formance of the duties of the Commission.

11 (B) FEDERAL EMPLOYEES.—Each member
12 of the Commission who is an officer or em-
13 ployee of the Federal Government shall serve
14 without compensation in addition to the com-
15 pensation received for the services of the mem-
16 ber as an officer or employee of the Federal
17 Government.

18 (C) TRAVEL EXPENSES.—A member of the
19 Commission shall be allowed travel expenses, in-
20 cluding per diem in lieu of subsistence, at rates
21 authorized for an employee of an agency under
22 subchapter I of chapter 57 of title 5, United
23 States Code, while away from the home or reg-
24 ular place of business of the member in the per-
25 formance of the duties of the Commission.

1 (3) COOPERATION.—The Commission may se-
2 cure directly from any Federal department or agency
3 such information as the Commission considers nec-
4 essary to carry out this Act. Upon request of the
5 Chairman of the Commission, the head of such de-
6 partment or agency shall furnish such information to
7 the Commission.

8 (e) PERMANENT COMMISSION.—Section 1013 of title
9 5, United States Code, shall not apply to the Commission.

10 (f) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated for fiscal year 2027 and
12 each fiscal year thereafter such sums as may be necessary
13 to carry out the duties of the Commission.

14 **SEC. 4507. GRANTS FOR HOSPITALS TO PROMOTE EQUI-**
15 **TABLE HEALTH CARE AND OUTCOMES.**

16 (a) IN GENERAL.—Not later than 180 days after the
17 date of the enactment of this Act, the Secretary of Health
18 and Human Services (in this section referred to as the
19 “Secretary”) shall award grants to hospitals to promote
20 equitable health care treatment and services, and reduce
21 disparities in care and outcomes.

22 (b) CONSULTATION.—In establishing the criteria for
23 grants under this section and evaluating applications for
24 such grants, the Secretary shall consult with the Director

1 for Civil Rights and Health Equity of the Department of
2 Health and Human Services.

3 (c) USE OF FUNDS.—A hospital shall use funds re-
4 ceived from a grant under this section to establish or ex-
5 pand programs to provide equitable health care to all pa-
6 tients and to ensure equitable health care outcomes. Such
7 uses may include—

8 (1) providing explicit and implicit bias training
9 to medical providers and staff;

10 (2) providing translation or interpretation serv-
11 ices for patients;

12 (3) recruiting and training a diverse workforce;

13 (4) tracking data related to care and outcomes;

14 and

15 (5) training on cultural sensitivity.

16 (d) PRIORITY.—In awarding grants under this sec-
17 tion, the Secretary shall give priority to hospitals that
18 have received disproportionate share hospital payments
19 under section 1886(r) of the Social Security Act (42
20 U.S.C. 1395ww(r)) or section 1923 of such Act (42 U.S.C.
21 1396r–4) with respect to fiscal year 2026.

22 (e) SUPPLEMENT, NOT SUPPLANT.—Grants awarded
23 under this section shall be used to supplement, not sup-
24 plant, any nongovernment efforts, or other Federal, State,
25 or local funds provided to a recipient.

1 (f) **EQUITABLE HEALTH CARE DEFINED.**—The term
 2 “equitable health care” has the meaning given such term
 3 in section 1886(b)(3)(B)(viii)(XIII)(cc) of the Social Secu-
 4 rity Act (42 U.S.C. 1395ww(b)(3)(B)(viii)(XIII)(cc)), as
 5 added by section 4502(a).

6 (g) **AUTHORIZATION OF APPROPRIATIONS.**—To carry
 7 out this section, there are authorized to be appropriated
 8 such sums as may be necessary for each of fiscal years
 9 2027 through 2031.

10 **Subtitle G—Investing in Equity**

11 **SEC. 4601. DEFINITIONS.**

12 In this subtitle:

13 (1) **ADVISORY COUNCIL.**—The term “Advisory
 14 Council” means the Pay for Equity Advisory Council
 15 convened under section 4603.

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

18 (3) **STRATEGY.**—The term “Strategy” means
 19 the Pay for Equity Strategy set forth under section
 20 4602.

21 **SEC. 4602. STRATEGY TO INCENTIVIZE HEALTH EQUITY.**

22 (a) **IN GENERAL.**—The Secretary, in consultation
 23 with the heads of other appropriate Federal agencies, shall
 24 develop jointly with the Advisory Council and submit to
 25 the Committee on Finance of the Senate and the Com-

1 mittee on Energy and Commerce and the Committee on
2 Ways and Means of the House of Representatives, and
3 make publicly available on the internet website of the De-
4 partment of Health and Human Services, a Pay for Eq-
5 uity Strategy.

6 (b) CONTENTS.—The Strategy shall establish goals
7 for Federal programs, including those authorized under ti-
8 tles XVIII and XIX of the Social Security Act, to
9 incentivize health equity, which may include at least—

10 (1) incorporating measures of equity into all
11 payment models by 2028;

12 (2) tying a percentage of reimbursement in
13 value-based payment models to equity measure per-
14 formance by 2031; and

15 (3) increasing the number of safety net pro-
16 viders participating in value-based payment by a set
17 percentage by 2033.

18 (c) DUTIES OF THE SECRETARY.—The Secretary, in
19 carrying out subsection (a), shall oversee the following:

20 (1) Collecting and making publicly available in-
21 formation submitted by the Advisory Council.

22 (2) Coordinating and assessing existing Federal
23 Government programs and activities to assess capac-
24 ity to meet equity goals.

1 (3) Providing technical assistance, as appro-
2 priate, such as disseminating identified best prac-
3 tices and information sharing based on reports de-
4 veloped as a result of this subtitle.

5 (d) INITIAL STRATEGY; UPDATES.—The Secretary
6 shall—

7 (1) not later than 18 months after the date of
8 enactment of this Act, develop, publish, and submit
9 to the Committee on Finance of the Senate and the
10 Committee on Energy and Commerce and the Com-
11 mittee on Ways and Means of the House of Rep-
12 resentatives the strategy outlined in subsection (a);
13 and

14 (2) biennially update, publish, and submit to
15 Congress an updated strategy to—

16 (A) reflect new developments, challenges,
17 opportunities, and solutions; and

18 (B) review progress and, based on the re-
19 sults of such review, recommend priority actions
20 for improving the implementation of such rec-
21 ommendations, as appropriate.

22 (e) PROCESS FOR PUBLIC INPUT.—The Secretary
23 shall establish a process for public input to inform the de-
24 velopment of, and updates to, the Strategy, including a
25 process for the public to submit recommendations to the

1 Advisory Council and an opportunity for public comment
2 on the proposed Strategy.

3 **SEC. 4603. PAY FOR EQUITY ADVISORY COUNCIL.**

4 (a) CONVENING.—The Secretary shall convene a Pay
5 for Equity Advisory Council to advise and provide rec-
6 ommendations, including identified best practices, to the
7 Secretary on the Pay for Equity Strategy.

8 (b) MEMBERSHIP.—

9 (1) IN GENERAL.—The members of the Advi-
10 sory Council shall consist of—

11 (A) the appointed members under para-
12 graph (2); and

13 (B) the Federal members under paragraph
14 (3).

15 (2) APPOINTED MEMBERS.—In addition to the
16 Federal members under paragraph (3), the Sec-
17 retary shall appoint not more than 15 voting mem-
18 bers of the Advisory Council who are not representa-
19 tives of Federal departments or agencies and who
20 shall include at least 1 representative of each of the
21 following:

22 (A) Beneficiaries of Medicare and Med-
23 icaid.

24 (B) Safety net health care providers.

25 (C) Value-based payment experts.

1 (D) Other members with expertise and
2 lived experience the Secretary deems appro-
3 priate.

4 (3) FEDERAL MEMBERS.—The Federal mem-
5 bers of the Advisory Council, who shall be nonvoting
6 members, shall consist of the following:

7 (A) The Administrator of the Centers for
8 Medicare & Medicaid Services (or the Adminis-
9 trator's designee).

10 (B) The Administrator of the Health Re-
11 sources and Services Administration.

12 (4) DIVERSE REPRESENTATION.—The Sec-
13 retary shall ensure that the membership of the Advi-
14 sory Council reflects the diversity of individuals im-
15 pacted by Federal health payment programs.

16 (c) MEETINGS.—The Advisory Council shall meet
17 quarterly during the 1-year period beginning on the date
18 of enactment of this Act and at least 3 times during each
19 year thereafter. Meetings of the Advisory Council shall be
20 open to the public.

1 **Subtitle H—Miscellaneous**

2 **SEC. 4701. COVERAGE FOR ACUPUNCTURIST SERVICES** 3 **UNDER THE MEDICARE PROGRAM.**

4 (a) IN GENERAL.—Section 1861 of the Social Secu-
 5 rity Act (42 U.S.C. 1395x), as amended by section
 6 2007(b), is amended—

7 (1) in subsection (s)(2)—

8 (A) in subparagraph (JJ), by striking
 9 “and” at the end;

10 (B) in subparagraph (KK), by inserting
 11 “and” after the semicolon; and

12 (C) by adding at the end the following new
 13 subparagraph:

14 “(LL) qualified acupuncturist services (as de-
 15 fined in subsection (ppp)(1));”; and

16 (2) by adding at the end the following new sub-
 17 section:

18 “(ppp) QUALIFIED ACUPUNCTURIST SERVICES.—

19 “(1) IN GENERAL.—The term ‘qualified
 20 acupuncturist services’ means such services fur-
 21 nished by a qualified acupuncturist (as defined in
 22 paragraph (2)), and such services and supplies fur-
 23 nished as an incident to services furnished by the
 24 qualified acupuncturist, as the qualified

1 acupuncturist is legally authorized to perform under
2 State law.

3 “(2) QUALIFIED ACUPUNCTURIST DEFINED.—
4 For purposes of this subsection, the term ‘qualified
5 acupuncturist’ means—

6 “(A) an individual who is licensed as an
7 acupuncturist by a State or, in the case of an
8 individual in a State that does not provide for
9 such licensure, meets such criteria (such as cer-
10 tification through an appropriate nationally rec-
11 ognized certification authority for
12 acupuncturists) as the Secretary may specify;
13 or

14 “(B) a physician who is legally authorized
15 to perform acupuncture as part of the practice
16 of medicine and surgery by the State in which
17 the physician performs such function or action.

18 In specifying requirements under subparagraph (A),
19 the Secretary may use the same requirements as
20 those established by a certification authority de-
21 scribed in such subparagraph.”.

22 (b) PAYMENT RULES.—

23 (1) PAYMENT UNDER PHYSICIAN FEE SCHED-
24 ULE.—Section 1848(j)(3) of the Social Security Act

1 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
 2 “(2)(LL),” before “(3),”.

3 (2) SEPARATE PAYMENT FOR SERVICES OF IN-
 4 STITUTIONAL PROVIDERS.—Section 1833(a)(2)(B)
 5 of the Social Security Act (42 U.S.C.
 6 1395l(a)(2)(B)) is amended—

7 (A) in clause (i), by inserting “and in the
 8 case of qualified acupuncturist services,” after
 9 “1999,”;

10 (B) in clause (ii), by inserting “or in the
 11 case of qualified acupuncturist services,” after
 12 “1999,”; and

13 (C) in clause (iii), by inserting “(other
 14 than qualified acupuncturist services)” after
 15 “such services”.

16 (3) QUALIFIED ACUPUNCTURIST TREATMENT
 17 AS A PRACTITIONER.—Section 1842(b)(18)(C) of the
 18 Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is
 19 amended by adding at the end the following new
 20 clause:

21 “(ix) A qualified acupuncturist (as defined in
 22 section 1861(ppp)(2)).”.

23 (4) SEPARATE BILLING FOR ACUPUNCTURIST
 24 SERVICES FURNISHED IN AN INPATIENT HOSPITAL
 25 SETTING.—Section 1861(b)(4) of the Social Security

1 Act (42 U.S.C. 1395x(b)(4)) is amended by insert-
 2 ing “qualified acupuncturist services,” after “quali-
 3 fied psychologist services,”.

4 (c) EFFECTIVE DATE.—The amendments made by
 5 this section apply with respect to services furnished on or
 6 after the date that is 270 days after the date of enactment
 7 of this Act.

8 **SEC. 4702. REPEAL OF DENIAL OF BENEFITS.**

9 Section 115 of the Personal Responsibility and Work
 10 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
 11 is amended—

12 (1) in the section heading, by striking “**AND**
 13 **BENEFITS**”;

14 (2) in subsection (a)—

15 (A) in paragraph (1), by striking “, or”
 16 and all that follows through “that Act” in para-
 17 graph (2) and inserting “(42 U.S.C. 601 et
 18 seq.)”; and

19 (B) in the matter preceding paragraph (1),
 20 by striking “for—” and all that follows through
 21 “assistance” in paragraph (1) and inserting
 22 “for assistance”;

23 (3) in subsection (b)—

24 (A) in the subsection heading, by striking
 25 “AND BENEFITS”;

1 (B) by striking paragraph (2); and

2 (C) in paragraph (1), by striking the para-
3 graph designation and heading and all that fol-
4 lows through “The amount” and inserting “The
5 amount”;

6 (4) in subsection (c), by striking “or benefits”;

7 and

8 (5) in subsection (e)—

9 (A) in the subsection heading, by striking
10 “DEFINITIONS” and inserting “DEFINITION”;

11 (B) in paragraph (1), by striking “, and”
12 and all that follows through “that Act” in para-
13 graph (2) and inserting “(42 U.S.C. 601 et
14 seq.)”; and

15 (C) in the matter preceding paragraph (1),
16 by striking “it—” and all that follows through
17 “in section 419(5)” and inserting “the term in
18 section 419(5)”.

19 **SEC. 4703. ADDRESSING DISPARITIES IN MEDICARE ADVAN-**
20 **TAGE BENCHMARK LEVELS BASED ON PENE-**
21 **TRATION.**

22 (a) IN GENERAL.—Section 1853(n) of the Social Se-
23 curity Act (42 U.S.C. 1395w–23(n)) is amended—

1 (1) in paragraph (1)(B), by striking “subse-
 2 quent year” and inserting “subsequent year, subject
 3 to paragraph (6),”; and

4 (2) by adding at the end the following new
 5 paragraph:

6 “(6) AVERAGE GEOGRAPHIC ADJUSTMENT
 7 FLOOR.—For 2027 and subsequent years, when cal-
 8 culating the adjusted average per capita cost under
 9 section 1876(a)(4) for the purposes of establishing
 10 the base payment amount specified in paragraph
 11 (2)(E), the average geographic adjustment shall not
 12 be less than 0.70 for any area. For the purposes of
 13 the previous sentence, the Secretary may define the
 14 term ‘average geographic adjustment’ under sub-
 15 paragraph (A) by program instruction or other-
 16 wise.”.

17 (b) ENSURING PLAN PAYMENTS FLOW TO PRO-
 18 VIDERS AND PATIENTS.—Section 1854(a)(6) of the Social
 19 Security Act (42 U.S.C. 1395w–24(a)(6)) is amended by
 20 adding at the end the following new subparagraph:

21 “(C) ENSURING INCREASED PAYMENTS
 22 SUPPORT CARE.—With respect to the increase
 23 in blended benchmark amount attributable to
 24 the application of section 1853(n)(6), no less
 25 than 50 percent shall be directed toward pay-

1 ment for basic benefits as defined in section
2 1852(a)(1)(B).”.

3 **SEC. 4704. WOMEN EXPANSION OF LEARNING AND LABOR**
4 **SAFETY (WELLS) ACT.**

5 (a) REQUIRING HOSPITALS PARTICIPATING IN MEDI-
6 CARE TO DEVELOP DISCHARGE PLANS FOR PREGNANT
7 INDIVIDUALS.—Section 1866 of the Social Security Act
8 (42 U.S.C. 1395cc) is amended—

9 (1) in subsection (a)(1)—

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

12 (B) in subparagraph (Y), by striking the
13 period at the end and inserting “, and”; and

14 (C) by inserting after subparagraph (Y)
15 the following new subparagraph:

16 “(Z) beginning January 1, 2027, in the
17 case of a hospital, critical access hospital, or
18 rural emergency hospital, to comply with the re-
19 quirements described in subsection (l)(1).”; and

20 (2) by adding at the end the following new sub-
21 section:

22 “(l) DISCHARGE PLAN REQUIREMENTS FOR PREG-
23 NANT INDIVIDUALS.—

24 “(1) IN GENERAL.—For purposes of subsection
25 (a)(1)(Z), the requirements described in this para-

1 graph are, with respect to a hospital, critical access
2 hospital, or rural emergency hospital, that the hos-
3 pital—

4 “(A) provides for the development and im-
5 plementation of a discharge plan meeting the
6 standards under paragraph (2) with respect to
7 any individual (whether or not eligible for bene-
8 fits under this title) admitted to the hospital
9 who—

10 “(i) is identified as pregnant;

11 “(ii) is experiencing signs or symp-
12 toms consistent with labor, which may in-
13 clude contractions; and

14 “(iii) is expected to be discharged
15 from the hospital, critical access hospital,
16 or rural emergency hospital prior to deliv-
17 ery, as determined based on the docu-
18 mented clinical judgment of the treating
19 physician or practitioner at the time that
20 such discharge is contemplated;

21 “(B) includes such discharge plan in the
22 individual’s medical record; and

23 “(C) provides for such discharge plan to be
24 discussed with the individual (or the individ-
25 ual’s representative) prior to discharge.

1 “(2) DISCHARGE PLAN STANDARDS.—A dis-
2 charge plan for an individual described in paragraph
3 (1)(A) meets the standards under this paragraph if
4 such plan includes at least the following information:

5 “(A) A clinical justification for the dis-
6 charge.

7 “(B) An assessment of travel distance and
8 time between the primary residence of the indi-
9 vidual and the hospital, critical access hospital,
10 or rural emergency hospital.

11 “(C) Verification of reliable transportation
12 between the primary residence of the individual
13 and the hospital, critical access hospital, or
14 rural emergency hospital.

15 “(D) Identification of a back-up hospital
16 or facility at which such individual may obtain
17 labor and delivery services.

18 “(E) Confirmation that the plan was re-
19 viewed and approved by a qualified medical pro-
20 fessional (as defined by the Secretary through
21 regulations).

22 “(F) Confirmation that the individual (or
23 the individual’s representative) has received the
24 information described in subparagraphs (A)
25 through (D), that such information was pro-

vided in the primary language of such individual (or representative), and that such individual (or representative) confirmed their understanding of such information.

“(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as limiting or otherwise affecting the discharge planning requirements otherwise applicable to a hospital, critical access hospital, or rural emergency hospital under this title.”.

(b) RURAL MATERNAL AND OBSTETRIC CARE TRAINING DEMONSTRATION GRANTS.—Section 764 of the Public Health Service Act (42 U.S.C. 294s) is amended—

(1) in subsection (c)(1)—

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

(B) by redesignating subparagraph (B) as subparagraph (C); and

(C) by inserting after subparagraph (A) the following:

“(B) shall use the grant funds to provide racial bias training as part of such training program; and”;

(2) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively;

1 (3) by inserting after subsection (c) the fol-
2 lowing:

3 “(d) MINIMUM PERFORMANCE MILESTONES.—

4 “(1) ESTABLISHMENT.—Beginning with the
5 grants awarded under this section for fiscal year
6 2027, the Secretary shall establish minimum per-
7 formance milestones that grant recipients must meet
8 during a fiscal year as a condition of remaining eli-
9 gible for funding through such a grant for any sub-
10 sequent fiscal year.

11 “(2) MILESTONES RELATED TO PERCENT OF
12 STAFF TRAINED.—The minimum performance mile-
13 stones referred to in paragraph (1) shall include
14 milestones related to the percent of all staff of the
15 grant recipient that are trained, or that receive re-
16 resher training, with support from a grant under
17 this section.”; and

18 (4) in subsection (e), as so redesignated—

19 (A) in the subsection heading, by striking
20 “REPORT” and inserting “REPORTS”;

21 (B) in paragraph (1)(B), by striking “the
22 report described in paragraph (2)” and insert-
23 ing “the reports described in paragraphs (2)
24 and (3)”;

25 (C) by adding at the end the following:

1 “(3) SUBSEQUENT REPORTS.—Not later than
2 January 1, 2027, and annually thereafter, the Sec-
3 retary shall submit to Congress, and make publicly
4 available, a report that includes—

5 “(A) updates to the information described
6 in subparagraphs (A) through (C) of paragraph
7 (2); and

8 “(B) additional information regarding the
9 grants under this section, including—

10 “(i) a list of the entities receiving
11 such grants;

12 “(ii) the number and amount of such
13 grants;

14 “(iii) whether training supported by
15 such grants was delivered in-person, vir-
16 tually, asynchronously, or through some
17 other format; and

18 “(iv) descriptions of the geographical
19 coverage of such grants, the number of
20 providers trained under such grants, and
21 patient-level metrics linked to such train-
22 ing (such as changes in clinical outcomes,
23 patient experience, and racial dispari-
24 ties).”.

1 (c) MULTI-CENTER IMPLEMENTATION SCIENCE INI-
2 TIATIVE FOR MATERNAL HEALTH.—The Secretary of
3 Health and Human Services, in consultation with the Di-
4 rector of the Agency for Healthcare Research and Quality
5 and the Director of the National Institutes of Health, shall
6 establish a multi-center implementation science initiative
7 for maternal health to rigorously evaluate different train-
8 ing models for health care professionals (including in-per-
9 son, virtual, simulation, and cohort-based) and the impact
10 of such models on provider behavior, patient outcomes,
11 and maternal health disparities.

12 (d) MATERNAL HEALTH DASHBOARD.—The Sec-
13 retary of Health and Human Services shall develop, main-
14 tain, and make publicly available on the websites of the
15 Department of Health and Human Services an inter-
16 agency maternal health dashboard, which shall include
17 maternal health outcome metrics from agencies within the
18 Department of Health and Human Services and the data
19 collected as part of the initiative under subsection (c),
20 such as data related to maternal mortality and severe ma-
21 ternal morbidity, the number and outcomes of discharges
22 of pregnant individuals prior to delivery from institutions,
23 and data on Federal investments in maternal health re-
24 search.

1 **SEC. 4705. ACCESS TO BIRTH CONTROL ACT.**

2 (a) SHORT TITLE.—This section may be cited as the
3 “Access to Birth Control Act”.

4 (b) FINDINGS.—Congress finds as follows:

5 (1) Family planning is basic health care. Access
6 to contraception helps people determine if and when
7 to become pregnant. Contraception is also a corner-
8 stone of reproductive autonomy and can help people
9 fulfill their educational, professional, and social aspi-
10 rations.

11 (2) As a result of the enactment of the Patient
12 Protection and Affordable Care Act (Public Law
13 111–148), approximately 151,600,000 individuals in
14 the United States were enrolled in private health in-
15 surance plans in the United States in 2020, includ-
16 ing 58,000,000 women between the ages of 19 and
17 64 who had coverage of contraceptive methods ap-
18 proved, cleared, or authorized by the Food and Drug
19 Administration without cost-sharing under such
20 plans.

21 (3) The Patient Protection and Affordable Care
22 Act saved women \$1,400,000,000 on birth control
23 pills alone in 2013.

24 (4) According to the Centers for Disease Con-
25 trol and Prevention, nearly $\frac{2}{3}$ of women between the
26 ages of 15 and 49 are currently using a contracep-

1 tive method, and among sexually active women who
2 were not seeking pregnancy, nearly 9 in 10 have
3 used contraception.

4 (5) Although the Centers for Disease Control
5 and Prevention included family planning in its pub-
6 lished list of the Ten Great Public Health Achieve-
7 ments in the 20th Century, people in the United
8 States face a myriad of barriers in accessing birth
9 control, including cost, geography, immigration sta-
10 tus, language access, discrimination, and stigma.
11 These contraceptive barriers are rooted in systemic
12 inequities, structural racism, and other forms of op-
13 pression in our health care system and society.

14 (6) In 2019, approximately 2,293,000 preg-
15 nancies, nearly 42 percent of all pregnancies, in the
16 United States were unintended.

17 (7) Systemic racism and discrimination, as well
18 as lack of access to comprehensive sex education, ex-
19 acerbates severe health inequities and creates addi-
20 tional barriers to accessing contraception; for exam-
21 ple, due to high uninsured rates and barriers, His-
22 panic women with low-incomes experience a signifi-
23 cantly higher rate of unintended pregnancy (58 per-
24 cent) compared to their White counterparts (33 per-
25 cent). In a 2023 study exploring challenges access-

1 ing contraceptive care among people who identified
2 as Asian-American, Native Hawaiian, or Pacific Is-
3 lander, Black or African-American, Indigenous, or
4 Latina/Latinx, 45 percent of respondents reported
5 experiencing at least one challenge accessing contra-
6 ception in the past year.

7 (8) In addition to preventing pregnancy, contra-
8 ceptives are used for a range of medical purposes,
9 such as treating abnormal uterine bleeding, irregular
10 menstrual cycles, and endometriosis, as well as for
11 people managing other chronic conditions, which are
12 generally higher in communities of color due to sys-
13 temic discrimination.

14 (9) The Food and Drug Administration has ap-
15 proved, cleared, or authorized multiple emergency
16 contraceptive methods as safe and effective in pre-
17 venting unintended pregnancy and has approved
18 over-the-counter access to some forms of emergency
19 contraception for all individuals, regardless of age. If
20 taken soon after unprotected sex or primary contra-
21 ceptive failure, emergency contraception can signifi-
22 cantly reduce a person's chance of unintended preg-
23 nancy. Additionally, in 2023, the Food and Drug
24 Administration approved the first over-the-counter
25 daily birth control pill which will give people of all

1 ages greater access to birth control options without
2 a prescription.

3 (10) Contraception is a protected fundamental
4 right in the United States and access to contracep-
5 tion should not be impeded by one individual's per-
6 sonal beliefs. Providers, including pharmacists, play
7 a key role in providing contraceptive services and
8 important information about prescription and over-
9 the-counter birth control options to people across the
10 country. It is critical that contraceptive care is pro-
11 vided to people of all ages in a supportive way that
12 is culturally appropriate and delivered without stig-
13 ma, bias, or delay.

14 (11) Reports of pharmacists refusing to fill pre-
15 scriptions for contraceptives, including emergency
16 contraceptives, or provide emergency contraception
17 over-the-counter have surfaced in States across the
18 Nation, including Alabama, Arizona, California, the
19 District of Columbia, Georgia, Illinois, Louisiana,
20 Massachusetts, Michigan, Minnesota, Missouri, Mon-
21 tana, New Hampshire, New Mexico, New York,
22 North Carolina, Ohio, Oklahoma, Oregon, Rhode Is-
23 land, Tennessee, Texas, Washington, West Virginia,
24 and Wisconsin.

1 (12) Since the Supreme Court decision in
2 Dobbs v. Jackson Women’s Health Organization
3 (142 S. Ct. 2228 (2022)), there have been increased
4 reports of people being denied birth control at phar-
5 macies.

6 (13) In 2022, the Department of Health and
7 Human Services issued guidance clarifying that re-
8 fusing to dispense birth control can be sex discrimi-
9 nation under section 1557 of the Patient Protection
10 and Affordable Care Act (42 U.S.C. 18116).

11 (c) DUTIES OF PHARMACIES TO ENSURE PROVISION
12 OF CONTRACEPTION AND MEDICATION RELATED TO CON-
13 TRACEPTION.—Part B of title II of the Public Health
14 Service Act (42 U.S.C. 238 et seq.) is amended by adding
15 at the end the following:

16 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
17 **OF CONTRACEPTION AND MEDICATION RE-**
18 **LATED TO CONTRACEPTION.**

19 “(a) IN GENERAL.—Subject to subsection (c), a
20 pharmacy that receives drugs or devices approved, cleared,
21 or authorized by the Food and Drug Administration in
22 interstate commerce shall maintain compliance with the
23 following:

24 “(1) If a customer requests a contraceptive or
25 a medication related to a contraceptive that is in

1 stock, the pharmacy shall ensure that the contracep-
2 tive or the medication related to a contraceptive is
3 provided to the customer without delay.

4 “(2) If a customer requests a contraceptive or
5 a medication related to a contraceptive that is not
6 in stock and the pharmacy in the normal course of
7 business stocks contraception or the medication re-
8 lated to contraception, the pharmacy shall imme-
9 diately inform the customer that the contraceptive or
10 the medication related to a contraceptive is not in
11 stock and without delay offer the customer the fol-
12 lowing options:

13 “(A) If the customer prefers to obtain the
14 contraceptive or the medication related to a
15 contraceptive through a referral or transfer, the
16 pharmacy shall—

17 “(i) locate a pharmacy of the cus-
18 tomer’s choice or the closest pharmacy
19 confirmed to have the contraceptive or the
20 medication related to a contraceptive in
21 stock; and

22 “(ii) refer the customer or transfer
23 the prescription to that pharmacy.

24 “(B) If the customer prefers for the phar-
25 macy to order the contraceptive or the medica-

tion related to a contraceptive, the pharmacy shall obtain the contraceptive or the medication related to a contraceptive under the pharmacy's standard procedure for expedited ordering of medication and notify the customer when the contraceptive or the medication related to a contraceptive arrives.

“(3) The pharmacy shall ensure that—

“(A) it does not operate an environment in which customers are intimidated, threatened, or harassed in the delivery of services relating to a request for contraception or a medication related to contraception;

“(B) its employees do not interfere with or obstruct the delivery of services relating to a request for contraception or a medication related to contraception;

“(C) its employees do not intentionally misrepresent or deceive customers about the availability of contraception or a medication related to contraception or its mechanism of action;

“(D) its employees do not breach medical confidentiality with respect to a request for contraception or a medication related to contracep-

1 tion or threaten to breach such confidentiality;
2 or

3 “(E) its employees do not refuse to return
4 a valid, lawful prescription for contraception or
5 a medication related to contraception upon cus-
6 tomer request.

7 “(b) CONTRACEPTIVES OR MEDICATION RELATED TO
8 A CONTRACEPTIVE NOT ORDINARILY STOCKED.—Noth-
9 ing in subsection (a)(2) shall be construed to require any
10 pharmacy to comply with such subsection if the pharmacy
11 does not ordinarily stock contraceptives or medication re-
12 lated to a contraceptive in the normal course of business.

13 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
14 MACY PRACTICE.—This section does not prohibit a phar-
15 macy from refusing to provide a contraceptive or a medi-
16 cation related to a contraceptive to a customer in accord-
17 ance with any of the following:

18 “(1) If it is unlawful to dispense the contracep-
19 tive or the medication related to a contraceptive to
20 the customer without a valid, lawful prescription and
21 no such prescription is presented.

22 “(2) If the customer is unable to pay for the
23 contraceptive or the medication related to a contra-
24 ceptive.

1 “(3) If the employee of the pharmacy refuses to
2 provide the contraceptive or the medication related
3 to a contraceptive on the basis of a professional clin-
4 ical judgment.

5 “(d) RELATION TO OTHER LAWS.—

6 “(1) RULE OF CONSTRUCTION.—Nothing in
7 this section shall be construed to invalidate or limit
8 rights, remedies, procedures, or legal standards
9 under title VII of the Civil Rights Act of 1964.

10 “(2) CERTAIN CLAIMS.—The Religious Free-
11 dom Restoration Act of 1993 shall not provide a
12 claim concerning, or a defense to a claim under, this
13 section, or provide a basis for challenging the appli-
14 cation or enforcement of this section.

15 “(e) PREEMPTION.—This section does not preempt
16 any provision of State law or any professional obligation
17 made applicable by a State board or other entity respon-
18 sible for licensing or discipline of pharmacies or phar-
19 macists, to the extent that such State law or professional
20 obligation provides protections for customers that are
21 greater than the protections provided by this section.

22 “(f) ENFORCEMENT.—

23 “(1) CIVIL PENALTY.—A pharmacy that vio-
24 lates a requirement of subsection (a) is liable to the
25 United States for a civil penalty in an amount not

1 exceeding \$1,000 per day of violation, not to exceed
2 \$100,000 for all violations adjudicated in a single
3 proceeding.

4 “(2) PRIVATE CAUSE OF ACTION.—Any person
5 aggrieved as a result of a violation of a requirement
6 of subsection (a) may, in any court of competent ju-
7 risdiction, commence a civil action against the phar-
8 macy involved to obtain appropriate relief, including
9 actual and punitive damages, injunctive relief, and a
10 reasonable attorney’s fee and cost.

11 “(3) LIMITATIONS.—A civil action under para-
12 graph (1) or (2) may not be commenced against a
13 pharmacy after the expiration of the 5-year period
14 beginning on the date on which the pharmacy alleg-
15 edly engaged in the violation involved.

16 “(g) DEFINITIONS.—In this section:

17 “(1) The term ‘contraception’ or ‘contraceptive’
18 means any drug or device approved, cleared, or au-
19 thorized by the Food and Drug Administration to
20 prevent pregnancy.

21 “(2) The term ‘employee’ means a person hired,
22 by contract or any other form of an agreement, by
23 a pharmacy.

24 “(3) The term ‘medication related to contracep-
25 tion’ or ‘medication related to a contraceptive’

1 means any drug or device approved, cleared, or au-
2 thorized by the Food and Drug Administration that
3 a medical professional determines necessary to use
4 before or in conjunction with contraception or a con-
5 traceptive.

6 “(4) The term ‘pharmacy’ means an entity
7 that—

8 “(A) is authorized by a State to engage in
9 the business of selling prescription drugs at re-
10 tail; and

11 “(B) employs one or more employees.

12 “(5) The term ‘product’ means a drug or device
13 approved, cleared, or authorized by the Food and
14 Drug Administration.

15 “(6) The term ‘professional clinical judgment’
16 means the use of professional knowledge and skills
17 to form a clinical judgment, in accordance with pre-
18 vailing medical standards.

19 “(7) The term ‘without delay’, with respect to
20 a pharmacy providing, providing a referral for, or
21 ordering contraception or a medication related to
22 contraception, or transferring the prescription for
23 contraception or a medication related to contracep-
24 tion, means within the usual and customary time-
25 frame at the pharmacy for providing, providing a re-

1 ferral for, or ordering other products, or transferring
 2 the prescription for other products, respectively.

3 “(h) **EFFECTIVE DATE.**—This section shall take ef-
 4 fect 31 days after the date of enactment of this section,
 5 without regard to whether the Secretary has issued any
 6 guidance or final rule regarding this section.”.

7 **SEC. 4706. ENABLING STATE MEDICAID PROGRAMS TO PRO-**
 8 **VIDE CARE THROUGH HEALTH HOMES TO IN-**
 9 **DIVIDUALS WITH SICKLE CELL DISEASE.**

10 Section 1945 of the Social Security Act (42 U.S.C.
 11 1396w–4) is amended—

12 (1) in subsection (a), by inserting “(and, begin-
 13 ning January 1, 2027, to eligible individuals with
 14 sickle cell disease (as defined in subsection (c)(5)))”
 15 after “chronic conditions”;

16 (2) in subsection (c)—

17 (A) in paragraph (1), by inserting “and
 18 each eligible individual with sickle cell disease”
 19 after “chronic conditions”; and

20 (B) by adding at the end the following new
 21 paragraph:

22 “(5) **SPECIAL RULE RELATING TO SICKLE CELL**
 23 **DISEASE HEALTH HOMES.**—

24 “(A) **IN GENERAL.**—Beginning January 1,
 25 2027, the Secretary may approve a State plan

1 amendment under this section that is designed
2 to provide health home services primarily to eli-
3 gible individuals with sickle cell disease (in this
4 section referred to as a ‘sickle cell disease-fo-
5 cused State plan amendment’).

6 “(B) REQUIREMENT TO PROVIDE DENTAL
7 AND VISION SERVICES.—In the case of a sickle
8 cell disease-focused State plan amendment ap-
9 proved by the Secretary on or after January 1,
10 2027, a State shall ensure the provision of den-
11 tal and vision services to eligible individuals
12 with sickle cell disease who are enrolled in such
13 health home. Such requirement shall apply irre-
14 spective of existing requirements related to
15 comparability or whether or not the State pro-
16 vides dental or vision services to other Medicaid
17 beneficiaries.

18 “(C) REPORT REQUIREMENTS.—

19 “(i) IN GENERAL.—In the case of a
20 State with a sickle cell disease-focused
21 State plan amendment, such State shall, at
22 the end of the first 8 fiscal year quarters
23 that such State plan amendment is in ef-
24 fect, submit to the Secretary a report on
25 the following, with respect to eligible indi-

viduals with sickle cell disease provided health home services under such State plan amendment:

“(I) The quality of health care provided to such individuals, with a focus on outcomes relevant to the recovery of each such individual.

“(II) The access of such individuals to health care.

“(III) The total expenditures of such individuals for health care.

“(ii) APPLICABLE MEASURES.—For purposes of the report required under this subparagraph, the Secretary shall specify all applicable measures for determining quality of health care provided to eligible individuals with sickle cell disease, access to health care by such individuals, and expenditures on health care by such individuals.

“(D) BEST PRACTICES.—Not later than June 30, 2027, the Secretary shall make publicly available on the website of the Centers for Medicare & Medicaid Services best practices for designing and implementing a sickle cell dis-

1 ease-focused State plan amendment, based on
2 clinical practice guidelines for sickle cell disease
3 developed by medical specialty societies and in
4 consultation with sickle cell disease providers
5 and patient advocacy organizations.

6 “(E) DEFINITIONS.—For purposes of this
7 section:

8 “(i) ELIGIBLE INDIVIDUAL WITH
9 SICKLE CELL DISEASE.—The term ‘eligible
10 individual with sickle cell disease’ means,
11 with respect to a State, an individual who
12 satisfies all of the following:

13 “(I) The individual is eligible for
14 medical assistance under the State
15 plan or under a waiver of such plan.

16 “(II) The individual has sickle
17 cell disease.

18 “(III) The individual may or may
19 not have previously received health
20 home services under any other State
21 plan amendment approved for the
22 State under this section by the Sec-
23 retary.

24 “(ii) SICKLE CELL DISEASE.—The
25 term ‘sickle cell disease’ means an inher-

1 ited blood disorder affecting red blood cells
 2 that occurs when an individual has inher-
 3 ited a sickle cell gene from each parent, as
 4 identified by a newborn screening or other
 5 genetic test.”; and

6 (3) in subsection (h)—

7 (A) in paragraph (3), by inserting “or an
 8 eligible individual with sickle cell disease” after
 9 “chronic conditions”; and

10 (B) in paragraph (5), by inserting “or a
 11 health home for eligible individuals with sickle
 12 cell disease” after “chronic conditions”.

13 **SEC. 4707. GRANT PROGRAM FOR COMMUNITY SCHOOLS**
 14 **AND HEALTH EQUITY.**

15 (a) IN GENERAL.—The Secretary of Education, in
 16 coordination with the Secretary of Health and Human
 17 Services, shall carry out a program under which the Sec-
 18 retary of Education makes grants to eligible entities, on
 19 a competitive basis, to support the implementation or ex-
 20 pansion of school-based health services in community
 21 schools.

22 (b) APPLICATIONS.—To be eligible to receive a grant
 23 under this section, an eligible entity shall submit to the
 24 Secretary of Education an application at such time, in

1 such manner, and containing such information as the Sec-
2 retary may require.

3 (c) USE OF FUNDS.—An eligible entity that receives
4 a grant under this section shall use the grant funds to
5 carry out one or more of the following activities:

6 (1) Expanding or establishing school-based
7 health services, including partnerships with Feder-
8 ally qualified health centers.

9 (2) Hiring and training personnel, including
10 school nurses, mental health professionals, social
11 workers, and community school coordinators.

12 (3) Providing wraparound services, including
13 nutrition assistance, housing support referrals, fam-
14 ily engagement, and legal services.

15 (4) Supporting programs that address social de-
16 terminants of health affecting students and families.

17 (5) Providing culturally and linguistically ap-
18 propriate services for English learners and immi-
19 grant families.

20 (6) Supporting trauma-informed practices and
21 crisis response services.

22 (7) Building partnerships with institutions of
23 higher education to develop health career pathways
24 for students.

1 (d) PRIORITY.—In awarding grants under this sec-
2 tion, the Secretary of Education shall give priority to eligi-
3 ble entities that—

4 (1) serve high concentrations of low-income stu-
5 dents;

6 (2) serve a significant number of English learn-
7 ers or students from immigrant families;

8 (3) demonstrate unmet health or mental health
9 needs among students;

10 (4) are located in medically underserved areas
11 or health professional shortage areas; or

12 (5) propose to partner with Federally qualified
13 health centers or public health agencies to carry out
14 activities supported with the grant.

15 (e) INTERAGENCY COORDINATION.—The Secretary of
16 Education and the Secretary of Health and Human Serv-
17 ices shall enter into a memorandum of understanding for
18 purposes of coordinating the implementation of the grant
19 program under this section. At a minimum, such memo-
20 randum shall provide for coordination between the Secre-
21 taries on—

22 (1) reducing the administrative burdens of im-
23 plementing the program; and

24 (2) providing technical assistance to eligible en-
25 tities.

1 (f) REPORTING AND OVERSIGHT.—

2 (1) GRANTEE REPORTS.—On an annual basis
3 for each year an eligible entity receives a grant
4 under this section, the entity shall submit to the
5 Secretary of Education a report on the activities car-
6 ried out with the grant. Each report shall include,
7 with respect to the year covered by the report—

8 (A) identification of the number of stu-
9 dents served by activities supported with the
10 grant;

11 (B) a description of student outcomes re-
12 lated to health, attendance, and academic per-
13 formance; and

14 (C) to the extent practicable, the informa-
15 tion described in subparagraphs (A) and (B)
16 and other relevant student data disaggregated
17 by income, race, ethnicity, and English learner
18 status.

19 (2) REPORTS TO CONGRESS.—Not later than 3
20 years after the date of enactment of this Act, and
21 not less frequently than once every 3 years there-
22 after, the Secretary of Education shall submit to
23 Congress a report on the grant program under this
24 section. Each report shall include, with respect to
25 the period covered by the report—

1 (A) an evaluation of the effectiveness of
2 the program; and

3 (B) based on the results of the program,
4 identification of any best practices or rec-
5 ommendations for improving coordination be-
6 tween the education and the health systems.

7 (g) RULE OF CONSTRUCTION.—Nothing in this sec-
8 tion shall be construed to alter or supersede any Federal
9 privacy protections, including those provided under section
10 444 of the General Education Provisions Act (20 U.S.C.
11 1232g; commonly known as the “Family Educational
12 Rights and Privacy Act of 1974”) and the amendments
13 made by the Health Insurance Portability and Account-
14 ability Act of 1996 (42 U.S.C. 201 et seq.).

15 (h) DEFINITIONS.—In this section:

16 (1) COMMUNITY SCHOOL.—The term “commu-
17 nity school” means a full-service community school
18 (as defined in section 4622 of the Elementary and
19 Secondary Education Act of 1965 (20 U.S.C.
20 7272)).

21 (2) ELIGIBLE ENTITY.—The term “eligible enti-
22 ty” means—

23 (A) a local educational agency;

24 (B) a consortium of local educational agen-
25 cies; or

1 (C) a partnership between a local edu-
2 cational agency and one or more—

3 (i) community-based organizations;

4 (ii) Federally qualified health centers
5 (as defined in section 1861(aa) of the So-
6 cial Security Act (42 U.S.C. 1395x));

7 (iii) public health agencies; or

8 (iv) institutions of higher education.

9 (3) LOCAL EDUCATIONAL AGENCY.—The term
10 “local educational agency” has the meaning given
11 the term in section 8101 of the Elementary and Sec-
12 ondary Education Act of 1965 (20 U.S.C. 7801).

13 (4) SCHOOL-BASED HEALTH SERVICES.—The
14 term “school-based health services” means com-
15 prehensive health services provided to students in a
16 school setting, including primary care, mental health
17 services, preventative services, and medical referrals.

Subtitle I—Territories Health Equity

PART 1—MEDICARE

Subpart A—Part A

SEC. 4801. CALCULATION OF MEDICARE DSH PAYMENTS FOR IPPS HOSPITALS IN PUERTO RICO.

Section 1886(d)(9)(D)(iii) of the Social Security Act (42 U.S.C. 1395ww(d)(9)(D)(iii)) is amended to read as follows:

“(iii) Subparagraph (F) (relating to disproportionate share payments), including application of subsection (r), except that for this purpose—

“(I) the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I); and

“(II) for discharges occurring on or after October 1, 2026, subclause (I) of paragraph (5)(F)(vi) shall be applied by substituting for the numerator described in such subclause the number of subsection (d) Puerto Rico hospital’s patient days for the cost reporting period involved which were

made up of patients who (for such days) were entitled to benefits under part A of this title and were—

“(aa) entitled to supplementary security income benefits (excluding any State supplementation) under title XVI;

“(bb) eligible for medical assistance under a State plan under title XIX; or

“(cc) receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI.”.

SEC. 4802. REBASING TARGET AMOUNT FOR HOSPITALS IN TERRITORIES.

Section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)) is amended by adding at the end the following new subparagraph:

“(M)(i) For each cost reporting period beginning on or after October 1, 2026, in the case of a hospital located in a territory of the United States, there shall be substituted for the target amount otherwise determined under subparagraph (A) the rebased target amount (as de-

1 fined in clause (ii)), if such substitution results
2 in an amount of payment under this section to
3 the hospital for such period that is greater than
4 the amount of payment that would be made
5 under this section to the hospital for such pe-
6 riod if this subparagraph were not to apply.

7 “(ii) For purposes of this subparagraph,
8 the term ‘rebased target amount’ has the mean-
9 ing given the term ‘target amount’ in subpara-
10 graph (A), except that—

11 “(I) for a cost reporting period begin-
12 ning on or after October 1, 2026, and be-
13 fore September 30, 2031, there shall be
14 substituted for the preceding 12-month
15 cost reporting period the 12-month cost re-
16 porting period beginning during fiscal year
17 2017;

18 “(II) for a cost reporting period be-
19 ginning on or after October 1, 2031, there
20 shall be substituted for the preceding 12-
21 month cost reporting period the cost re-
22 porting period for which the target amount
23 determined under subparagraph (A) is the
24 highest among the 5 cost reporting periods

for which the Secretary has the most recent settled cost reports;

“(III) any reference in subparagraph (A)(i) to the ‘first such cost reporting period’ is deemed a reference to the first cost reporting period following the 12-month cost reporting period beginning during fiscal year 2017; and

“(IV) the applicable percentage increase shall only be applied under subparagraph (B)(ii) for cost reporting periods beginning on or after October 1, 2026.”.

SEC. 4803. MEDICARE DSH TARGET ADJUSTMENT FOR HOSPITALS IN TERRITORIES.

Section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), as amended by section 4802, is further amended by adding at the end the following new subparagraph:

“(N)(i) For each cost reporting period beginning on or after October 1, 2026, in the case of a hospital that is located in a territory of the United States other than Puerto Rico and that would be a subsection (d) hospital if it were located in one of the 50 States, the target amount shall be increased by—

1 “(I) in the case that such hospital has
2 a disproportionate patient percentage of
3 not less than 15 percent and not greater
4 than 40 percent, 10 percent; and

5 “(II) in the case that such hospital
6 has a disproportionate patient percentage
7 of greater than 40 percent, 10 percent plus
8 60 percent of the number of percentage
9 points by which such hospital’s dispropor-
10 tionate patient percentage exceeds 40 per-
11 cent.

12 “(ii) For purposes of this subparagraph,
13 the term ‘disproportionate patient percentage’
14 has the meaning given such term in subsection
15 (d)(5)(F)(vi), except that in applying such
16 meaning any reference under such subsection to
17 individuals entitled to supplementary security
18 income under title XVI shall be deemed for pur-
19 poses of this subparagraph to include individ-
20 uals—

21 “(I) eligible for medical assistance
22 under a State plan under title XIX; or

23 “(II) receiving aid or assistance under
24 any plan of the territory approved under
25 title I, X, XIV, or XVI.”.

Subpart B—Part B

SEC. 4811. ELIMINATING LATE ENROLLMENT PENALTIES
UNDER PART B OF THE MEDICARE PROGRAM
FOR CERTAIN INDIVIDUALS RESIDING IN
PUERTO RICO.

(a) IN GENERAL.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended in the second sentence by inserting “or months occurring in the 5-year period beginning on the date on which the individual becomes entitled to benefits under part A if such individual was residing in Puerto Rico as of such date and such date is after the date that is 4 years before the date of the enactment of the Health Equity and Accountability Act of 2026” before the period at the end of such sentence.

(b) APPLICATION.—The amendment made by subsection (a) shall apply with respect to premiums paid for months beginning on or after the date of the enactment of this Act.

Subpart C—Medicare Advantage (Part C)

SEC. 4821. ADJUSTMENT IN BENCHMARK FOR LOW-BASE
PAYMENT COUNTIES IN PUERTO RICO.

Section 1853(n) of the Social Security Act (42 U.S.C. 1395w–23(n)) is amended—

(1) in paragraph (1), by striking “and (5)” and inserting “(5), and (6)”;

1 (2) in paragraph (4), by striking “In no case”
2 and inserting “Subject to paragraph (6), in no
3 case”; and

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

6 “(6) SPECIAL RULES FOR BLENDED BENCH-
7 MARK AMOUNT FOR TERRITORIES.—

8 “(A) IN GENERAL.—Subject to paragraph
9 (2), the blended benchmark amount for an area
10 in a territory for a year (beginning with 2027)
11 shall not be less than 80 percent of the national
12 average of the base payment amounts specified
13 in subparagraph (2)(E) for such year for areas
14 within the 50 States and the District of Colum-
15 bia.

16 “(B) LIMITATION.—In no case shall the
17 blended benchmark amount for an area in a
18 territory for a year under subparagraph (A) ex-
19 ceed the lowest blended benchmark amount for
20 any area within the 50 States and the District
21 of Columbia for such year.”.

Subpart D—Part D

SEC. 4831. AUTOMATIC ELIGIBILITY OF CERTAIN LOW-IN-COME TERRITORIAL RESIDENTS FOR PREMIUM AND COST-SHARING SUBSIDIES UNDER THE MEDICARE PROGRAM; SUNSET OF ENHANCED ALLOTMENT PROGRAM.

(a) AUTOMATIC ELIGIBILITY OF CERTAIN LOW-IN-COME TERRITORIAL RESIDENTS FOR PREMIUM AND COST-SHARING SUBSIDIES UNDER THE MEDICARE PROGRAM.—

(1) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)) is amended—

(A) in subparagraph (B)(v)—

(i) in subclause (I), by striking “and” at the end;

(ii) in subclause (II), by striking the period and inserting “; and”; and

(iii) by inserting after subclause (II) the following new subclause:

“(III) with respect to plan years beginning on or after January 1, 2027, shall provide that any part D eligible individual who is enrolled for medical assistance under the State Medicaid plan of a territory (as de-

1 fined in section 1935(f)) under title
 2 XIX (or a waiver of such a plan) shall
 3 be treated as a subsidy eligible indi-
 4 vidual described in paragraph (1).”;
 5 and

6 (B) in subparagraph (F), by adding at the
 7 end the following new sentence: “The previous
 8 sentence shall not apply with respect to eligi-
 9 bility determinations for premium and cost-
 10 sharing subsidies under this section made on or
 11 after January 1, 2027.”.

12 (2) CONFORMING AMENDMENT.—Section
 13 1860D–31(j)(2)(D) of the Social Security Act (42
 14 U.S.C. 1395w–141(j)(2)(D)) is amended by adding
 15 at the end the following new sentence: “The previous
 16 sentence shall not apply with respect to amounts
 17 made available to a State under this paragraph on
 18 or after January 1, 2026.”.

19 (b) SUNSET OF ENHANCED ALLOTMENT PRO-
 20 GRAM.—

21 (1) IN GENERAL.—Section 1935(e) of the So-
 22 cial Security Act (42 U.S.C. 1396u–5(e)) is amend-
 23 ed—

1 (A) in paragraph (1)(A), by inserting after
 2 “such State” the following: “before January 1,
 3 2027”; and

4 (B) in paragraph (3)—

5 (i) in subparagraph (A), in the matter
 6 preceding clause (i), by inserting after “a
 7 year” the following: “(before 2027)”; and

8 (ii) in subparagraph (B)(iii), by strik-
 9 ing “a subsequent year” and inserting
 10 “each of fiscal years 2010 through 2026”.

11 (2) TERRITORY DEFINED.—Section 1935 of the
 12 Social Security Act (42 U.S.C. 1396u–5) is amended
 13 by adding at the end the following new subsection:
 14 “(f) TERRITORY DEFINED.—In this section, the term
 15 ‘territory’ means Puerto Rico, the Virgin Islands, Guam,
 16 the Northern Mariana Islands, and American Samoa.”.

17 **PART 2—MISCELLANEOUS**

18 **SEC. 4841. MEDICAID AND CHIP TERRITORY TRANS-**
 19 **PARENCY AND INFORMATION.**

20 (a) PUBLICATION OF INFORMATION ON FEDERAL
 21 EXPENDITURES UNDER MEDICAID AND CHIP IN THE
 22 TERRITORIES.—Not later than 180 days after the date
 23 of the enactment of this section, the Secretary of Health
 24 and Human Services shall publish, and periodically up-
 25 date, on the internet site of the Centers for Medicare &

1 Medicaid Services information on Medicaid and CHIP car-
2 ried out in the territories of the United States. Such infor-
3 mation shall include, with respect to each such territory—

4 (1) the income levels established by the terri-
5 tory for purposes of eligibility of an individual to re-
6 ceive medical assistance under Medicaid or child
7 health assistance under CHIP;

8 (2) the number of individuals enrolled in Med-
9 icaid and CHIP in such territory;

10 (3) any State plan amendments in effect to
11 carry out Medicaid or CHIP in such territory;

12 (4) any waiver of the requirements of title XIX
13 or title XXI issued by the Secretary to carry out
14 Medicaid or CHIP in the territory, including a waiv-
15 er under section 1115 of the Social Security Act (42
16 U.S.C. 1315), any application for such a waiver, and
17 any documentation related to such application (in-
18 cluding correspondence);

19 (5) the amount of the Federal and non-Federal
20 share of expenditures under Medicaid and CHIP in
21 such territory;

22 (6) the systems in place for the furnishing of
23 health care items and services under Medicaid and
24 CHIP in such territory;

25 (7) the design of CHIP in such territory; and

1 (8) other information regarding the carrying
 2 out of Medicaid and CHIP in the territory that is
 3 published on such internet site with respect to car-
 4 rying out Medicaid and CHIP in each State and the
 5 District of Columbia.

6 (b) DEFINITIONS.—In this section:

7 (1) CHIP.—The term “CHIP” means the
 8 State Children’s Health Insurance Program under
 9 title XXI of the Social Security Act.

10 (2) MEDICAID.—The term “Medicaid” means
 11 the Medicaid program under title XIX of the Social
 12 Security Act.

13 (3) TERRITORY.—The term “territory of the
 14 United States” includes Puerto Rico, the Virgin Is-
 15 lands of the United States, Guam, the Northern
 16 Mariana Islands, and American Samoa.

17 **SEC. 4842. REPORT ON EXCLUSION OF TERRITORIES FROM**
 18 **EXCHANGES.**

19 (a) IN GENERAL.—Not later than February 1, 2028,
 20 the Secretary of Health and Human Services shall submit
 21 to Congress a report that details the adverse impacts in
 22 each territory from the practical exclusion of the terri-
 23 tories from the provisions of part 2 of subtitle D of title
 24 I of the Patient Protection and Affordable Care Act (42
 25 U.S.C. 18031 et seq.) insofar as such provisions provide

1 for the establishment of an American Health Benefit Ex-
2 change or the administration of a federally facilitated Ex-
3 change in each State and in the District of Columbia for
4 the purpose of making health insurance more affordable
5 and accessible for individuals and small businesses.

6 (b) INFORMATION IN REPORT.—The report shall in-
7 clude information on the following:

8 (1) An estimate of the total number of unin-
9 sured and underinsured individuals residing in each
10 territory.

11 (2) The number of health insurance issuers in
12 each territory and a description of the health insur-
13 ance plans such issuers offer.

14 (3) An estimate of the number of individuals re-
15 siding in each territory who are denied premium or
16 cost-sharing assistance under section 36B of the In-
17 ternal Revenue Code of 1986 or section 1402 of the
18 Patient Protection and Affordable Care Act (42
19 U.S.C. 18071) that would otherwise be available to
20 them for obtaining health insurance coverage
21 through an Exchange if they resided in one of the
22 50 States or in the District of Columbia.

23 (4) An estimate of the amount of Federal as-
24 sistance described in paragraph (3) that is not being
25 made available to residents of each territory.

1 (5) An estimate of the number of small employ-
 2 ers in each territory that would be eligible to pur-
 3 chase health insurance coverage through a Small
 4 Business Health Options Program (SHOP) Market-
 5 place that would operate as part of an Exchange if
 6 the employers were in one of the 50 States or in the
 7 District of Columbia.

8 **SEC. 4843. ACCESS TO COVERAGE FOR INDIVIDUALS IN**
 9 **CERTAIN AREAS WITHOUT ANY AVAILABLE**
 10 **EXCHANGE PLANS.**

11 Part 2 of subtitle D of title I of the Patient Protec-
 12 tion and Affordable Care Act (42 U.S.C. 18031 et seq.)
 13 is amended by adding at the end the following:

14 **“SEC. 1314. ACCESS TO COVERAGE FOR INDIVIDUALS IN**
 15 **CERTAIN AREAS WITHOUT ANY AVAILABLE**
 16 **EXCHANGE PLANS.**

17 “(a) IN GENERAL.—

18 “(1) COVERAGE THROUGH DC EXCHANGE.—

19 Not later than 3 months after the date of enactment
 20 of this section, the Secretary, in consultation with
 21 the Secretary of the Treasury and the Director of
 22 the Office of Personnel Management, shall establish
 23 a mechanism to ensure that, for any plan year be-
 24 ginning on or after the date described in subsection
 25 (c), any individual described in paragraph (2) has

1 access to health insurance coverage which is at least
2 as broad as the coverage available to Members of
3 Congress and congressional staff (as defined in sec-
4 tion 1312(d)(3)(D)) through the Exchange operating
5 in the District of Columbia. Such individuals shall
6 be eligible for any premium tax credit under section
7 36B of the Internal Revenue Code of 1986, reduced
8 cost sharing under section 1402, and advance deter-
9 mination and payment of such credits or such reduc-
10 tions under section 1412 to be administered by the
11 Secretary, in consultation with the Secretary of the
12 Treasury and the Director of the Office of Personnel
13 Management. The District of Columbia, its resi-
14 dents, and small businesses shall be held harmless
15 from any increased costs resulting from the enact-
16 ment of this section.

17 “(2) INDIVIDUAL DESCRIBED.—An individual
18 described in this paragraph is any individual who—

19 “(A) is not eligible to enroll in an em-
20 ployer-sponsored health plan (excluding such a
21 plan that would not be considered minimum es-
22 sential coverage due to the application of sub-
23 paragraph (C) of section 36B(c)(2) of the In-
24 ternal Revenue Code of 1986 if such subpara-
25 graph applied to such plan); and

1 “(B) is a bona fide resident of any posses-
2 sion of the United States (as determined under
3 section 937(a) of such Code) in which the Sec-
4 retary certifies that no qualified health plan is
5 offered through an Exchange established under
6 this title.

7 “(3) POSSESSION OF THE UNITED STATES.—
8 For purposes of this section, the term ‘possession of
9 the United States’ shall include such possessions as
10 are specified in section 937(a)(1) of the Internal
11 Revenue Code of 1986.

12 “(b) TREATMENT OF POSSESSIONS.—

13 “(1) PAYMENTS TO POSSESSIONS.—

14 “(A) MIRROR CODE POSSESSION.—The
15 Secretary of the Treasury shall periodically (but
16 not less frequently than annually) pay to each
17 possession of the United States with a mirror
18 code tax system amounts equal to the loss to
19 that possession by reason of the application of
20 this section (determined without regard to para-
21 graph (2)) with respect to taxable years begin-
22 ning after the date described in subsection (c).
23 Such amounts shall be determined by the Sec-
24 retary of the Treasury based on information

1 provided by the government of the respective
2 possession.

3 “(B) OTHER POSSESSIONS.—The Sec-
4 retary of the Treasury shall periodically (but
5 not less frequently than annually) pay to each
6 possession of the United States which does not
7 have a mirror code tax system amounts esti-
8 mated by the Secretary of the Treasury as
9 being equal to the aggregate benefits that would
10 have been provided to residents of such posses-
11 sion by reason of the application of this section
12 for any taxable years beginning after the date
13 described in subsection (c) if a mirror code tax
14 system had been in effect in such possession.
15 The preceding sentence shall not apply with re-
16 spect to any possession of the United States un-
17 less such possession has a plan, which has been
18 approved by the Secretary of the Treasury,
19 under which such possession will promptly dis-
20 tribute such payments to the residents of such
21 possession.

22 “(2) COORDINATION WITH CREDIT ALLOWED
23 AGAINST UNITED STATES INCOME TAXES.—No cred-
24 it shall be allowed against United States income

1 taxes for any taxable year under section 36B of the
2 Internal Revenue Code of 1986 to any person—

3 “(A) to whom a credit is allowed against
4 taxes imposed by the possession by reason of
5 this section (determined without regard to this
6 paragraph) for such taxable year, or

7 “(B) who is eligible for a payment under
8 a plan described in paragraph (1)(B) with re-
9 spect to such taxable year.

10 “(3) MIRROR CODE TAX SYSTEM.—For pur-
11 poses of this subsection, the term ‘mirror code tax
12 system’ means, with respect to any possession of the
13 United States, the income tax system of such posses-
14 sion if the income tax liability of the residents of
15 such possession under such system is determined by
16 reference to the income tax laws of the United
17 States as if such possession were the United States.

18 “(4) TREATMENT OF PAYMENTS.—For pur-
19 poses of section 1324(b)(2) of title 31, United
20 States Code, or any similar rule of law, the pay-
21 ments under this subsection shall be treated in the
22 same manner as a refund due from the credit al-
23 lowed under section 36B of the Internal Revenue
24 Code of 1986.

1 “(c) DATE DESCRIBED.—The date described in this
2 subsection is the date on which the Secretary establishes
3 the mechanism described in subsection (a)(1).”.

4 **SEC. 4844. PROHIBITION ON DISCLOSING MEDICAID DATA.**

5 Notwithstanding section 552a of title 5, United
6 States Code, the Secretary of Health and Human Services
7 and the Administrator of the Centers for Medicare & Med-
8 icaid Services shall not disclose the individually identifi-
9 able health information (as defined in section 1171(6) of
10 the Social Security Act (42 U.S.C. 1320d(6))) of an indi-
11 vidual that is obtained in relation to such individual’s en-
12 rollment under a State plan (or waiver of such plan) under
13 title XIX of such Act (42 U.S.C. 1396 et seq.) to any
14 person, including U.S. Immigration and Customs Enforce-
15 ment, for the purpose of enforcing the immigration laws
16 (as such term is defined in section 101 of the Immigration
17 and Nationality Act (8 U.S.C. 1101)).

1 **TITLE V—IMPROVING HEALTH**
2 **OUTCOMES FOR WOMEN,**
3 **GENDER-DIVERSE PEOPLE,**
4 **CHILDREN, AND FAMILIES**
5 **Subtitle A—Underserved**
6 **Communities**

7 **SEC. 5001. GRANTS TO PROMOTE HEALTH FOR UNDER-**
8 **SERVED COMMUNITIES.**

9 Part Q of title III of the Public Health Service Act
10 (42 U.S.C. 280h et seq.) is amended by adding at the end
11 the following:

12 **“SEC. 399Z-3. GRANTS TO PROMOTE HEALTH FOR UNDER-**
13 **SERVED COMMUNITIES.**

14 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
15 laboration with the Administrator of the Health Resources
16 and Services Administration and other Federal officials
17 determined appropriate by the Secretary, may award
18 grants to eligible entities—

19 “(1) to promote health for medically under-
20 served communities, such as racial and ethnic minor-
21 ity women, racial and ethnic minority children, ado-
22 lescents, and lesbian, gay, bisexual, transgender,
23 queer, nonbinary, gender-nonconforming, or ques-
24 tioning communities; and

1 “(2) to strengthen health outreach initiatives in
2 medically underserved communities, including lin-
3 guistically isolated populations.

4 “(b) USE OF FUNDS.—Grants awarded pursuant to
5 subsection (a) may be used to support the activities of
6 community health workers, including such activities—

7 “(1) to provide education and outreach regard-
8 ing enrollment in health insurance including the
9 State Children’s Health Insurance Program under
10 title XXI of the Social Security Act, Medicare under
11 title XVIII of such Act, and Medicaid under title
12 XIX of such Act;

13 “(2) to provide education and outreach in a
14 community setting regarding health problems preva-
15 lent among medically underserved communities, and
16 especially among racial and ethnic minority women,
17 racial and ethnic minority children, adolescents, and
18 lesbian, gay, bisexual, transgender, queer, nonbinary,
19 gender-nonconforming, or questioning communities;

20 “(3) to provide education and experiential
21 learning opportunities and target risk factors and
22 healthy behaviors that impede or contribute to
23 achieving positive health outcomes, including—

24 “(A) healthy nutrition;

25 “(B) physical activity;

1 “(C) overweight or obesity;

2 “(D) tobacco use, including the use of e-
3 cigarettes and vaping;

4 “(E) alcohol and substance use;

5 “(F) injury and violence;

6 “(G) sexual health;

7 “(H) mental health;

8 “(I) musculoskeletal health and arthritis;

9 “(J) prenatal and postnatal care;

10 “(K) dental and oral health;

11 “(L) understanding informed consent;

12 “(M) stigma; and

13 “(N) environmental hazards;

14 “(4) to promote community wellness and aware-
15 ness; and

16 “(5) to provide education and refer target popu-
17 lations to appropriate health care agencies and com-
18 munity-based programs and organizations in order
19 to increase access to quality health care services, in-
20 cluding preventive health services.

21 “(c) APPLICATION.—

22 “(1) IN GENERAL.—Each eligible entity that
23 desires to receive a grant under subsection (a) shall
24 submit an application to the Secretary at such time,

1 in such manner, and accompanied by such additional
2 information as the Secretary may require.

3 “(2) CONTENTS.—Each application submitted
4 pursuant to paragraph (1) shall—

5 “(A) describe the activities for which as-
6 sistance under this section is sought;

7 “(B) contain an assurance that, with re-
8 spect to each community health worker pro-
9 gram receiving funds under the grant awarded,
10 such program provides in-language training and
11 supervision to community health workers to en-
12 able such workers to provide authorized pro-
13 gram activities in (at least) the most commonly
14 used languages within a particular geographic
15 region;

16 “(C) contain an assurance that the appli-
17 cant will evaluate the effectiveness of commu-
18 nity health worker programs receiving funds
19 under the grant;

20 “(D) contain an assurance that each com-
21 munity health worker program receiving funds
22 under the grant will provide culturally com-
23 petent services in the linguistic context most
24 appropriate for the individuals served by the
25 program;

1 “(E) contain a plan to document and dis-
2 seminate project descriptions and results to
3 other States and organizations as identified by
4 the Secretary; and

5 “(F) describe plans to enhance the capac-
6 ity of individuals to utilize health services and
7 health-related social services under Federal,
8 State, and local programs by—

9 “(i) assisting individuals in estab-
10 lishing eligibility under the programs and
11 in receiving the services or other benefits
12 of the programs; and

13 “(ii) providing other services, as the
14 Secretary determines to be appropriate,
15 which may include transportation and
16 translation services.

17 “(d) PRIORITY.—In awarding grants under sub-
18 section (a), the Secretary shall give priority to those appli-
19 cants—

20 “(1) who propose to target geographic areas
21 that—

22 “(A)(i) have a high percentage of residents
23 who are uninsured or underinsured (if the tar-
24 geted geographic area is located in a State that
25 has elected to make medical assistance available

1 under section 1902(a)(10)(A)(i)(VIII) of the
2 Social Security Act to individuals described in
3 such section);

4 “(ii) have a high percentage of under-
5 insured residents in a particular geographic
6 area (if the targeted geographic area is located
7 in a State that has not so elected); or

8 “(iii) have a high number of households ex-
9 perienceing extreme poverty; and

10 “(B) have a high percentage of families for
11 whom English is not their primary language or
12 including smaller limited English-proficient
13 communities within the region that are not oth-
14 erwise reached by linguistically appropriate
15 health services;

16 “(2) with experience in providing health or
17 health-related social services to individuals who are
18 underserved with respect to such services; and

19 “(3) with documented community activity and
20 experience with community health workers.

21 “(e) COLLABORATION WITH ACADEMIC INSTITU-
22 TIONS.—The Secretary shall encourage community health
23 worker programs receiving funds under this section to col-
24 laborate with academic institutions, including minority-

1 serving institutions. Nothing in this section shall be con-
2 strued to require such collaboration.

3 “(f) QUALITY ASSURANCE AND COST-EFFECTIVE-
4 NESS.—The Secretary shall establish guidelines for ensur-
5 ing the quality of the training and supervision of commu-
6 nity health workers under the programs funded under this
7 section and for ensuring the cost-effectiveness of such pro-
8 grams.

9 “(g) MONITORING.—The Secretary shall monitor
10 community health worker programs identified in approved
11 applications and shall determine whether such programs
12 are in compliance with the guidelines established under
13 subsection (f).

14 “(h) TECHNICAL ASSISTANCE.—The Secretary may
15 provide technical assistance to community health worker
16 programs identified in approved applications with respect
17 to planning, developing, and operating programs under the
18 grant.

19 “(i) REPORT TO CONGRESS.—

20 “(1) IN GENERAL.—Not later than 4 years
21 after the date on which the Secretary first awards
22 grants under subsection (a), the Secretary shall sub-
23 mit to Congress a report regarding the grant
24 project.

1 “(2) CONTENTS.—The report required under
2 paragraph (1) shall include the following:

3 “(A) A description of the programs for
4 which grant funds were used.

5 “(B) The number of individuals served.

6 “(C) An evaluation of—

7 “(i) the effectiveness of these pro-
8 grams;

9 “(ii) the cost of these programs; and

10 “(iii) the impact of these programs on
11 the health outcomes of the community resi-
12 dents.

13 “(D) Recommendations for sustaining the
14 community health worker programs developed
15 or assisted under this section.

16 “(E) Recommendations regarding training
17 to enhance career opportunities for community
18 health workers.

19 “(j) DEFINITIONS.—In this section:

20 “(1) COMMUNITY HEALTH WORKER.—The term
21 ‘community health worker’ means an individual who
22 promotes health or nutrition within the community
23 in which the individual resides—

24 “(A) by serving as a liaison between com-
25 munities and health care agencies;

1 “(B) by providing guidance and social as-
2 sistance to community residents;

3 “(C) by enhancing community residents’
4 ability to effectively communicate with health
5 care providers;

6 “(D) by providing culturally and linguis-
7 tically appropriate health or nutrition edu-
8 cation;

9 “(E) by advocating for individual and com-
10 munity health, including dental, oral, mental,
11 and environmental health, or nutrition needs;

12 “(F) by taking into consideration the
13 needs of the communities served, including the
14 prevalence rates of risk factors that impede
15 achieving positive healthy outcomes among
16 pregnant, birthing, and postpartum people and
17 children, especially among racial and ethnic mi-
18 nority pregnant, birthing, and postpartum peo-
19 ple and children; or

20 “(G) by providing referral and followup
21 services.

22 “(2) COMMUNITY SETTING.—The term ‘commu-
23 nity setting’ means a home or a community organi-
24 zation that serves a population.

1 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
2 tity’ means—

3 “(A) a unit of State, territorial, local, or
4 Tribal government (including a federally recog-
5 nized Tribe or Alaska Native village); or

6 “(B) a community-based organization.

7 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
8 The term ‘medically underserved community’ means
9 a community—

10 “(A) that has a substantial number of in-
11 dividuals who are members of a medically un-
12 derserved population, as defined by section
13 330(b)(3);

14 “(B) a significant portion of which is a
15 health professional shortage area as designated
16 under section 332; and

17 “(C) that includes populations that are lin-
18 guistically isolated, such as geographic areas
19 with a shortage of health professionals able to
20 provide linguistically appropriate services.

21 “(5) SUPPORT.—The term ‘support’ means the
22 provision of training, supervision, and materials
23 needed to effectively deliver the services described in
24 subsection (b), reimbursement for services, and
25 other benefits.

1 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$15,000,000 for each of fiscal years 2027 through 2031.”.

4 **Subtitle B—Pregnancy Screening**

5 **SEC. 5101. PREGNANCY INTENTION SCREENING INITIATIVE** 6 **DEMONSTRATION PROGRAM.**

7 Part P of title III of the Public Health Service Act
8 (42 U.S.C. 280g et seq.) is amended by adding at the end
9 the following:

10 **“SEC. 399V-8. PREGNANCY INTENTION SCREENING INITIA-** 11 **TIVE DEMONSTRATION PROGRAM.**

12 “(a) PROGRAM ESTABLISHMENT.—The Secretary,
13 acting through the Director of the Centers for Disease
14 Control and Prevention, shall establish a demonstration
15 program to facilitate the clinical adoption of pregnancy in-
16 tention screening initiatives by health care and social serv-
17 ices providers.

18 “(b) GRANTS.—The Secretary may carry out the
19 demonstration program through awarding grants to eligi-
20 ble entities to implement pregnancy intention screening
21 initiatives, collect data, and evaluate such initiatives.

22 “(c) ELIGIBLE ENTITIES.—To be eligible for a grant
23 under this section, an entity shall—

24 “(1) provide non-directive, comprehensive,
25 medically accurate information; and

1 “(2) be a community-based organization, vol-
2 untary health organization, public health depart-
3 ment, community health center, or other interested
4 public or private primary, behavioral, or other health
5 care or social service provider or organization.

6 “(d) PREGNANCY INTENTION SCREENING INITIA-
7 TIVE.—For purposes of this section, the term ‘pregnancy
8 intention screening initiative’ means any initiative by an
9 eligible entity to routinely screen people with respect to
10 their pregnancy intentions and goals to either prevent un-
11 intended pregnancies or improve the likelihood of healthy
12 pregnancies, in order to better provide health care that
13 meets the contraceptive or pre-pregnancy needs and goals
14 of such people.

15 “(e) EVALUATION.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Director of the Centers for Disease
18 Control and Prevention, shall, by grant or contract,
19 and after consultation as described in paragraph (2),
20 conduct an evaluation of the demonstration pro-
21 gram, with respect to pregnancy intention screening
22 initiatives, conducted under this section. Such eval-
23 uation shall include:

24 “(A) Assessment of the implementation of
25 pregnancy intention screening protocols among

1 a diverse group of patients and providers, in-
2 cluding collecting data on the experiences and
3 outcomes for diverse patient populations in a
4 variety of clinical settings.

5 “(B) Analysis of outcome measures that
6 will facilitate effective and widespread adoption
7 of such protocols by health care providers for
8 inquiring about and responding to pregnancy
9 goals of people with both contraceptive and pre-
10 pregnancy care.

11 “(C) Consideration of health inequities
12 among the population served.

13 “(D) Assessment of the equitable and vol-
14 untary application of such initiatives to minor-
15 ity and medically underserved communities.

16 “(E) Assessment of the training, capacity,
17 and ongoing technical assistance needed for
18 providers to effectively implement such preg-
19 nancy intention screening protocols.

20 “(F) Assessment of whether referral sys-
21 tems for selected protocols follow evidence-based
22 standards that ensure access to comprehensive
23 health services and appropriate follow-up care.

1 “(G) Measuring through rigorous methods
2 the effect of such initiatives on key health out-
3 comes.

4 “(2) CONSULTATION WITH INDEPENDENT, EX-
5 PERT ADVISORY PANEL.—In conducting the evalua-
6 tion under paragraph (1), the Director of the Cen-
7 ters for Disease Control and Prevention shall consult
8 with physicians, physician assistants, advanced prac-
9 tice registered nurses, nurse midwives, and other
10 health care providers who specialize in women’s
11 health, and other experts in public health, clinical
12 practice, program evaluation, and research.

13 “(3) REPORT.—Not later than one year after
14 the last day of the demonstration program under
15 this section, the Director of the Centers for Disease
16 Control and Prevention shall—

17 “(A) submit to Congress a report on the
18 results of the evaluation conducted under para-
19 graph (1); and

20 “(B) make the report publicly available.

21 “(f) FUNDING.—

22 “(1) AUTHORIZATION OF APPROPRIATIONS.—
23 To carry out this section, there is authorized to be
24 appropriated \$10,000,000 for each of fiscal years
25 2027 through 2031.

1 “(2) LIMITATION.—Not more than 20 percent
 2 of funds appropriated to carry out this section pur-
 3 suant to paragraph (1) for a fiscal year may be used
 4 for purposes of the evaluation under subsection
 5 (e).”.

6 **SEC. 5102. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
 7 **AND AWARENESS.**

8 (a) IN GENERAL.—The Secretary shall establish and
 9 implement a birth defects prevention and public awareness
 10 program, consisting of the activities described in sub-
 11 sections (b) and (c).

12 (b) NATIONWIDE MEDIA CAMPAIGN.—In carrying
 13 out subsection (a), the Secretary shall conduct or support
 14 a nationwide media campaign to increase awareness
 15 among health care providers and at-risk populations about
 16 pregnancy and breastfeeding information services.

17 (c) GRANTS FOR PREGNANCY AND BREASTFEEDING
 18 INFORMATION SERVICES.—

19 (1) IN GENERAL.—In carrying out subsection
 20 (a), the Secretary shall award grants to State or re-
 21 gional agencies or organizations for any of the fol-
 22 lowing:

23 (A) INFORMATION SERVICES.—The provi-
 24 sion of, or campaigns to increase awareness

1 about, pregnancy and breastfeeding information
2 services.

3 (B) SURVEILLANCE AND RESEARCH.—The
4 conduct or support of—

5 (i) surveillance of or research on—

6 (I) maternal exposures and ma-
7 ternal health conditions that may in-
8 fluence the risk of birth defects, pre-
9 maturity, or other adverse pregnancy
10 outcomes; and

11 (II) maternal exposures that may
12 influence health risks to a breastfed
13 infant; or

14 (ii) networking to facilitate surveil-
15 lance or research described in this sub-
16 paragraph.

17 (2) PREFERENCE FOR CERTAIN STATES.—The
18 Secretary, in making any grant under this sub-
19 section, shall give preference to States, otherwise
20 equally qualified, that have pregnancy and
21 breastfeeding information services in place.

22 (3) MATCHING FUNDS.—The Secretary may
23 only award a grant under this subsection to a State
24 or regional agency or organization that agrees, with
25 respect to the costs to be incurred in carrying out

1 the grant activities, to make available (directly or
2 through donations from public or private entities)
3 non-Federal funds toward such costs in an amount
4 equal to not less than 25 percent of the amount of
5 the grant.

6 (4) COORDINATION.—The Secretary shall en-
7 sure that activities funded through a grant under
8 this subsection are coordinated, to the maximum ex-
9 tent practicable, with other birth defects prevention
10 and environmental health activities of the Federal
11 Government, including with respect to pediatric envi-
12 ronmental health specialty units and children’s envi-
13 ronmental health centers.

14 (d) EVALUATION.—The Secretary shall provide for
15 an evaluation of pregnancy and breastfeeding information
16 services carried out by States to identify efficient and ef-
17 fective models of—

18 (1) providing information;

19 (2) raising awareness and increasing knowledge
20 about birth defects prevention measures and tar-
21 geting education to at-risk groups;

22 (3) modifying risk behaviors; or

23 (4) other outcome measures as determined ap-
24 propriate by the Secretary.

25 (e) DEFINITIONS.—In this section:

1 (1) MATERNAL.—The term “maternal” refers
2 to people who are pregnant or breastfeeding.

3 (2) PREGNANCY AND BREASTFEEDING INFOR-
4 MATION SERVICES.—The term “pregnancy and
5 breastfeeding information services” includes only—

6 (A) information services to provide accu-
7 rate, evidence-based, clinical information re-
8 garding maternal exposures during pregnancy
9 or breastfeeding that may be associated with
10 birth defects, health risks to a breastfed infant,
11 or other health risks, such as exposures to
12 medications, chemicals, infections, foodborne
13 pathogens, illnesses, nutrition, lifestyle, or
14 climate- and weather-related factors;

15 (B) the provision of accurate, evidence-
16 based information weighing risks of exposures
17 during breastfeeding against the benefits of
18 breastfeeding; and

19 (C) the provision of information described
20 in subparagraph (A) or (B) through counselors,
21 websites, fact sheets, telephonic or electronic
22 communication, community outreach efforts, or
23 other appropriate means.

24 (3) SECRETARY.—The term “Secretary” means
25 the Secretary of Health and Human Services, acting

1 through the Director of the Centers for Disease
2 Control and Prevention.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there are authorized to be appropriated—

5 (1) \$5,000,000 for fiscal year 2027;

6 (2) \$6,000,000 for fiscal year 2028;

7 (3) \$7,000,000 for fiscal year 2029;

8 (4) \$8,000,000 for fiscal year 2030; and

9 (5) \$9,000,000 for fiscal year 2031.

10 **Subtitle C—Pregnancy-Related** 11 **Care**

12 **SEC. 5201. COMMUNITY ACCESS, RESOURCES, AND EM-** 13 **POWERMENT FOR MOMS.**

14 (a) SHORT TITLE.—This section may be cited as the
15 “Community Access, Resources, and Empowerment for
16 Moms Act” or the “CARE for Moms Act”.

17 (b) IMPROVING FEDERAL EFFORTS WITH RESPECT
18 TO PREVENTION OF MATERNAL MORTALITY.—

19 (1) FUNDING FOR STATE-BASED PERINATAL
20 QUALITY COLLABORATIVES DEVELOPMENT AND SUS-
21 TAINABILITY.—

22 (A) IN GENERAL.—Not later than one year
23 after the date of enactment of this Act, the Sec-
24 retary of Health and Human Services, acting
25 through the Division of Reproductive Health of

1 the Centers for Disease Control and Prevention
2 (referred to in this paragraph as the “Sec-
3 retary”), shall establish a grant program to be
4 known as the “State-Based Perinatal Quality
5 Collaborative Grant Program”, under which the
6 Secretary shall award grants to eligible entities
7 for the purpose of development and sustain-
8 ability of State-based perinatal quality
9 collaboratives in every State, the District of Co-
10 lumbia, and eligible territories, in order to
11 measurably improve perinatal care and
12 perinatal health outcomes for pregnant and
13 postpartum women and their infants.

14 (B) GRANT AMOUNTS.—Grants awarded
15 under this paragraph shall be in amounts not to
16 exceed \$250,000 per year, for the duration of
17 the grant period.

18 (C) STATE-BASED PERINATAL QUALITY
19 COLLABORATIVE DEFINED.—For purposes of
20 this paragraph, the term “State-based perinatal
21 quality collaborative” means a network of teams
22 that—

23 (i) is multidisciplinary in nature and
24 includes the full range of perinatal and
25 maternity care providers;

1 (ii) works to improve measurable out-
2 comes for maternal and infant health by
3 advancing evidence-informed clinical prac-
4 tices using quality improvement principles;

5 (iii) works with hospital-based or out-
6 patient facility-based clinical teams, ex-
7 perts, and stakeholders, including patients
8 and families, to spread best practices and
9 optimize resources to improve perinatal
10 care and outcomes;

11 (iv) employs strategies that include
12 the use of the collaborative learning model
13 to provide opportunities for hospitals and
14 clinical teams to collaborate on improve-
15 ment strategies, rapid-response data to
16 provide timely feedback to hospital and
17 other clinical teams to track progress, and
18 quality improvement science to provide
19 support and coaching to hospital and clin-
20 ical teams;

21 (v) has the goal of improving popu-
22 lation-level outcomes in maternal and in-
23 fant health; and

24 (vi) has the goal of improving out-
25 comes of all birthing people, through the

1 coordination, integration, and collaboration
 2 across birth settings.

3 (D) AUTHORIZATION OF APPROPRIA-
 4 TIONS.—For purposes of carrying out this
 5 paragraph, there is authorized to be appro-
 6 priated \$35,000,000 for each of fiscal years
 7 2027 through 2031.

8 (2) EXPANSION OF MEDICAID AND CHIP COV-
 9 ERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

10 (A) REQUIRING COVERAGE OF ORAL
 11 HEALTH SERVICES FOR PREGNANT AND
 12 POSTPARTUM WOMEN.—

13 (i) MEDICAID.—Section 1905 of the
 14 Social Security Act (42 U.S.C. 1396d), as
 15 amended by section 4251(d)(3)(A), is
 16 amended—

17 (I) in subsection (a)(4)—

18 (aa) by striking “; and (D)”

19 and inserting “; (D)”;

20 (bb) by striking “; and (E)”

21 and inserting “; (E)”;

22 (cc) by striking “; and (F)”

23 and inserting “; (F)”;

24 (dd) by striking the semi-

25 colon at the end and inserting “;

1 and (G) oral health services for
 2 pregnant and postpartum women
 3 (as defined in subsection (nn));”;
 4 and
 5 (II) by adding at the end the fol-
 6 lowing new subsection:

7 “(nn) ORAL HEALTH SERVICES FOR PREGNANT AND
 8 POSTPARTUM WOMEN.—

9 “(1) IN GENERAL.—For purposes of this title,
 10 the term ‘oral health services for pregnant and
 11 postpartum women’ means dental services necessary
 12 to prevent disease and promote oral health, restore
 13 oral structures to health and function, and treat
 14 emergency conditions that are furnished to a woman
 15 during pregnancy (or during the 1-year period be-
 16 ginning on the last day of the pregnancy).

17 “(2) COVERAGE REQUIREMENTS.—To satisfy
 18 the requirement to provide oral health services for
 19 pregnant and postpartum women, a State shall, at
 20 a minimum, provide coverage for preventive, diag-
 21 nostic, periodontal, and restorative care consistent
 22 with recommendations for perinatal oral health care
 23 and dental care during pregnancy from the Amer-
 24 ican Academy of Pediatric Dentistry and the Amer-
 25 ican College of Obstetricians and Gynecologists.”.

1 (ii) CHIP.—Section 2103(c)(6) of the
2 Social Security Act (42 U.S.C.
3 1397cc(c)(6)) is amended—

4 (I) in subparagraph (A)—

5 (aa) by inserting “or a tar-
6 geted low-income pregnant
7 woman” after “targeted low-in-
8 come child”; and

9 (bb) by inserting “, and, in
10 the case of a targeted low-income
11 child who is pregnant or a tar-
12 geted low-income pregnant
13 woman, satisfy the coverage re-
14 quirements specified in section
15 1905(nn)” after “emergency con-
16 ditions”; and

17 (II) in subparagraph (B), by in-
18 serting “(but only if, in the case of a
19 targeted low-income child who is preg-
20 nant or a targeted low-income preg-
21 nant woman, the benchmark dental
22 benefit package satisfies the coverage
23 requirements specified in section
24 1905(nn))” after “subparagraph (C)”.

1 (B) REQUIRING 12-MONTH CONTINUOUS
 2 COVERAGE OF FULL BENEFITS FOR PREGNANT
 3 AND POSTPARTUM INDIVIDUALS UNDER MED-
 4 ICAID AND CHIP.—

5 (i) MEDICAID.—Section 1902 of the
 6 Social Security Act (42 U.S.C. 1396a) is
 7 amended—

8 (I) in subsection (a)—

9 (aa) in paragraph (89), by
 10 striking “and” at the end;

11 (bb) in paragraph (90)(C),
 12 by striking the period at the end
 13 and inserting “; and”; and

14 (cc) by inserting after para-
 15 graph (90)(C) the following new
 16 paragraph:

17 “(91) provide that the State plan is in compli-
 18 ance with subsection (e)(16).”; and

19 (II) in subsection (e)(16)—

20 (aa) in subparagraph (A),
 21 by striking “At the option of the
 22 State, the State plan (or waiver
 23 of such State plan) may provide”
 24 and inserting “A State plan (or

1 waiver of such State plan) shall
 2 provide”;

3 (bb) in subparagraph (B), in
 4 the matter preceding clause (i),
 5 by striking “by a State making
 6 an election under this para-
 7 graph” and inserting “under a
 8 State plan (or a waiver of such
 9 State plan)”;

10 (cc) by striking subpara-
 11 graph (C).

12 (ii) CHIP.—

13 (I) IN GENERAL.—Section
 14 2107(e)(1)(K) of the Social Security
 15 Act (42 U.S.C. 1397gg(e)(1)(J)) is
 16 amended to read as follows:

17 “(K) Paragraphs (5) and (16) of section
 18 1902(e) (relating to the requirement to provide
 19 medical assistance under the State plan or
 20 waiver consisting of full benefits during preg-
 21 nancy and throughout the 12-month
 22 postpartum period under title XIX).”.

23 (II) CONFORMING.—Section
 24 2112(d)(2)(A) of the Social Security
 25 Act (42 U.S.C. 1397ll(d)(2)(A)) is

1 amended by striking “the month in
2 which the 60-day period” and all that
3 follows through “pursuant to section
4 2107(e)(1),”.

5 (C) MAINTENANCE OF EFFORT.—

6 (i) MEDICAID.—Section 1902(l) of the
7 Social Security Act (42 U.S.C. 1396a(l)) is
8 amended by adding at the end the fol-
9 lowing new paragraph:

10 “(5) During the period that begins on the date of
11 enactment of this paragraph and ends on the date that
12 is 5 years after such date of enactment, as a condition
13 for receiving any Federal payments under section 1903(a)
14 for calendar quarters occurring during such period, a
15 State shall not have in effect, with respect to women who
16 are eligible for medical assistance under the State plan
17 or under a waiver of such plan on the basis of being preg-
18 nant or having been pregnant, eligibility standards, meth-
19 odologies, or procedures under the State plan or waiver
20 that are more restrictive than the eligibility standards,
21 methodologies, or procedures, respectively, under such
22 plan or waiver that are in effect on the date of enactment
23 of this paragraph.”.

24 (ii) CHIP.—Section 2105(d) of the
25 Social Security Act (42 U.S.C. 1397ee(d))

1 is amended by adding at the end the fol-
2 lowing new paragraph:

3 “(4) IN ELIGIBILITY STANDARDS FOR TAR-
4 GETED LOW-INCOME PREGNANT WOMEN.—During
5 the period that begins on the date of enactment of
6 this paragraph and ends on the date that is 5 years
7 after such date of enactment, as a condition of re-
8 ceiving payments under subsection (a) and section
9 1903(a), a State that elects to provide assistance to
10 women on the basis of being pregnant (including
11 pregnancy-related assistance provided to targeted
12 low-income pregnant women (as defined in section
13 2112(d)), pregnancy-related assistance provided to
14 women who are eligible for such assistance through
15 application of section 1903(v)(4)(A)(i) under section
16 2107(e)(1), or any other assistance under the State
17 child health plan (or a waiver of such plan) which
18 is provided to women on the basis of being preg-
19 nant) shall not have in effect, with respect to such
20 women, eligibility standards, methodologies, or pro-
21 cedures under such plan (or waiver) that are more
22 restrictive than the eligibility standards, methodolo-
23 gies, or procedures, respectively, under such plan (or
24 waiver) that are in effect on the date of enactment
25 of this paragraph.”.

1 (D) INFORMATION ON BENEFITS.—The
2 Secretary of Health and Human Services shall
3 make publicly available on the internet website
4 of the Department of Health and Human Serv-
5 ices, information regarding benefits available to
6 pregnant and postpartum women and under the
7 Medicaid program and the Children’s Health
8 Insurance Program, including information on—

9 (i) benefits that States are required to
10 provide to pregnant and postpartum
11 women under such programs;

12 (ii) optional benefits that States may
13 provide to pregnant and postpartum
14 women under such programs; and

15 (iii) the availability of different kinds
16 of benefits for pregnant and postpartum
17 women, including oral health and mental
18 health benefits and breastfeeding services
19 and supplies, under such programs.

20 (E) FEDERAL FUNDING FOR COST OF EX-
21 TENDED MEDICAID AND CHIP COVERAGE FOR
22 POSTPARTUM WOMEN.—

23 (i) MEDICAID.—Section 1905 of the
24 Social Security Act (42 U.S.C. 1396d), as

1 amended by title IV and subparagraph
2 (A)(i)(II), is further amended—

3 (I) in subsection (b), by striking
4 “and (mm)” and inserting “(mm),
5 and (oo)”;

6 (II) by adding at the end the fol-
7 lowing:

8 “(oo) INCREASED FMAP FOR EXTENDED MEDICAL
9 ASSISTANCE FOR POSTPARTUM INDIVIDUALS.—

10 “(1) IN GENERAL.—Notwithstanding subsection
11 (b), the Federal medical assistance percentage for a
12 State, with respect to amounts expended by such
13 State for medical assistance for an individual who is
14 eligible for such assistance on the basis of being
15 pregnant or having been pregnant that is provided
16 during the 305-day period that begins on the 60th
17 day after the last day of the individual’s pregnancy
18 (including any such assistance provided during the
19 month in which such period ends), shall be equal
20 to—

21 “(A) during the first 20-quarter period for
22 which this subsection is in effect with respect to
23 a State, 100 percent; and

24 “(B) with respect to a State, during each
25 quarter thereafter, 90 percent.

1 “(2) EXCLUSION FROM TERRITORIAL CAPS.—

2 Any payment made to a territory for expenditures
3 for medical assistance for an individual described in
4 paragraph (1) that is subject to the Federal medical
5 assistance percentage specified under paragraph (1)
6 shall not be taken into account for purposes of ap-
7 plying payment limits under subsections (f) and (g)
8 of section 1108.”.

9 (ii) CHIP.—Section 2105(c) of the
10 Social Security Act (42 U.S.C. 1397ee(c))
11 is amended by adding at the end the fol-
12 lowing new paragraph:

13 “(13) ENHANCED PAYMENT FOR EXTENDED
14 ASSISTANCE PROVIDED TO PREGNANT WOMEN.—
15 Notwithstanding subsection (b), the enhanced
16 FMAP, with respect to payments under subsection
17 (a) for expenditures under the State child health
18 plan (or a waiver of such plan) for assistance pro-
19 vided under the plan (or waiver) to a woman who is
20 eligible for such assistance on the basis of being
21 pregnant (including pregnancy-related assistance
22 provided to a targeted low-income pregnant woman
23 (as defined in section 2112(d)), pregnancy-related
24 assistance provided to a woman who is eligible for
25 such assistance through application of section

1 1903(v)(4)(A)(i) under section 2107(e)(1), or any
 2 other assistance under the plan (or waiver) provided
 3 to a woman who is eligible for such assistance on the
 4 basis of being pregnant) during the 305-day period
 5 that begins on the 60th day after the last day of her
 6 pregnancy (including any such assistance provided
 7 during the month in which such period ends), shall
 8 be equal to—

9 “(A) during the first 20-quarter period for
 10 which this subsection is in effect with respect to
 11 a State, 100 percent; and

12 “(B) with respect to a State, during each
 13 quarter thereafter, 90 percent.”.

14 (F) GUIDANCE ON STATE OPTIONS FOR
 15 MEDICAID COVERAGE OF DOULA SERVICES.—
 16 Not later than 1 year after the date of the en-
 17 actment of this section, the Secretary of Health
 18 and Human Services shall issue guidance for
 19 the States concerning options for Medicaid cov-
 20 erage and payment for support services pro-
 21 vided by doulas.

22 (G) ENHANCED FMAP FOR RURAL OBSTET-
 23 RIC AND GYNECOLOGICAL SERVICES.—Section
 24 1905 of the Social Security Act (42 U.S.C.

1 1396d), as amended by title IV and subpara-
2 graphs (A) and (E), is further amended—

3 (i) in subsection (b), by striking “and
4 (oo)” and inserting “(oo), and (pp)”; and

5 (ii) by adding at the end the following
6 new subsection:

7 “(pp) INCREASED FMAP FOR MEDICAL ASSISTANCE
8 FOR OBSTETRIC AND GYNECOLOGICAL SERVICES FUR-
9 NISHED AT RURAL HOSPITALS.—

10 “(1) IN GENERAL.—Notwithstanding subsection
11 (b), the Federal medical assistance percentage for a
12 State, with respect to amounts expended by such
13 State for medical assistance for obstetric or gyneco-
14 logical services that are furnished in a hospital that
15 is located in a rural area (as defined for purposes
16 of section 1886) shall be equal to 90 percent for
17 each calendar quarter beginning with the first cal-
18 endar quarter during which this subsection is in ef-
19 fect.

20 “(2) EXCLUSION FROM TERRITORIAL CAPS.—

21 Any payment made to a territory for expenditures
22 for medical assistance described in paragraph (1)
23 that is subject to the Federal medical assistance per-
24 centage specified under paragraph (1) shall not be
25 taken into account for purposes of applying payment

1 limits under subsections (f) and (g) of section
2 1108.”.

3 (H) EFFECTIVE DATES.—

4 (i) IN GENERAL.—Subject to clauses
5 (ii) and (iii)—

6 (I) the amendments made by
7 subparagraphs (A), (B), and (E) shall
8 take effect on the first day of the first
9 calendar quarter that begins on or
10 after the date that is 1 year after the
11 date of enactment of this section;

12 (II) the amendments made by
13 subparagraph (C) shall take effect on
14 the date of enactment of this section;
15 and

16 (III) the amendments made by
17 subparagraph (G) shall take effect on
18 the first day of the first calendar
19 quarter that begins on or after the
20 date of enactment of this section.

21 (ii) EXCEPTION FOR STATE LEGISLA-
22 TION.—In the case of a State plan under
23 title XIX of the Social Security Act or a
24 State child health plan under title XXI of
25 such Act that the Secretary of Health and

1 Human Services determines requires State
2 legislation in order for the respective plan
3 to meet any requirement imposed by
4 amendments made by this paragraph, the
5 respective plan shall not be regarded as
6 failing to comply with the requirements of
7 such title solely on the basis of its failure
8 to meet such an additional requirement be-
9 fore the first day of the first calendar
10 quarter beginning after the close of the
11 first regular session of the State legislature
12 that begins after the date of enactment of
13 this section. For purposes of the previous
14 sentence, in the case of a State that has a
15 2-year legislative session, each year of the
16 session shall be considered to be a separate
17 regular session of the State legislature.

18 (iii) STATE OPTION FOR EARLIER EF-
19 FECTIVE DATE.—A State may elect to have
20 subsection (e)(16) of section 1902 of the
21 Social Security Act (42 U.S.C. 1396a) and
22 subparagraph (K) of section 2107(e)(1) of
23 the Social Security Act (42 U.S.C.
24 1397gg(e)(1)), as amended by subpara-
25 graph (B), and subsection (oo) of section

1 1905 of the Social Security Act (42 U.S.C.
 2 1396d) and paragraph (13) of section
 3 2105(c) of the Social Security Act (42
 4 U.S.C. 1397ee(c)), as added by subpara-
 5 graph (E), take effect with respect to the
 6 State on the first day of any fiscal quarter
 7 that begins before the date described in
 8 clause (i) and apply to amounts payable to
 9 the State for expenditures for medical as-
 10 sistance, child health assistance, or preg-
 11 nancy-related assistance to pregnant or
 12 postpartum individuals furnished on or
 13 after such day.

14 (3) REGIONAL CENTERS OF EXCELLENCE.—
 15 Part P of title III of the Public Health Service Act
 16 (42 U.S.C. 280g et seq.) (as amended by section
 17 5101) is amended by adding at the end the fol-
 18 lowing:

19 **“SEC. 399V-9. REGIONAL CENTERS OF EXCELLENCE AD-**
 20 **DRESSING IMPLICIT BIAS AND CULTURAL**
 21 **COMPETENCY IN PATIENT-PROVIDER INTER-**
 22 **ACTIONS EDUCATION.**

23 “(a) IN GENERAL.—Not later than one year after the
 24 date of enactment of this section, the Secretary, in con-
 25 sultation with such other agency heads as the Secretary

1 determines appropriate, shall award cooperative agree-
2 ments for the establishment or support of regional centers
3 of excellence addressing implicit bias, cultural competency,
4 and respectful care practices in patient-provider inter-
5 actions education for the purpose of enhancing and im-
6 proving how health care professionals are educated in im-
7 plicit bias and delivering culturally competent health care.

8 “(b) ELIGIBILITY.—To be eligible to receive a cooper-
9 ative agreement under subsection (a), an entity shall—

10 “(1) be a public or other nonprofit entity speci-
11 fied by the Secretary that provides educational and
12 training opportunities for students and health care
13 professionals, which may be a health system, teach-
14 ing hospital, community health center, medical
15 school, school of public health, school of nursing,
16 dental school, social work school, school of profes-
17 sional psychology, or any other health professional
18 school or program at an institution of higher edu-
19 cation (as defined in section 101 of the Higher Edu-
20 cation Act of 1965) focused on the prevention, treat-
21 ment, or recovery of health conditions that con-
22 tribute to maternal mortality and the prevention of
23 maternal mortality and severe maternal morbidity;

24 “(2) demonstrate community engagement and
25 participation, such as through partnerships with

1 home visiting and case management programs and
2 community-based organizations serving minority
3 populations;

4 “(3) demonstrate engagement with groups en-
5 gaged in the implementation of health care profes-
6 sional training in implicit bias and delivering cul-
7 turally competent care, such as departments of pub-
8 lic health, perinatal quality collaboratives, hospital
9 systems, and health care professional groups, in
10 order to obtain input on resources needed for effec-
11 tive implementation strategies; and

12 “(4) provide to the Secretary such information,
13 at such time and in such manner, as the Secretary
14 may require.

15 “(c) DIVERSITY.—In awarding a cooperative agree-
16 ment under subsection (a), the Secretary shall take into
17 account any regional differences among eligible entities
18 and make an effort to ensure geographic diversity among
19 award recipients.

20 “(d) DISSEMINATION OF INFORMATION.—

21 “(1) PUBLIC AVAILABILITY.—The Secretary
22 shall make publicly available on the internet website
23 of the Department of Health and Human Services
24 information submitted to the Secretary under sub-
25 section (b)(4).

1 “(2) EVALUATION.—The Secretary shall evalu-
 2 ate each regional center of excellence established or
 3 supported pursuant to subsection (a) and dissemi-
 4 nate the findings resulting from each such evalua-
 5 tion to the appropriate public and private entities.

6 “(3) DISTRIBUTION.—The Secretary shall share
 7 evaluations and overall findings with State depart-
 8 ments of health and other relevant State level offices
 9 to inform State and local best practices.

10 “(e) MATERNAL MORTALITY DEFINED.—In this sec-
 11 tion, the term ‘maternal mortality’ means death of a
 12 woman that occurs during pregnancy or within the one-
 13 year period following the end of such pregnancy.

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
 15 purposes of carrying out this section, there is authorized
 16 to be appropriated \$5,000,000 for each of fiscal years
 17 2027 through 2031.”.

18 (4) SPECIAL SUPPLEMENTAL NUTRITION PRO-
 19 GRAM FOR WOMEN, INFANTS, AND CHILDREN.—Sec-
 20 tion 17(d)(3)(A)(ii) of the Child Nutrition Act of
 21 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

22 (A) by striking the clause designation and
 23 heading and all that follows through “A State”
 24 and inserting the following:

25 “(ii) WOMEN.—

1 “(I) BREASTFEEDING WOMEN.—
2 A State”;

3 (B) in subclause (I) (as so designated), by
4 striking “1 year” and all that follows through
5 “earlier” and inserting “2 years postpartum”;
6 and

7 (C) by adding at the end the following:

8 “(II) POSTPARTUM WOMEN.—A
9 State may elect to certify a
10 postpartum woman for a period of 2
11 years.”.

12 (c) FULL SPECTRUM DOULA WORKFORCE.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services shall establish and implement a
15 program to award grants or contracts to health pro-
16 fessions schools, schools of public health, academic
17 health centers, State or local governments, terri-
18 tories, Indian Tribes and Tribal organizations,
19 Urban Indian organizations, Native Hawaiian orga-
20 nizations, or other appropriate public or private non-
21 profit entities or community-based organizations (or
22 consortia of any such entities, including entities pro-
23 moting multidisciplinary approaches), to establish or
24 expand programs to grow and diversify the doula

1 workforce, including through improving the capacity
2 and supply of health care providers.

3 (2) USE OF FUNDS.—Amounts made available
4 by paragraph (1) shall be used for the following ac-
5 tivities:

6 (A) Establishing programs that provide
7 education and training to individuals seeking
8 appropriate training or certification as full
9 spectrum doulas.

10 (B) Expanding the capacity of existing
11 programs described in subparagraph (A), for
12 the purpose of increasing the number of stu-
13 dents enrolled in such programs, including by
14 awarding scholarships for students who agree to
15 work in underserved communities after receiv-
16 ing such education and training.

17 (C) Developing and implementing strate-
18 gies to recruit and retain students from under-
19 served communities, particularly from demo-
20 graphic groups experiencing high rates of ma-
21 ternal mortality and severe maternal morbidity,
22 including racial and ethnic minority groups,
23 into programs described in subparagraphs (A)
24 and (B).

1 (3) FUNDING.—In addition to amounts other-
 2 wise available, there is appropriated to the Secretary
 3 of Health and Human Services for fiscal year 2027,
 4 out of any money in the Treasury not otherwise ap-
 5 propriated, \$50,000,000, to remain available until
 6 expended, for carrying out this subsection.

7 (d) GRANTS FOR RURAL OBSTETRIC MOBILE
 8 HEALTH UNITS.—Part B of title III of the Public Health
 9 Service Act (42 U.S.C. 243 et seq.) is amended by adding
 10 at the end the following:

11 **“SEC. 320C. GRANTS FOR RURAL OBSTETRIC MOBILE**
 12 **HEALTH UNITS.**

13 “(a) IN GENERAL.—The Secretary, acting through
 14 the Administrator of the Health Resources and Services
 15 Administration (referred to in this section as the ‘Sec-
 16 retary’), shall establish a pilot program under which the
 17 Secretary shall make grants to States—

18 “(1) to purchase and equip rural mobile health
 19 units for the purpose of providing pre-conception,
 20 pregnancy, postpartum, and obstetric emergency
 21 services in rural and underserved communities;

22 “(2) to train providers including obstetrician-
 23 gynecologists, certified nurse-midwives, nurse practi-
 24 tioners, nurses, and midwives to operate and provide
 25 obstetric services, including training and planning

1 for obstetric emergencies, in such mobile health
2 units; and

3 “(3) to address access issues, including social
4 determinants of health and wrap-around clinical and
5 community services including nutrition, housing, lac-
6 tation services, and transportation support and re-
7 ferrals.

8 “(b) NO SHARING OF DATA WITH LAW ENFORCE-
9 MENT.—As a condition of receiving a grant under this sec-
10 tion, a State shall submit to the Secretary an assurance
11 that the State will not make available to Federal or State
12 law enforcement any personally identifiable information
13 regarding any pregnant or postpartum individual collected
14 pursuant to such grant.

15 “(c) GRANT DURATION.—The period of a grant
16 under this section shall not exceed 5 years.

17 “(d) IMPLEMENTING AND REPORTING.—

18 “(1) IN GENERAL.—States that receive pilot
19 grants under this section shall—

20 “(A) implement the program funded by the
21 pilot grants; and

22 “(B) not later than 3 years after the date
23 of enactment of this section, and not later than
24 6 years after such date of enactment, submit to

1 the Secretary a report that describes the results
2 of such program, including—

3 “(i) relevant information and relevant
4 quantitative indicators of the programs’
5 success in improving the standard of care
6 and maternal health outcomes for individ-
7 uals in rural and underserved communities
8 seen for pre-conception, pregnancy, or
9 postpartum visits in the rural mobile
10 health units, stratified by the categories of
11 data specified in paragraph (2);

12 “(ii) relevant qualitative evaluations
13 from individuals receiving pre-conception,
14 pregnant, or postpartum care from rural
15 mobile health units, including measures of
16 patient-reported experience of care and
17 measures of patient-reported issues with
18 access to care without the rural mobile
19 health unit pilot; and

20 “(iii) strategies to sustain such pro-
21 grams beyond the duration of the grant
22 and expand such programs to other rural
23 and underserved communities.

24 “(2) CATEGORIES OF DATA.—The categories of
25 data specified in this paragraph are the following:

1 “(A) Race, ethnicity, sex, gender, gender
2 identity, primary language, age, geography, in-
3 surance status, disability status.

4 “(B) Number of visits provided for pre-
5 conception, prenatal, or postpartum care.

6 “(C) Number of repeat visits provided for
7 preconception, prenatal, or postpartum care.

8 “(D) Number of screenings or tests pro-
9 vided for smoking, substance use, hypertension,
10 sexually-transmitted diseases, diabetes, HIV,
11 depression, intimate partner violence, pap
12 smears, and pregnancy.

13 “(3) DATA PRIVACY PROTECTION.—The reports
14 referred to in paragraph (1)(B) shall not contain
15 any personally identifiable information regarding
16 any pregnant or postpartum individual.

17 “(e) EVALUATION.—The Secretary shall conduct an
18 evaluation of the pilot program under this section to deter-
19 mine the impact of the pilot program with respect to—

20 “(1) the effectiveness of the grants awarded
21 under this section to improve maternal health out-
22 comes in rural and underserved communities, with
23 data stratified by race, ethnicity, primary language,
24 socioeconomic status, geography, insurance type, and

1 other factors as the Secretary determines appro-
2 priate;

3 “(2) spending on maternity care by States par-
4 ticipating in the pilot program;

5 “(3) to the extent practicable, qualitative and
6 quantitative measures of patient experience; and

7 “(4) any other areas of assessment that the
8 Secretary determines relevant.

9 “(f) REPORT.—Not later than one year after the
10 completion of the pilot program under this section, the
11 Secretary shall submit to Congress, and make publicly
12 available, a report that describes—

13 “(1) the results of the evaluation conducted
14 under subsection (e); and

15 “(2) a recommendation regarding whether the
16 pilot program should be continued after fiscal year
17 2031 and expanded on a national basis.

18 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to the Secretary to carry
20 out this section \$10,000,000 for each of fiscal years 2027
21 through 2031.”.

22 (e) REQUIRING NOTIFICATION OF IMPENDING HOS-
23 PITAL OBSTETRIC UNIT CLOSURE.—Section 1866(a)(1)
24 of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is
25 amended—

1 (1) in subparagraph (X), by striking “and” at
2 the end;

3 (2) in subparagraph (Y)(ii)(V), by striking the
4 period and inserting “, and”; and

5 (3) by inserting after subparagraph (Y) the fol-
6 lowing new subparagraph:

7 “(Z) beginning 180 days after the date of the
8 enactment of this subparagraph, in the case of a
9 hospital, not less than 90 days prior to the closure
10 of any obstetric unit of the hospital, to submit to the
11 Secretary a notification which shall include—

12 “(i) a report analyzing the impact the clo-
13 sure will have on the community;

14 “(ii) steps the hospital will take to identify
15 other health care providers that can alleviate
16 any service gaps as a result of the closure; and

17 “(iii) any additional information as may be
18 required by the Secretary.”.

19 (f) EVALUATION AND REPORT ON MATERNAL
20 HEALTH NEEDS.—

21 (1) IN GENERAL.—Not later than 2 years after
22 the date of enactment of this Act, the Secretary of
23 Health and Human Services shall conduct, and sub-
24 mit to Congress a report that describes the results
25 of, an evaluation of—

1 (A) where the maternal health needs are
2 greatest in the United States; and

3 (B) the Federal expenditures made to ad-
4 dress such needs.

5 (2) PERIOD COVERED.—The evaluation under
6 paragraph (1) shall cover the period of calendar
7 years 2000 through 2026.

8 (3) ANALYSIS.—The evaluation under para-
9 graph (1) shall include analysis of the following:

10 (A) How Federal funds provided to States
11 for maternal health were distributed across re-
12 gions, States, and localities or counties.

13 (B) Barriers to applying for and receiving
14 Federal funds for maternal health, including,
15 with respect to initial applications—

16 (i) requirements for submission in
17 partnership with other entities; and

18 (ii) stringent network requirements.

19 (C) Why applicants did not receive fund-
20 ing, including limited availability of funds, the
21 strength of the respective applications, and fail-
22 ure to adhere to requirements.

23 (4) DISAGGREGATION OF DATA.—The report
24 under paragraph (1) shall disaggregate data on

1 mothers served by race, ethnicity, insurance status,
2 and language spoken.

3 (g) INCREASING EXCISE TAXES ON CIGARETTES AND
4 ESTABLISHING EXCISE TAX EQUITY AMONG ALL TO-
5 BACCO PRODUCT TAX RATES.—

6 (1) TAX PARITY FOR ROLL-YOUR-OWN TO-
7 BACCO.—Section 5701(g) of the Internal Revenue
8 Code of 1986 is amended by striking “\$24.78” and
9 inserting “\$49.56”.

10 (2) TAX PARITY FOR PIPE TOBACCO.—Section
11 5701(f) of the Internal Revenue Code of 1986 is
12 amended by striking “\$2.8311 cents” and inserting
13 “\$49.56”.

14 (3) TAX PARITY FOR SMOKELESS TOBACCO.—

15 (A) Section 5701(e) of the Internal Rev-
16 enue Code of 1986 is amended—

17 (i) in paragraph (1), by striking
18 “\$1.51” and inserting “\$26.84”;

19 (ii) in paragraph (2), by striking
20 “50.33 cents” and inserting “\$10.74”; and

21 (iii) by adding at the end the fol-
22 lowing:

23 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
24 SINGLE-USE UNITS.—On discrete single-use units,
25 \$100.66 per thousand.”.

1 (B) Section 5702(m) of such Code is
2 amended—

3 (i) in paragraph (1), by striking “or
4 chewing tobacco” and inserting “, chewing
5 tobacco, or discrete single-use unit”;

6 (ii) in paragraphs (2) and (3), by in-
7 serting “and which is not a discrete single-
8 use unit” before the period in each such
9 paragraph; and

10 (iii) by adding at the end the fol-
11 lowing:

12 “(4) DISCRETE SINGLE-USE UNIT.—The term
13 ‘discrete single-use unit’ means any product con-
14 taining, made from, or derived from tobacco or nico-
15 tine that—

16 “(A) is not intended to be smoked; and

17 “(B) is in the form of a lozenge, tablet,
18 pill, pouch, dissolvable strip, or other discrete
19 single-use or single-dose unit.”.

20 (4) TAX PARITY FOR SMALL CIGARS.—Para-
21 graph (1) of section 5701(a) of the Internal Revenue
22 Code of 1986 is amended by striking “\$50.33” and
23 inserting “\$100.66”.

24 (5) TAX PARITY FOR LARGE CIGARS.—

1 (A) IN GENERAL.—Paragraph (2) of sec-
2 tion 5701(a) of the Internal Revenue Code of
3 1986 is amended by striking “52.75 percent”
4 and all that follows through the period and in-
5 serting the following: “\$49.56 per pound and a
6 proportionate tax at the like rate on all frac-
7 tional parts of a pound but not less than
8 10.066 cents per cigar.”.

9 (B) GUIDANCE.—The Secretary of the
10 Treasury, or the Secretary’s delegate, may issue
11 guidance regarding the appropriate method for
12 determining the weight of large cigars for pur-
13 poses of calculating the applicable tax under
14 section 5701(a)(2) of the Internal Revenue
15 Code of 1986.

16 (C) CONFORMING AMENDMENT.—Section
17 5702 of such Code is amended by striking sub-
18 section (l).

19 (6) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO
20 AND CERTAIN PROCESSED TOBACCO.—Subsection (o)
21 of section 5702 of the Internal Revenue Code of
22 1986 is amended by adding at the end the following:
23 “Such term includes processed tobacco that is re-
24 moved for delivery or delivered to a person other
25 than a person with a permit provided under section

1 5713, but does not include removals of processed to-
2 bacco for exportation.”.

3 (7) CLARIFYING TAX RATE FOR OTHER TO-
4 BACCO PRODUCTS.—

5 (A) IN GENERAL.—Section 5701 of the In-
6 ternal Revenue Code of 1986 is amended by
7 adding at the end the following new subsection:

8 “(i) OTHER TOBACCO PRODUCTS.—Any product not
9 otherwise described under this section that has been deter-
10 mined to be a tobacco product by the Food and Drug Ad-
11 ministration through its authorities under the Family
12 Smoking Prevention and Tobacco Control Act shall be
13 taxed at a level of tax equivalent to the tax rate for ciga-
14 rettes on an estimated per use basis as determined by the
15 Secretary.”.

16 (B) ESTABLISHING PER USE BASIS.—For
17 purposes of section 5701(i) of the Internal Rev-
18 enue Code of 1986, not later than 12 months
19 after the later of the date of the enactment of
20 this Act or the date that a product has been de-
21 termined to be a tobacco product by the Food
22 and Drug Administration, the Secretary of the
23 Treasury (or the Secretary of the Treasury’s
24 delegate) shall issue final regulations estab-
25 lishing the level of tax for such product that is

1 equivalent to the tax rate for cigarettes on an
 2 estimated per use basis.

3 (8) CLARIFYING DEFINITION OF TOBACCO
 4 PRODUCTS.—

5 (A) IN GENERAL.—Subsection (c) of sec-
 6 tion 5702 of the Internal Revenue Code of 1986
 7 is amended to read as follows:

8 “(c) TOBACCO PRODUCTS.—The term ‘tobacco prod-
 9 ucts’ means—

10 “(1) cigars, cigarettes, smokeless tobacco, pipe
 11 tobacco, and roll-your-own tobacco, and

12 “(2) any other product subject to tax pursuant
 13 to section 5701(i).”.

14 (B) CONFORMING AMENDMENTS.—Sub-
 15 section (d) of section 5702 of such Code is
 16 amended by striking “cigars, cigarettes, smoke-
 17 less tobacco, pipe tobacco, or roll-your-own to-
 18 bacco” each place it appears and inserting “to-
 19 bacco products”.

20 (9) INCREASING TAX ON CIGARETTES.—

21 (A) SMALL CIGARETTES.—Section
 22 5701(b)(1) of such Code is amended by striking
 23 “\$50.33” and inserting “\$100.66”.

1 (B) LARGE CIGARETTES.—Section
 2 5701(b)(2) of such Code is amended by striking
 3 “\$105.69” and inserting “\$211.38”.

4 (10) TAX RATES ADJUSTED FOR INFLATION.—
 5 Section 5701 of such Code, as amended by para-
 6 graph (7), is amended by adding at the end the fol-
 7 lowing new subsection:

8 “(j) INFLATION ADJUSTMENT.—

9 “(1) IN GENERAL.—In the case of any calendar
 10 year beginning after 2026, the dollar amounts pro-
 11 vided under this chapter shall each be increased by
 12 an amount equal to—

13 “(A) such dollar amount, multiplied by

14 “(B) the cost-of-living adjustment deter-
 15 mined under section 1(f)(3) for the calendar
 16 year, determined by substituting ‘calendar year
 17 2025’ for ‘calendar year 2016’ in subparagraph
 18 (A)(ii) thereof.

19 “(2) ROUNDING.—If any amount as adjusted
 20 under paragraph (1) is not a multiple of \$0.01, such
 21 amount shall be rounded to the next highest multiple
 22 of \$0.01.”.

23 (11) FLOOR STOCKS TAXES.—

24 (A) IMPOSITION OF TAX.—On tobacco
 25 products manufactured in or imported into the

1 United States which are removed before any tax
2 increase date and held on such date for sale by
3 any person, there is hereby imposed a tax in an
4 amount equal to the excess of—

5 (i) the tax which would be imposed
6 under section 5701 of the Internal Rev-
7 enue Code of 1986 on the article if the ar-
8 ticle had been removed on such date, over

9 (ii) the prior tax (if any) imposed
10 under section 5701 of such Code on such
11 article.

12 (B) CREDIT AGAINST TAX.—Each person
13 shall be allowed as a credit against the taxes
14 imposed by subparagraph (A) an amount equal
15 to the lesser of \$1,000 or the amount of such
16 taxes. For purposes of the preceding sentence,
17 all persons treated as a single employer under
18 subsection (b), (c), (m), or (o) of section 414 of
19 the Internal Revenue Code of 1986 shall be
20 treated as 1 person for purposes of this sub-
21 paragraph.

22 (C) LIABILITY FOR TAX AND METHOD OF
23 PAYMENT.—

24 (i) LIABILITY FOR TAX.—A person
25 holding tobacco products on any tax in-

crease date to which any tax imposed by subparagraph (A) applies shall be liable for such tax.

(ii) METHOD OF PAYMENT.—The tax imposed by subparagraph (A) shall be paid in such manner as the Secretary shall prescribe by regulations.

(iii) TIME FOR PAYMENT.—The tax imposed by subparagraph (A) shall be paid on or before the date that is 120 days after the effective date of the tax rate increase.

(D) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.), or any other provision of law, any article which is located in a foreign trade zone on any tax increase date shall be subject to the tax imposed by subparagraph (A) if—

(i) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the first proviso of section 3(a) of such Act, or

1 (ii) such article is held on such date
2 under the supervision of an officer of the
3 United States Customs and Border Protec-
4 tion of the Department of Homeland Secu-
5 rity pursuant to the second proviso of such
6 section 3(a).

7 (E) DEFINITIONS.—For purposes of this
8 paragraph—

9 (i) IN GENERAL.—Any term used in
10 this paragraph which is also used in sec-
11 tion 5702 of such Code shall have the
12 same meaning as such term has in such
13 section.

14 (ii) TAX INCREASE DATE.—The term
15 “tax increase date” means the effective
16 date of any increase in any tobacco prod-
17 uct excise tax rate pursuant to the amend-
18 ments made by this subsection (other than
19 paragraph (10) thereof).

20 (iii) SECRETARY.—The term “Sec-
21 retary” means the Secretary of the Treas-
22 ury or the Secretary’s delegate.

23 (F) CONTROLLED GROUPS.—Rules similar
24 to the rules of section 5061(e)(3) of such Code
25 shall apply for purposes of this paragraph.

1 (G) OTHER LAWS APPLICABLE.—All provi-
2 sions of law, including penalties, applicable with
3 respect to the taxes imposed by section 5701 of
4 such Code shall, insofar as applicable and not
5 inconsistent with the provisions of this para-
6 graph, apply to the floor stocks taxes imposed
7 by subparagraph (A), to the same extent as if
8 such taxes were imposed by such section 5701.
9 The Secretary may treat any person who bore
10 the ultimate burden of the tax imposed by sub-
11 paragraph (A) as the person to whom a credit
12 or refund under such provisions may be allowed
13 or made.

14 (12) EFFECTIVE DATES.—

15 (A) IN GENERAL.—Except as provided in
16 subparagraphs (B) and (C), the amendments
17 made by this subsection shall apply to articles
18 removed (as defined in section 5702(j) of the
19 Internal Revenue Code of 1986) after the last
20 day of the month which includes the date of the
21 enactment of this Act.

22 (B) DISCRETE SINGLE-USE UNITS, LARGE
23 CIGARS, AND PROCESSED TOBACCO.—The
24 amendments made by paragraphs (3)(A)(iii),
25 (3)(B), (5), and (6) shall apply to articles re-

1 moved (as defined in section 5702(j) of the In-
 2 ternal Revenue Code of 1986) after the date
 3 that is 6 months after the date of the enact-
 4 ment of this Act.

5 (C) OTHER TOBACCO PRODUCTS.—The
 6 amendments made by paragraph (7)(A) shall
 7 apply to products removed after the last day of
 8 the month which includes the date that the Sec-
 9 retary of the Treasury (or the Secretary of the
 10 Treasury’s delegate) issues final regulations es-
 11 tablishing the level of tax for such product.

12 **SEC. 5202. MOMMIES.**

13 (a) GAO STUDY AND REPORT.—

14 (1) IN GENERAL.—Not later than 1 year after
 15 the date of the enactment of this Act, the Comp-
 16 troller General of the United States shall submit to
 17 Congress a report on the gaps in coverage with re-
 18 spect to—

19 (A) pregnant individuals enrolled under a
 20 State plan (or waiver of such plan) under title
 21 XIX of the Social Security Act (42 U.S.C. 1396
 22 et seq.) and the Children’s Health Insurance
 23 Program under title XXI of the Social Security
 24 Act (42 U.S.C. 1397aa et seq.); and

1 (B) postpartum individuals enrolled under
2 a State plan (or waiver of such plan) under title
3 XIX of the Social Security Act (42 U.S.C. 1396
4 et seq.) and the Children's Health Insurance
5 Program under title XXI of the Social Security
6 Act (42 U.S.C. 1397aa et seq.) who received as-
7 sistance under either such program during their
8 pregnancy.

9 (2) CONTENT OF REPORT.—The report re-
10 quired under this subsection shall include the fol-
11 lowing:

12 (A) Information about the abilities and
13 successes of State Medicaid agencies in deter-
14 mining whether pregnant and postpartum indi-
15 viduals are eligible under another insurance af-
16 fordability program, and in transitioning any
17 such individuals who are so eligible to coverage
18 under such a program at the end of their period
19 of eligibility for medical assistance, pursuant to
20 section 435.1200 of the title 42, Code of Fed-
21 eral Regulations (as in effect on September 1,
22 2018).

23 (B) Information on factors contributing to
24 gaps in coverage that disproportionately impact
25 underserved populations, including low-income

1 individuals, Black, Indigenous, and other indi-
2 viduals of color, individuals who reside in a
3 health professional shortage area (as defined in
4 section 332(a)(1)(A) of the Public Health Serv-
5 ice Act (42 U.S.C. 254e(a)(1)(A))) or individ-
6 uals who are members of a medically under-
7 served population (as defined by section
8 330(b)(3) of such Act (42 U.S.C.
9 254b(b)(3)(A))).

10 (C) Recommendations for addressing and
11 reducing such gaps in coverage.

12 (D) Such other information as the Comp-
13 troller General deems necessary.

14 (3) DATA DISAGGREGATION.—To the greatest
15 extent possible, the Comptroller General shall
16 disaggregate data presented in the report, including
17 by age, gender identity, race, ethnicity, income level,
18 and other demographic factors.

19 (b) MATERNITY CARE HOME DEMONSTRATION
20 PROJECT.—Title XIX of the Social Security Act (42
21 U.S.C. 1396 et seq.) is amended by inserting the following
22 new section after section 1948:

1 **“SEC. 1949. MATERNITY CARE HOME DEMONSTRATION**
 2 **PROJECT.**

3 “(a) IN GENERAL.—Not later than 1 year after the
 4 date of the enactment of this section, the Secretary shall
 5 establish a demonstration project (in this section referred
 6 to as the ‘demonstration project’) under which the Sec-
 7 retary shall provide grants to States to enter into arrange-
 8 ments with eligible entities to implement or expand a ma-
 9 ternity care home model for eligible individuals.

10 “(b) GOALS OF DEMONSTRATION PROJECT.—The
 11 goals of the demonstration project are the following:

12 “(1) To improve—

13 “(A) maternity and infant care outcomes;

14 “(B) birth equity;

15 “(C) health equity for—

16 “(i) Black, Indigenous, and other peo-
 17 ple of color;

18 “(ii) lesbian, gay, bisexual,
 19 transgender, queer, non-binary, and gender
 20 nonconforming individuals;

21 “(iii) individuals with disabilities; and

22 “(iv) other underserved populations;

23 “(D) communication by maternity, infant
 24 care, oral health services, and social services
 25 providers;

1 “(E) integration of perinatal support serv-
 2 ices, including community health workers,
 3 doulas, social workers, public health nurses,
 4 peer lactation counselors, lactation consultants,
 5 childbirth educators, peer mental health work-
 6 ers, and others, into health care entities and or-
 7 ganizations;

8 “(F) care coordination between maternity,
 9 infant care, oral health services, and social serv-
 10 ices providers within the community;

11 “(G) the quality and safety of maternity
 12 and infant care;

13 “(H) the experience of individuals receiv-
 14 ing maternity care, including by increasing the
 15 ability of an individual to develop and follow
 16 their own birthing plans; and

17 “(I) access to adequate prenatal and
 18 postpartum care, including—

19 “(i) prenatal care that is initiated in
 20 a timely manner;

21 “(ii) not fewer than 5 post-pregnancy
 22 visits to a maternity care provider; and

23 “(iii) interpregnancy care.

1 “(2) To provide coordinated, evidence-based, re-
2 spectful, culturally and linguistically appropriate,
3 and person-centered maternity care management.

4 “(3) To decrease—

5 “(A) severe and preventable maternal mor-
6 bidity and maternal mortality;

7 “(B) overall health care spending;

8 “(C) unnecessary emergency department
9 visits;

10 “(D) inequities in maternal and infant care
11 outcomes, including racial, economic, disability,
12 gender-based, and geographical inequities;

13 “(E) racial, gender, economic, and other
14 discrimination among health care professionals;

15 “(F) racism, discrimination, disrespect,
16 and abuse in maternity care settings;

17 “(G) the rate of cesarean deliveries for
18 low-risk pregnancies;

19 “(H) the rate of pre-term births and in-
20 fants born with low birth weight; and

21 “(I) the rate of avoidable maternal and
22 newborn hospitalizations and admissions to in-
23 tensive care units.

1 “(c) CONSULTATION.—In designing and imple-
2 menting the demonstration project the Secretary shall
3 consult with stakeholders, including—

4 “(1) States;

5 “(2) organizations representing relevant health
6 care professionals, including oral health services pro-
7 fessionals;

8 “(3) organizations (including reproductive jus-
9 tice and birth justice organizations led by people of
10 color) that represent consumers of maternal health
11 care, including consumers of maternal health care
12 who are disproportionately impacted by poor mater-
13 nal health outcomes;

14 “(4) representatives with experience imple-
15 menting other maternity care home models, includ-
16 ing representatives from the Center for Medicare
17 and Medicaid Innovation;

18 “(5) community-based health care professionals,
19 including doulas, lactation consultants, and other
20 stakeholders;

21 “(6) experts in promoting health equity and
22 combating racial bias in health care settings; and

23 “(7) Black, Indigenous, and other maternal
24 health care consumers of color who have experienced
25 severe maternal morbidity.

1 “(d) APPLICATION AND SELECTION OF STATES.—

2 “(1) IN GENERAL.—A State seeking to partici-
3 pate in the demonstration project shall submit an
4 application to the Secretary at such time and in
5 such manner as the Secretary shall require.

6 “(2) SELECTION OF STATES.—

7 “(A) IN GENERAL.—The Secretary shall
8 select at least 10 States to participate in the
9 demonstration project.

10 “(B) SELECTION REQUIREMENTS.—In se-
11 lecting States to participate in the demonstra-
12 tion project, the Secretary shall—

13 “(i) ensure that there is geographic
14 and regional diversity in the areas in which
15 activities will be carried out under the
16 project;

17 “(ii) ensure that States with signifi-
18 cant inequities in maternal and infant
19 health outcomes, including severe maternal
20 morbidity, and other inequities based on
21 race, income, or access to maternity care,
22 are included; and

23 “(iii) ensure that at least 1 territory
24 is included.

25 “(e) GRANTS.—

1 “(1) IN GENERAL.—Subject to the availability
2 of appropriations, the Secretary shall award 1 grant
3 for each year of the demonstration project to each
4 State that is selected to participate in the dem-
5 onstration project.

6 “(2) USE OF GRANT FUNDS.—A State may use
7 funds received under this section to—

8 “(A) award grants or make payments to
9 eligible entities as part of an arrangement de-
10 scribed in subsection (f)(2);

11 “(B) provide financial incentives to health
12 care professionals, including community-based
13 health care workers and community-based
14 doulas, who participate in the State’s maternity
15 care home model;

16 “(C) provide adequate training for health
17 care professionals, including community-based
18 health care workers, doulas, and care coordina-
19 tors, who participate in the State’s maternity
20 care home model, which may include training
21 for cultural humility and antiracism, racial bias,
22 health equity, reproductive and birth justice,
23 trauma-informed care, home visiting skills, and
24 respectful communication and listening skills,
25 particularly in regards to maternal health;

1 “(D) pay for personnel and administrative
2 expenses associated with designing, imple-
3 menting, and operating the State’s maternity
4 care home model;

5 “(E) pay for items and services that are
6 furnished under the State’s maternity care
7 home model and for which payment is otherwise
8 unavailable under this title;

9 “(F) pay for services and materials to en-
10 sure culturally and linguistically appropriate
11 communication, including—

12 “(i) language services such as inter-
13 preters and translation of written mate-
14 rials; and

15 “(ii) development of culturally and lin-
16 guistically appropriate materials, as well as
17 auxiliary aids and services; and

18 “(G) pay for other costs related to the
19 State’s maternity care home model, as deter-
20 mined by the Secretary.

21 “(3) GRANT FOR NATIONAL INDEPENDENT
22 EVALUATOR.—

23 “(A) IN GENERAL.—From the amounts
24 appropriated under subsection (l), prior to
25 awarding any grants under paragraph (1), the

1 Secretary shall enter into a contract with a na-
2 tional external entity to create a single, uniform
3 process to—

4 “(i) ensure that States that receive
5 grants under paragraph (1) comply with
6 the requirements of this section; and

7 “(ii) evaluate the outcomes of the
8 demonstration project in each participating
9 State.

10 “(B) ANNUAL REPORT.—The contract de-
11 scribed in subparagraph (A) shall require the
12 national external entity to submit to the Sec-
13 retary—

14 “(i) a yearly evaluation report for
15 each year of the demonstration project;
16 and

17 “(ii) a final impact report after the
18 demonstration project has concluded.

19 “(C) SECRETARY’S AUTHORITY.—Nothing
20 in this paragraph shall prevent the Secretary
21 from making a determination that a State is
22 not in compliance with the requirements of this
23 section without the national external entity
24 making such a determination.

25 “(f) PARTNERSHIP WITH ELIGIBLE ENTITIES.—

1 “(1) IN GENERAL.—As a condition of receiving
2 a grant under this section, a State shall enter into
3 an arrangement with 1 or more eligible entities that
4 meet the requirements of paragraph (2).

5 “(2) ARRANGEMENTS WITH ELIGIBLE ENTI-
6 TIES.—Under an arrangement between a State and
7 an eligible entity under this subsection, the eligible
8 entity shall perform the following functions, with re-
9 spect to eligible individuals enrolled with the entity
10 under the State’s maternity care home model:

11 “(A) Provide culturally and linguistically
12 appropriate congruent care, which may include
13 prenatal care, family planning services, medical
14 care, mental and behavioral care, postpartum
15 care, and oral health services to such eligible in-
16 dividuals through a team of health care profes-
17 sionals, which may include obstetrician-gyne-
18 cologists, maternal-fetal medicine specialists,
19 family physicians, primary care providers, oral
20 health providers, physician assistants, advanced
21 practice registered nurses (such as nurse practi-
22 tioners and certified nurse midwives), certified
23 midwives, certified professional midwives, phys-
24 ical therapists, social workers, traditional and
25 community-based doulas, lactation consultants,

1 childbirth educators, community health workers,
2 peer mental health supporters, and other health
3 care professionals.

4 “(B) Conduct a risk assessment of each
5 such eligible individual to determine if their
6 pregnancy is high or low risk, and, based on the
7 results of such risk assessment, establish for
8 each such eligible individual a tailored preg-
9 nancy care plan, which—

10 “(i) takes into consideration the indi-
11 vidual’s own preferences, pregnancy care,
12 and birthing plans; and

13 “(ii) determines the appropriate sup-
14 port services to reduce the individual’s
15 medical, social, and environmental risk fac-
16 tors.

17 “(C) Assign each such eligible individual to
18 a culturally and linguistically appropriate care
19 coordinator, which may be a nurse, social work-
20 er, traditional or community-based doula, com-
21 munity health worker, midwife, or other health
22 care provider, who is responsible for ensuring
23 that such eligible individual receives the nec-
24 essary medical care and connections to essential
25 support services.

1 “(D) Provide, or arrange for the provision
2 of, essential support services, such as services
3 that address—

4 “(i) food access, nutrition, and exer-
5 cise;

6 “(ii) smoking cessation;

7 “(iii) substance use disorder and ad-
8 diction treatment;

9 “(iv) anxiety, depression, trauma, and
10 other mental and behavioral health issues;

11 “(v) breastfeeding, chestfeeding, or
12 other infant feeding options supports, initi-
13 ation, continuation, and duration;

14 “(vi) stable, affordable, safe, and
15 healthy housing;

16 “(vii) transportation;

17 “(viii) intimate partner violence;

18 “(ix) community and police violence;

19 “(x) home visiting services;

20 “(xi) childbirth and newborn care edu-
21 cation;

22 “(xii) oral health education;

23 “(xiii) continuous labor support;

24 “(xiv) group prenatal care;

1 “(xv) family planning and contracep-
2 tive care and supplies; and

3 “(xvi) affordable child care.

4 “(E) As appropriate, facilitate connections
5 to a usual primary care provider, which may be
6 a reproductive health care provider.

7 “(F) Refer to guidelines and opinions of
8 medical associations when determining whether
9 an elective delivery should be performed on an
10 eligible individual before 39 weeks of gestation.

11 “(G) Provide such eligible individual with
12 evidence-based and culturally and linguistically
13 appropriate education and resources to identify
14 potential warning signs of pregnancy and
15 postpartum complications, including informa-
16 tion regarding when and how to obtain medical
17 attention.

18 “(H) Provide, or arrange for the provision
19 of, culturally and linguistically appropriate
20 pregnancy and postpartum health services, in-
21 cluding family planning counseling and services,
22 to eligible individuals.

23 “(I) Track and report postpartum health
24 and birth outcomes of such eligible individuals
25 and their children.

1 “(J) Ensure that care is person-centered,
2 culturally and linguistically appropriate, and
3 patient-led, including by engaging eligible indi-
4 viduals in their own care, including through
5 communication and education.

6 “(K) Ensure adequate training for appro-
7 priately serving the population of individuals
8 who are eligible for medical assistance under
9 the State plan (or waiver of such plan), includ-
10 ing through reproductive justice, birth justice,
11 birth equity, and anti-racist frameworks, home
12 visiting skills, and knowledge of social services.

13 “(g) TERM OF DEMONSTRATION PROJECT.—The
14 Secretary shall conduct the demonstration project for a
15 period of 5 years.

16 “(h) REPORT.—Not later than 18 months after the
17 date of the enactment of this section and annually there-
18 after for each year of the demonstration project term, the
19 Secretary shall submit a report to Congress on the results
20 of the demonstration project, including—

21 “(1) the results of the final report of the na-
22 tional external entity required under subsection
23 (e)(3)(B)(ii); and

24 “(2) recommendations on whether the model
25 studied in the demonstration project should be con-

1 tinued or more widely adopted, including by private
2 health plans.

3 “(i) WAIVER AUTHORITY.—To the extent that the
4 Secretary determines necessary in order to carry out the
5 demonstration project, the Secretary may waive section
6 1902(a)(1) (relating to statewideness) and section
7 1902(a)(10)(B) (relating to comparability).

8 “(j) TECHNICAL ASSISTANCE.—The Secretary shall
9 establish a process to provide technical assistance to
10 States that are awarded grants under this section and to
11 eligible entities and other providers participating in a
12 State maternity care home model funded by such a grant.

13 “(k) DEFINITIONS.—In this section:

14 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
15 tity’ means an entity or organization that provides
16 medically accurate, comprehensive maternity services
17 to individuals who are eligible for medical assistance
18 under a State plan under this title or a waiver of
19 such a plan, and may include:

20 “(A) A freestanding birth center.

21 “(B) An entity or organization receiving
22 assistance under section 330 of the Public
23 Health Service Act.

24 “(C) A federally qualified health center.

25 “(D) A rural health clinic.

1 “(E) A health facility operated by an In-
 2 dian tribe or tribal organization (as those terms
 3 are defined in section 4 of the Indian Health
 4 Care Improvement Act).

5 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
 6 individual’ means a pregnant individual or a for-
 7 merly pregnant individual during the 1-year period
 8 beginning on the last day of the pregnancy, or dur-
 9 ing such longer period beginning on the last day of
 10 the pregnancy as a State may elect, who is—

11 “(A) enrolled in a State plan under this
 12 title, a waiver of such a plan, or a State child
 13 health plan under title XXI; and

14 “(B) a patient of an eligible entity which
 15 has entered into an arrangement with a State
 16 under subsection (f).

17 “(1) AUTHORIZATION OF APPROPRIATIONS.—There
 18 are authorized to be appropriated to the Secretary, for
 19 each of fiscal years 2027 through 2034, such sums as may
 20 be necessary to carry out this section.”.

21 (c) REAPPLICATION OF MEDICARE PAYMENT RATE
 22 FLOOR TO PRIMARY CARE SERVICES FURNISHED UNDER
 23 MEDICAID AND INCLUSION OF ADDITIONAL PRO-
 24 VIDERS.—

1 (1) REAPPLICATION OF PAYMENT FLOOR; ADDI-
2 TIONAL PROVIDERS.—

3 (A) IN GENERAL.—Section 1902(a)(13) of
4 the Social Security Act (42 U.S.C.
5 1396a(a)(13)) is amended—

6 (i) in subparagraph (B), by striking “;
7 and” and inserting a semicolon;

8 (ii) in subparagraph (C), by striking
9 the semicolon and inserting “; and”; and

10 (iii) by adding at the end the fol-
11 lowing new subparagraph:

12 “(D) payment for primary care services (as
13 defined in subsection (jj)(1)) furnished in the
14 period that begins on the first day of the first
15 month that begins after the date of enactment
16 of this subparagraph by a provider described in
17 subsection (jj)(2)—

18 “(i) at a rate that is not less than 100
19 percent of the payment rate that applies to
20 such services and the provider of such
21 services under part B of title XVIII;

22 “(ii) in the case of items and services
23 that are not items and services provided
24 under such part, at a rate to be established
25 by the Secretary; and

1 “(iii) in the case of items and services
 2 that are furnished in rural areas (as de-
 3 fined in section 1886(d)(2)(D)), health
 4 professional shortage areas (as defined in
 5 section 332(a)(1)(A) of the Public Health
 6 Service Act (42 U.S.C. 254e(a)(1)(A))), or
 7 medically underserved areas (according to
 8 a designation under section 330(b)(3)(A)
 9 of the Public Health Service Act (42
 10 U.S.C. 254b(b)(3)(A))), at the rate other-
 11 wise applicable to such items or services
 12 under clause (i) or (ii) increased, at the
 13 Secretary’s discretion, by not more than 25
 14 percent;”.

15 (B) CONFORMING AMENDMENTS.—

16 (i) Section 1902(a)(13)(C) of the So-
 17 cial Security Act (42 U.S.C.
 18 1396a(a)(13)(C)) is amended by striking
 19 “subsection (jj)” and inserting “subsection
 20 (jj)(1)”.

21 (ii) Section 1905(dd) of the Social Se-
 22 curity Act (42 U.S.C. 1396d(dd)) is
 23 amended—

24 (I) by striking “Notwith-
 25 standing” and inserting the following:

1 “(1) IN GENERAL.—Notwithstanding”;

2 (II) by striking “section
3 1902(a)(13)(C)” and inserting “sub-
4 paragraph (C) of section
5 1902(a)(13)”;

6 (III) by inserting “or for services
7 described in subparagraph (D) of sec-
8 tion 1902(a)(13) furnished during an
9 additional period specified in para-
10 graph (2),” after “2015,”;

11 (IV) by striking “under such sec-
12 tion” and inserting “under subpara-
13 graph (C) or (D) of section
14 1902(a)(13), as applicable”; and

15 (V) by adding at the end the fol-
16 lowing:

17 “(2) ADDITIONAL PERIODS.—For purposes of
18 paragraph (1), an additional period includes the pe-
19 riod that begins on the first day of the first month
20 that begins after the date of enactment of this para-
21 graph.”.

22 (2) IMPROVED TARGETING OF PRIMARY
23 CARE.—Section 1902(jj) of the Social Security Act
24 (42 U.S.C. 1396a(jj)) is amended—

1 (A) by redesignating paragraphs (1) and
2 (2) as clauses (i) and (ii), respectively, and re-
3 aligning the left margins accordingly;

4 (B) by striking “For purposes of sub-
5 section (a)(13)(C)” and inserting the following:

6 “(1) IN GENERAL.—

7 “(A) DEFINITION.—For purposes of sub-
8 paragraphs (C) and (D) of subsection (a)(13)”;
9 and

10 (C) by inserting after clause (ii) (as so re-
11 designated) the following:

12 “(B) EXCLUSIONS.—Such term does not
13 include any services described in subparagraph
14 (A) if such services are provided in an emer-
15 gency department of a hospital.

16 “(2) ADDITIONAL PROVIDERS.—For purposes
17 of subparagraph (D) of subsection (a)(13), a pro-
18 vider described in this paragraph is any of the fol-
19 lowing:

20 “(A) A physician with a primary specialty
21 designation of family medicine, general internal
22 medicine, pediatric medicine, or obstetrics and
23 gynecology.

1 “(B) An advanced practice clinician, as de-
2 fined by the Secretary, that works under the
3 supervision of—

4 “(i) a physician that satisfies the cri-
5 teria specified in subparagraph (A);

6 “(ii) a nurse practitioner or a physi-
7 cian assistant (as such terms are defined
8 in section 1861(aa)(5)(A)) who is working
9 in accordance with State law; or

10 “(iii) or a certified nurse-midwife (as
11 defined in section 1861(gg)) or a certified
12 professional midwife who is working in ac-
13 cordance with State law.

14 “(C) A rural health clinic, federally quali-
15 fied health center, health center that receives
16 funding under title X of the Public Health
17 Service Act, or other health clinic that receives
18 reimbursement on a fee schedule applicable to
19 a physician.

20 “(D) An advanced practice clinician super-
21 vised by a physician described in subparagraph
22 (A), another advanced practice clinician, or a
23 certified nurse-midwife.

24 “(E) A midwife who is working in accord-
25 ance with State law.”.

1 (3) ENSURING PAYMENT BY MANAGED CARE
2 ENTITIES.—

3 (A) IN GENERAL.—Section 1903(m)(2)(A)
4 of the Social Security Act (42 U.S.C.
5 1396b(m)(2)(A)) is amended—

6 (i) in clause (xii), by striking “and”
7 after the semicolon;

8 (ii) by realigning the left margin of
9 clause (xiii) so as to align with the left
10 margin of clause (xii) and by striking the
11 period at the end of clause (xiii) and in-
12 serting “; and”; and

13 (iii) by inserting after clause (xiii) the
14 following:

15 “(xiv) such contract provides that (I) payments
16 to providers specified in section 1902(a)(13)(D) for
17 primary care services (as defined in section
18 1902(jj)(1)) that are furnished during a year or pe-
19 riod (as specified in section 1902(a)(13)(D) and sec-
20 tion 1905(dd)) are at least equal to the amounts set
21 forth and required by the Secretary by regulation;
22 (II) the entity shall, upon request, provide docu-
23 mentation to the State, sufficient to enable the State
24 and the Secretary to ensure compliance with sub-
25 clause (I); and (III) the Secretary shall approve pay-

1 ments described in subclause (I) that are furnished
 2 through an agreed upon capitation, partial capita-
 3 tion, or other value-based payment arrangement if
 4 the capitation, partial capitation, or other value-
 5 based payment arrangement is based on a reason-
 6 able methodology and the entity provides docu-
 7 mentation to the State sufficient to enable the State
 8 and the Secretary to ensure compliance with sub-
 9 clause (I).”.

10 (B) CONFORMING AMENDMENT.—Section
 11 1932(f) of the Social Security Act (42 U.S.C.
 12 1396u–2(f)) is amended—

13 (i) by striking “section
 14 1902(a)(13)(C)” and inserting “sub-
 15 sections (C) and (D) of section
 16 1902(a)(13)”;

17 (ii) by inserting “, and clause (xiv) of
 18 section 1903(m)(2)(A)” before the period.

19 (d) MACPAC REPORT AND CMS GUIDANCE ON IN-
 20 CREASING ACCESS TO DOULA SERVICES FOR MEDICAID
 21 BENEFICIARIES.—

22 (1) MACPAC REPORT.—

23 (A) IN GENERAL.—Not later than 1 year
 24 after the date of the enactment of this Act, the
 25 Medicaid and CHIP Payment and Access Com-

1 mission (referred to in this subsection as
2 “MACPAC”) shall publish a report on the cov-
3 erage of doula services under State Medicaid
4 programs, which shall at a minimum include
5 the following:

6 (i) Information about coverage for
7 doula services under State Medicaid pro-
8 grams that, as of the date of enactment of
9 this Act, provide coverage for such care,
10 including the type of doula services offered
11 (such as prenatal, labor and delivery,
12 postpartum support, as well as community-
13 based and traditional doula services).

14 (ii) An analysis of barriers to covering
15 doula services under State Medicaid pro-
16 grams.

17 (iii) An identification of effective
18 strategies to increase the use of doula serv-
19 ices in order to provide better care and
20 achieve better maternal and infant health
21 outcomes, including strategies that States
22 may use to recruit, train, and certify a di-
23 verse doula workforce, particularly from
24 underserved communities, communities of

1 color, and communities facing linguistic or
2 cultural barriers.

3 (iv) Recommendations for legislative
4 and administrative actions to increase ac-
5 cess to doula services in State Medicaid
6 programs, including actions that ensure
7 doulas may earn a living wage that ac-
8 counts for their time and costs associated
9 with providing care, and to provide for the
10 administration and operation of commu-
11 nity-based doula programs.

12 (B) STAKEHOLDER CONSULTATION.—In
13 developing the report required under subpara-
14 graph (A), MACPAC shall consult with relevant
15 stakeholders, including—

16 (i) States;

17 (ii) organizations (especially reproduc-
18 tive justice and birth justice organizations
19 led by people of color) representing con-
20 sumers of maternal health care, including
21 those that are disproportionately impacted
22 by poor maternal health outcomes;

23 (iii) organizations and individuals rep-
24 resenting doulas, including community-
25 based doula programs and those who serve

underserved communities (including communities of color, and communities facing linguistic or cultural barriers);

(iv) organizations representing health care providers; and

(v) Black, Indigenous, and other maternal health care consumers of color who have experienced severe maternal morbidity.

(2) CMS GUIDANCE.—

(A) IN GENERAL.—Not later than 1 year after the date that MACPAC publishes the report required under paragraph (1)(A), the Administrator of the Centers for Medicare & Medicaid Services shall issue guidance to States on increasing access to doula services under Medicaid. Such guidance shall, at a minimum, include—

(i) options for States to provide medical assistance for doula services under State Medicaid programs;

(ii) best practices for ensuring that doulas, including community-based doulas, receive reimbursement for doula services provided under a State Medicaid program

1 at a level that allows doulas to earn a liv-
2 ing wage that accounts for their time and
3 costs associated with providing care and
4 community-based doula program adminis-
5 tration; and

6 (iii) best practices for increasing ac-
7 cess to doula services, including services
8 provided by community-based doulas,
9 under State Medicaid programs.

10 (B) STAKEHOLDER CONSULTATION.—In
11 developing the guidance required under sub-
12 paragraph (A), the Administrator of the Cen-
13 ters for Medicare & Medicaid Services shall con-
14 sult with MACPAC and other relevant stake-
15 holders, including—

16 (i) State Medicaid officials;

17 (ii) organizations representing con-
18 sumers of maternal health care, including
19 those that are disproportionately impacted
20 by poor maternal health outcomes;

21 (iii) organizations representing doulas,
22 including community-based doulas and
23 those who serve underserved communities,
24 such as communities of color and commu-

1 nities facing linguistic or cultural barriers;
2 and
3 (iv) organizations representing med-
4 ical professionals.

5 (e) GAO REPORT ON STATE MEDICAID PROGRAMS'
6 USE OF TELEHEALTH TO INCREASE ACCESS TO MATER-
7 NITY CARE.—Not later than 1 year after the date of the
8 enactment of this Act, the Comptroller General of the
9 United States shall submit a report to Congress on State
10 Medicaid programs' use of telehealth to increase access to
11 maternity care. Such report shall include the following:

12 (1) The number of State Medicaid programs
13 that utilize telehealth that increases access to mater-
14 nity care.

15 (2) With respect to State Medicaid programs
16 that utilize telehealth that increases access to mater-
17 nity care, information about—

18 (A) common characteristics of such pro-
19 grams' approaches to utilizing telehealth that
20 increases access to maternity care;

21 (B) differences in States' approaches to
22 utilizing telehealth to improve access to mater-
23 nity care, and the resulting differences in State
24 maternal health outcomes, as determined by
25 factors described in subsection (C); and

1 (C) when compared to patients who receive
2 maternity care in person, what is known
3 about—

4 (i) the demographic characteristics,
5 such as race, ethnicity, sex, sexual orienta-
6 tion, gender identity, disability status, age,
7 and preferred language of the individuals
8 enrolled in such programs who use tele-
9 health to access maternity care;

10 (ii) health outcomes for such individ-
11 uals, including frequency of mortality and
12 severe morbidity, as compared to individ-
13 uals with similar characteristics who did
14 not use telehealth to access maternity care;

15 (iii) the services provided to individ-
16 uals through telehealth, including family
17 planning services, mental health care serv-
18 ices, and oral health services;

19 (iv) the devices and equipment pro-
20 vided to individuals for remote patient
21 monitoring and telehealth, including blood
22 pressure monitors and blood glucose mon-
23 itors;

24 (v) the quality of maternity care pro-
25 vided through telehealth, including whether

1 maternity care provided through telehealth
2 is culturally and linguistically appropriate;

3 (vi) the level of patient satisfaction
4 with maternity care provided through tele-
5 health to individuals enrolled in State Med-
6 icaid programs;

7 (vii) the impact of utilizing telehealth
8 to increase access to maternity care on
9 spending, cost savings, access to care, and
10 utilization of care under State Medicaid
11 programs; and

12 (viii) the accessibility and effectiveness
13 of telehealth for maternity care during the
14 COVID–19 pandemic.

15 (3) An identification and analysis of the bar-
16 riers to using telehealth to increase access to mater-
17 nity care under State Medicaid programs.

18 (4) Recommendations for such legislative and
19 administrative actions related to increasing access to
20 telehealth maternity services under Medicaid as the
21 Comptroller General deems appropriate.

22 **SEC. 5203. SOCIAL DETERMINANTS FOR MOMS.**

23 (a) TASK FORCE TO DEVELOP A STRATEGY TO AD-
24 DRESS SOCIAL DETERMINANTS OF MATERNAL
25 HEALTH.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services shall convene a task force (in this
3 subsection referred to as the “Task Force”) to de-
4 velop a strategy to coordinate efforts between Fed-
5 eral agencies to address social determinants of ma-
6 ternal health with respect to pregnant and
7 postpartum individuals.

8 (2) EX OFFICIO MEMBERS.—The ex officio
9 members of the Task Force shall consist of the fol-
10 lowing:

11 (A) The Secretary of Health and Human
12 Services (or a designee thereof).

13 (B) The Secretary of Housing and Urban
14 Development (or a designee thereof).

15 (C) The Secretary of Transportation (or a
16 designee thereof).

17 (D) The Secretary of Agriculture (or a
18 designee thereof).

19 (E) The Secretary of Labor (or a designee
20 thereof).

21 (F) The Administrator of the Environ-
22 mental Protection Agency (or a designee there-
23 of).

1 (G) The Assistant Secretary for the Ad-
2 ministration for Children and Families (or a
3 designee thereof).

4 (H) The Administrator of the Centers for
5 Medicare & Medicaid Services (or a designee
6 thereof).

7 (I) The Director of the Indian Health
8 Service (or a designee thereof).

9 (J) The Director of the National Institutes
10 of Health (or a designee thereof).

11 (K) The Administrator of the Health Re-
12 sources and Services Administration (or a des-
13 ignee thereof).

14 (L) The Deputy Assistant Secretary for
15 Minority Health of the Department of Health
16 and Human Services (or a designee thereof).

17 (M) The Deputy Assistant Secretary for
18 Women's Health of the Department of Health
19 and Human Services (or a designee thereof).

20 (N) The Director of the Centers for Dis-
21 ease Control and Prevention (or a designee
22 thereof).

23 (O) The Director of the Office on Violence
24 Against Women of the Department of Justice
25 (or a designee thereof).

1 (3) APPOINTED MEMBERS.—In addition to the
2 ex officio members of the Task Force, the Secretary
3 of Health and Human Services shall appoint the fol-
4 lowing members of the Task Force:

5 (A) At least two representatives of pa-
6 tients, to include—

7 (i) a representative of patients who
8 have suffered from severe maternal mor-
9 bidity; or

10 (ii) a representative of patients who is
11 a family member of an individual who suf-
12 fered a pregnancy-related death.

13 (B) At least two leaders of community-
14 based organizations that address maternal mor-
15 tality and severe maternal morbidity with a spe-
16 cific focus on racial and ethnic inequities. In
17 appointing such leaders under this subpara-
18 graph, the Secretary of Health and Human
19 Services shall give priority to individuals who
20 are leaders of organizations led by individuals
21 from racial and ethnic minority groups.

22 (C) At least two perinatal health workers.

23 (D) A professionally diverse panel of ma-
24 ternity care providers.

1 (4) CHAIR.—The Secretary of Health and
2 Human Services shall select the chair of the Task
3 Force from among the members of the Task Force.

4 (5) REPORT.—Not later than 2 years after the
5 date of enactment of this Act, the Task Force shall
6 submit to Congress a report on—

7 (A) the strategy developed under para-
8 graph (1);

9 (B) recommendations on funding amounts
10 with respect to implementing such strategy; and

11 (C) recommendations for how to expand
12 coverage of social services to address social de-
13 terminants of maternal health under Medicaid
14 managed care organizations and State Medicaid
15 programs.

16 (6) TERMINATION.—Section 1013 of title 5,
17 United States Code, shall not apply to the Task
18 Force with respect to termination.

19 (b) HOUSING FOR MOMS GRANT PROGRAM.—

20 (1) DEFINITIONS.—In this subsection:

21 (A) ELIGIBLE ENTITY.—The term “eligible
22 entity” means—

23 (i) a community-based organization;

1 (ii) a State or local governmental enti-
2 ty, including a State or local public health
3 department;

4 (iii) an Indian tribe or Tribal organi-
5 zation (as such terms are defined in sec-
6 tion 4 of the Indian Self-Determination
7 and Education Assistance Act (25 U.S.C.
8 5304)); or

9 (iv) an Urban Indian organization (as
10 such term is defined in section 4 of the In-
11 dian Health Care Improvement Act (25
12 U.S.C. 1603)).

13 (B) SECRETARY.—The term “Secretary”
14 means the Secretary of Housing and Urban De-
15 velopment.

16 (2) ESTABLISHMENT.—The Secretary shall es-
17 tablish a Housing for Moms grant program to make
18 grants to eligible entities to increase access to safe,
19 stable, affordable, and adequate housing for preg-
20 nant and postpartum individuals and their families.

21 (3) APPLICATION.—To be eligible to receive a
22 grant under this subsection, an eligible entity shall
23 submit to the Secretary an application at such time,
24 in such manner, and containing such information as
25 the Secretary may provide.

1 (4) PRIORITY.—In awarding grants under this
2 subsection, the Secretary shall give priority to an eli-
3 gible entity that—

4 (A) is a community-based organization or
5 will partner with a community-based organiza-
6 tion to implement initiatives to increase access
7 to safe, stable, affordable, and adequate hous-
8 ing for pregnant and postpartum individuals
9 and their families;

10 (B) is operating in an area with high rates
11 of adverse maternal health outcomes or signifi-
12 cant racial or ethnic inequities in maternal
13 health outcomes, to the extent such data are
14 available; and

15 (C) is operating in an area with a high
16 poverty rate or a significant number of individ-
17 uals who lack consistent access to safe, stable,
18 affordable, and adequate housing.

19 (5) USE OF FUNDS.—An eligible entity that re-
20 ceives a grant under this subsection shall use funds
21 from the grant for the purposes of—

22 (A) identifying and conducting outreach to
23 pregnant and postpartum individuals who are
24 low-income and lack consistent access to safe,
25 stable, affordable, and adequate housing;

1 (B) providing safe, stable, affordable, and
2 adequate housing options to such individuals;

3 (C) connecting such individuals with local
4 organizations offering safe, stable, affordable,
5 and adequate housing options;

6 (D) providing application assistance to
7 such individuals seeking to enroll in programs
8 offering safe, stable, affordable, and adequate
9 housing options;

10 (E) providing direct financial assistance to
11 such individuals for the purposes of maintaining
12 safe, stable, and adequate housing for the dura-
13 tion of the individual's pregnancy and
14 postpartum periods; and

15 (F) working with relevant stakeholders to
16 ensure that local housing and homeless shelter
17 infrastructure is supportive to pregnant and
18 postpartum individuals, including through—

19 (i) health-promoting housing codes;

20 (ii) enforcement of housing codes;

21 (iii) proactive rental inspection pro-
22 grams;

23 (iv) code enforcement officer training;

24 and

1 (v) partnerships between regional of-
2 fices of the Department of Housing and
3 Urban Development and community-based
4 organizations to ensure housing laws are
5 understood and violations are discovered.

6 (6) REPORTING.—

7 (A) ELIGIBLE ENTITIES.—The Secretary
8 shall require each eligible entity receiving a
9 grant under this subsection to annually submit
10 to the Secretary and make publicly available a
11 report on the status of activities conducted
12 using the grant.

13 (B) SECRETARY.—Not later than the end
14 of each fiscal year in which grants are made
15 under this subsection, the Secretary shall sub-
16 mit to Congress and make publicly available a
17 report that—

18 (i) summarizes the reports received
19 under subparagraph (A);

20 (ii) evaluates the effectiveness of
21 grants awarded under this subsection in
22 increasing access to safe, stable, afford-
23 able, and adequate housing for pregnant
24 and postpartum individuals and their fami-
25 lies; and

1 (iii) makes recommendations with re-
2 spect to ensuring activities described in
3 paragraph (5) continue after grant
4 amounts made available under this sub-
5 section are expended.

6 (7) AUTHORIZATION OF APPROPRIATIONS.—
7 There is authorized to be appropriated to carry out
8 this subsection \$10,000,000 for fiscal year 2027,
9 which shall remain available until expended.

10 (c) DEPARTMENT OF TRANSPORTATION.—

11 (1) REPORT.—Not later than 1 year after the
12 date of enactment of this Act, the Secretary of
13 Transportation shall submit to Congress and make
14 publicly available a report containing—

15 (A) an assessment of transportation bar-
16 riers preventing individuals from attending pre-
17 natal and postpartum appointments, accessing
18 maternal health care services, or accessing serv-
19 ices and resources related to social deter-
20 minants of maternal health;

21 (B) recommendations on how to overcome
22 the barriers assessed under subparagraph (A);
23 and

1 (C) an assessment of transportation safety
2 risks for pregnant individuals and recommenda-
3 tions on how to mitigate those risks.

4 (2) CONSIDERATIONS.—In carrying out para-
5 graph (1), the Secretary of Transportation shall give
6 special consideration to solutions for—

7 (A) pregnant and postpartum individuals
8 living in a health professional shortage area
9 designated under section 332 of the Public
10 Health Service Act (42 U.S.C. 254e);

11 (B) pregnant and postpartum individuals
12 living in areas with high maternal mortality or
13 severe morbidity rates or significant racial or
14 ethnic inequities in maternal health outcomes;
15 and

16 (C) pregnant and postpartum individuals
17 with a disability that impacts mobility.

18 (d) DEPARTMENT OF AGRICULTURE.—

19 (1) SPECIAL SUPPLEMENTAL NUTRITION PRO-
20 GRAM FOR WOMEN, INFANTS, AND CHILDREN.—

21 (A) EXTENSION OF POSTPARTUM PE-
22 RIOD.—Section 17(b)(10) of the Child Nutri-
23 tion Act of 1966 (42 U.S.C. 1786(b)(10)) is
24 amended by striking “six” and inserting “24”.

1 (B) REPORT.—Not later than 2 years after
2 the date of enactment of this Act, the Secretary
3 shall submit to Congress a report that evaluates
4 the effect of the amendment made by subpara-
5 graph (A) on—

6 (i) maternal and infant health out-
7 comes, including racial and ethnic inequi-
8 ties with respect to those outcomes;

9 (ii) breastfeeding rates among
10 postpartum individuals;

11 (iii) qualitative evaluations of family
12 experiences under the special supplemental
13 nutrition program for women, infants, and
14 children established under section 17 of
15 the Child Nutrition Act of 1966 (42
16 U.S.C. 1786); and

17 (iv) other relevant information as de-
18 termined by the Secretary.

19 (2) GRANT PROGRAM FOR HEALTHY FOOD AND
20 CLEAN WATER FOR PREGNANT AND POSTPARTUM
21 INDIVIDUALS.—

22 (A) IN GENERAL.—The Secretary shall es-
23 tablish a program (referred to in this paragraph
24 as the “program”) to award grants, on a com-

petitive basis, to eligible entities to carry out the activities described in subparagraph (D).

(B) APPLICATION.—To be eligible for a grant under the program, an eligible entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary determines appropriate.

(C) PRIORITY.—In awarding grants under the program, the Secretary shall give priority to an eligible entity that—

(i) is, or will partner with, an eligible entity described in paragraph (3)(A)(i); and

(ii) is operating in an area with a high rate of—

(I) adverse maternal health outcomes; or

(II) significant racial or ethnic inequities in maternal health outcomes.

(D) USE OF FUNDS.—An eligible entity shall use a grant awarded under the program to deliver healthy food, infant formula, clean water, or diapers to pregnant and postpartum

1 individuals located in areas that are food
2 deserts, as determined by the Secretary using
3 data from the Food Access Research Atlas of
4 the Department of Agriculture.

5 (E) REPORTS.—

6 (i) ELIGIBLE ENTITIES.—Not later
7 than 1 year after the date on which an eli-
8 gible entity receives a grant under the pro-
9 gram, and annually thereafter, the eligible
10 entity shall submit to the Secretary a re-
11 port on the status of activities conducted
12 using the grant, which shall contain such
13 information as the Secretary may require.

14 (ii) SECRETARY.—

15 (I) IN GENERAL.—Not later than
16 2 years after the date on which the
17 first grant is awarded under the pro-
18 gram, the Secretary shall submit to
19 Congress a report that includes—

20 (aa) a summary of the re-
21 ports submitted by eligible enti-
22 ties under clause (i);

23 (bb) an assessment of the
24 extent to which food distributed
25 using grants awarded under the

1 program was purchased from
2 local and regional food systems;

3 (cc) an evaluation of the ef-
4 fect of the program on maternal
5 and infant health outcomes, in-
6 cluding racial and ethnic inequi-
7 ties with respect to those out-
8 comes; and

9 (dd) recommendations with
10 respect to ensuring the activities
11 described in subparagraph (D)
12 continue after the grant period
13 funding those activities expires.

14 (II) PUBLICATION.—The Sec-
15 retary shall make the report sub-
16 mitted under subclause (I) publicly
17 available on the website of the De-
18 partment of Agriculture.

19 (F) AUTHORIZATION OF APPROPRIA-
20 TIONS.—There is authorized to be appropriated
21 to carry out the program \$5,000,000 for the
22 period of fiscal years 2027 through 2031.

23 (3) DEFINITIONS.—In this subsection:

24 (A) ELIGIBLE ENTITY.—The term “eligible
25 entity” means—

- 1 (i) a community-based organization;
- 2 (ii) a State or local governmental enti-
- 3 ty, including a State or local public health
- 4 department;
- 5 (iii) an Indian Tribe or Tribal organi-
- 6 zation (as those terms are defined in sec-
- 7 tion 4 of the Indian Self-Determination
- 8 and Education Assistance Act (25 U.S.C.
- 9 5304)); and
- 10 (iv) an Urban Indian organization (as
- 11 defined in section 4 of the Indian Health
- 12 Care Improvement Act (25 U.S.C. 1603)).

13 (B) SECRETARY.—The term “Secretary”
 14 means the Secretary of Agriculture.

15 (e) ENVIRONMENTAL STUDY THROUGH NATIONAL
 16 ACADEMIES.—

17 (1) IN GENERAL.—Not later than 60 days after
 18 the date of enactment of this Act, the Administrator
 19 of the Environmental Protection Agency shall seek
 20 to enter into an agreement with the National Acad-
 21 emies of Sciences, Engineering, and Medicine (re-
 22 ferred to in this subsection as the “National Acad-
 23 emies”) under which the National Academies agree
 24 to conduct a study on the impacts of, with respect
 25 to maternal and infant health incomes, water and

1 air quality, exposure to extreme temperatures, envi-
2 ronmental chemicals, environmental risks in the
3 workplace and the home, and pollution levels.

4 (2) STUDY REQUIREMENTS.—The agreement
5 under paragraph (1) shall direct the National Acad-
6 emies to make recommendations for—

7 (A) improving environmental conditions to
8 improve maternal and infant health outcomes;
9 and

10 (B) reducing or eliminating racial and eth-
11 nic inequities in those outcomes.

12 (3) REPORT.—The agreement under paragraph
13 (1) shall direct the National Academies to complete
14 the study under this subsection, and submit to Con-
15 gress and make publicly available a report on the re-
16 sults of the study, not later than 1 year after the
17 date of enactment of this Act.

18 (f) CHILD CARE ACCESS.—

19 (1) GRANT PROGRAM.—The Secretary of
20 Health and Human Services (in this subsection re-
21 ferred to as the “Secretary”) shall award grants to
22 eligible organizations to carry out programs to pro-
23 vide pregnant and postpartum individuals with free
24 and accessible drop-in child care services during pre-
25 natal and postpartum appointments.

1 (2) APPLICATION.—To be eligible to receive a
2 grant under this subsection, an eligible entity shall
3 submit to the Secretary an application at such time,
4 in such manner, and containing such information as
5 the Secretary may require.

6 (3) ELIGIBLE ORGANIZATIONS.—

7 (A) ELIGIBILITY.—To be eligible to receive
8 a grant under this subsection, an organization
9 shall be an organization that—

10 (i) provides child care services; and

11 (ii) can carry out a program providing
12 pregnant and postpartum individuals with
13 free and accessible drop-in child care serv-
14 ices during prenatal and postpartum ap-
15 pointments.

16 (B) PRIORITIZATION.—In selecting grant
17 recipients under this subsection, the Secretary
18 shall give priority to eligible organizations that
19 operate in an area that has, to the extent data
20 with respect to such an area are available—

21 (i) high rates of adverse maternal
22 health outcomes; or

23 (ii) significant racial or ethnic inequi-
24 ties in maternal health outcomes.

1 (4) TIMING.—The Secretary shall commence
2 the grant program under paragraph (1) not later
3 than 1 year after the date of enactment of this Act.

4 (5) REPORTING.—

5 (A) GRANTEES.—Each recipient of a grant
6 under this subsection shall annually submit to
7 the Secretary and make publicly available a re-
8 port on the status of activities conducted using
9 the grant. Each such report shall include—

10 (i) an analysis of the effect of the
11 funded program on prenatal and
12 postpartum appointment attendance rates;

13 (ii) summaries of qualitative assess-
14 ments of the funded program from—

15 (I) pregnant and postpartum in-
16 dividuals participating in the pro-
17 gram; and

18 (II) the families of such individ-
19 uals; and

20 (iii) such additional information as
21 the Secretary may require.

22 (B) SECRETARY.—Not later than the end
23 of fiscal year 2027, the Secretary shall submit
24 to the Congress, and make publicly available, a
25 report containing each of the following:

1 (i) A summary of the reports received
2 under subparagraph (A).

3 (ii) An assessment of the effects, if
4 any, of the funded programs on maternal
5 health outcomes, with a specific focus on
6 racial and ethnic inequities in such out-
7 comes.

8 (iii) A description of actions the Sec-
9 retary can take to ensure that pregnant
10 and postpartum individuals eligible for
11 medical assistance under a State plan
12 under title XIX of the Social Security Act
13 (42 U.S.C. 1936 et seq.) have access to
14 free and accessible drop-in child care serv-
15 ices during prenatal and postpartum ap-
16 pointments, including identification of the
17 funding necessary to carry out such ac-
18 tions.

19 (6) DROP-IN CHILD CARE SERVICES DE-
20 FINED.—In this subsection, the term “drop-in child
21 care services” means child care (including early
22 childhood education) services that are—

23 (A) delivered at a facility that meets the
24 requirements of all applicable laws and regula-
25 tions of the State or local government in which

1 it is located, including the requirements for li-
2 censing of the facility as a child care facility;
3 and

4 (B) provided in single encounters without
5 requiring full-time enrollment of a person in a
6 child care program.

7 (7) AUTHORIZATION OF APPROPRIATIONS.—To
8 carry out this subsection, there is authorized to be
9 appropriated \$5,000,000 for the period of fiscal
10 years 2027 through 2029.

11 (g) GRANTS TO LOCAL ENTITIES ADDRESSING SO-
12 CIAL DETERMINANTS OF MATERNAL HEALTH.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services (in this subsection referred to as
15 the “Secretary”) shall award grants to eligible enti-
16 ties to—

17 (A) address social determinants of mater-
18 nal health for pregnant and postpartum individ-
19 uals; and

20 (B) eliminate racial and ethnic inequities
21 in maternal health outcomes.

22 (2) APPLICATION.—To be eligible to receive a
23 grant under this subsection an eligible entity shall
24 submit to the Secretary an application at such time,

1 in such manner, and containing such information as
2 the Secretary may provide.

3 (3) PRIORITIZATION.—In awarding grants
4 under paragraph (1), the Secretary shall give pri-
5 ority to an eligible entity that—

6 (A) is a community-based organization, or
7 will partner with a community-based organiza-
8 tion to carry out the activities under paragraph
9 (4);

10 (B) is operating in an area with high rates
11 of adverse maternal health outcomes or signifi-
12 cant racial or ethnic inequities in maternal
13 health outcomes; and

14 (C) is operating in an area with a high
15 poverty rate.

16 (4) ACTIVITIES.—An eligible entity that re-
17 ceives a grant under this subsection may use funds
18 received through the grant to—

19 (A) hire and retain staff;

20 (B) develop and distribute a list of avail-
21 able resources with respect to social service pro-
22 grams in a community;

23 (C) establish a resource center that pro-
24 vides multiple social service programs in a sin-
25 gle location;

1 (D) offer programs and resources in the
2 communities in which the respective eligible en-
3 tities are located to address social determinants
4 of health for pregnant and postpartum individ-
5 uals; and

6 (E) consult with such pregnant and
7 postpartum individuals to conduct an assess-
8 ment of the activities under this paragraph.

9 (5) TECHNICAL ASSISTANCE.—The Secretary
10 shall provide to grant recipients under this sub-
11 section technical assistance to plan for sustaining
12 programs to address social determinants of maternal
13 health among pregnant and postpartum individuals
14 after the period of the grant.

15 (6) REPORTING.—

16 (A) GRANTEES.—Not later than 1 year
17 after the date on which an eligible entity first
18 receives a grant under this subsection, and an-
19 nually thereafter, an eligible entity shall submit
20 to the Secretary, and make publicly available, a
21 report on the status of activities conducted
22 using the grant. Each such report shall include
23 data on the effects of such activities,
24 disaggregated by race, ethnicity, gender, and
25 other relevant factors.

1 (B) SECRETARY.—Not later than the end
2 of fiscal year 2031, the Secretary shall submit
3 to Congress a report that includes—

4 (i) a summary of the reports received
5 under subparagraph (A); and

6 (ii) recommendations for—

7 (I) improving maternal health
8 outcomes; and

9 (II) reducing or eliminating ra-
10 cial and ethnic inequities in maternal
11 health outcomes.

12 (7) AUTHORIZATION OF APPROPRIATIONS.—

13 There is authorized to be appropriated to carry out
14 this subsection \$15,000,000 for each of fiscal years
15 2027 through 2031.

16 (h) DEFINITIONS.—In this section:

17 (1) CULTURALLY CONGRUENT.—The term “cul-
18 turally congruent”, with respect to care or maternity
19 care provided to a health care consumer, means care
20 that is in agreement with the preferred cultural val-
21 ues, beliefs, worldview, language, and practices of
22 the health care consumer and other relevant stake-
23 holders.

1 (2) MATERNITY CARE PROVIDER.—The term
2 “maternity care provider” means a health care pro-
3 vider who—

4 (A) is a physician, physician assistant,
5 midwife who meets at a minimum the inter-
6 national definition of the midwife and global
7 standards for midwifery education as estab-
8 lished by the International Confederation of
9 Midwives, nurse practitioner, or clinical nurse
10 specialist; and

11 (B) has a focus on maternal or perinatal
12 health.

13 (3) MATERNAL MORTALITY.—The term “mater-
14 nal mortality” means a death occurring during or
15 within a one-year period after pregnancy, caused by
16 pregnancy-related or childbirth complications, in-
17 cluding a suicide, overdose, or other death resulting
18 from a mental health or substance use disorder at-
19 tributed to or aggravated by pregnancy-related or
20 childbirth complications.

21 (4) PERINATAL HEALTH WORKER.—The term
22 “perinatal health worker” means a doula, commu-
23 nity health worker, peer supporter, breastfeeding
24 and lactation educator or counselor, nutritionist or

dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(5) POSTPARTUM AND POSTPARTUM PERIOD.—

The terms “postpartum” and “postpartum period” refer to the 1-year period beginning on the last day of the pregnancy of an individual.

(6) RACIAL AND ETHNIC MINORITY GROUP.—

The term “racial and ethnic minority group” has the meaning given such term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

(7) SEVERE MATERNAL MORBIDITY.—The term

“severe maternal morbidity” means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(8) SOCIAL DETERMINANTS OF MATERNAL

HEALTH DEFINED.—The term “social determinants of maternal health” means non-clinical factors that impact maternal health outcomes, including—

(A) economic factors, which may include

poverty, employment, food security, support for

1 and access to lactation and other infant feeding
2 options, housing stability, and related factors;

3 (B) neighborhood factors, which may in-
4 clude quality of housing, access to transpor-
5 tation, access to child care, availability of
6 healthy foods and nutrition counseling, avail-
7 ability of clean water, air and water quality,
8 ambient temperatures, neighborhood crime and
9 violence, access to broadband, and related fac-
10 tors;

11 (C) social and community factors, which
12 may include systemic racism, gender discrimi-
13 nation or discrimination based on other pro-
14 tected classes, workplace conditions, incarcer-
15 ation, and related factors;

16 (D) household factors, which may include
17 ability to conduct lead testing and abatement,
18 car seat installation, indoor air temperatures,
19 and related factors;

20 (E) education access and quality factors,
21 which may include educational attainment, lan-
22 guage and literacy, and related factors; and

23 (F) health care access factors, including
24 health insurance coverage, access to culturally
25 congruent health care services, providers, and

1 non-clinical support, access to home visiting
2 services, access to wellness and stress manage-
3 ment programs, health literacy, access to tele-
4 health and items required to receive telehealth
5 services, and related factors.

6 **SEC. 5204. KIRA JOHNSON ACT.**

7 (a) INVESTMENTS IN COMMUNITY-BASED ORGANIZA-
8 TIONS TO IMPROVE BLACK MATERNAL HEALTH OUT-
9 COMES.—

10 (1) AWARDS.—Following the 1-year period de-
11 scribed in paragraph (3), the Secretary of Health
12 and Human Services (in this subsection referred to
13 as the “Secretary”) shall award grants to eligible
14 entities to establish or expand programs to prevent
15 maternal mortality and severe maternal morbidity
16 among Black pregnant and postpartum individuals.

17 (2) ELIGIBILITY.—To be eligible to seek a
18 grant under this subsection, an entity shall be a
19 community-based organization offering programs
20 and resources aligned with evidence-based practices
21 for improving maternal health outcomes for Black
22 pregnant and postpartum individuals.

23 (3) OUTREACH AND TECHNICAL ASSISTANCE
24 PERIOD.—During the 1-year period beginning on the
25 date of enactment of this Act, the Secretary shall—

1 (A) conduct outreach to encourage eligible
2 entities to apply for grants under this sub-
3 section; and

4 (B) provide technical assistance to eligible
5 entities on best practices for applying for grants
6 under this subsection.

7 (4) SPECIAL CONSIDERATION.—

8 (A) OUTREACH.—In conducting outreach
9 under paragraph (3), the Secretary shall give
10 special consideration to eligible entities that—

11 (i) are based in, and provide support
12 for, communities with high rates of adverse
13 maternal health outcomes or significant ra-
14 cial and ethnic inequities in maternal
15 health outcomes, to the extent such data
16 are available;

17 (ii) are led by Black people; and

18 (iii) offer programs and resources that
19 are aligned with evidence-based practices
20 for improving maternal health outcomes
21 for Black pregnant and postpartum indi-
22 viduals.

23 (B) AWARDS.—In awarding grants under
24 this subsection, the Secretary shall give special
25 consideration to eligible entities that—

1 (i) are described in clauses (i), (ii),
2 and (iii) of subparagraph (A);

3 (ii) offer programs and resources de-
4 signed in consultation with and intended
5 for Black pregnant and postpartum indi-
6 viduals; and

7 (iii) offer programs and resources in
8 the communities in which the respective el-
9 igible entities are located that—

10 (I) promote maternal mental
11 health and maternal substance use
12 disorder treatments and supports that
13 are aligned with evidence-based prac-
14 tices for improving maternal mental
15 and behavioral health outcomes for
16 Black pregnant and postpartum indi-
17 viduals;

18 (II) address social determinants
19 of maternal health for pregnant and
20 postpartum individuals;

21 (III) promote evidence-based
22 health literacy and pregnancy, child-
23 birth, and parenting education for
24 pregnant and postpartum individuals;

1 (IV) provide support from
2 perinatal health workers to pregnant
3 and postpartum individuals;

4 (V) provide culturally congruent
5 training to perinatal health workers;

6 (VI) conduct or support research
7 on maternal health issues dispropor-
8 tionately impacting Black pregnant
9 and postpartum individuals;

10 (VII) provide support to family
11 members of individuals who suffered a
12 pregnancy-associated death or preg-
13 nancy-related death;

14 (VIII) operate midwifery prac-
15 tices that provide culturally congruent
16 maternal health care and support, in-
17 cluding for the purposes of—

18 (aa) supporting additional
19 education, training, and certifi-
20 cation programs, including sup-
21 port for distance learning;

22 (bb) providing financial sup-
23 port to current and future mid-
24 wives to address education costs,
25 debts, and other needs;

- 1 (cc) clinical site investments;
- 2 (dd) supporting preceptor
- 3 development trainings;
- 4 (ee) expanding the mid-
- 5 wifery practice; or
- 6 (ff) related needs identified
- 7 by the midwifery practice and de-
- 8 scribed in the practice's applica-
- 9 tion; or
- 10 (IX) have developed other pro-
- 11 grams and resources that address
- 12 community-specific needs for pregnant
- 13 and postpartum individuals and are
- 14 aligned with evidence-based practices
- 15 for improving maternal health out-
- 16 comes for Black pregnant and
- 17 postpartum individuals.

18 (5) TECHNICAL ASSISTANCE.—The Secretary
19 shall provide to grant recipients under this sub-
20 section technical assistance on—

- 21 (A) capacity building to establish or ex-
- 22 pand programs to prevent adverse maternal
- 23 health outcomes among Black pregnant and
- 24 postpartum individuals;

1 (B) best practices in data collection, meas-
2 urement, evaluation, and reporting; and

3 (C) planning for sustaining programs to
4 prevent maternal mortality and severe maternal
5 morbidity among Black pregnant and
6 postpartum individuals after the period of the
7 grant.

8 (6) EVALUATION.—Not later than the end of
9 fiscal year 2031, the Secretary shall submit to the
10 Congress an evaluation of the grant program under
11 this subsection that—

12 (A) assesses the effectiveness of outreach
13 efforts during the application process in diversi-
14 fying the pool of grant recipients;

15 (B) makes recommendations for future
16 outreach efforts to diversify the pool of grant
17 recipients for Department of Health and
18 Human Services grant programs and funding
19 opportunities related to maternal health;

20 (C) assesses the effectiveness of programs
21 funded by grants under this subsection in im-
22 proving maternal health outcomes for Black
23 pregnant and postpartum individuals, to the ex-
24 tent practicable; and

1 (D) makes recommendations for future
2 Department of Health and Human Services
3 grant programs and funding opportunities that
4 deliver funding to community-based organiza-
5 tions that provide programs and resources that
6 are aligned with evidence-based practices for
7 improving maternal health outcomes for Black
8 pregnant and postpartum individuals.

9 (7) AUTHORIZATION OF APPROPRIATIONS.—To
10 carry out this subsection, there is authorized to be
11 appropriated \$10,000,000 for each of fiscal years
12 2027 through 2031.

13 (b) INVESTMENTS IN COMMUNITY-BASED ORGANIZA-
14 TIONS TO IMPROVE MATERNAL HEALTH OUTCOMES IN
15 UNDERSERVED COMMUNITIES.—

16 (1) AWARDS.—Following the 1-year period de-
17 scribed in paragraph (3), the Secretary of Health
18 and Human Services (in this subsection referred to
19 as the “Secretary”) shall award grants to eligible
20 entities to establish or expand programs to prevent
21 maternal mortality and severe maternal morbidity
22 among underserved groups.

23 (2) ELIGIBILITY.—To be eligible to seek a
24 grant under this subsection, an entity shall be a
25 community-based organization offering programs

1 and resources aligned with evidence-based practices
2 for improving maternal health outcomes for preg-
3 nant and postpartum individuals.

4 (3) OUTREACH AND TECHNICAL ASSISTANCE
5 PERIOD.—During the 1-year period beginning on the
6 date of enactment of this Act, the Secretary shall—

7 (A) conduct outreach to encourage eligible
8 entities to apply for grants under this sub-
9 section; and

10 (B) provide technical assistance to eligible
11 entities on best practices for applying for grants
12 under this subsection.

13 (4) SPECIAL CONSIDERATION.—

14 (A) OUTREACH.—In conducting outreach
15 under paragraph (3), the Secretary shall give
16 special consideration to eligible entities that—

17 (i) are based in, and provide support
18 for, communities with high rates of adverse
19 maternal health outcomes or significant ra-
20 cial and ethnic inequities in maternal
21 health outcomes, to the extent such data
22 are available;

23 (ii) are led by individuals from ra-
24 cially, ethnically, and geographically di-
25 verse backgrounds; and

1 (iii) offer programs and resources that
2 are aligned with evidence-based practices
3 for improving maternal health outcomes
4 for pregnant and postpartum individuals.

5 (B) AWARDS.—In awarding grants under
6 this subsection, the Secretary shall give special
7 consideration to eligible entities that—

8 (i) are described in clauses (i), (ii),
9 and (iii) of subparagraph (A);

10 (ii) offer programs and resources de-
11 signed in consultation with and intended
12 for pregnant and postpartum individuals
13 from underserved groups;

14 (iii) offer programs and resources in
15 the communities in which the respective el-
16 igible entities are located that—

17 (I) promote maternal mental
18 health and maternal substance use
19 disorder treatments and support that
20 are aligned with evidence-based prac-
21 tices for improving maternal mental
22 and behavioral health outcomes for
23 pregnant and postpartum individuals;

1 (II) address social determinants
2 of maternal health for pregnant and
3 postpartum individuals;

4 (III) promote evidence-based
5 health literacy and pregnancy, child-
6 birth, and parenting education for
7 pregnant and postpartum individuals;

8 (IV) provide support from
9 perinatal health workers to pregnant
10 and postpartum individuals;

11 (V) provide culturally congruent
12 training to perinatal health workers;

13 (VI) conduct or support research
14 on maternal health outcomes and in-
15 equities;

16 (VII) provide support to family
17 members of individuals who suffered a
18 pregnancy-associated death or preg-
19 nancy-related death; or

20 (VIII) operate midwifery prac-
21 tices that provide culturally congruent
22 maternal health care and support, in-
23 cluding for the purposes of—

24 (aa) supporting additional
25 education, training, and certifi-

1 cation programs, including sup-
2 port for distance learning;

3 (bb) providing financial sup-
4 port to current and future mid-
5 wives to address education costs,
6 debts, and other needs;

7 (cc) clinical site investments;

8 (dd) supporting preceptor
9 development trainings;

10 (ee) expanding the mid-
11 wifery practice; or

12 (ff) related needs identified
13 by the midwifery practice and de-
14 scribed in the practice's applica-
15 tion; or

16 (iv) have developed other programs
17 and resources that address community-spe-
18 cific needs for pregnant and postpartum
19 individuals and are aligned with evidence-
20 based practices for improving maternal
21 health outcomes for pregnant and
22 postpartum individuals.

23 (5) TECHNICAL ASSISTANCE.—The Secretary
24 shall provide to grant recipients under this sub-
25 section technical assistance on—

1 (A) capacity building to establish or ex-
2 pand programs to prevent adverse maternal
3 health outcomes among pregnant and
4 postpartum individuals from underserved
5 groups;

6 (B) best practices in data collection, meas-
7 urement, evaluation, and reporting; and

8 (C) planning for sustaining programs to
9 prevent maternal mortality and severe maternal
10 morbidity among pregnant and postpartum in-
11 dividuals from underserved groups after the pe-
12 riod of the grant.

13 (6) EVALUATION.—Not later than the end of
14 fiscal year 2031, the Secretary shall submit to the
15 Congress an evaluation of the grant program under
16 this subsection that—

17 (A) assesses the effectiveness of outreach
18 efforts during the application process in diversi-
19 fying the pool of grant recipients;

20 (B) makes recommendations for future
21 outreach efforts to diversify the pool of grant
22 recipients for Department of Health and
23 Human Services grant programs and funding
24 opportunities related to maternal health;

1 (C) assesses the effectiveness of programs
2 funded by grants under this subsection in im-
3 proving maternal health outcomes for pregnant
4 and postpartum individuals from underserved
5 groups, to the extent practicable; and

6 (D) makes recommendations for future
7 Department of Health and Human Services
8 grant programs and funding opportunities that
9 deliver funding to community-based organiza-
10 tions that provide programs and resources that
11 are aligned with evidence-based practices for
12 improving maternal health outcomes for preg-
13 nant and postpartum individuals.

14 (7) DEFINITION.—In this subsection, the term
15 “underserved groups” refers to pregnant and
16 postpartum individuals—

17 (A) from racial and ethnic minority
18 groups;

19 (B) whose household income is equal to or
20 less than 150 percent of the Federal poverty
21 line;

22 (C) who live in health professional shortage
23 areas (as such term is defined in section 332 of
24 the Public Health Service Act (42 U.S.C.
25 254e));

1 (D) who live in counties with no hospital
 2 offering obstetric care, no birth center, and no
 3 obstetric provider; or

4 (E) who live in counties with a level of vul-
 5 nerability of moderate-to-high or higher, accord-
 6 ing to the Social Vulnerability Index of the Cen-
 7 ters for Disease Control and Prevention.

8 (8) AUTHORIZATION OF APPROPRIATIONS.—To
 9 carry out this subsection, there is authorized to be
 10 appropriated \$10,000,000 for each of fiscal years
 11 2027 through 2031.

12 (c) RESPECTFUL MATERNITY CARE TRAINING FOR
 13 ALL EMPLOYEES IN MATERNITY CARE SETTINGS.—Part
 14 B of title VII of the Public Health Service Act (42 U.S.C.
 15 293 et seq.) (as amended by section 3002), is amended
 16 by adding at the end the following:

17 **“SEC. 743. RESPECTFUL MATERNITY CARE TRAINING FOR**
 18 **ALL EMPLOYEES IN MATERNITY CARE SET-**
 19 **TINGS.**

20 “(a) GRANTS.—The Secretary shall award grants for
 21 programs to reduce and prevent bias, racism, and dis-
 22 crimination in maternity care settings and to advance re-
 23 spectful, culturally congruent, trauma-informed care.

1 “(b) SPECIAL CONSIDERATION.—In awarding grants
2 under subsection (a), the Secretary shall give special con-
3 sideration to applications for programs that would—

4 “(1) apply to all maternity care providers and
5 any employees who interact with pregnant and
6 postpartum individuals in the provider setting, in-
7 cluding front desk employees, sonographers, sched-
8 ulers, health care professionals, hospital or health
9 system administrators, security staff, and other em-
10 ployees;

11 “(2) emphasize periodic, as opposed to one-
12 time, trainings for all birthing professionals and em-
13 ployees described in paragraph (1);

14 “(3) address implicit bias, racism, and cultural
15 humility;

16 “(4) be delivered in ongoing education settings
17 for providers maintaining their licenses, with a pref-
18 erence for trainings that provide continuing edu-
19 cation units;

20 “(5) include trauma-informed care best prac-
21 tices and an emphasis on shared decision making be-
22 tween providers and patients;

23 “(6) include antiracism training and programs;

24 “(7) be delivered in undergraduate programs
25 that funnel into health professions schools;

1 “(8) be delivered in settings that apply to pro-
2 viders of the special supplemental nutrition program
3 for women, infants, and children under section 17 of
4 the Child Nutrition Act of 1966;

5 “(9) integrate bias training in obstetric emer-
6 gency simulation trainings or related trainings;

7 “(10) include training for emergency depart-
8 ment employees and emergency medical technicians
9 on recognizing warning signs for severe pregnancy-
10 related complications;

11 “(11) offer training to all maternity care pro-
12 viders on the value of racially, ethnically, and profes-
13 sionally diverse maternity care teams to provide cul-
14 turally congruent care; or

15 “(12) be based on one or more programs de-
16 signed by a historically Black college or university or
17 other minority-serving institution.

18 “(c) APPLICATION.—To seek a grant under sub-
19 section (a), an entity shall submit an application at such
20 time, in such manner, and containing such information as
21 the Secretary may require.

22 “(d) REPORTING TO SECRETARY.—Each recipient of
23 a grant under this section shall annually submit to the
24 Secretary a report on the status of activities conducted
25 using the grant, including, as applicable, a description of

1 the impact of training provided through the grant on pa-
2 tient outcomes and patient experience for pregnant and
3 postpartum individuals from racial and ethnic minority
4 groups and their families.

5 “(e) DISSEMINATION OF FINDINGS.—Based on the
6 annual reports submitted pursuant to subsection (d), the
7 Secretary—

8 “(1) shall produce an annual report on the find-
9 ings resulting from programs funded through this
10 section;

11 “(2) shall disseminate such report to all recipi-
12 ents of grants under this section and to the public;
13 and

14 “(3) may include in such report findings on
15 best practices for improving patient outcomes and
16 patient experience for pregnant and postpartum in-
17 dividuals from racial and ethnic minority groups and
18 their families in maternity care settings.

19 “(f) DEFINITIONS.—In this section:

20 “(1) CULTURALLY CONGRUENT.—The term
21 ‘culturally congruent’ means in agreement with the
22 preferred cultural values, beliefs, world view, lan-
23 guage, and practices of the health care consumer
24 and other stakeholders.

1 “(2) MATERNITY CARE PROVIDER.—The term
2 ‘maternity care provider’ means a health care pro-
3 vider who—

4 “(A) is a physician, physician assistant,
5 midwife who meets at a minimum the inter-
6 national definition of the midwife and global
7 standards for midwifery education as estab-
8 lished by the International Confederation of
9 Midwives, nurse practitioner, or clinical nurse
10 specialist; and

11 “(B) has a focus on maternal or perinatal
12 health.

13 “(3) POSTPARTUM.—The term ‘postpartum’
14 means the one-year period beginning on the last day
15 of an individual’s pregnancy.

16 “(4) RACIAL AND ETHNIC MINORITY GROUP.—
17 The term ‘racial and ethnic minority group’ has the
18 meaning given such term in section 1707(g)(1).

19 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
20 carry out this section, there is authorized to be appro-
21 priated \$5,000,000 for each of fiscal years 2027 through
22 2031.”.

23 (d) STUDY ON REDUCING AND PREVENTING BIAS,
24 RACISM, AND DISCRIMINATION IN MATERNITY CARE SET-
25 TINGS.—

1 (1) IN GENERAL.—The Secretary of Health and
 2 Human Services shall seek to enter into an agree-
 3 ment, not later than 90 days after the date of enact-
 4 ment of this Act, with the National Academies of
 5 Sciences, Engineering, and Medicine (referred to in
 6 this subsection as the “National Academies”) under
 7 which the National Academies agree to—

8 (A) conduct a study on the design and im-
 9 plementation of programs to reduce and prevent
 10 bias, racism, and discrimination in maternity
 11 care settings and to advance respectful, cul-
 12 turally congruent, trauma-informed care; and

13 (B) not later than 2 years after the date
 14 of enactment of this Act—

15 (i) complete the study; and

16 (ii) transmit a report on the results of
 17 the study to the Congress.

18 (2) POSSIBLE TOPICS.—The agreement entered
 19 into pursuant to paragraph (1) may provide for the
 20 study of any of the following:

21 (A) The development of a scorecard or
 22 other evaluation standards for programs de-
 23 signed to reduce and prevent bias, racism, and
 24 discrimination in maternity care settings to as-
 25 sess the effectiveness of such programs in im-

1 proving patient outcomes and patient experi-
2 ence for pregnant and postpartum individuals
3 from racial and ethnic minority groups and
4 their families.

5 (B) Determination of the types and fre-
6 quency of training to reduce and prevent bias,
7 racism, and discrimination in maternity care
8 settings that are demonstrated to improve pa-
9 tient outcomes or patient experience for preg-
10 nant and postpartum individuals from racial
11 and ethnic minority groups and their families.

12 (e) RESPECTFUL MATERNITY CARE COMPLIANCE
13 PROGRAM.—

14 (1) IN GENERAL.—The Secretary of Health and
15 Human Services (referred to in this subsection as
16 the “Secretary”) shall award grants to accredited
17 hospitals, health systems, and other maternity care
18 settings to establish as an integral part of quality
19 implementation initiatives within one or more hos-
20 pitals or other birth settings a respectful maternity
21 care compliance program.

22 (2) PROGRAM REQUIREMENTS.—A respectful
23 maternity care compliance program funded through
24 a grant under this subsection shall—

1 (A) institutionalize mechanisms to allow
2 patients receiving maternity care services, the
3 families of such patients, or perinatal health
4 workers supporting such patients to report in-
5 stances of racism or evidence of bias on the
6 basis of race, ethnicity, or another protected
7 class;

8 (B) institutionalize response mechanisms
9 through which representatives of the program
10 can directly follow up with the patient, if pos-
11 sible, and the patient's family in a timely man-
12 ner;

13 (C) prepare, and make publicly available, a
14 hospital- or health system-wide strategy to re-
15 duce bias on the basis of race, ethnicity, or an-
16 other protected class in the delivery of mater-
17 nity care that includes—

18 (i) information on the training pro-
19 grams to reduce and prevent bias, racism,
20 and discrimination on the basis of race,
21 ethnicity, or another protected class for all
22 employees in maternity care settings;

23 (ii) information on the number of
24 cases reported to the compliance program;
25 and

1 (iii) the development of methods to
2 routinely assess the extent to which bias,
3 racism, or discrimination on the basis of
4 race, ethnicity, or another protected class
5 are present in the delivery of maternity
6 care to patients from racial and ethnic mi-
7 nority groups;

8 (D) develop mechanisms to routinely col-
9 lect and publicly report hospital-level data re-
10 lated to patient-reported experience of care; and

11 (E) provide annual reports to the Sec-
12 retary with information about each case re-
13 ported to the compliance program over the
14 course of the year containing such information
15 as the Secretary may require, such as—

16 (i) de-identified demographic informa-
17 tion on the patient in the case, such as
18 race, ethnicity, gender identity, and pri-
19 mary language;

20 (ii) the content of the report from the
21 patient or the family of the patient to the
22 compliance program;

23 (iii) the response from the compliance
24 program; and

1 (iv) to the extent applicable, institu-
2 tional changes made as a result of the
3 case.

4 (3) SECRETARY REQUIREMENTS.—

5 (A) PROCESSES.—Not later than 180 days
6 after the date of enactment of this Act, the Sec-
7 retary shall establish processes for—

8 (i) disseminating best practices for es-
9 tablishing and implementing a respectful
10 maternity care compliance program within
11 a hospital or other birth setting;

12 (ii) promoting coordination and col-
13 laboration between hospitals, health sys-
14 tems, and other maternity care delivery
15 settings on the establishment and imple-
16 mentation of respectful maternity care
17 compliance programs; and

18 (iii) evaluating the effectiveness of re-
19 spectful maternity care compliance pro-
20 grams on maternal health outcomes and
21 patient and family experiences, especially
22 for patients from racial and ethnic minor-
23 ity groups and their families.

24 (B) STUDY.—

1 (i) IN GENERAL.—Not later than 2
2 years after the date of enactment of this
3 Act, the Secretary shall, through a con-
4 tract with an independent research organi-
5 zation, conduct a study on strategies to ad-
6 dress—

7 (I) racism or bias on the basis of
8 race, ethnicity, or another protected
9 class in the delivery of maternity care
10 services; and

11 (II) successful implementation of
12 respectful care initiatives.

13 (ii) COMPONENTS OF STUDY.—The
14 study shall include the following:

15 (I) An assessment of the reports
16 submitted to the Secretary from the
17 respectful maternity care compliance
18 programs pursuant to paragraph
19 (2)(E).

20 (II) Based on such assessment,
21 recommendations for potential ac-
22 countability mechanisms related to
23 cases of racism or bias on the basis of
24 race, ethnicity, or another protected
25 class in the delivery of maternity care

1 services at hospitals and other birth
2 settings. Such recommendations shall
3 take into consideration medical and
4 non-medical factors that contribute to
5 adverse patient experiences and ma-
6 ternal health outcomes.

7 (iii) REPORT.—The Secretary shall
8 submit to the Congress, and make publicly
9 available, a report on the results of the
10 study under this subparagraph.

11 (4) AUTHORIZATION OF APPROPRIATIONS.—To
12 carry out this subsection, there is authorized to be
13 appropriated such sums as may be necessary for fis-
14 cal years 2027 through 2032.

15 (f) GAO REPORT.—

16 (1) IN GENERAL.—Not later than 2 years after
17 the date of enactment of this Act and annually
18 thereafter, the Comptroller General of the United
19 States shall submit to the Congress, and make pub-
20 licly available, a report on the establishment of re-
21 spectful maternity care compliance programs within
22 hospitals, health systems, and other maternity care
23 settings.

24 (2) MATTERS INCLUDED.—The report under
25 paragraph (1) shall include the following:

1 (A) Information regarding the extent to
2 which hospitals, health systems, and other ma-
3 ternity care settings have elected to establish
4 respectful maternity care compliance programs,
5 including—

6 (i) which hospitals and other birth
7 settings elect to establish compliance pro-
8 grams and when such programs are estab-
9 lished;

10 (ii) to the extent practicable, impacts
11 of the establishment of such programs on
12 maternal health outcomes and patient and
13 family experiences in the hospitals and
14 other birth settings that have established
15 such programs, especially for patients from
16 racial and ethnic minority groups and their
17 families;

18 (iii) information on geographic areas,
19 and types of hospitals or other birth set-
20 tings, where respectful maternity care com-
21 pliance programs are not being established
22 and information on factors contributing to
23 decisions to not establish such programs;
24 and

1 (iv) recommendations for establishing
 2 respectful maternity care compliance pro-
 3 grams in geographic areas, and types of
 4 hospitals or other birth settings, where
 5 such programs are not being established.

6 (B) Whether the funding made available to
 7 carry out this subsection has been sufficient
 8 and, if applicable, recommendations for addi-
 9 tional appropriations to carry out this sub-
 10 section.

11 (C) Such other information as the Comp-
 12 troller General determines appropriate.

13 (g) DEFINITIONS.—In this section:

14 (1) CULTURALLY CONGRUENT.—The term “cul-
 15 turally congruent”, with respect to care or maternity
 16 care, means care that is in agreement with the pre-
 17 ferred cultural values, beliefs, worldview, language,
 18 and practices of the health care consumer and other
 19 stakeholders.

20 (2) MATERNITY CARE PROVIDER.—The term
 21 “maternity care provider” means a health care pro-
 22 vider who—

23 (A) is a physician, physician assistant,
 24 midwife who meets at a minimum the inter-
 25 national definition of the midwife and global

1 standards for midwifery education as estab-
2 lished by the International Confederation of
3 Midwives, nurse practitioner, or clinical nurse
4 specialist; and

5 (B) has a focus on maternal or perinatal
6 health.

7 (3) MATERNAL MORTALITY.—The term “mater-
8 nal mortality” means a death occurring during or
9 within a one-year period after pregnancy, caused by
10 pregnancy-related or childbirth complications, in-
11 cluding a suicide, overdose, or other death resulting
12 from a mental health or substance use disorder at-
13 tributed to or aggravated by pregnancy-related or
14 childbirth complications.

15 (4) PERINATAL HEALTH WORKER.—The term
16 “perinatal health worker” means a doula, commu-
17 nity health worker, peer supporter, breastfeeding
18 and lactation educator or counselor, nutritionist or
19 dietitian, childbirth educator, social worker, home
20 visitor, language interpreter, or navigator.

21 (5) POSTPARTUM AND POSTPARTUM PERIOD.—
22 The terms “postpartum” and “postpartum period”
23 mean the 1-year period beginning on the last day of
24 the pregnancy of an individual.

1 (6) PREGNANCY-ASSOCIATED DEATH.—The
2 term “pregnancy-associated death” means a death of
3 a pregnant or postpartum individual, by any cause,
4 that occurs during, or within 1 year following, the
5 individual’s pregnancy, regardless of the outcome,
6 duration, or site of the pregnancy.

7 (7) PREGNANCY-RELATED DEATH.—The term
8 “pregnancy-related death” means a death of a preg-
9 nant or postpartum individual that occurs during, or
10 within 1 year following, the individual’s pregnancy,
11 from a pregnancy complication, a chain of events
12 initiated by pregnancy, or the aggravation of an un-
13 related condition by the physiologic effects of preg-
14 nancy.

15 (8) RACIAL AND ETHNIC MINORITY GROUP.—
16 The term “racial and ethnic minority group” has the
17 meaning given such term in section 1707(g)(1) of
18 the Public Health Service Act (42 U.S.C. 300u–
19 6(g)(1)).

20 (9) SEVERE MATERNAL MORBIDITY.—The term
21 “severe maternal morbidity” means a health condi-
22 tion, including mental health conditions and sub-
23 stance use disorders, attributed to or aggravated by
24 pregnancy or childbirth that results in significant

1 short-term or long-term consequences to the health
2 of the individual who was pregnant.

3 (10) SOCIAL DETERMINANTS OF MATERNAL
4 HEALTH DEFINED.—The term “social determinants
5 of maternal health” means non-clinical factors that
6 impact maternal health outcomes, including—

7 (A) economic factors, which may include
8 poverty, employment, food security, support for
9 and access to lactation and other infant feeding
10 options, housing stability, and related factors;

11 (B) neighborhood factors, which may in-
12 clude quality of housing, access to transpor-
13 tation, access to child care, availability of
14 healthy foods and nutrition counseling, avail-
15 ability of clean water, air and water quality,
16 ambient temperatures, neighborhood crime and
17 violence, access to broadband, and related fac-
18 tors;

19 (C) social and community factors, which
20 may include systemic racism, gender discrimi-
21 nation or discrimination based on other pro-
22 tected classes, workplace conditions, incarcer-
23 ation, and related factors;

24 (D) household factors, which may include
25 ability to conduct lead testing and abatement,

1 car seat installation, indoor air temperatures,
2 and related factors;

3 (E) education access and quality factors,
4 which may include educational attainment, lan-
5 guage and literacy, and related factors; and

6 (F) health care access factors, including
7 health insurance coverage, access to culturally
8 congruent health care services, providers, and
9 non-clinical support, access to home visiting
10 services, access to wellness and stress manage-
11 ment programs, health literacy, access to tele-
12 health and items required to receive telehealth
13 services, and related factors.

14 **SEC. 5205. PERINATAL WORKFORCE.**

15 (a) HHS AGENCY DIRECTIVES.—

16 (1) GUIDANCE TO STATES.—

17 (A) IN GENERAL.—Not later than 2 years
18 after the date of enactment of this Act, the Sec-
19 retary of Health and Human Services shall
20 issue and disseminate guidance to States to
21 educate providers, managed care entities, and
22 other insurers about the value and process of
23 delivering respectful maternal health care
24 through diverse and multidisciplinary care pro-
25 vider models.

1 (B) CONTENTS.—The guidance required
2 by subparagraph (A) shall address how States
3 can encourage and incentivize hospitals, health
4 systems, midwifery practices, freestanding birth
5 centers, other maternity care provider groups,
6 managed care entities, and other insurers—

7 (i) to recruit and retain maternity
8 care providers, mental and behavioral
9 health care providers acting in accordance
10 with State law, registered dietitians or nu-
11 trition professionals (as such term is de-
12 fined in section 1861(vv)(2) of the Social
13 Security Act (42 U.S.C. 1395x(vv)(2))),
14 and lactation consultants certified by the
15 International Board of Lactation Consult-
16 ants Examiners—

17 (I) from racially, ethnically, and
18 linguistically diverse backgrounds;

19 (II) with experience practicing in
20 racially and ethnically diverse commu-
21 nities; and

22 (III) who have undergone train-
23 ing on implicit bias and racism;

24 (ii) to incorporate into maternity care
25 teams—

1 (I) midwives who meet, at a min-
 2 imum, the international definition of
 3 the midwife and global standards for
 4 midwifery education, as established by
 5 the International Confederation of
 6 Midwives; and

7 (II) perinatal health workers;

8 (iii) to provide collaborative, culturally
 9 congruent care; and

10 (iv) to provide opportunities for indi-
 11 viduals enrolled in accredited midwifery
 12 education programs to participate in job
 13 shadowing with maternity care teams in
 14 hospitals, health systems, midwifery prac-
 15 tices, and freestanding birth centers.

16 (2) STUDY ON RESPECTFUL AND CULTURALLY
 17 CONGRUENT MATERNITY CARE.—

18 (A) STUDY.—The Secretary of Health and
 19 Human Services, acting through the Director of
 20 the National Institutes of Health (in this para-
 21 graph referred to as the “Secretary”), shall
 22 conduct a study on best practices in respectful
 23 and culturally congruent maternity care.

1 (B) REPORT.—Not later than 2 years after
2 the date of enactment of this Act, the Secretary
3 shall—

4 (i) complete the study required by
5 subparagraph (A);

6 (ii) submit to the Congress, and make
7 publicly available, a report on the results
8 of such study; and

9 (iii) include in such report—

10 (I) a compendium of examples of
11 hospitals, health systems, midwifery
12 practices, freestanding birth centers,
13 other maternity care provider groups,
14 managed care entities, and other in-
15 surers that are delivering respectful
16 and culturally congruent maternal
17 health care;

18 (II) a compendium of examples
19 of hospitals, health systems, midwifery
20 practices, freestanding birth centers,
21 other maternity care provider groups,
22 managed care entities, and other in-
23 surers that have made progress in re-
24 ducing inequities in maternal health
25 outcomes and improving birthing ex-

1 periences for pregnant and
 2 postpartum individuals from racial
 3 and ethnic minority groups; and

4 (III) recommendations to hos-
 5 pitals, health systems, midwifery prac-
 6 tices, freestanding birth centers, other
 7 maternity care provider groups, man-
 8 aged care entities, and other insurers,
 9 for best practices in respectful and
 10 culturally congruent maternity care.

11 (b) GRANTS TO GROW AND DIVERSIFY THE
 12 PERINATAL WORKFORCE.—Title VII of the Public Health
 13 Service Act is amended by inserting after section 757 (42
 14 U.S.C. 294f) the following:

15 **“SEC. 758. PERINATAL WORKFORCE GRANTS.**

16 “(a) IN GENERAL.—The Secretary shall award
 17 grants to entities to establish or expand programs de-
 18 scribed in subsection (b) to grow and diversify the
 19 perinatal workforce.

20 “(b) USE OF FUNDS.—Recipients of grants under
 21 this section shall use the grants to grow and diversify the
 22 perinatal workforce by—

23 “(1) establishing schools or programs that pro-
 24 vide education and training to individuals seeking
 25 appropriate licensing or certification as—

1 “(A) physician assistants who will complete
2 clinical training in the field of maternal and
3 perinatal health; or

4 “(B) perinatal health workers; and

5 “(2) expanding the capacity of existing schools
6 or programs described in paragraph (1), for the pur-
7 poses of increasing the number of students enrolled
8 in such schools or programs, including by awarding
9 scholarships for students.

10 “(c) PRIORITIZATION.—In awarding grants under
11 this section, the Secretary shall give priority to any entity
12 that—

13 “(1) has demonstrated a commitment to re-
14 cruiting and retaining students and faculty from ra-
15 cial and ethnic minority groups;

16 “(2) has developed a strategy to recruit and re-
17 tain a diverse pool of students into the perinatal
18 workforce program or school supported by funds re-
19 ceived through the grant, particularly from racial
20 and ethnic minority groups and other underserved
21 populations;

22 “(3) has developed a strategy to recruit and re-
23 tain students who plan to practice in a health pro-
24 fessional shortage area designated under section
25 332;

1 “(4) has developed a strategy to recruit and re-
2 tain students who plan to practice in an area with
3 significant racial and ethnic inequities in maternal
4 health outcomes, to the extent practicable; and

5 “(5) includes in the standard curriculum for all
6 students within the perinatal workforce program or
7 school a bias, racism, or discrimination training pro-
8 gram that includes training on implicit bias and rac-
9 ism.

10 “(d) REPORTING.—As a condition on receipt of a
11 grant under this section for a perinatal workforce program
12 or school, an entity shall agree to submit to the Secretary
13 an annual report on the activities conducted through the
14 grant, including—

15 “(1) the number and demographics of students
16 participating in the program or school;

17 “(2) the extent to which students in the pro-
18 gram or school are entering careers in—

19 “(A) health professional shortage areas
20 designated under section 332; and

21 “(B) areas with significant racial and eth-
22 nic inequities in maternal health outcomes, to
23 the extent such data are available; and

24 “(3) whether the program or school has in-
25 cluded in the standard curriculum for all students a

1 bias, racism, or discrimination training program that
2 includes explicit and implicit bias, and if so the ef-
3 fectiveness of such training program.

4 “(e) PERIOD OF GRANTS.—The period of a grant
5 under this section shall not exceed 5 years.

6 “(f) APPLICATION.—To seek a grant under this sec-
7 tion, an entity shall submit to the Secretary an application
8 at such time, in such manner, and containing such infor-
9 mation as the Secretary may require, including any infor-
10 mation necessary for prioritization under subsection (c).

11 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
12 provide, directly or by contract, technical assistance to en-
13 tities seeking or receiving a grant under this section on
14 the development, use, evaluation, and post-grant period
15 sustainability of the perinatal workforce programs or
16 schools proposed to be, or being, established or expanded
17 through the grant.

18 “(h) REPORT BY THE SECRETARY.—Not later than
19 4 years after the date of enactment of this section, the
20 Secretary shall prepare and submit to the Congress, and
21 post on the internet website of the Department of Health
22 and Human Services, a report on the effectiveness of the
23 grant program under this section at—

24 “(1) recruiting students from racial and ethnic
25 minority groups;

1 “(2) increasing the number of physician assist-
2 ants who will complete clinical training in the field
3 of maternal and perinatal health, and perinatal
4 health workers, from racial and ethnic minority
5 groups and other underserved populations;

6 “(3) increasing the number of physician assist-
7 ants who will complete clinical training in the field
8 of maternal and perinatal health, and perinatal
9 health workers, working in health professional short-
10 age areas designated under section 332; and

11 “(4) increasing the number of physician assist-
12 ants who will complete clinical training in the field
13 of maternal and perinatal health, and perinatal
14 health workers, working in areas with significant ra-
15 cial and ethnic inequities in maternal health out-
16 comes, to the extent such data are available.

17 “(i) DEFINITION OF RACIAL AND ETHNIC MINORITY
18 GROUP.—In this section, the term ‘racial and ethnic mi-
19 nority group’ has the meaning given such term in section
20 1707(g).

21 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this section, there is authorized to be appro-
23 priated \$15,000,000 for each of fiscal years 2027 through
24 2031.”.

1 (c) GRANTS TO GROW AND DIVERSIFY THE NURSING
2 WORKFORCE IN MATERNAL AND PERINATAL HEALTH.—
3 Title VIII of the Public Health Service Act is amended
4 by inserting after section 811 (42 U.S.C. 296j) the fol-
5 lowing:

6 **“SEC. 812. PERINATAL NURSING WORKFORCE GRANTS.**

7 “(a) IN GENERAL.—The Secretary shall award
8 grants to schools of nursing to grow and diversify the
9 perinatal nursing workforce.

10 “(b) USE OF FUNDS.—Recipients of grants under
11 this section shall use the grants to grow and diversify the
12 perinatal nursing workforce by providing scholarships to
13 students seeking to become—

14 “(1) nurse practitioners whose education in-
15 cludes a focus on maternal and perinatal health; or

16 “(2) clinical nurse specialists whose education
17 includes a focus on maternal and perinatal health.

18 “(c) PRIORITIZATION.—In awarding grants under
19 this section, the Secretary shall give priority to any school
20 of nursing that—

21 “(1) has developed a strategy to recruit and re-
22 tain a diverse pool of students seeking to enter ca-
23 reers focused on maternal and perinatal health, par-
24 ticularly students from racial and ethnic minority
25 groups and other underserved populations;

1 “(2) has developed a partnership with a prac-
 2 tice setting in a health professional shortage area
 3 designated under section 332 for the clinical place-
 4 ments of the school’s students;

5 “(3) has developed a strategy to recruit and re-
 6 tain students who plan to practice in an area with
 7 significant racial and ethnic inequities in maternal
 8 health outcomes, to the extent practicable; and

9 “(4) includes in the standard curriculum for all
 10 students seeking to enter careers focused on mater-
 11 nal and perinatal health a bias, racism, or discrimi-
 12 nation training program that includes education on
 13 implicit bias and racism.

14 “(d) REPORTING.—As a condition on receipt of a
 15 grant under this section, a school of nursing shall agree
 16 to submit to the Secretary an annual report on the activi-
 17 ties conducted through the grant, including, to the extent
 18 practicable—

19 “(1) the number and demographics of students
 20 in the school of nursing seeking to enter careers fo-
 21 cused on maternal and perinatal health;

22 “(2) the extent to which such students are pre-
 23 paring to enter careers in—

24 “(A) health professional shortage areas
 25 designated under section 332; and

1 “(B) areas with significant racial and eth-
2 nic inequities in maternal health outcomes, to
3 the extent such data are available; and

4 “(3) whether the standard curriculum for all
5 students seeking to enter careers focused on mater-
6 nal and perinatal health includes a bias, racism, or
7 discrimination training program that includes edu-
8 cation on implicit bias and racism.

9 “(e) PERIOD OF GRANTS.—The period of a grant
10 under this section shall be up to 5 years.

11 “(f) APPLICATION.—To seek a grant under this sec-
12 tion, an entity shall submit to the Secretary an applica-
13 tion, at such time, in such manner, and containing such
14 information as the Secretary may require, including any
15 information necessary for prioritization under subsection
16 (c).

17 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
18 provide, directly or by contract, technical assistance to
19 schools of nursing seeking or receiving a grant under this
20 section on the processes of awarding and evaluating schol-
21 arships through the grant.

22 “(h) REPORT BY THE SECRETARY.—Not later than
23 4 years after the date of enactment of this section, the
24 Secretary shall prepare and submit to the Congress, and
25 post on the internet website of the Department of Health

1 and Human Services, a report on the effectiveness of the
2 grant program under this section at—

3 “(1) recruiting students from racial and ethnic
4 minority groups and other underserved populations;

5 “(2) increasing the number of nurse practi-
6 tioners and clinical nurse specialists entering careers
7 focused on maternal and perinatal health from racial
8 and ethnic minority groups and other underserved
9 populations;

10 “(3) increasing the number of nurse practi-
11 tioners and clinical nurse specialists entering careers
12 focused on maternal and perinatal health working in
13 health professional shortage areas designated under
14 section 332; and

15 “(4) increasing the number of nurse practi-
16 tioners and clinical nurse specialists entering careers
17 focused on maternal and perinatal health working in
18 areas with significant racial and ethnic inequities in
19 maternal health outcomes, to the extent such data
20 are available.

21 “(i) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this section, there is authorized to be appro-
23 priated \$15,000,000 for each of fiscal years 2027 through
24 2031.”.

25 (d) GAO REPORT.—

1 (1) IN GENERAL.—Not later than 2 years after
2 the date of enactment of this Act, and every 5 years
3 thereafter, the Comptroller General of the United
4 States shall submit to Congress a report on barriers
5 to maternal health education and access to care in
6 the United States. Such report shall include the in-
7 formation and recommendations described in para-
8 graph (2).

9 (2) CONTENT OF REPORT.—The report under
10 paragraph (1) shall include—

11 (A) an assessment of current barriers to
12 entering accredited midwifery education pro-
13 grams, and recommendations for addressing
14 such barriers, particularly for low-income people
15 and people from racial and ethnic minority
16 groups;

17 (B) an assessment of current barriers to
18 entering and successfully completing accredited
19 education programs for other health profes-
20 sional careers related to maternity care, includ-
21 ing maternity care providers, mental and behav-
22 ioral health care providers acting in accordance
23 with State law, registered dietitians or nutrition
24 professionals (as such term is defined in section
25 1861(vv)(2) of the Social Security Act (42

1 U.S.C. 1395x(vv)(2))), and lactation consult-
2 ants certified by the International Board of
3 Lactation Consultants Examiners, particularly
4 for low-income people and people from racial
5 and ethnic minority groups;

6 (C) an assessment of current barriers that
7 prevent midwives from meeting the inter-
8 national definition of the midwife and global
9 standards for midwifery education as estab-
10 lished by the International Confederation of
11 Midwives, and recommendations for addressing
12 such barriers, particularly for low-income people
13 and people from racial and ethnic minority
14 groups;

15 (D) an assessment of inequities in access
16 to maternity care providers, mental or behav-
17 ioral health care providers acting in accordance
18 with State law, registered dietitians or nutrition
19 professionals (as such term is defined in section
20 1861(vv)(2) of the Social Security Act (42
21 U.S.C. 1395x(vv)(2))), lactation consultants
22 certified by the International Board of Lacta-
23 tion Consultants Examiners, and perinatal
24 health workers, stratified by race, ethnicity,
25 gender identity, geographic location, and insur-

ance type and recommendations to promote
greater access equity; and

(E) recommendations to promote greater
equity in compensation for perinatal health
workers under public and private insurers, par-
ticularly for such individuals from racially and
ethnically diverse backgrounds.

(e) DEFINITIONS.—In this section:

(1) CULTURALLY CONGRUENT.—The term “cul-
turally congruent”, with respect to care or maternity
care, means care that is in agreement with the pre-
ferred cultural values, beliefs, worldview, language,
and practices of the health care consumer and other
stakeholders.

(2) MATERNITY CARE PROVIDER.—The term
“maternity care provider” means a health care pro-
vider who—

(A) is a physician, physician assistant,
midwife who meets at a minimum the inter-
national definition of the midwife and global
standards for midwifery education as estab-
lished by the International Confederation of
Midwives, nurse practitioner, or clinical nurse
specialist; and

1 (B) has a focus on maternal or perinatal
2 health.

3 (3) PERINATAL HEALTH WORKER.—The term
4 “perinatal health worker” means a doula, commu-
5 nity health worker, peer supporter, breastfeeding
6 and lactation educator or counselor, nutritionist or
7 dietitian, childbirth educator, social worker, home
8 visitor, language interpreter, or navigator.

9 (4) POSTPARTUM.—The terms “postpartum”
10 means the 1-year period beginning on the last day
11 of the pregnancy of an individual.

12 (5) RACIAL AND ETHNIC MINORITY GROUP.—
13 The term “racial and ethnic minority group” has the
14 meaning given such term in section 1707(g)(1) of
15 the Public Health Service Act (42 U.S.C. 300u-
16 6(g)(1)).

17 **SEC. 5206. DATA TO SAVE MOMS ACT.**

18 (a) SHORT TITLE.—This section may be cited as the
19 “Data To Save Moms Act”.

20 (b) FUNDING FOR MATERNAL MORTALITY REVIEW
21 COMMITTEES TO PROMOTE REPRESENTATIVE COMMU-
22 NITY ENGAGEMENT.—

23 (1) IN GENERAL.—Section 317K(d) of the Pub-
24 lic Health Service Act (42 U.S.C. 247b-12(d)) is
25 amended by adding at the end the following:

1 “(9) GRANTS TO PROMOTE REPRESENTATIVE
2 COMMUNITY ENGAGEMENT IN MATERNAL MOR-
3 TALITY REVIEW COMMITTEES.—

4 “(A) IN GENERAL.—The Secretary may,
5 using funds made available pursuant to sub-
6 paragraph (C), provide assistance to an applica-
7 ble maternal mortality review committee of a
8 State, Indian tribe, tribal organization, or
9 Urban Indian organization (as such terms are
10 defined in section 4 of the Indian Health Care
11 Improvement Act)—

12 “(i) to select for inclusion in the mem-
13 bership of such a committee community
14 members from the State, Indian tribe, trib-
15 al organization, or Urban Indian organiza-
16 tion by—

17 “(I) prioritizing community mem-
18 bers who can increase the diversity of
19 the committee’s membership with re-
20 spect to race and ethnicity, location,
21 and professional background, includ-
22 ing members with non-clinical experi-
23 ences; and

24 “(II) to the extent applicable,
25 using funds reserved under subsection

1 (g), to address barriers to maternal
2 mortality review committee participa-
3 tion for community members, includ-
4 ing through providing required train-
5 ing, reducing transportation barriers,
6 providing compensation, and providing
7 other supports as may be necessary;

8 “(ii) to establish initiatives to conduct
9 outreach and community engagement ef-
10 forts within communities throughout the
11 State or Indian tribe to seek input from
12 community members on the work of such
13 maternal mortality review committee, with
14 a particular focus on outreach to people
15 who are members of minority groups; and

16 “(iii) to release public reports assess-
17 ing—

18 “(I) the pregnancy-related death
19 and pregnancy-associated death review
20 processes of the maternal mortality
21 review committee, with a particular
22 focus on the maternal mortality re-
23 view committee’s sensitivity to the
24 unique circumstances of pregnant and
25 postpartum individuals from racial

1 and ethnic minority groups (as such
2 term is defined in section 1707(g)(1))
3 who have suffered pregnancy-related
4 deaths; and

5 “(II) the impact of the use of
6 funds made available pursuant to
7 paragraph (C) on increasing the diver-
8 sity of the maternal mortality review
9 committee membership and promoting
10 community engagement efforts
11 throughout the State or Indian tribe.

12 “(B) TECHNICAL ASSISTANCE.—The Sec-
13 retary shall provide (either directly through the
14 Department of Health and Human Services or
15 by contract) technical assistance to any mater-
16 nal mortality review committee receiving a
17 grant under this paragraph on best practices
18 for increasing the diversity of the maternal
19 mortality review committee’s membership and
20 for conducting effective community engagement
21 throughout the State or Indian tribe.

22 “(C) AUTHORIZATION OF APPROPRIA-
23 TIONS.—In addition to any funds made avail-
24 able under subsection (g), there are authorized
25 to be appropriated to carry out this paragraph

1 \$10,000,000 for each of fiscal years 2027
2 through 2031.”.

3 (2) RESERVATION OF FUNDS.—Section
4 317K(g) of the Public Health Service Act (42
5 U.S.C. 247b–12(g)) is amended—

6 (A) by striking “2026 through 2030” and
7 inserting “2027 through 2031”; and

8 (B) by adding at the end the following:
9 “Of the amount made available under the pre-
10 ceding sentence for a fiscal year, not less than
11 \$1,500,000 shall be reserved for grants award-
12 ed under subsection (d)(9) to Indian tribes,
13 tribal organizations, or Urban Indian organiza-
14 tions (as such terms are defined in section 4 of
15 the Indian Health Care Improvement Act).”.

16 (c) DATA COLLECTION AND REVIEW.—Section
17 317K(d)(3)(A)(i) of the Public Health Service Act (42
18 U.S.C. 247b–12(d)(3)(A)(i)) is amended—

19 (1) by redesignating subclauses (II) and (III)
20 as subclauses (V) and (VI), respectively; and

21 (2) by inserting after subclause (I) the fol-
22 lowing:

23 “(II) to the extent practicable,
24 reviewing cases of severe maternal

1 morbidity, according to the most up-
 2 to-date indicators;

3 “(III) to the extent practicable,
 4 reviewing deaths during pregnancy or
 5 up to 1 year after the end of a preg-
 6 nancy from suicide, overdose, or other
 7 death from a mental health condition
 8 or substance use disorder attributed
 9 to, or aggravated by, pregnancy or
 10 childbirth complications;

11 “(IV) to the extent practicable,
 12 consulting with local community-based
 13 organizations representing pregnant
 14 and postpartum individuals from de-
 15 mographic groups disproportionately
 16 impacted by poor maternal health out-
 17 comes to ensure that, in addition to
 18 clinical factors, non-clinical factors
 19 that might have contributed to a preg-
 20 nancy-related death are appropriately
 21 considered;”.

22 (d) REVIEW OF MATERNAL HEALTH DATA COLLEC-
 23 TION PROCESSES AND QUALITY MEASURES.—

24 (1) IN GENERAL.—The Secretary of Health and
 25 Human Services, acting through the Administrator

1 for the Centers for Medicare & Medicaid Services
2 and the Director of the Agency for Healthcare Re-
3 search and Quality (referred to in this subsection as
4 the “Secretary”), shall consult with relevant stake-
5 holders—

6 (A) to review existing maternal health data
7 collection processes and quality measures; and

8 (B) to make recommendations to improve
9 such processes and measures, including topics
10 described in paragraph (3).

11 (2) COLLABORATION.—In carrying out this sub-
12 section, the Secretary shall consult with a diverse
13 group of maternal health stakeholders, which may
14 include—

15 (A) pregnant and postpartum individuals
16 and their family members, and nonprofit orga-
17 nizations representing such individuals, with a
18 particular focus on patients from racial and
19 ethnic minority groups;

20 (B) community-based organizations that
21 provide support for pregnant and postpartum
22 individuals, with a particular focus on patients
23 from racial and ethnic minority groups;

24 (C) membership organizations for mater-
25 nity care providers;

1 (D) organizations representing perinatal
2 health workers;

3 (E) organizations that focus on maternal
4 mental or behavioral health;

5 (F) organizations that focus on intimate
6 partner violence;

7 (G) institutions of higher education, with a
8 particular focus on minority-serving institu-
9 tions;

10 (H) licensed and accredited hospitals, birth
11 centers, midwifery practices, or other medical
12 practices that provide maternal health care
13 services to pregnant and postpartum patients;

14 (I) relevant State and local public agencies,
15 including State maternal mortality review com-
16 mittees; and

17 (J) the National Quality Forum, or such
18 other standard-setting organizations specified
19 by the Secretary.

20 (3) TOPICS.—The review of maternal health
21 data collection processes and recommendations to
22 improve such processes and measures required under
23 paragraph (1) shall assess all available relevant in-
24 formation, including information from State-level
25 sources, and shall consider at least the following:

1 (A) Current State and Tribal practices for
2 maternal health, maternal mortality, and severe
3 maternal morbidity data collection and dissemi-
4 nation, including consideration of—

5 (i) the timeliness of processes for
6 amending a death certificate when new in-
7 formation pertaining to the death becomes
8 available to reflect whether the death was
9 a pregnancy-related death;

10 (ii) relevant data collected with elec-
11 tronic health records, including data on
12 race, ethnicity, socioeconomic status, insur-
13 ance type, and other relevant demographic
14 information;

15 (iii) maternal health data collected
16 and publicly reported by hospitals, health
17 systems, midwifery practices, and birth
18 centers;

19 (iv) the barriers preventing States
20 from correlating maternal outcome data
21 with race and ethnicity data;

22 (v) processes for determining the
23 cause of a pregnancy-associated death in
24 States that do not have a maternal mor-
25 tality review committee;

1 (vi) whether maternal mortality review
2 committees include multidisciplinary and
3 diverse membership (as described in sec-
4 tion 317K(d)(1)(A) of the Public Health
5 Service Act (42 U.S.C. 247b–
6 12(d)(1)(A)));

7 (vii) whether members of maternal
8 mortality review committees participate in
9 trainings on bias, racism, or discrimina-
10 tion, and the quality of such trainings;

11 (viii) the extent to which States have
12 implemented systematic processes of listen-
13 ing to the stories of pregnant and
14 postpartum individuals and their family
15 members, with a particular focus on preg-
16 nant and postpartum individuals from ra-
17 cial and ethnic minority groups and their
18 family members, to fully understand the
19 causes of, and inform potential solutions
20 to, the maternal mortality and severe ma-
21 ternal morbidity crisis within their respec-
22 tive States;

23 (ix) the extent to which maternal mor-
24 tality review committees are considering
25 social determinants of maternal health

1 when examining the causes of pregnancy-
2 associated and pregnancy-related deaths;

3 (x) the extent to which maternal mor-
4 tality review committees are making ac-
5 tionable recommendations based on their
6 reviews of adverse maternal health out-
7 comes and the extent to which such rec-
8 ommendations are being implemented by
9 appropriate stakeholders;

10 (xi) the legal and administrative bar-
11 riers preventing the collection, collation,
12 and dissemination of State maternity care
13 data;

14 (xii) the effectiveness of data collec-
15 tion and reporting processes in separating
16 pregnancy-associated deaths from preg-
17 nancy-related deaths; and

18 (xiii) the current Federal, State, local,
19 and Tribal funding support for the activi-
20 ties referred to in clauses (i) through (xii).

21 (B) Whether the funding support referred
22 to in subparagraph (A)(xiii) is adequate for
23 States to carry out optimal data collection and
24 dissemination processes with respect to mater-

1 nal health, maternal mortality, and severe ma-
2 ternal morbidity.

3 (C) Current quality measures for mater-
4 nity care, including prenatal measures, labor
5 and delivery measures, and postpartum meas-
6 ures, including topics such as—

7 (i) effective quality measures for ma-
8 ternity care used by hospitals, health sys-
9 tems, midwifery practices, birth centers,
10 health plans, and other relevant entities;

11 (ii) the sufficiency of current outcome
12 measures used to evaluate maternity care
13 for driving improved care, experiences, and
14 outcomes in maternity care payment and
15 delivery system models;

16 (iii) maternal health quality measures
17 that other countries effectively use;

18 (iv) validated measures that have been
19 used for research purposes that could be
20 tested, refined, and submitted for national
21 endorsement;

22 (v) barriers preventing maternity care
23 providers and insurers from implementing
24 quality measures that are aligned with best
25 practices;

1 (vi) the frequency with which mater-
2 nity care quality measures are reviewed
3 and revised;

4 (vii) the strengths and weaknesses of
5 the Prenatal and Postpartum Care meas-
6 ures of the Health Plan Employer Data
7 and Information Set measures established
8 by the National Committee for Quality As-
9 surance;

10 (viii) the strengths and weaknesses of
11 maternity care quality measures under the
12 Medicaid program under title XIX of the
13 Social Security Act (42 U.S.C. 1396 et
14 seq.) and the Children's Health Insurance
15 Program under title XXI of such Act (42
16 U.S.C. 1397aa et seq.), including the ex-
17 tent to which States voluntarily report rel-
18 evant measures;

19 (ix) the extent to which maternity
20 care quality measures are informed by pa-
21 tient experiences that include measures of
22 patient-reported experience of care;

23 (x) the current processes for collecting
24 stratified data on the race and ethnicity of
25 pregnant and postpartum individuals in

1 hospitals, health systems, midwifery prac-
 2 tices, and birth centers, and for incor-
 3 porating such racially and ethnically strati-
 4 fied data in maternity care quality meas-
 5 ures;

6 (xi) the extent to which maternity
 7 care quality measures account for the
 8 unique experiences of pregnant and
 9 postpartum individuals from racial and
 10 ethnic minority groups; and

11 (xii) the extent to which hospitals,
 12 health systems, midwifery practices, and
 13 birth centers are implementing existing
 14 maternity care quality measures.

15 (D) Recommendations on authorizing addi-
 16 tional funds and providing additional technical
 17 assistance to improve maternal mortality review
 18 committees and State and Tribal maternal
 19 health data collection and reporting processes.

20 (E) Recommendations for new authorities
 21 that may be granted to maternal mortality re-
 22 view committees to be able to—

23 (i) access records from other Federal
 24 and State agencies and departments that
 25 may be necessary to identify causes of

1 pregnancy-associated and pregnancy-re-
2 lated deaths that are unique to pregnant
3 and postpartum individuals from specific
4 populations, such as veterans and individ-
5 uals who are incarcerated; and

6 (ii) work with relevant experts who
7 are not members of the maternal mortality
8 review committee to assist in the review of
9 pregnancy-associated deaths of pregnant
10 and postpartum individuals from specific
11 populations, such as veterans and individ-
12 uals who are incarcerated.

13 (F) Recommendations to improve and
14 standardize current quality measures for mater-
15 nity care, with a particular focus on racial and
16 ethnic inequities in maternal health outcomes.

17 (G) Recommendations to improve the co-
18 ordination by the Department of Health and
19 Human Services of the efforts undertaken by
20 the agencies and organizations within the De-
21 partment related to maternal health data and
22 quality measures.

23 (4) REPORT.—Not later than 1 year after the
24 date of enactment of this Act, the Secretary shall
25 submit to Congress, and make publicly available, a

1 report on the results of the review of maternal
 2 health data collection processes and quality meas-
 3 ures and recommendations to improve such proc-
 4 esses and measures required under paragraph (1).

5 (5) DEFINITION OF MATERNAL MORTALITY RE-
 6 VIEW COMMITTEE.—In this subsection, the term
 7 “maternal mortality review committee” means a ma-
 8 ternal mortality review committee duly authorized by
 9 a State and receiving funding under section
 10 317K(a)(2)(D) of the Public Health Service Act (42
 11 U.S.C. 247b–12(a)(2)(D)).

12 (6) AUTHORIZATION OF APPROPRIATIONS.—
 13 There are authorized to be appropriated such sums
 14 as may be necessary to carry out this subsection for
 15 each of fiscal years 2027 through 2031.

16 (e) INDIAN HEALTH SERVICE STUDY ON MATERNAL
 17 MORTALITY AND SEVERE MATERNAL MORBIDITY.—

18 (1) IN GENERAL.—The Director of the Indian
 19 Health Service (referred to in this subsection as the
 20 “Director”) shall, in coordination with entities de-
 21 scribed in paragraph (2)—

22 (A) not later than 90 days after the date
 23 of enactment of this Act, enter into a contract
 24 with an independent research organization or
 25 Tribal Epidemiology Center to conduct a com-

1 prehensive study on maternal mortality and se-
2 vere maternal morbidity in the populations of
3 American Indian and Alaska Native individuals;
4 and

5 (B) not later than 3 years after the date
6 of enactment of this Act, submit to Congress a
7 report on that study that contains recommenda-
8 tions for policies and practices that can be
9 adopted to improve maternal health outcomes
10 for pregnant and postpartum American Indian
11 and Alaska Native individuals.

12 (2) PARTICIPATING ENTITIES.—

13 (A) IN GENERAL.—The entities referred to
14 in paragraph (1) shall consist of 12 members,
15 selected by the Director from among individuals
16 nominated by Indian Tribes and Tribal organi-
17 zations (as those terms are defined in section 4
18 of the Indian Self-Determination and Education
19 Assistance Act (25 U.S.C. 5304)) and Urban
20 Indian organizations (as defined in section 4 of
21 the Indian Health Care Improvement Act (25
22 U.S.C. 1603)).

23 (B) REQUIREMENT.—In selecting members
24 under subparagraph (A), the Director shall en-

1 sure that each of the 12 service areas of the In-
2 dian Health Service are represented.

3 (3) CONTENTS OF STUDY.—The study con-
4 ducted pursuant to paragraph (1)(A) shall—

5 (A) examine the causes of maternal mor-
6 tality and severe maternal morbidity that are
7 unique to American Indian and Alaska Native
8 individuals;

9 (B) include a systematic process of listen-
10 ing to the stories of American Indian and Alas-
11 ka Native pregnant and postpartum individuals
12 to fully understand the causes of, and inform
13 potential solutions to, the maternal mortality
14 and severe maternal morbidity crisis within the
15 communities of those individuals;

16 (C) distinguish between the causes of,
17 landscape of maternity care at, and rec-
18 ommendations to improve maternal health out-
19 comes within the different settings in which
20 American Indian and Alaska Native pregnant
21 and postpartum individuals receive maternity
22 care, including—

23 (i) facilities operated by the Indian
24 Health Service;

1 (ii) an Indian health program oper-
2 ated by an Indian Tribe or a Tribal orga-
3 nization (as those terms are defined in sec-
4 tion 4 of the Indian Self-Determination
5 and Education Assistance Act (25 U.S.C.
6 5304)) pursuant to a contract, grant, coop-
7 erative agreement, or compact with the In-
8 dian Health Service pursuant to the Indian
9 Self-Determination and Education Assist-
10 ance Act (25 U.S.C. 5301 et seq.); and

11 (iii) an Urban Indian health program
12 operated by an Urban Indian organization
13 (as defined in section 4 of the Indian
14 Health Care Improvement Act (25 U.S.C.
15 1603)) pursuant to a grant or contract
16 with the Indian Health Service pursuant to
17 title V of the Indian Health Care Improve-
18 ment Act (25 U.S.C. 1651 et seq.);

19 (D) review processes for coordinating pro-
20 grams of the Indian Health Service with social
21 services provided through other programs ad-
22 ministered by the Secretary of Health and
23 Human Services (other than the Medicare pro-
24 gram under title XVIII of the Social Security
25 Act (42 U.S.C. 1395 et seq.), the Medicaid pro-

1 gram under title XIX of that Act (42 U.S.C.
2 1396 et seq.), and the State Children’s Health
3 Insurance Program under title XXI of that Act
4 (42 U.S.C. 1397aa et seq.));

5 (E) review current data collection and
6 quality measurement processes and practices;

7 (F) assess causes and frequency of mater-
8 nal mental health conditions and substance use
9 disorders;

10 (G) consider social determinants of health,
11 including poverty, lack of health insurance, un-
12 employment, sexual violence, and environmental
13 conditions in Tribal areas;

14 (H) consider the role that historical mis-
15 treatment of American Indian and Alaska Na-
16 tive people has played in causing currently high
17 rates of maternal mortality and severe maternal
18 morbidity;

19 (I) consider how current funding of the In-
20 dian Health Service affects the ability of the In-
21 dian Health Service to deliver quality maternity
22 care;

23 (J) consider the extent to which the deliv-
24 ery of maternity care services is culturally ap-

1 appropriate for American Indian and Alaska Na-
2 tive pregnant and postpartum individuals;

3 (K) make recommendations to reduce
4 misclassification of American Indian and Alaska
5 Native pregnant and postpartum individuals,
6 including consideration of best practices in
7 training for maternal mortality review com-
8 mittee members to be able to correctly classify
9 American Indian and Alaska Native individuals;
10 and

11 (L) make recommendations informed by
12 the stories shared by American Indian and
13 Alaska Native pregnant and postpartum indi-
14 viduals pursuant to subparagraph (B) to im-
15 prove maternal health outcomes for those indi-
16 viduals.

17 (4) REPORT.—The agreement entered into
18 under paragraph (1)(A) with an independent re-
19 search organization or Tribal Epidemiology Center
20 shall require that the independent research organiza-
21 tion or Tribal Epidemiology Center, as applicable,
22 submit to Congress a report on the results of the
23 study conducted pursuant to that agreement not
24 later than 36 months after the date of enactment of
25 this Act.

1 (5) AUTHORIZATION OF APPROPRIATIONS.—

2 There is authorized to be appropriated to carry out
3 this subsection \$2,000,000 for each of fiscal years
4 2027 through 2029.

5 (f) GRANTS TO MINORITY-SERVING INSTITUTIONS
6 TO STUDY MATERNAL MORTALITY, SEVERE MATERNAL
7 MORBIDITY, AND OTHER ADVERSE MATERNAL HEALTH
8 OUTCOMES.—

9 (1) IN GENERAL.—The Secretary of Health and
10 Human Services (referred to in this subsection as
11 the “Secretary”) shall establish a program under
12 which the Secretary shall award grants to research
13 centers, health professions schools and programs,
14 and other entities at minority-serving institutions to
15 study specific aspects of the maternal health crisis
16 among pregnant and postpartum individuals from
17 racial and ethnic minority groups. Such research
18 may—

19 (A) include the development and imple-
20 mentation of systematic processes of listening
21 to the stories of pregnant and postpartum indi-
22 viduals from racial and ethnic minority groups,
23 and perinatal health workers supporting such
24 individuals, to fully understand the causes of,
25 and inform potential solutions to, the maternal

1 mortality and severe maternal morbidity crisis
2 within their respective communities;

3 (B) assess the potential causes of relatively
4 low rates of maternal mortality among Hispanic
5 individuals, including potential racial
6 misclassification and other data collection and
7 reporting issues that might be misrepresenting
8 maternal mortality rates among Hispanic indi-
9 viduals in the United States; and

10 (C) assess differences in rates of adverse
11 maternal health outcomes among subgroups
12 identifying as Hispanic.

13 (2) APPLICATION.—To be eligible to receive a
14 grant under paragraph (1), an entity described in
15 such paragraph shall submit to the Secretary an ap-
16 plication at such time, in such manner, and con-
17 taining such information as the Secretary may re-
18 quire.

19 (3) TECHNICAL ASSISTANCE.—The Secretary
20 may use not more than 10 percent of the funds
21 made available under paragraph (7)—

22 (A) to conduct outreach to minority-serv-
23 ing institutions to raise awareness of the avail-
24 ability of grants under paragraph (1);

1 (B) to provide technical assistance in the
2 application process for such a grant; and

3 (C) to promote capacity building, as need-
4 ed to enable entities described in such para-
5 graph to submit such an application.

6 (4) REPORTING REQUIREMENT.—Each entity
7 awarded a grant under this subsection shall periodi-
8 cally submit to the Secretary a report on the status
9 of activities conducted using the grant.

10 (5) EVALUATION.—Beginning one year after
11 the date on which the first grant is awarded under
12 this subsection, the Secretary shall submit to Con-
13 gress an annual report summarizing the findings of
14 research conducted using funds made available
15 under this subsection.

16 (6) MINORITY-SERVING INSTITUTIONS DE-
17 FINED.—In this subsection, the term “minority-serv-
18 ing institution” means an eligible institution de-
19 scribed in section 371(a) of the Higher Education
20 Act of 1965 (20 U.S.C. 1067q(a)).

21 (7) AUTHORIZATION OF APPROPRIATIONS.—
22 There are authorized to be appropriated to carry out
23 this subsection \$10,000,000 for each of fiscal years
24 2027 through 2031.

25 (g) DEFINITIONS.—In this section:

1 (1) CULTURALLY CONGRUENT.—The term “cul-
 2 turally congruent”, with respect to care or maternity
 3 care, means care that is in agreement with the pre-
 4 ferred cultural values, beliefs, worldview, language,
 5 and practices of the health care consumer and other
 6 stakeholders.

7 (2) MATERNITY CARE PROVIDER.—The term
 8 “maternity care provider” means a health care pro-
 9 vider who—

10 (A) is a physician, physician assistant,
 11 midwife who meets at a minimum the inter-
 12 national definition of the midwife and global
 13 standards for midwifery education as estab-
 14 lished by the International Confederation of
 15 Midwives, nurse practitioner, or clinical nurse
 16 specialist; and

17 (B) has a focus on maternal or perinatal
 18 health.

19 (3) MATERNAL MORTALITY.—The term “mater-
 20 nal mortality” means a death occurring during or
 21 within a one-year period after pregnancy, caused by
 22 pregnancy-related or childbirth complications, in-
 23 cluding a suicide, overdose, or other death resulting
 24 from a mental health or substance use disorder at-

1 tributed to or aggravated by pregnancy-related or
2 childbirth complications.

3 (4) PERINATAL HEALTH WORKER.—The term
4 “perinatal health worker” means a doula, commu-
5 nity health worker, peer supporter, breastfeeding
6 and lactation educator or counselor, nutritionist or
7 dietitian, childbirth educator, social worker, home
8 visitor, language interpreter, or navigator.

9 (5) POSTPARTUM AND POSTPARTUM PERIOD.—
10 The terms “postpartum” and “postpartum period”
11 mean the 1-year period beginning on the last day of
12 the pregnancy of an individual.

13 (6) PREGNANCY-ASSOCIATED.—The term
14 “pregnancy-associated”, with respect to a death,
15 means a death of a pregnant or postpartum indi-
16 vidual, by any cause, that occurs during, or within
17 1 year following, the individual’s pregnancy, regard-
18 less of the outcome, duration, or site of the preg-
19 nancy.

20 (7) PREGNANCY-RELATED.—The term “preg-
21 nancy-related”, with respect to a death, means a
22 death of a pregnant or postpartum individual that
23 occurs during, or within 1 year following, the indi-
24 vidual’s pregnancy, from a pregnancy complication,
25 a chain of events initiated by pregnancy, or the ag-

1 gravation of an unrelated condition by the physio-
2 logic effects of pregnancy.

3 (8) RACIAL AND ETHNIC MINORITY GROUP.—

4 The term “racial and ethnic minority group” has the
5 meaning given such term in section 1707(g)(1) of
6 the Public Health Service Act (42 U.S.C. 300u-
7 6(g)(1)).

8 (9) SEVERE MATERNAL MORBIDITY.—The term

9 “severe maternal morbidity” means a health condi-
10 tion, including mental health conditions and sub-
11 stance use disorders, attributed to or aggravated by
12 pregnancy or childbirth that results in significant
13 short-term or long-term consequences to the health
14 of the individual who was pregnant.

15 (10) SOCIAL DETERMINANTS OF MATERNAL

16 HEALTH.—The term “social determinants of mater-
17 nal health” means non-clinical factors that impact
18 maternal health outcomes, including—

19 (A) economic factors, which may include

20 poverty, employment, food security, support for
21 and access to lactation and other infant feeding
22 options, housing stability, and related factors;

23 (B) neighborhood factors, which may in-

24 clude quality of housing, access to transpor-
25 tation, access to child care, availability of

1 healthy foods and nutrition counseling, avail-
2 ability of clean water, air and water quality,
3 ambient temperatures, neighborhood crime and
4 violence, access to broadband, and related fac-
5 tors;

6 (C) social and community factors, which
7 may include systemic racism, gender discrimi-
8 nation or discrimination based on other pro-
9 tected classes, workplace conditions, incarcer-
10 ation, and related factors;

11 (D) household factors, which may include
12 ability to conduct lead testing and abatement,
13 car seat installation, indoor air temperatures,
14 and related factors;

15 (E) education access and quality factors,
16 which may include educational attainment, lan-
17 guage and literacy, and related factors; and

18 (F) health care access factors, including
19 health insurance coverage, access to culturally
20 congruent health care services, providers, and
21 non-clinical support, access to home visiting
22 services, access to wellness and stress manage-
23 ment programs, health literacy, access to tele-
24 health and items required to receive telehealth
25 services, and related factors.

1 **SEC. 5207. MOMS MATTER.**

2 (a) MATERNAL MENTAL HEALTH EQUITY GRANT
3 PROGRAM.—

4 (1) IN GENERAL.—The Secretary shall establish
5 a program to award grants to eligible entities to ad-
6 dress maternal mental health conditions and sub-
7 stance use disorders with respect to pregnant and
8 postpartum individuals, with a focus on racial and
9 ethnic minority groups.

10 (2) APPLICATION.—To be eligible to receive a
11 grant under this subsection, an eligible entity shall
12 submit to the Secretary an application at such time,
13 in such manner, and containing such information as
14 the Secretary may provide, including how such entity
15 will use funds for activities described in paragraph
16 (4) that are culturally congruent.

17 (3) PRIORITY.—In awarding grants under this
18 subsection, the Secretary shall give priority to an eli-
19 gible entity that—

20 (A) is, or will partner with, a community-
21 based organization to address maternal mental
22 health conditions and substance use disorders
23 described in paragraph (1);

24 (B) is operating in an area with high rates
25 of—

1 (i) adverse maternal health outcomes;

2 or

3 (ii) significant racial or ethnic inequi-

4 ties in maternal health outcomes; and

5 (C) is operating in a health professional

6 shortage area designated under section 332 of

7 the Public Health Service Act (42 U.S.C.

8 254e).

9 (4) USE OF FUNDS.—An eligible entity that re-
10 ceives a grant under this subsection shall use funds
11 for the following:

12 (A) Establishing or expanding maternity
13 care programs to improve the integration of
14 maternal health and behavioral health care
15 services into primary care settings where preg-
16 nant individuals regularly receive health care
17 services.

18 (B) Establishing or expanding group pre-
19 natal care programs or postpartum care pro-
20 grams.

21 (C) Expanding existing programs that im-
22 prove maternal mental and behavioral health
23 during the prenatal and postpartum periods,
24 with a focus on individuals from racial and eth-
25 nic minority groups.

1 (D) Providing services and support for
2 pregnant and postpartum individuals with ma-
3 ternal mental health conditions and substance
4 use disorders, including referrals to addiction
5 treatment centers that offer evidence-based
6 treatment options.

7 (E) Addressing stigma associated with ma-
8 ternal mental health conditions and substance
9 use disorders, with a focus on racial and ethnic
10 minority groups.

11 (F) Raising awareness of warning signs of
12 maternal mental health conditions and sub-
13 stance use disorders, with a focus on pregnant
14 and postpartum individuals from racial and eth-
15 nic minority groups.

16 (G) Establishing or expanding programs to
17 prevent suicide or self-harm among pregnant
18 and postpartum individuals.

19 (H) Offering evidence-aligned programs at
20 freestanding birth centers that provide maternal
21 mental and behavioral health care education,
22 treatments, and services, and other services for
23 individuals throughout the prenatal and
24 postpartum period.

1 (I) Establishing or expanding programs to
2 provide education and training to maternity
3 care providers with respect to—

4 (i) identifying potential warning signs
5 for maternal mental health conditions or
6 substance use disorders in pregnant and
7 postpartum individuals, with a focus on in-
8 dividuals from racial and ethnic minority
9 groups; and

10 (ii) in the case where such providers
11 identify such warning signs, offering refer-
12 rals to mental and behavioral health care
13 professionals.

14 (J) Developing a website, or other source,
15 that includes information on health care pro-
16 viders who treat maternal mental health condi-
17 tions and substance use disorders.

18 (K) Establishing or expanding programs in
19 communities to improve coordination between
20 maternity care providers and mental and behav-
21 ioral health care providers who treat maternal
22 mental health conditions and substance use dis-
23 orders, including through the use of toll-free
24 hotlines.

1 (L) Carrying out other programs aligned
2 with evidence-based practices for addressing
3 maternal mental health conditions and sub-
4 stance use disorders for pregnant and
5 postpartum individuals from racial and ethnic
6 minority groups.

7 (5) REPORTING.—

8 (A) ELIGIBLE ENTITIES.—An eligible enti-
9 ty that receives a grant under paragraph (1)
10 shall submit annually to the Secretary, and
11 make publicly available, a report on the activi-
12 ties conducted using funds received through a
13 grant under this subsection. Such reports shall
14 include quantitative and qualitative evaluations
15 of such activities, including the experience of in-
16 dividuals who received health care through such
17 grant.

18 (B) SECRETARY.—Not later than the end
19 of fiscal year 2028, the Secretary shall submit
20 to Congress a report that includes—

21 (i) a summary of the reports received
22 under subparagraph (A);

23 (ii) an evaluation of the effectiveness
24 of grants awarded under this subsection;

(iii) recommendations with respect to expanding coverage of evidence-based screenings and treatments for maternal mental health conditions and substance use disorders; and

(iv) recommendations with respect to ensuring activities described under paragraph (4) continue after the end of a grant period.

(6) DEFINITIONS.—In this subsection:

(A) CULTURALLY CONGRUENT.—The term “culturally congruent”, with respect to care or maternity care, means care that is in agreement with the preferred cultural values, beliefs, worldview, language, and practices of the health care consumer and other stakeholders.

(B) ELIGIBLE ENTITY.—The term “eligible entity” means—

(i) a community-based organization serving pregnant and postpartum individuals, including such organizations serving individuals from racial and ethnic minority groups and other underserved populations;

1 (ii) a nonprofit or patient advocacy
2 organization with expertise in maternal
3 mental and behavioral health;

4 (iii) a maternity care provider;

5 (iv) a mental or behavioral health care
6 provider who treats maternal mental health
7 conditions or substance use disorders;

8 (v) a State or local governmental enti-
9 ty, including a State or local public health
10 department;

11 (vi) an Indian Tribe or Tribal organi-
12 zation (as such terms are defined in sec-
13 tion 4 of the Indian Self-Determination
14 and Education Assistance Act (25 U.S.C.
15 5304)); and

16 (vii) an Urban Indian organization (as
17 such term is defined in section 4 of the In-
18 dian Health Care Improvement Act (25
19 U.S.C. 1603)).

20 (C) FREESTANDING BIRTH CENTER.—The
21 term “freestanding birth center” has the mean-
22 ing given that term under section 1905(l) of the
23 Social Security Act (42 U.S.C. 1396d(1)).

1 (D) MATERNITY CARE PROVIDER.—The
2 term “maternity care provider” means a health
3 care provider who—

4 (i) is a physician, physician assistant,
5 midwife who meets at a minimum the
6 international definition of the midwife and
7 global standards for midwifery education
8 as established by the International Confed-
9 eration of Midwives, nurse practitioner, or
10 clinical nurse specialist; and

11 (ii) has a focus on maternal or
12 perinatal health.

13 (E) SECRETARY.—The term “Secretary”
14 means the Secretary of Health and Human
15 Services, acting through the Assistant Secretary
16 for Mental Health and Substance Use.

17 (7) AUTHORIZATION OF APPROPRIATIONS.—To
18 carry out this subsection, there is authorized to be
19 appropriated \$25,000,000 for each of fiscal years
20 2027 through 2030.

21 (b) GRANTS TO GROW AND DIVERSIFY THE MATER-
22 NAL MENTAL AND BEHAVIORAL HEALTH CARE WORK-
23 FORCE.—Title VII of the Public Health Service Act is
24 amended by inserting after section 758 (as added by sec-
25 tion 5205(b)) the following:

1 **“SEC. 758A. MATERNAL MENTAL AND BEHAVIORAL HEALTH**
2 **CARE WORKFORCE GRANTS.**

3 “(a) IN GENERAL.—The Secretary may award grants
4 to entities to establish or expand programs described in
5 subsection (b) to grow and diversify the maternal mental
6 and behavioral health care workforce.

7 “(b) USE OF FUNDS.—Recipients of grants under
8 this section shall use the grants to grow and diversify the
9 maternal mental and behavioral health care workforce
10 by—

11 “(1) establishing schools or programs that pro-
12 vide education and training to individuals seeking
13 appropriate licensing or certification as mental or
14 behavioral health care providers who will specialize
15 in maternal mental health conditions or substance
16 use disorders; or

17 “(2) expanding the capacity of existing schools
18 or programs described in paragraph (1), for the pur-
19 poses of increasing the number of students enrolled
20 in such schools or programs, including by awarding
21 scholarships for students.

22 “(c) PRIORITIZATION.—In awarding grants under
23 this section, the Secretary shall give priority to any entity
24 that—

1 “(1) has demonstrated a commitment to re-
2 cruiting and retaining students and faculty from ra-
3 cial and ethnic minority groups;

4 “(2) has developed a strategy to recruit and re-
5 tain a diverse pool of students into the maternal
6 mental or behavioral health care workforce program
7 or school supported by funds received through the
8 grant, particularly from racial and ethnic minority
9 groups and other underserved populations;

10 “(3) has developed a strategy to recruit and re-
11 tain students who plan to practice in a health pro-
12 fessional shortage area designated under section
13 332;

14 “(4) has developed a strategy to recruit and re-
15 tain students who plan to practice in an area with
16 significant racial and ethnic inequities in maternal
17 health outcomes, to the extent practicable; and

18 “(5) includes in the standard curriculum for all
19 students within the maternal mental or behavioral
20 health care workforce program or school a bias, rac-
21 ism, or discrimination training program that in-
22 cludes training on implicit bias and racism.

23 “(d) REPORTING.—As a condition on receipt of a
24 grant under this section for a maternal mental or behav-
25 ioral health care workforce program or school, an entity

1 shall agree to submit to the Secretary an annual report
2 on the activities conducted through the grant, including—

3 “(1) the number and demographics of students
4 participating in the program or school;

5 “(2) the extent to which students in the pro-
6 gram or school are entering careers in—

7 “(A) health professional shortage areas
8 designated under section 332; and

9 “(B) areas with significant racial and eth-
10 nic inequities in maternal health outcomes, to
11 the extent such data are available; and

12 “(3) whether the program or school has in-
13 cluded in the standard curriculum for all students a
14 bias, racism, or discrimination training program that
15 includes training on implicit bias and racism, and if
16 so the effectiveness of such training program.

17 “(e) PERIOD OF GRANTS.—The period of a grant
18 under this section shall be up to 5 years.

19 “(f) APPLICATION.—To seek a grant under this sec-
20 tion, an entity shall submit to the Secretary an application
21 at such time, in such manner, and containing such infor-
22 mation as the Secretary may require, including any infor-
23 mation necessary for prioritization under subsection (c).

24 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
25 provide, directly or by contract, technical assistance to en-

1 titles seeking or receiving a grant under this section on
2 the development, use, evaluation, and post-grant period
3 sustainability of the maternal mental or behavioral health
4 care workforce programs or schools proposed to be, or
5 being, established or expanded through the grant.

6 “(h) REPORT BY THE SECRETARY.—Not later than
7 4 years after the date of enactment of this section, the
8 Secretary shall prepare and submit to the Congress, and
9 post on the internet website of the Department of Health
10 and Human Services, a report on the effectiveness of the
11 grant program under this section at—

12 “(1) recruiting students from racial and ethnic
13 minority groups and other underserved populations;

14 “(2) increasing the number of mental or behav-
15 ioral health care providers specializing in maternal
16 mental health conditions or substance use disorders
17 from racial and ethnic minority groups and other
18 underserved populations;

19 “(3) increasing the number of mental or behav-
20 ioral health care providers specializing in maternal
21 mental health conditions or substance use disorders
22 working in health professional shortage areas des-
23 ignated under section 332; and

24 “(4) increasing the number of mental or behav-
25 ioral health care providers specializing in maternal

1 mental health conditions or substance use disorders
2 working in areas with significant racial and ethnic
3 inequities in maternal health outcomes, to the extent
4 such data are available.

5 “(i) DEFINITIONS.—In this section:

6 “(1) RACIAL AND ETHNIC MINORITY GROUP.—

7 The term ‘racial and ethnic minority group’ has the
8 meaning given such term in section 1707(g)(1).

9 “(2) MENTAL OR BEHAVIORAL HEALTH CARE

10 PROVIDER.—The term ‘mental or behavioral health
11 care provider’ refers to a health care provider in the
12 field of mental and behavioral health, including sub-
13 stance use disorders, acting in accordance with State
14 law.

15 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
16 carry out this section, there is authorized to be appro-
17 priated \$15,000,000 for each of fiscal years 2027 through
18 2031.”.

19 **SEC. 5208. JUSTICE FOR INCARCERATED MOMS.**

20 (a) ENDING THE SHACKLING OF PREGNANT INDIV-
21 VIDUALS.—

22 (1) IN GENERAL.—Beginning on the date that
23 is 6 months after the date of enactment of this Act,
24 and annually thereafter, in each State that receives
25 a grant under subpart 1 of part E of title I of the

1 Omnibus Crime Control and Safe Streets Act of
2 1968 (34 U.S.C. 10151 et seq.) (commonly referred
3 to as the “Edward Byrne Memorial Justice Assist-
4 ance Grant Program”) and that does not have in ef-
5 fect throughout the State for such fiscal year laws
6 restricting the use of restraints on pregnant individ-
7 uals in prison that are substantially similar to the
8 rights, procedures, requirements, effects, and pen-
9 alties set forth in section 4322 of title 18, United
10 States Code, the amount of such grant that would
11 otherwise be allocated to such State under such sub-
12 part for the fiscal year shall be decreased by 25 per-
13 cent.

14 (2) REALLOCATION.—Amounts not allocated to
15 a State for failure to comply with paragraph (1)
16 shall be reallocated in accordance with subpart 1 of
17 part E of title I of the Omnibus Crime Control and
18 Safe Streets Act of 1968 (34 U.S.C. 10151 et seq.)
19 to States that have complied with such paragraph.

20 (b) CREATING MODEL PROGRAMS FOR THE CARE OF
21 INCARCERATED INDIVIDUALS IN THE PRENATAL AND
22 POSTPARTUM PERIODS.—

23 (1) IN GENERAL.—Not later than 1 year after
24 the date of enactment of this Act, the Attorney Gen-
25 eral, acting through the Director of the Bureau of

1 Prisons, shall establish, in not fewer than 6 Bureau
2 of Prisons facilities, programs to optimize maternal
3 health outcomes for pregnant and postpartum indi-
4 viduals incarcerated in such facilities. The Attorney
5 General shall establish such programs in consulta-
6 tion with stakeholders such as—

7 (A) relevant community-based organiza-
8 tions, particularly organizations that represent
9 incarcerated and formerly incarcerated individ-
10 uals and organizations that seek to improve ma-
11 ternal health outcomes for pregnant and
12 postpartum individuals from demographic
13 groups with elevated rates of maternal mor-
14 tality, severe maternal morbidity, maternal
15 health disparities, or other adverse perinatal or
16 childbirth outcomes;

17 (B) relevant organizations representing pa-
18 tients, with a particular focus on patients from
19 demographic groups with elevated rates of ma-
20 ternal mortality, severe maternal morbidity, ma-
21 ternal health disparities, or other adverse
22 perinatal or childbirth outcomes;

23 (C) organizations representing maternity
24 care providers and maternal health care edu-
25 cation programs;

1 (D) perinatal health workers; and

2 (E) researchers and policy experts in fields
3 related to maternal health care for incarcerated
4 individuals.

5 (2) START DATE.—Each selected facility shall
6 begin facility programs not later than 18 months
7 after the date of enactment of this Act.

8 (3) FACILITY PRIORITY.—In carrying out para-
9 graph (1), the Director shall give priority to a facil-
10 ity based on—

11 (A) the number of pregnant and
12 postpartum individuals incarcerated in such fa-
13 cility and, among such individuals, the number
14 of pregnant and postpartum individuals from
15 demographic groups with elevated rates of ma-
16 ternal mortality, severe maternal morbidity, ma-
17 ternal health disparities, or other adverse
18 perinatal or childbirth outcomes; and

19 (B) the extent to which the leaders of such
20 facility have demonstrated a commitment to de-
21 veloping exemplary programs for pregnant and
22 postpartum individuals incarcerated in such fa-
23 cility.

1 (4) PROGRAM DURATION.—The programs es-
2 tablished under this subsection shall be for a 5-year
3 period.

4 (5) PROGRAMS.—Bureau of Prisons facilities
5 selected by the Director shall establish programs for
6 pregnant and postpartum incarcerated individuals,
7 and such programs may—

8 (A) provide access to perinatal health
9 workers from pregnancy through the
10 postpartum period;

11 (B) provide access to healthy foods and
12 counseling on nutrition, recommended activity
13 levels, and safety measures throughout preg-
14 nancy;

15 (C) train correctional officers to ensure
16 that pregnant incarcerated individuals receive
17 safe and respectful treatment;

18 (D) train medical personnel to ensure that
19 pregnant incarcerated individuals receive trau-
20 ma-informed, culturally and linguistically con-
21 gruent care that promotes the health and safety
22 of the pregnant individuals;

23 (E) provide counseling and treatment for
24 individuals who have suffered from—

1 (i) diagnosed mental or behavioral
2 health conditions, including trauma and
3 substance use disorders;

4 (ii) trauma or violence, including do-
5 mestic violence;

6 (iii) human immunodeficiency virus;

7 (iv) sexual abuse;

8 (v) pregnancy or infant loss; or

9 (vi) chronic conditions;

10 (F) provide evidence-based pregnancy and
11 childbirth education, parenting support, and
12 other relevant forms of health literacy;

13 (G) provide clinical education opportunities
14 to maternity care providers in training to ex-
15 pand pathways into maternal health care ca-
16 reers serving incarcerated individuals;

17 (H) offer opportunities for postpartum in-
18 dividuals to maintain contact with the individ-
19 ual's newborn child to promote bonding, includ-
20 ing enhanced visitation policies, access to prison
21 nursery programs, or breastfeeding support;

22 (I) provide reentry assistance, particularly
23 to—

24 (i) ensure access to health insurance
25 coverage and transfer of health records to

1 community providers if an incarcerated in-
2 dividual exits the criminal justice system
3 during such individual's pregnancy or in
4 the postpartum period; and

5 (ii) connect individuals exiting the
6 criminal justice system during pregnancy
7 or in the postpartum period to community-
8 based resources, such as referrals to health
9 care providers, substance use disorder
10 treatments, and social services that ad-
11 dress social determinants of maternal
12 health; or

13 (J) establish partnerships with local public
14 entities, private community entities, community-
15 based organizations, Indian Tribes and Tribal
16 organizations (as such terms are defined in sec-
17 tion 4 of the Indian Self-Determination and
18 Education Assistance Act (25 U.S.C. 5304)),
19 and Urban Indian organizations (as such term
20 is defined in section 4 of the Indian Health
21 Care Improvement Act (25 U.S.C. 1603)) to es-
22 tablish or expand pretrial diversion programs as
23 an alternative to incarceration for pregnant and
24 postpartum individuals. Such programs may in-
25 clude—

- 1 (i) evidence-based childbirth education
- 2 or parenting classes;
- 3 (ii) prenatal health coordination;
- 4 (iii) family and individual counseling;
- 5 (iv) evidence-based screenings, edu-
- 6 cation, and, as needed, treatment for men-
- 7 tal and behavioral health conditions, in-
- 8 cluding drug and alcohol treatments;
- 9 (v) family case management services;
- 10 (vi) domestic violence education and
- 11 prevention;
- 12 (vii) physical and sexual abuse coun-
- 13 seling; and
- 14 (viii) programs to address social de-
- 15 terminants of health such as employment,
- 16 housing, education, transportation, and nu-
- 17 trition.

18 (6) IMPLEMENTATION AND REPORTING.—A se-

19 lected facility shall be responsible for—

- 20 (A) implementing programs, which may in-
- 21 clude the programs described in paragraph (5);
- 22 and
- 23 (B) not later than 3 years after the date
- 24 of enactment of this Act, and 6 years after the
- 25 date of enactment of this Act, reporting results

1 of the programs to the Director, including in-
2 formation describing—

3 (i) relevant quantitative indicators of
4 success in improving the standard of care
5 and health outcomes for pregnant and
6 postpartum incarcerated individuals in the
7 facility, including data stratified by race,
8 ethnicity, sex, gender, primary language,
9 age, geography, disability status, the cat-
10 egory of the criminal charge against such
11 individual, rates of pregnancy-related
12 deaths, pregnancy-associated deaths, cases
13 of infant mortality and morbidity, rates of
14 preterm births and low-birthweight births,
15 cases of severe maternal morbidity, cases
16 of violence against pregnant or postpartum
17 individuals, diagnoses of maternal mental
18 or behavioral health conditions, and other
19 such information as appropriate;

20 (ii) relevant qualitative and quan-
21 titative evaluations from pregnant and
22 postpartum incarcerated individuals who
23 participated in such programs, including
24 measures of patient-reported experience of
25 care; and

1 (iii) strategies to sustain such pro-
2 grams after fiscal year 2031 and expand
3 such programs to other facilities.

4 (7) REPORT.—Not later than 6 years after the
5 date of enactment of this Act, the Director shall
6 submit to the Attorney General and to Congress a
7 report describing the results of the programs funded
8 under this subsection.

9 (8) OVERSIGHT.—Not later than 1 year after
10 the date of enactment of this Act, the Attorney Gen-
11 eral shall award a contract to an independent orga-
12 nization or independent organizations to conduct
13 oversight of the programs described in paragraph
14 (5).

15 (9) AUTHORIZATION OF APPROPRIATIONS.—
16 There is authorized to be appropriated to carry out
17 this subsection \$10,000,000 for each of fiscal years
18 2027 through 2031.

19 (c) GRANT PROGRAM TO IMPROVE MATERNAL
20 HEALTH OUTCOMES FOR INDIVIDUALS IN STATE AND
21 LOCAL PRISONS AND JAILS.—

22 (1) ESTABLISHMENT.—Not later than 1 year
23 after the date of enactment of this Act, the Attorney
24 General, acting through the Director of the Bureau
25 of Justice Assistance, shall award Justice for Incar-

1 cerated Moms grants to States to establish or ex-
2 pand programs in State and local prisons and jails
3 for pregnant and postpartum incarcerated individ-
4 uals. The Attorney General shall award such grants
5 in consultation with stakeholders such as—

6 (A) relevant community-based organiza-
7 tions, particularly organizations that represent
8 incarcerated and formerly incarcerated individ-
9 uals and organizations that seek to improve ma-
10 ternal health outcomes for pregnant and
11 postpartum individuals from demographic
12 groups with elevated rates of maternal mor-
13 tality, severe maternal morbidity, maternal
14 health disparities, or other adverse perinatal or
15 childbirth outcomes;

16 (B) relevant organizations representing pa-
17 tients, with a particular focus on patients from
18 demographic groups with elevated rates of ma-
19 ternal mortality, severe maternal morbidity, ma-
20 ternal health disparities, or other adverse
21 perinatal or childbirth outcomes;

22 (C) organizations representing maternity
23 care providers and maternal health care edu-
24 cation programs;

25 (D) perinatal health workers; and

1 (E) researchers and policy experts in fields
2 related to maternal health care for incarcerated
3 individuals.

4 (2) APPLICATIONS.—Each applicant for a grant
5 under this subsection shall submit to the Director of
6 the Bureau of Justice Assistance an application at
7 such time, in such manner, and containing such in-
8 formation as the Director may require.

9 (3) USE OF FUNDS.—A State that is awarded
10 a grant under this subsection shall use such grant
11 to establish or expand programs for pregnant and
12 postpartum incarcerated individuals, and such pro-
13 grams may—

14 (A) provide access to perinatal health
15 workers from pregnancy through the
16 postpartum period;

17 (B) provide access to healthy foods and
18 counseling on nutrition, recommended activity
19 levels, and safety measures throughout preg-
20 nancy;

21 (C) train correctional officers to ensure
22 that pregnant incarcerated individuals receive
23 safe and respectful treatment;

24 (D) train medical personnel to ensure that
25 pregnant incarcerated individuals receive trau-

1 ma-informed, culturally and linguistically con-
2 gruent care that promotes the health and safety
3 of the pregnant individuals;

4 (E) provide counseling and treatment for
5 individuals who have suffered from—

6 (i) diagnosed mental or behavioral
7 health conditions, including trauma and
8 substance use disorders;

9 (ii) trauma or violence, including do-
10 mestic violence;

11 (iii) human immunodeficiency virus;

12 (iv) sexual abuse;

13 (v) pregnancy or infant loss; or

14 (vi) chronic conditions;

15 (F) provide evidence-based pregnancy and
16 childbirth education, parenting support, and
17 other relevant forms of health literacy;

18 (G) provide clinical education opportunities
19 to maternity care providers in training to ex-
20 pand pathways into maternal health care ca-
21 reers serving incarcerated individuals;

22 (H) offer opportunities for postpartum in-
23 dividuals to maintain contact with the individ-
24 ual's newborn child to promote bonding, includ-

1 ing enhanced visitation policies, access to prison
2 nursery programs, or breastfeeding support;

3 (I) provide reentry assistance, particularly
4 to—

5 (i) ensure access to health insurance
6 coverage and transfer of health records to
7 community providers if an incarcerated in-
8 dividual exits the criminal justice system
9 during such individual's pregnancy or in
10 the postpartum period; and

11 (ii) connect individuals exiting the
12 criminal justice system during pregnancy
13 or in the postpartum period to community-
14 based resources, such as referrals to health
15 care providers, substance use disorder
16 treatments, and social services that ad-
17 dress social determinants of maternal
18 health; or

19 (J) establish partnerships with local public
20 entities, private community entities, community-
21 based organizations, Indian Tribes and Tribal
22 organizations (as such terms are defined in sec-
23 tion 4 of the Indian Self-Determination and
24 Education Assistance Act (25 U.S.C. 5304)),
25 and Urban Indian organizations (as such term

1 is defined in section 4 of the Indian Health
2 Care Improvement Act (25 U.S.C. 1603)) to es-
3 tablish or expand pretrial diversion programs as
4 an alternative to incarceration for pregnant and
5 postpartum individuals. Such programs may in-
6 clude—

7 (i) evidence-based childbirth education
8 or parenting classes;

9 (ii) prenatal health coordination;

10 (iii) family and individual counseling;

11 (iv) evidence-based screenings, edu-
12 cation, and, as needed, treatment for men-
13 tal and behavioral health conditions, in-
14 cluding drug and alcohol treatments;

15 (v) family case management services;

16 (vi) domestic violence education and
17 prevention;

18 (vii) physical and sexual abuse coun-
19 seling; and

20 (viii) programs to address social de-
21 terminants of health such as employment,
22 housing, education, transportation, and nu-
23 trition.

24 (4) PRIORITY.—In awarding grants under this
25 subsection, the Director of the Bureau of Justice

1 Assistance shall give priority to applicants based
2 on—

3 (A) the number of pregnant and
4 postpartum individuals incarcerated in the
5 State and, among such individuals, the number
6 of pregnant and postpartum individuals from
7 demographic groups with elevated rates of ma-
8 ternal mortality, severe maternal morbidity, ma-
9 ternal health disparities, or other adverse
10 perinatal or childbirth outcomes; and

11 (B) the extent to which the State has dem-
12 onstrated a commitment to developing exem-
13 plary programs for pregnant and postpartum
14 individuals incarcerated in the prisons and jails
15 in the State.

16 (5) GRANT DURATION.—A grant awarded under
17 this subsection shall be for a 5-year period.

18 (6) IMPLEMENTING AND REPORTING.—A State
19 that receives a grant under this subsection shall be
20 responsible for—

21 (A) implementing the program funded by
22 the grant; and

23 (B) not later than 3 years after the date
24 of enactment of this Act, and 6 years after the
25 date of enactment of this Act, reporting results

1 of such program to the Attorney General, in-
2 cluding information describing—

3 (i) relevant quantitative indicators of
4 the program's success in improving the
5 standard of care and health outcomes for
6 pregnant and postpartum incarcerated in-
7 dividuals in the facility, including data
8 stratified by race, ethnicity, sex, gender,
9 primary language, age, geography, dis-
10 ability status, category of the criminal
11 charge against such individual, incidence
12 rates of pregnancy-related deaths, preg-
13 nancy-associated deaths, cases of infant
14 mortality and morbidity, rates of preterm
15 births and low-birthweight births, cases of
16 severe maternal morbidity, cases of vio-
17 lence against pregnant or postpartum indi-
18 viduals, diagnoses of maternal mental or
19 behavioral health conditions, and other
20 such information as appropriate;

21 (ii) relevant qualitative and quan-
22 titative evaluations from pregnant and
23 postpartum incarcerated individuals who
24 participated in such programs, including

1 measures of patient-reported experience of
2 care; and

3 (iii) strategies to sustain such pro-
4 grams beyond the duration of the grant
5 and expand such programs to other facili-
6 ties.

7 (7) REPORT.—Not later than 6 years after the
8 date of enactment of this Act, the Attorney General
9 shall submit to Congress a report describing the re-
10 sults of such grant programs.

11 (8) OVERSIGHT.—Not later than 1 year after
12 the date of enactment of this Act, the Attorney Gen-
13 eral shall award a contract to an independent orga-
14 nization or independent organizations to conduct
15 oversight of the programs described in paragraph
16 (3).

17 (9) AUTHORIZATION OF APPROPRIATIONS.—
18 There is authorized to be appropriated to carry out
19 this subsection \$10,000,000 for each of fiscal years
20 2027 through 2031.

21 (d) GAO REPORT.—

22 (1) IN GENERAL.—Not later than 2 years after
23 the date of enactment of this Act, the Comptroller
24 General of the United States shall submit to Con-
25 gress a report on adverse maternal and infant health

1 outcomes among incarcerated individuals and infants
2 born to such individuals, with a particular focus on
3 racial and ethnic disparities in maternal and infant
4 health outcomes for incarcerated individuals.

5 (2) CONTENTS OF REPORT.—The report de-
6 scribed in this subsection shall include—

7 (A) to the extent practicable—

8 (i) the number of pregnant individuals
9 who are incarcerated in Bureau of Prisons
10 facilities;

11 (ii) the number of incarcerated indi-
12 viduals, including those incarcerated in
13 Federal, State, and local correctional facili-
14 ties, who have experienced a pregnancy-re-
15 lated death, pregnancy-associated death, or
16 the death of an infant in the most recent
17 10 years of available data;

18 (iii) the number of cases of severe ma-
19 ternal morbidity among incarcerated indi-
20 viduals, including those incarcerated in
21 Federal, State, and local detention facili-
22 ties, in the most recent 10 years of avail-
23 able data;

24 (iv) the number of preterm and low-
25 birthweight births of infants born to incar-

1 cerated individuals, including those incar-
2 cerated in Federal, State, and local correc-
3 tional facilities, in the most recent 10
4 years of available data; and

5 (v) statistics on the racial and ethnic
6 disparities in maternal and infant health
7 outcomes and severe maternal morbidity
8 rates among incarcerated individuals, in-
9 cluding those incarcerated in Federal,
10 State, and local detention facilities;

11 (B) in the case that the Comptroller Gen-
12 eral of the United States is unable determine
13 the information required in clauses (i) through
14 (iii) of subparagraph (A), an assessment of the
15 barriers to determining such information and
16 recommendations for improvements in tracking
17 maternal health outcomes among incarcerated
18 individuals, including those incarcerated in Fed-
19 eral, State, and local detention facilities;

20 (C) the implications of pregnant and
21 postpartum incarcerated individuals being ineli-
22 gible for medical assistance under a State plan
23 under title XIX of the Social Security Act (42
24 U.S.C. 1396 et seq.) including information
25 about—

1 (i) the effects of such ineligibility on
2 maternal health outcomes for pregnant and
3 postpartum incarcerated individuals, with
4 emphasis given to such effects for preg-
5 nant and postpartum individuals from ra-
6 cial and ethnic minority groups; and

7 (ii) potential implications on maternal
8 health outcomes resulting from temporarily
9 suspending, rather than permanently ter-
10 minating, such eligibility when a pregnant
11 or postpartum individual is incarcerated;

12 (D) the extent to which Federal, State,
13 and local correctional facilities are holding preg-
14 nant and postpartum individuals who test posi-
15 tive for illicit drug use in detention with special
16 conditions, such as additional bond require-
17 ments, due to the individual's drug use, and the
18 effect of such detention policies on maternal
19 and infant health outcomes;

20 (E) causes of adverse maternal health out-
21 comes that are unique to incarcerated individ-
22 uals, including those incarcerated in Federal,
23 State, and local detention facilities;

24 (F) causes of adverse maternal health out-
25 comes and severe maternal morbidity that are

1 unique to incarcerated individuals from racial
2 and ethnic minority groups;

3 (G) recommendations to reduce maternal
4 mortality and severe maternal morbidity among
5 incarcerated individuals and to address racial
6 and ethnic disparities in maternal health out-
7 comes for incarcerated individuals in Bureau of
8 Prisons facilities and State and local prisons
9 and jails; and

10 (H) such other information as may be ap-
11 propriate to reduce the occurrence of adverse
12 maternal health outcomes among incarcerated
13 individuals and to address racial and ethnic dis-
14 parities in maternal health outcomes for such
15 individuals.

16 (e) DEFINITIONS.—In this section:

17 (1) CULTURALLY AND LINGUISTICALLY CON-
18 GRUENT.—The term “culturally and linguistically
19 congruent”, with respect to care or maternity care,
20 means care that is in agreement with the preferred
21 cultural values, beliefs, worldview, language, and
22 practices of the health care consumer and other
23 stakeholders.

24 (2) MATERNAL MORTALITY.—The term “mater-
25 nal mortality” means a death occurring during or

1 within a 1-year period after pregnancy, caused by
2 pregnancy-related or childbirth complications, in-
3 cluding a suicide, overdose, or other death resulting
4 from a mental health or substance use disorder at-
5 tributed to or aggravated by pregnancy-related or
6 childbirth complications.

7 (3) MATERNITY CARE PROVIDER.—The term
8 “maternity care provider” means a health care pro-
9 vider who—

10 (A) is a physician, a physician assistant, a
11 midwife who meets, at a minimum, the inter-
12 national definition of a midwife and global
13 standards for midwifery education as estab-
14 lished by the International Confederation of
15 Midwives, an advanced practice registered
16 nurse, or a lactation consultant certified by the
17 International Board of Lactation Consultant
18 Examiners; and

19 (B) has a focus on maternal or perinatal
20 health.

21 (4) PERINATAL HEALTH WORKER.—The term
22 “perinatal health worker” means a nonclinical health
23 worker focused on maternal or perinatal health, such
24 as a doula, community health worker, peer sup-
25 porter, lactation educator or counselor, nutritionist

1 or dietitian, childbirth educator, social worker, home
2 visitor, patient navigator or coordinator, or language
3 interpreter.

4 (5) POSTPARTUM AND POSTPARTUM PERIOD.—
5 The terms “postpartum” and “postpartum period”
6 mean the 1-year period beginning on the last day of
7 the pregnancy of an individual.

8 (6) PREGNANCY-ASSOCIATED DEATH.—The
9 term “pregnancy-associated death” means a death of
10 a pregnant or postpartum individual, by any cause,
11 that occurs during, or within 1 year following, the
12 individual’s pregnancy, regardless of the outcome,
13 duration, or site of the pregnancy.

14 (7) PREGNANCY-RELATED DEATH.—The term
15 “pregnancy-related death” means a death of a preg-
16 nant or postpartum individual that occurs during, or
17 within 1 year following, the individual’s pregnancy,
18 from a pregnancy complication, a chain of events
19 initiated by pregnancy, or the aggravation of an un-
20 related condition by the physiologic effects of preg-
21 nancy.

22 (8) RACIAL AND ETHNIC MINORITY GROUP.—
23 The term “racial and ethnic minority group” has the
24 meaning given such term in section 1707(g)(1) of

1 the Public Health Service Act (42 U.S.C. 300u–
2 6(g)(1)).

3 (9) SEVERE MATERNAL MORBIDITY.—The term
4 “severe maternal morbidity” means a health condi-
5 tion, including mental health conditions and sub-
6 stance use disorders, attributed to or aggravated by
7 pregnancy or childbirth that results in significant
8 short-term or long-term consequences to the health
9 of the individual who was pregnant.

10 (10) SOCIAL DETERMINANTS OF MATERNAL
11 HEALTH.—The term “social determinants of mater-
12 nal health” means nonclinical factors that impact
13 maternal health outcomes.

14 **SEC. 5209. TECH TO SAVE MOMS.**

15 (a) DEFINITIONS.—In this section:

16 (1) POSTPARTUM AND POSTPARTUM PERIOD.—
17 The terms “postpartum” and “postpartum period”
18 mean the 1-year period beginning on the last day of
19 the pregnancy of an individual.

20 (2) RACIAL AND ETHNIC MINORITY GROUP.—
21 The term “racial and ethnic minority group” has the
22 meaning given such term in section 1707(g)(1) of
23 the Public Health Service Act (42 U.S.C. 300u–
24 6(g)(1)).

1 (3) SEVERE MATERNAL MORBIDITY.—The term
2 “severe maternal morbidity” means a health condi-
3 tion, including mental health conditions and sub-
4 stance use disorders, attributed to or aggravated by
5 pregnancy or childbirth that results in significant
6 short-term or long-term consequences to the health
7 of the individual who was pregnant.

8 (4) SOCIAL DETERMINANTS OF MATERNAL
9 HEALTH.—The term “social determinants of mater-
10 nal health” means non-clinical factors that impact
11 maternal health outcomes, including—

12 (A) economic factors, which may include
13 poverty, employment, food security, support for
14 and access to lactation and other infant feeding
15 options, housing stability, and related factors;

16 (B) neighborhood factors, which may in-
17 clude quality of housing, access to transpor-
18 tation, access to child care, availability of
19 healthy foods and nutrition counseling, avail-
20 ability of clean water, air and water quality,
21 ambient temperatures, neighborhood crime and
22 violence, access to broadband, and related fac-
23 tors;

24 (C) social and community factors, which
25 may include systemic racism, gender discrimi-

1 nation or discrimination based on other pro-
 2 tected classes, workplace conditions, incarcer-
 3 ation, and related factors;

4 (D) household factors, which may include
 5 ability to conduct lead testing and abatement,
 6 car seat installation, indoor air temperatures,
 7 and related factors;

8 (E) education access and quality factors,
 9 which may include educational attainment, lan-
 10 guage and literacy, and related factors; and

11 (F) health care access factors, including
 12 health insurance coverage, access to culturally
 13 congruent health care services, providers, and
 14 non-clinical support, access to home visiting
 15 services, access to wellness and stress manage-
 16 ment programs, health literacy, access to tele-
 17 health and items required to receive telehealth
 18 services, and related factors.

19 (b) INTEGRATED TELEHEALTH MODELS IN MATER-
 20 NITY CARE SERVICES.—

21 (1) IN GENERAL.—Section 1115A(b)(2)(B) of
 22 the Social Security Act (42 U.S.C. 1315a(b)(2)(B))
 23 is amended by adding at the end the following:

24 “(xxviii) Focusing on title XIX, pro-
 25 viding for the adoption of and use of tele-

1 health tools that allow for screening, moni-
 2 toring, and management of common health
 3 complications with respect to an individual
 4 receiving medical assistance during such
 5 individual's pregnancy and for not more
 6 than a 1-year period beginning on the last
 7 day of the pregnancy.”.

8 (2) EFFECTIVE DATE.—The amendment made
 9 by paragraph (1) shall take effect 1 year after the
 10 date of the enactment of this section.

11 (c) GRANTS TO EXPAND THE USE OF TECHNOLOGY-
 12 ENABLED COLLABORATIVE LEARNING AND CAPACITY
 13 MODELS FOR PREGNANT AND POSTPARTUM INDIVID-
 14 UALS.—Title III of the Public Health Service Act is
 15 amended by inserting after section 330N (42 U.S.C.
 16 254c–20) the following:

17 **“SEC. 330N–1. EXPANDING CAPACITY FOR MATERNAL**
 18 **HEALTH OUTCOMES.**

19 “(a) ESTABLISHMENT.—Beginning not later than 1
 20 year after the date of enactment of this section, the Sec-
 21 retary shall award grants to eligible entities to evaluate,
 22 develop, and expand the use of technology-enabled collabo-
 23 rative learning and capacity building models and improve
 24 maternal health outcomes—

25 “(1) in health professional shortage areas;

1 “(2) in areas with high rates of maternal mor-
2 tality and severe maternal morbidity;

3 “(3) in areas with significant racial and ethnic
4 inequities in maternal health outcomes; and

5 “(4) for medically underserved populations and
6 American Indians and Alaska Natives, including In-
7 dian Tribes, Tribal organizations, and Urban Indian
8 organizations.

9 “(b) USE OF FUNDS.—

10 “(1) REQUIRED USES.—Recipients of grants
11 under this section shall use the grants to—

12 “(A) train maternal health care providers,
13 students, and other similar professionals
14 through models that include—

15 “(i) methods to increase safety and
16 health care quality;

17 “(ii) training to increase awareness of,
18 and eliminate implicit bias, racism, and
19 discrimination in, the provision of health
20 care;

21 “(iii) best practices in screening for
22 and, as needed, evaluating and treating
23 maternal mental health conditions and
24 substance use disorders;

1 “(iv) training on best practices in ma-
 2 ternity care for pregnant and postpartum
 3 individuals during the COVID–19 public
 4 health emergency or future public health
 5 emergencies;

6 “(v) methods to screen for social de-
 7 terminants of maternal health risks in the
 8 prenatal and postpartum periods; and

9 “(vi) the use of remote patient moni-
 10 toring tools for pregnancy-related com-
 11 plications described in section
 12 1115A(b)(2)(B)(xxviii) of the Social Secu-
 13 rity Act;

14 “(B) evaluate and collect information on
 15 the effect of such models on—

16 “(i) access to, and quality of, care;

17 “(ii) outcomes with respect to the
 18 health of an individual; and

19 “(iii) the experience of individuals who
 20 receive pregnancy-related health care;

21 “(C) develop qualitative and quantitative
 22 measures to identify best practices for the ex-
 23 pansion and use of such models;

1 “(D) study the effect of such models on
2 patient outcomes and maternity care providers;
3 and

4 “(E) conduct any other activity, as deter-
5 mined by the Secretary.

6 “(2) PERMISSIBLE USES.—Recipients of grants
7 under this section may use grants to support—

8 “(A) the use and expansion of technology-
9 enabled collaborative learning and capacity
10 building models, including hardware and soft-
11 ware that—

12 “(i) enable distance learning and tech-
13 nical support; and

14 “(ii) support the secure exchange of
15 electronic health information; and

16 “(B) maternity care providers, students,
17 and other similar professionals in the provision
18 of maternity care through such models.

19 “(c) APPLICATION.—

20 “(1) IN GENERAL.—An eligible entity seeking a
21 grant under subsection (a) shall submit to the Sec-
22 retary an application, at such time, in such manner,
23 and containing such information as the Secretary
24 may require.

1 “(2) ASSURANCE.—An application under para-
2 graph (1) shall include an assurance that such entity
3 shall collect information on, and assess the effect of,
4 the use of technology-enabled collaborative learning
5 and capacity building models, including with respect
6 to—

7 “(A) maternal health outcomes;

8 “(B) access to maternal health care serv-
9 ices;

10 “(C) quality of maternal health care; and

11 “(D) retention of maternity care providers
12 serving areas and populations described in sub-
13 section (a).

14 “(d) LIMITATIONS.—

15 “(1) NUMBER.—The Secretary may not award
16 more than 1 grant under this section to an eligible
17 entity.

18 “(2) DURATION.—A grant awarded under this
19 section shall be for a 5-year period.

20 “(e) ACCESS TO BROADBAND.—In administering
21 grants under this section, the Secretary may coordinate
22 with other agencies to ensure that funding opportunities
23 are available to support access to reliable, high-speed
24 internet for grantees.

1 “(f) TECHNICAL ASSISTANCE.—The Secretary shall
2 provide (either directly or by contract) technical assistance
3 to eligible entities, including recipients of grants under
4 subsection (a), on the development, use, and sustainability
5 of technology-enabled collaborative learning and capacity
6 building models to expand access to maternal health care
7 services provided by such entities, including—

8 “(1) in health professional shortage areas;

9 “(2) in areas with high rates of maternal mor-
10 tality and severe maternal morbidity or significant
11 racial and ethnic inequities in maternal health out-
12 comes; and

13 “(3) for medically underserved populations or
14 American Indians and Alaska Natives.

15 “(g) RESEARCH AND EVALUATION.—The Secretary,
16 in consultation with experts, shall develop a strategic plan
17 to research and evaluate the evidence for such models.

18 “(h) REPORTING.—

19 “(1) ELIGIBLE ENTITIES.—An eligible entity
20 that receives a grant under subsection (a) shall sub-
21 mit to the Secretary a report, at such time, in such
22 manner, and containing such information as the Sec-
23 retary may require.

24 “(2) SECRETARY.—Not later than 4 years after
25 the date of enactment of this section, the Secretary

1 shall submit to the Congress, and make available on
 2 the website of the Department of Health and
 3 Human Services, a report that includes—

4 “(A) a description of grants awarded
 5 under subsection (a) and the purpose and
 6 amounts of such grants;

7 “(B) a summary of—

8 “(i) the evaluations conducted under
 9 subsection (b)(1)(B);

10 “(ii) any technical assistance provided
 11 under subsection (f); and

12 “(iii) the activities conducted under
 13 subsection (a); and

14 “(C) a description of any significant find-
 15 ings with respect to—

16 “(i) patient outcomes; and

17 “(ii) best practices for expanding,
 18 using, or evaluating technology-enabled col-
 19 laborative learning and capacity building
 20 models.

21 “(i) AUTHORIZATION OF APPROPRIATIONS.—There is
 22 authorized to be appropriated to carry out this section,
 23 \$6,000,000 for each of fiscal years 2027 through 2031.

24 “(j) DEFINITIONS.—In this section:

25 “(1) ELIGIBLE ENTITY.—

1 “(A) IN GENERAL.—The term ‘eligible en-
 2 tity’ means an entity that provides, or supports
 3 the provision of, maternal health care services
 4 or other evidence-based services for pregnant
 5 and postpartum individuals—

6 “(i) in health professional shortage
 7 areas;

8 “(ii) in areas with high rates of ad-
 9 verse maternal health outcomes or signifi-
 10 cant racial and ethnic inequities in mater-
 11 nal health outcomes; or

12 “(iii) who are—

13 “(I) members of medically under-
 14 served populations; or

15 “(II) American Indians and Alas-
 16 ka Natives, including Indian Tribes,
 17 Tribal organizations, and Urban In-
 18 dian organizations.

19 “(B) INCLUSIONS.—An eligible entity may
 20 include entities that lead, or are capable of
 21 leading, a technology-enabled collaborative
 22 learning and capacity building model.

23 “(2) HEALTH PROFESSIONAL SHORTAGE
 24 AREA.—The term ‘health professional shortage area’

1 means a health professional shortage area des-
2 ignated under section 332.

3 “(3) INDIAN TRIBE.—The term ‘Indian Tribe’
4 has the meaning given such term in section 4 of the
5 Indian Self-Determination and Education Assistance
6 Act.

7 “(4) MATERNAL MORTALITY.—The term ‘ma-
8 ternal mortality’ means a death occurring during or
9 within the 1-year period after pregnancy caused by
10 pregnancy-related or childbirth complications, in-
11 cluding a suicide, overdose, or other death resulting
12 from a mental health or substance use disorder at-
13 tributed to or aggravated by pregnancy or childbirth
14 complications.

15 “(5) MEDICALLY UNDERSERVED POPU-
16 LATION.—The term ‘medically underserved popu-
17 lation’ has the meaning given such term in section
18 330(b)(3).

19 “(6) POSTPARTUM.—The term ‘postpartum’
20 means the 1-year period beginning on the last date
21 of an individual’s pregnancy.

22 “(7) SEVERE MATERNAL MORBIDITY.—The
23 term ‘severe maternal morbidity’ means a health
24 condition, including a mental health or substance
25 use disorder, attributed to or aggravated by preg-

nancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

“(8) TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY BUILDING MODEL.—The term ‘technology-enabled collaborative learning and capacity building model’ means a distance health education model that connects health care professionals, and other specialists, through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

“(9) TRIBAL ORGANIZATION.—The term ‘Tribal organization’ has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act.

“(10) URBAN INDIAN ORGANIZATION.—The term ‘Urban Indian organization’ has the meaning given such term in section 4 of the Indian Health Care Improvement Act.”.

(d) GRANTS TO PROMOTE EQUITY IN MATERNAL HEALTH OUTCOMES THROUGH DIGITAL TOOLS.—

(1) IN GENERAL.—Beginning not later than 1 year after the date of enactment of this Act, the

1 Secretary of Health and Human Services (referred
2 to in this subsection as the “Secretary”) shall make
3 grants to eligible entities to reduce racial and ethnic
4 inequities in maternal health outcomes by increasing
5 access to digital tools related to maternal health
6 care.

7 (2) APPLICATIONS.—To be eligible to receive a
8 grant under this subsection, an eligible entity shall
9 submit to the Secretary an application at such time,
10 in such manner, and containing such information as
11 the Secretary may require.

12 (3) PRIORITIZATION.—In awarding grants
13 under this subsection, the Secretary shall prioritize
14 an eligible entity—

15 (A) in an area with high rates of adverse
16 maternal health outcomes or significant racial
17 and ethnic inequities in maternal health out-
18 comes;

19 (B) in a health professional shortage area
20 designated under section 332 of the Public
21 Health Service Act (42 U.S.C. 254e); and

22 (C) that promotes technology that address-
23 es racial and ethnic inequities in maternal
24 health outcomes.

25 (4) LIMITATIONS.—

1 (A) NUMBER.—The Secretary may award
2 not more than 1 grant under this subsection to
3 an eligible entity.

4 (B) DURATION.—A grant awarded under
5 this subsection shall be for a 5-year period.

6 (5) TECHNICAL ASSISTANCE.—The Secretary
7 shall provide technical assistance to an eligible entity
8 on the development, use, evaluation, and post-grant
9 sustainability of digital tools for purposes of pro-
10 moting equity in maternal health outcomes.

11 (6) REPORTING.—

12 (A) ELIGIBLE ENTITIES.—An eligible enti-
13 ty that receives a grant under paragraph (1)
14 shall submit to the Secretary a report, at such
15 time, in such manner, and containing such in-
16 formation as the Secretary may require.

17 (B) SECRETARY.—Not later than 4 years
18 after the date of enactment of this Act, the Sec-
19 retary shall submit to Congress a report that
20 includes—

21 (i) an evaluation on the effectiveness
22 of grants awarded under this subsection to
23 improve health outcomes for pregnant and
24 postpartum individuals from racial and
25 ethnic minority groups;

1 (ii) recommendations on new grant
2 programs that promote the use of tech-
3 nology to improve such maternal health
4 outcomes; and

5 (iii) recommendations with respect
6 to—

7 (I) technology-based privacy and
8 security safeguards in maternal health
9 care;

10 (II) reimbursement rates for ma-
11 ternal telehealth services;

12 (III) the use of digital tools to
13 analyze large data sets to identify po-
14 tential pregnancy-related complica-
15 tions;

16 (IV) barriers that prevent mater-
17 nity care providers from providing
18 telehealth services across States;

19 (V) the use of consumer digital
20 tools such as mobile phone applica-
21 tions, patient portals, and wearable
22 technologies to improve maternal
23 health outcomes;

24 (VI) barriers that prevent access
25 to telehealth services, including a lack

of access to reliable, high-speed internet or electronic devices;

(VII) barriers to data sharing between the Special Supplemental Nutrition Program for Women, Infants, and Children and maternity care providers, and recommendations for addressing such barriers; and

(VIII) lessons learned from expanded access to telehealth related to maternity care during the COVID–19 public health emergency.

(7) AUTHORIZATION OF APPROPRIATIONS.—

There is authorized to be appropriated to carry out this subsection \$6,000,000 for each of fiscal years 2027 through 2031.

(e) REPORT ON THE USE OF TECHNOLOGY IN MATERNITY CARE.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into an agreement with the National Academies of Sciences, Engineering, and Medicine (referred to in this section as the “National Academies”) under which the National Academies shall conduct a study on the use

1 of technology and patient monitoring devices in ma-
2 ternity care.

3 (2) CONTENT.—The agreement entered into
4 pursuant to paragraph (1) shall provide for the
5 study of the following:

6 (A) The use of innovative technology (in-
7 cluding artificial intelligence) in maternal
8 health care, including the extent to which such
9 technology has affected racial or ethnic biases
10 in maternal health care.

11 (B) The use of patient monitoring devices
12 (including pulse oximeter devices) in maternal
13 health care, including the extent to which such
14 devices have affected racial or ethnic biases in
15 maternal health care.

16 (C) Best practices for reducing and pre-
17 venting racial or ethnic biases in the use of in-
18 novative technology and patient monitoring de-
19 vices in maternity care.

20 (D) Best practices in the use of innovative
21 technology and patient monitoring devices for
22 pregnant and postpartum individuals from ra-
23 cial and ethnic minority groups.

24 (E) Best practices with respect to privacy
25 and security safeguards in such use.

1 (3) REPORT.—Not later than 2 years after the
2 date of enactment of this Act, the National Acad-
3 emies shall complete the study under this subsection,
4 and transmit a report of the results of such study
5 to Congress.

6 **SEC. 5210. IMPACT TO SAVE MOMS ACT.**

7 (a) PERINATAL CARE ALTERNATIVE PAYMENT
8 MODEL DEMONSTRATION PROJECT.—

9 (1) IN GENERAL.—For the period of fiscal
10 years 2027 through 2030, the Secretary of Health
11 and Human Services (referred to in this subsection
12 as the “Secretary”), acting through the Adminis-
13 trator of the Centers for Medicare & Medicaid Serv-
14 ices, shall establish and implement, in accordance
15 with the requirements of this subsection, a dem-
16 onstration project, to be known as the Perinatal
17 Care Alternative Payment Model Demonstration
18 Project (referred to in this subsection as the “Dem-
19 onstration Project”), for purposes of allowing States
20 to test payment models under their State plans
21 under title XIX of the Social Security Act (42
22 U.S.C. 1396 et seq.) and State child health plans
23 under title XXI of such Act (42 U.S.C. 1397aa et
24 seq.) with respect to maternity care provided to

1 pregnant and postpartum individuals enrolled in
2 such State plans and State child health plans.

3 (2) COORDINATION.—In establishing the Dem-
4 onstration Project, the Secretary shall coordinate
5 with stakeholders such as—

6 (A) State Medicaid programs;

7 (B) relevant organizations representing
8 maternal health care providers;

9 (C) relevant organizations representing pa-
10 tients, with a particular focus on individuals
11 from demographic groups with disproportionate
12 rates of adverse maternal health outcomes;

13 (D) relevant community-based organiza-
14 tions, particularly organizations that seek to
15 improve maternal health outcomes for individ-
16 uals from demographic groups with dispropor-
17 tionate rates of adverse maternal health out-
18 comes;

19 (E) non-clinical perinatal health workers
20 such as doulas, community health workers, peer
21 supporters, certified lactation consultants, nu-
22 tritionists and dieticians, social workers, home
23 visitors, and navigators;

24 (F) relevant health insurance issuers;

(G) hospitals, health systems, freestanding birth centers (as such term is defined in paragraph (3)(B) of section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l))), Federally qualified health centers (as such term is defined in paragraph (2)(B) of such section), and rural health clinics (as such term is defined in section 1861(aa) of such Act (42 U.S.C. 1395x(aa)));

(H) researchers and policy experts in fields related to maternity care payment models; and

(I) any other stakeholders as the Secretary determines appropriate, with a particular focus on stakeholders from demographic groups with disproportionate rates of adverse maternal health outcomes.

(3) CONSIDERATIONS.—In establishing the Demonstration Project, the Secretary shall consider each of the following:

(A) Findings from any evaluations of the Strong Start for Mothers and Newborns initiative carried out by the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, and the Administration on Children and Families.

(B) Any alternative payment model that—

1 (i) is designed to improve maternal
2 health outcomes for racial and ethnic
3 groups with disproportionate rates of ad-
4 verse maternal health outcomes;

5 (ii) includes methods for stratifying
6 patients by pregnancy risk level and, as
7 appropriate, adjusting payments under
8 such model to take into account pregnancy
9 risk level;

10 (iii) establishes evidence-based quality
11 metrics for such payments;

12 (iv) includes consideration of non-hos-
13 pital birth settings such as freestanding
14 birth centers (as so defined);

15 (v) includes consideration of social de-
16 terminants of health that are relevant to
17 maternal health outcomes such as housing,
18 transportation, nutrition, and other non-
19 clinical factors that influence maternal
20 health outcomes; or

21 (vi) includes diverse maternity care
22 teams that include—

23 (I) maternity care providers, in-
24 cluding obstetrician-gynecologists,
25 family physicians, physician assist-

ants, midwives who meet, at a minimum, the international definition of the term “midwife” and global standards for midwifery education (as established by the International Confederation of Midwives), and nurse practitioners—

(aa) from racially, ethnically, and professionally diverse backgrounds;

(bb) with experience practicing in racially and ethnically diverse communities; or

(cc) who have undergone trainings on racism, implicit bias, and explicit bias; and

(II) non-clinical perinatal health workers such as doulas, community health workers, peer supporters, certified lactation consultants, nutritionists and dieticians, social workers, home visitors, and navigators.

(4) ELIGIBILITY.—To be eligible to participate in the Demonstration Project, a State shall submit an application to the Secretary at such time, in such

1 manner, and containing such information as the Sec-
2 retary may require.

3 (5) EVALUATION.—The Secretary shall conduct
4 an evaluation of the Demonstration Project to deter-
5 mine the impact of the Demonstration Project on—

6 (A) maternal health outcomes, with data
7 stratified by race, ethnicity, socioeconomic indi-
8 cators, and any other factors as the Secretary
9 determines appropriate;

10 (B) spending on maternity care by States
11 participating in the Demonstration Project;

12 (C) to the extent practicable, subjective
13 measures of patient experience; and

14 (D) any other areas of assessment that the
15 Secretary determines relevant.

16 (6) REPORT.—Not later than 1 year after the
17 completion or termination date of the Demonstration
18 Project, the Secretary shall submit to the Committee
19 on Energy and Commerce, the Committee on Ways
20 and Means, and the Committee on Education and
21 Workforce of the House of Representatives and the
22 Committee on Finance and the Committee on
23 Health, Education, Labor, and Pensions of the Sen-
24 ate, and make publicly available, a report con-
25 taining—

1 (A) the results of any evaluation conducted
 2 under paragraph (5); and

3 (B) a recommendation regarding whether
 4 the Demonstration Project should be continued
 5 after fiscal year 2030 and expanded on a na-
 6 tional basis.

7 (7) AUTHORIZATION OF APPROPRIATIONS.—
 8 There are authorized to be appropriated such sums
 9 as are necessary to carry out this subsection.

10 (8) DEFINITIONS.—In this subsection:

11 (A) ALTERNATIVE PAYMENT MODEL.—The
 12 term “alternative payment model” has the
 13 meaning given such term in section
 14 1833(z)(3)(C) of the Social Security Act (42
 15 U.S.C. 1395l(z)(3)(C)).

16 (B) PERINATAL.—The term “perinatal”
 17 means the period beginning on the day a person
 18 becomes pregnant and ending on the last day of
 19 the 1-year period beginning on the last day of
 20 such person’s pregnancy.

21 (b) MACPAC REPORT.—

22 (1) IN GENERAL.—Not later than 2 years after
 23 the date of the enactment of this section, the Med-
 24 icaid and CHIP Payment and Access Commission
 25 shall publish a report on issues relating to the con-

1 tinuity of coverage under State plans under title
2 XIX of the Social Security Act (42 U.S.C. 1396 et
3 seq.) and State child health plans under title XXI of
4 such Act (42 U.S.C. 1397aa et seq.) for pregnant
5 and postpartum individuals. Such report shall, at a
6 minimum, include the following:

7 (A) An assessment of any existing policies
8 under such State plans and such State child
9 health plans regarding presumptive eligibility
10 for pregnant individuals while their application
11 for enrollment in such a State plan or such a
12 State child health plan is being processed.

13 (B) An assessment of any existing policies
14 under such State plans and such State child
15 health plans regarding measures to ensure con-
16 tinuity of coverage under such a State plan or
17 such a State child health plan for pregnant and
18 postpartum individuals, including such individ-
19 uals who need to change their health insurance
20 coverage during their pregnancy or the
21 postpartum period following their pregnancy.

22 (C) An assessment of any existing policies
23 under such State plans and such State child
24 health plans regarding measures to automati-
25 cally reenroll individuals who are eligible to en-

1 roll under such a State plan or such a State
 2 child health plan as a parent.

3 (D) If determined appropriate by the Com-
 4 mission, any recommendations for the Depart-
 5 ment of Health and Human Services, or such
 6 State plans and such State child health plans,
 7 to ensure continuity of coverage under such a
 8 State plan or such a State child health plan for
 9 pregnant and postpartum people.

10 (2) POSTPARTUM DEFINED.—In this sub-
 11 section, the term “postpartum” means the 1-year
 12 period beginning on the last day of a person’s preg-
 13 nancy.

14 **SEC. 5211. PROTECTING MOMS AND BABIES AGAINST CLI-**
 15 **MATE CHANGE.**

16 (a) GRANT PROGRAM TO PROTECT VULNERABLE
 17 MOTHERS AND BABIES FROM CLIMATE CHANGE
 18 RISKS.—

19 (1) IN GENERAL.—Not later than 180 days
 20 after the date of enactment of this section, the Sec-
 21 retary of Health and Human Services (in this sec-
 22 tion referred to as the “Secretary”) shall establish
 23 a grant program (in this subsection referred to as
 24 the “Program”) to protect vulnerable individuals
 25 from risks associated with climate change.

1 (2) GRANT AUTHORITY.—In carrying out the
2 Program, the Secretary may award, on a competitive
3 basis, grants to 10 covered entities.

4 (3) APPLICATIONS.—To be eligible for a grant
5 under the Program, a covered entity shall submit to
6 the Secretary an application at such time, in such
7 form, and containing such information as the Sec-
8 retary may require, which shall include, at a min-
9 imum, a description of the following:

10 (A) Plans for the use of grant funds
11 awarded under the Program and how patients
12 and stakeholder organizations were involved in
13 the development of such plans.

14 (B) How such grant funds will be targeted
15 to geographic areas that have disproportionately
16 high levels of risks associated with climate
17 change for vulnerable individuals.

18 (C) How such grant funds will be used to
19 address racial and ethnic inequities in—

20 (i) adverse maternal and infant health
21 outcomes; and

22 (ii) exposure to risks associated with
23 climate change for vulnerable individuals.

24 (D) Strategies to prevent an initiative as-
25 sisted with such grant funds from causing—

- 1 (i) adverse environmental impacts;
- 2 (ii) displacement of residents and
- 3 businesses;
- 4 (iii) rent and housing price increases;
- 5 or
- 6 (iv) disproportionate adverse impacts
- 7 on racial and ethnic minority groups and
- 8 other underserved populations.

9 (4) SELECTION OF GRANT RECIPIENTS.—

10 (A) TIMING.—Not later than 270 days
11 after the date of enactment of this Act, the Sec-
12 retary shall select the recipients of grants under
13 the Program.

14 (B) CONSULTATION.—In selecting covered
15 entities for grants under the Program, the Sec-
16 retary shall consult with—

- 17 (i) representatives of stakeholder or-
- 18 ganizations;
- 19 (ii) the Administrator of the Environ-
- 20 mental Protection Agency;
- 21 (iii) the Administrator of the National
- 22 Oceanic and Atmospheric Administration;
- 23 and
- 24 (iv) from the Department of Health
- 25 and Human Services—

1 (I) the Deputy Assistant Sec-
2 retary for Minority Health;

3 (II) the Administrator of the
4 Centers for Medicare & Medicaid
5 Services;

6 (III) the Administrator of the
7 Health Resources and Services Ad-
8 ministration;

9 (IV) the Director of the National
10 Institutes of Health; and

11 (V) the Director of the Centers
12 for Disease Control and Prevention.

13 (C) PRIORITY.—In selecting a covered en-
14 tity to be awarded a grant under the Program,
15 the Secretary shall give priority to covered enti-
16 ties that serve a county—

17 (i) designated, or located in an area
18 designated, as a nonattainment area pur-
19 suant to section 107 of the Clean Air Act
20 (42 U.S.C. 7407) for any air pollutant for
21 which air quality criteria have been issued
22 under section 108(a) of such Act (42
23 U.S.C. 7408(a));

24 (ii) with a level of vulnerability of
25 moderate-to-high or higher, according to

1 the Social Vulnerability Index of the Cen-
2 ters for Disease Control and Prevention; or
3 (iii) with temperatures that pose a
4 risk to human health, as determined by the
5 Secretary, in consultation with the Admin-
6 istrator of the National Oceanic and At-
7 mospheric Administration and the Chair of
8 the United States Global Change Research
9 Program, based on the best available
10 science.

11 (D) LIMITATION.—A recipient of grant
12 funds under the Program may not use such
13 grant funds to serve a county that is served by
14 any other recipient of a grant under the Pro-
15 gram.

16 (5) USE OF FUNDS.—A covered entity awarded
17 grant funds under the Program may only use such
18 grant funds for the following:

19 (A) Initiatives to identify risks associated
20 with climate change for vulnerable individuals
21 and to provide services and support to such in-
22 dividuals that address such risks, which may in-
23 clude—

24 (i) training for health care providers,
25 doulas, and other employees in hospitals,

1 birth centers, midwifery practices, and
2 other health care practices that provide
3 prenatal or labor and delivery services to
4 vulnerable individuals on the identification
5 of, and patient counseling relating to, risks
6 associated with climate change for vulner-
7 able individuals;

8 (ii) hiring, training, or providing re-
9 sources to community health workers and
10 perinatal health workers who can help
11 identify risks associated with climate
12 change for vulnerable individuals, provide
13 patient counseling about such risks, and
14 carry out the distribution of relevant serv-
15 ices and support;

16 (iii) enhancing the monitoring of risks
17 associated with climate change for vulner-
18 able individuals, including by—

19 (I) collecting data on such risks
20 in specific census tracts, neighbor-
21 hoods, or other geographic areas; and

22 (II) sharing such data with local
23 health care providers, doulas, and
24 other employees in hospitals, birth
25 centers, midwifery practices, and

1 other health care practices that pro-
2 vide prenatal or labor and delivery
3 services to local vulnerable individuals;
4 and

5 (iv) providing vulnerable individuals—

6 (I) air conditioning units, resi-
7 dential weatherization support, filtra-
8 tion systems, household appliances, or
9 related items;

10 (II) direct financial assistance;

11 and

12 (III) services and support, in-
13 cluding housing and transportation
14 assistance, to prepare for or recover
15 from extreme weather events, which
16 may include floods, hurricanes,
17 wildfires, droughts, and related
18 events.

19 (B) Initiatives to mitigate levels of and ex-
20 posure to risks associated with climate change
21 for vulnerable individuals, which shall be based
22 on the best available science and which may in-
23 clude initiatives to—

1 (i) develop, maintain, or expand urban
2 or community forestry initiatives and tree
3 canopy coverage initiatives;

4 (ii) improve infrastructure, including
5 buildings and paved surfaces;

6 (iii) develop or improve community
7 outreach networks to provide culturally
8 and linguistically appropriate information
9 and notifications about risks associated
10 with climate change for vulnerable individ-
11 uals; and

12 (iv) provide enhanced services to ra-
13 cial and ethnic minority groups and other
14 underserved populations.

15 (6) LENGTH OF AWARD.—A grant under this
16 subsection shall be disbursed over 4 fiscal years.

17 (7) TECHNICAL ASSISTANCE.—The Secretary
18 shall provide technical assistance to a covered entity
19 awarded a grant under the Program to support the
20 development, implementation, and evaluation of ac-
21 tivities funded with such grant.

22 (8) REPORTS TO SECRETARY.—

23 (A) ANNUAL REPORT.—For each fiscal
24 year during which a covered entity is disbursed
25 grant funds under the Program, such covered

1 entity shall submit to the Secretary a report
2 that summarizes the activities carried out by
3 such covered entity with such grant funds dur-
4 ing such fiscal year, which shall include a de-
5 scription of the following:

6 (i) The involvement of stakeholder or-
7 ganizations in the implementation of initia-
8 tives assisted with such grant funds.

9 (ii) Relevant health and environmental
10 data, disaggregated, to the extent prac-
11 ticable, by race, ethnicity, gender, and
12 pregnancy status.

13 (iii) Qualitative feedback received
14 from vulnerable individuals with respect to
15 initiatives assisted with such grant funds.

16 (iv) Criteria used in selecting the geo-
17 graphic areas assisted with such grant
18 funds.

19 (v) Efforts to address racial and eth-
20 nic inequities in adverse maternal and in-
21 fant health outcomes and in exposure to
22 risks associated with climate change for
23 vulnerable individuals.

1 (vi) Any negative and unintended im-
2 pacts of initiatives assisted with such grant
3 funds, including—

4 (I) adverse environmental im-
5 pacts;

6 (II) displacement of residents
7 and businesses;

8 (III) rent and housing price in-
9 creases; and

10 (IV) disproportionate adverse im-
11 pacts on racial and ethnic minority
12 groups and other underserved popu-
13 lations.

14 (vii) How the covered entity will ad-
15 dress and prevent any impacts described in
16 clause (vi).

17 (B) PUBLICATION.—Not later than 30
18 days after the date on which a report is sub-
19 mitted under subparagraph (A), the Secretary
20 shall publish such report on a public website of
21 the Department of Health and Human Services.

22 (9) REPORT TO CONGRESS.—Not later than the
23 date that is 5 years after the date on which the Pro-
24 gram is established, the Secretary shall submit to
25 Congress and publish on a public website of the De-

1 department of Health and Human Services a report on
2 the results of the Program, including the following:

3 (A) Summaries of the annual reports sub-
4 mitted under paragraph (8).

5 (B) Evaluations of the initiatives assisted
6 with grant funds under the Program.

7 (C) An assessment of the effectiveness of
8 the Program in—

9 (i) identifying risks associated with
10 climate change for vulnerable individuals;

11 (ii) providing services and support to
12 such individuals;

13 (iii) mitigating levels of and exposure
14 to such risks; and

15 (iv) addressing racial and ethnic in-
16 equities in adverse maternal and infant
17 health outcomes and in exposure to such
18 risks.

19 (D) A description of how the Program
20 could be expanded, including—

21 (i) monitoring efforts or data collec-
22 tion that would be required to identify
23 areas with high levels of risks associated
24 with climate change for vulnerable individ-
25 uals;

1 (ii) how such areas could be identified
2 using the strategy developed under sub-
3 section (d); and

4 (iii) recommendations for additional
5 funding.

6 (10) COVERED ENTITY DEFINED.—In this sub-
7 section, the term “covered entity” means a consor-
8 tium of organizations serving a county that—

9 (A) shall include a community-based orga-
10 nization; and

11 (B) may include—

12 (i) another stakeholder organization;

13 (ii) the government of such county;

14 (iii) the governments of one or more
15 municipalities within such county;

16 (iv) a State or local public health de-
17 partment or emergency management agen-
18 cy;

19 (v) a local health care practice, which
20 may include a licensed and accredited hos-
21 pital, birth center, midwifery practice, or
22 other health care practice that provides
23 prenatal or labor and delivery services to
24 vulnerable individuals;

1 (vi) an Indian tribe or tribal organiza-
2 tion (as such terms are defined in section
3 4 of the Indian Self-Determination and
4 Education Assistance Act (25 U.S.C.
5 5304));

6 (vii) an Urban Indian organization (as
7 defined in section 4 of the Indian Health
8 Care Improvement Act (25 U.S.C. 1603));
9 and

10 (viii) an institution of higher edu-
11 cation.

12 (11) AUTHORIZATION OF APPROPRIATIONS.—

13 There is authorized to be appropriated to carry out
14 this subsection \$100,000,000 for fiscal years 2027
15 through 2030.

16 (b) GRANT PROGRAM FOR EDUCATION AND TRAIN-
17 ING AT HEALTH PROFESSION SCHOOLS.—

18 (1) IN GENERAL.—Not later than 1 year after
19 the date of enactment of this Act, the Secretary
20 shall establish a grant program (in this subsection
21 referred to as the “Program”) to provide funds to
22 health profession schools to support the development
23 and integration of education and training programs
24 for identifying and addressing risks associated with
25 climate change for vulnerable individuals.

1 (2) GRANT AUTHORITY.—In carrying out the
2 Program, the Secretary may award, on a competitive
3 basis, grants to health profession schools.

4 (3) APPLICATION.—To be eligible for a grant
5 under the Program, a health profession school shall
6 submit to the Secretary an application at such time,
7 in such form, and containing such information as
8 the Secretary may require, which shall include, at a
9 minimum, a description of the following:

10 (A) How such health profession school will
11 engage with vulnerable individuals, and stake-
12 holder organizations representing such individ-
13 uals, in developing and implementing the edu-
14 cation and training programs supported by
15 grant funds awarded under the Program.

16 (B) How such health profession school will
17 ensure that such education and training pro-
18 grams will address racial and ethnic inequities
19 in exposure to, and the effects of, risks associ-
20 ated with climate change for vulnerable individ-
21 uals.

22 (4) USE OF FUNDS.—A health profession school
23 awarded a grant under the Program shall use the
24 grant funds to develop, and integrate into the cur-
25 riculum and continuing education of such health

1 profession school, education and training on each of
2 the following:

3 (A) Identifying risks associated with cli-
4 mate change for vulnerable individuals and indi-
5 viduals with the intent to become pregnant.

6 (B) How risks associated with climate
7 change affect vulnerable individuals and individ-
8 uals with the intent to become pregnant.

9 (C) Racial and ethnic inequities in expo-
10 sure to, and the effects of, risks associated with
11 climate change for vulnerable individuals and
12 individuals with the intent to become pregnant.

13 (D) Patient counseling and mitigation
14 strategies relating to risks associated with cli-
15 mate change for vulnerable individuals.

16 (E) Relevant services and support for vul-
17 nerable individuals relating to risks associated
18 with climate change and strategies for ensuring
19 vulnerable individuals have access to such serv-
20 ices and support.

21 (F) Implicit and explicit bias, racism, and
22 discrimination.

23 (G) Related topics identified by such
24 health profession school based on the engage-
25 ment of such health profession school with vul-

1 nerable individuals and stakeholder organiza-
2 tions representing such individuals.

3 (5) PARTNERSHIPS.—In carrying out activities
4 with grant funds, a health profession school awarded
5 a grant under the Program may partner with one or
6 more of the following:

7 (A) A State or local public health depart-
8 ment.

9 (B) A health care professional membership
10 organization.

11 (C) A stakeholder organization.

12 (D) A health profession school.

13 (E) An institution of higher education.

14 (6) REPORTS TO SECRETARY.—

15 (A) ANNUAL REPORT.—For each fiscal
16 year during which a health profession school is
17 disbursed grant funds under the Program, such
18 health profession school shall submit to the Sec-
19 retary a report that describes the activities car-
20 ried out with such grant funds during such fis-
21 cal year.

22 (B) FINAL REPORT.—Not later than the
23 date that is 1 year after the end of the last fis-
24 cal year during which a health profession school
25 is disbursed grant funds under the Program,

1 the health profession school shall submit to the
2 Secretary a final report that summarizes the
3 activities carried out with such grant funds.

4 (7) REPORT TO CONGRESS.—Not later than the
5 date that is 6 years after the date on which the Pro-
6 gram is established, the Secretary shall submit to
7 Congress and publish on a public website of the De-
8 partment of Health and Human Services a report
9 that includes the following:

10 (A) A summary of the reports submitted
11 under paragraph (6).

12 (B) Recommendations to improve edu-
13 cation and training programs at health profes-
14 sion schools with respect to identifying and ad-
15 dressing risks associated with climate change
16 for vulnerable individuals.

17 (8) HEALTH PROFESSION SCHOOL DEFINED.—
18 In this subsection, the term “health profession
19 school” means an accredited—

20 (A) medical school;

21 (B) school of nursing;

22 (C) midwifery program;

23 (D) physician assistant education program;

24 (E) teaching hospital;

25 (F) residency or fellowship program; or

1 (G) other school or program determined
2 appropriate by the Secretary.

3 (9) AUTHORIZATION OF APPROPRIATIONS.—

4 There is authorized to be appropriated to carry out
5 this subsection \$5,000,000 for fiscal years 2027
6 through 2030.

7 (c) NIH CONSORTIUM ON BIRTH AND CLIMATE
8 CHANGE RESEARCH.—

9 (1) ESTABLISHMENT.—Not later than 1 year
10 after the date of enactment of this Act, the Director
11 of the National Institutes of Health (in this sub-
12 section referred to as the “Director of NIH”) shall
13 establish the Consortium on Birth and Climate
14 Change Research (in this subsection referred to as
15 the “Consortium”).

16 (2) DUTIES.—

17 (A) IN GENERAL.—The Consortium shall
18 coordinate, across the institutes, centers, and
19 offices of the National Institutes of Health, re-
20 search on the risks associated with climate
21 change for vulnerable individuals.

22 (B) REQUIRED ACTIVITIES.—In carrying
23 out subparagraph (A), the Consortium shall—

24 (i) establish research priorities, in-
25 cluding by prioritizing research that—

1 (I) identifies the risks associated
2 with climate change for vulnerable in-
3 dividuals with a particular focus on
4 inequities in such risks among racial
5 and ethnic minority groups and other
6 underserved populations; and

7 (II) identifies strategies to reduce
8 levels of, and exposure to, such risks,
9 with a particular focus on risks
10 among racial and ethnic minority
11 groups and other underserved popu-
12 lations;

13 (ii) identify gaps in available data re-
14 lated to such risks;

15 (iii) identify gaps in, and opportuni-
16 ties for, research collaborations;

17 (iv) identify funding opportunities for
18 community-based organizations and re-
19 searchers from racially, ethnically, and
20 geographically diverse backgrounds; and

21 (v) publish annual reports on the
22 work and findings of the Consortium on a
23 public website of the National Institutes of
24 Health.

1 (3) MEMBERSHIP.—The Director of NIH shall
2 appoint to the Consortium representatives of such
3 institutes, centers, and offices of the National Insti-
4 tutes of Health as the Director of NIH considers ap-
5 propriate, including, at a minimum, representatives
6 of—

7 (A) the National Institute of Environ-
8 mental Health Sciences;

9 (B) the National Institute on Minority
10 Health and Health Disparities;

11 (C) the Eunice Kennedy Shriver National
12 Institute of Child Health and Human Develop-
13 ment;

14 (D) the National Institute of Nursing Re-
15 search; and

16 (E) the Office of Research on Women’s
17 Health.

18 (4) CHAIRPERSON.—The Chairperson of the
19 Consortium shall be designated by the Director of
20 NIH and selected from among the representatives
21 appointed under paragraph (3).

22 (5) CONSULTATION.—In carrying out the duties
23 described in paragraph (2), the Consortium shall
24 consult with—

1 (A) the heads of relevant Federal agencies,
2 including—

3 (i) the Environmental Protection
4 Agency;

5 (ii) the National Oceanic and Atmos-
6 pheric Administration;

7 (iii) the Occupational Safety and
8 Health Administration; and

9 (iv) from the Department of Health
10 and Human Services—

11 (I) the Office of Minority Health
12 in the Office of the Secretary;

13 (II) the Centers for Medicare &
14 Medicaid Services;

15 (III) the Health Resources and
16 Services Administration;

17 (IV) the Centers for Disease
18 Control and Prevention;

19 (V) the Indian Health Service;
20 and

21 (VI) the Administration for Chil-
22 dren and Families; and

23 (B) representatives of—

24 (i) stakeholder organizations;

1 (ii) health care providers and profes-
 2 sional membership organizations with ex-
 3 pertise in maternal health or environ-
 4 mental justice;

5 (iii) State and local public health de-
 6 partments;

7 (iv) licensed and accredited hospitals,
 8 birth centers, midwifery practices, or other
 9 health care practices that provide prenatal
 10 or labor and delivery services to vulnerable
 11 individuals; and

12 (v) institutions of higher education,
 13 including such institutions that are minor-
 14 ity-serving institutions or have expertise in
 15 maternal health or environmental justice.

16 (d) STRATEGY FOR IDENTIFYING CLIMATE CHANGE
 17 RISK ZONES FOR VULNERABLE MOTHERS AND BABIES.—

18 (1) IN GENERAL.—The Secretary, acting
 19 through the Director of the Centers for Disease
 20 Control and Prevention, shall develop a strategy (in
 21 this subsection referred to as the “Strategy”) for
 22 designating areas that the Secretary determines to
 23 have a high risk of adverse maternal and infant
 24 health outcomes among vulnerable individuals as a
 25 result of risks associated with climate change.

1 (2) STRATEGY REQUIREMENTS.—

2 (A) IN GENERAL.—In developing the
3 Strategy, the Secretary shall establish a process
4 to identify areas where vulnerable individuals
5 are exposed to a high risk of adverse maternal
6 and infant health outcomes as a result of risks
7 associated with climate change in conjunction
8 with other factors that can impact such health
9 outcomes, including—

10 (i) the incidence of diseases associated
11 with air pollution, extreme heat, and other
12 environmental factors;

13 (ii) the availability and accessibility of
14 maternal and infant health care providers;

15 (iii) English-language proficiency
16 among people of reproductive age;

17 (iv) the health insurance status of
18 people of reproductive age;

19 (v) the number of people of reproduc-
20 tive age who are members of racial or eth-
21 nic groups with disproportionately high
22 rates of adverse maternal and infant
23 health outcomes;

1 (vi) the socioeconomic status of people
 2 of reproductive age, including with respect
 3 to—

4 (I) poverty;
 5 (II) unemployment;
 6 (III) household income; and
 7 (IV) educational attainment; and
 8 (vii) access to quality housing, trans-
 9 portation, and nutrition.

10 (B) RESOURCES.—In developing the Strat-
 11 egy, the Secretary shall identify, and incor-
 12 porate a description of, the following:

13 (i) Existing mapping tools or Federal
 14 programs that identify—

15 (I) risks associated with climate
 16 change for vulnerable individuals; and
 17 (II) other factors that can influ-
 18 ence maternal and infant health out-
 19 comes, including the factors described
 20 in subparagraph (A).

21 (ii) Environmental, health, socio-
 22 economic, and demographic data relevant
 23 to identifying risks associated with climate
 24 change for vulnerable individuals.

1 (iii) Existing monitoring networks
2 that collect data described in clause (ii),
3 and any gaps in such networks.

4 (iv) Federal, State, and local stake-
5 holders involved in maintaining monitoring
6 networks identified under clause (iii), and
7 how such stakeholders are coordinating
8 their monitoring efforts.

9 (v) Additional monitoring networks,
10 and enhancements to existing monitoring
11 networks, that would be required to ad-
12 dress gaps identified under clause (iii), in-
13 cluding at the subcounty and census tract
14 level.

15 (vi) Funding amounts required to es-
16 tablish the monitoring networks identified
17 under clause (v) and recommendations for
18 Federal, State, and local coordination with
19 respect to such networks.

20 (vii) Potential uses for data collected
21 and generated as a result of the Strategy,
22 including how such data may be used in
23 determining recipients of grants under the
24 program established by subsection (a) or
25 other similar programs.

1 (viii) Other information the Secretary
2 considers relevant for the development of
3 the Strategy.

4 (3) COORDINATION AND CONSULTATION.—In
5 developing the Strategy, the Secretary shall—

6 (A) coordinate with the Administrator of
7 the Environmental Protection Agency and the
8 Administrator of the National Oceanic and At-
9 mospheric Administration; and

10 (B) consult with—

11 (i) stakeholder organizations;

12 (ii) health care providers and profes-
13 sional membership organizations with ex-
14 pertise in maternal health or environ-
15 mental justice;

16 (iii) State and local public health de-
17 partments;

18 (iv) licensed and accredited hospitals,
19 birth centers, midwifery practices, or other
20 health care providers that provide prenatal
21 or labor and delivery services to vulnerable
22 individuals; and

23 (v) institutions of higher education,
24 including such institutions that are minor-

1 ity-serving institutions or have expertise in
2 maternal health or environmental justice.

3 (4) NOTICE AND COMMENT.—At least 240 days
4 before the date on which the Strategy is published
5 in accordance with paragraph (5), the Secretary
6 shall provide—

7 (A) notice of the Strategy on a public
8 website of the Department of Health and
9 Human Services; and

10 (B) an opportunity for public comment of
11 at least 90 days.

12 (5) PUBLICATION.—Not later than 18 months
13 after the date of enactment of this Act, the Sec-
14 retary shall publish on a public website of the De-
15 partment of Health and Human Services—

16 (A) the Strategy;

17 (B) the public comments received under
18 paragraph (4); and

19 (C) the responses of the Secretary to such
20 public comments.

21 (e) DEFINITIONS.—In this section:

22 (1) ADVERSE MATERNAL AND INFANT HEALTH
23 OUTCOMES.—The term “adverse maternal and in-
24 fant health outcomes” includes the outcomes of pre-

1 term birth, low birth weight, stillbirth, infant or ma-
2 ternal mortality, and severe maternal morbidity.

3 (2) INSTITUTION OF HIGHER EDUCATION.—The
4 term “institution of higher education” has the
5 meaning given such term in section 101 of the High-
6 er Education Act of 1965 (20 U.S.C. 1001).

7 (3) MINORITY-SERVING INSTITUTION.—The
8 term “minority-serving institution” means an entity
9 specified in any of paragraphs (1) through (7) of
10 section 371(a) of the Higher Education Act of 1965
11 (20 U.S.C. 1067q(a)).

12 (4) RACIAL AND ETHNIC MINORITY GROUP.—
13 The term “racial and ethnic minority group” has the
14 meaning given such term in section 1707(g) of the
15 Public Health Service Act (42 U.S.C. 300u–6(g)).

16 (5) RISKS ASSOCIATED WITH CLIMATE
17 CHANGE.—The term “risks associated with climate
18 change” includes risks associated with extreme heat,
19 air pollution, extreme weather events, and other en-
20 vironmental issues associated with climate change
21 that can result in adverse maternal and infant
22 health outcomes.

23 (6) STAKEHOLDER ORGANIZATION.—The term
24 “stakeholder organization” means—

1 (A) a community-based organization with
2 expertise in providing assistance to vulnerable
3 individuals;

4 (B) a nonprofit organization with expertise
5 in maternal or infant health or environmental
6 justice; and

7 (C) a patient advocacy organization rep-
8 resenting vulnerable individuals.

9 (7) VULNERABLE INDIVIDUAL.—The term “vul-
10 nerable individual” means—

11 (A) an individual who is pregnant;

12 (B) an individual who was pregnant during
13 any portion of the preceding 1-year period; and

14 (C) an individual under 3 years of age.

15 **SEC. 5212. PROTECT MOMS FROM DOMESTIC VIOLENCE.**

16 (a) STUDY BY DEPARTMENT OF HEALTH AND
17 HUMAN SERVICES.—

18 (1) STUDY.—The Secretary, in collaboration
19 with the Health Resources and Services Administra-
20 tion, the Substance Abuse and Mental Health Serv-
21 ices Administration, and the Administration for
22 Children and Families, and in consultation with the
23 Attorney General of the United States, the Director
24 of the Indian Health Service, and stakeholders (in-
25 cluding community-based organizations, culturally

1 specific organizations, and Tribal public health au-
2 thorities), shall conduct a study on the extent to
3 which individuals are more at risk of maternal mor-
4 tality or severe maternal morbidity as a result of
5 being a victim of domestic violence, dating violence,
6 sexual assault, stalking, human trafficking, sex traf-
7 ficking, child sexual abuse, or forced marriage.

8 (2) REPORTS.—Not later than 2 years after the
9 date of enactment of this Act, the Secretary shall
10 complete the study under paragraph (1) and submit
11 a report to the Congress on the results of such
12 study. Such report shall include—

13 (A) an analysis of the extent to which do-
14 mestic violence, dating violence, sexual assault,
15 stalking, human trafficking, sex trafficking,
16 child sexual abuse, and forced marriage con-
17 tribute to, or result in, maternal mortality;

18 (B) an analysis of the impact of domestic
19 violence, dating violence, sexual assault, stalk-
20 ing, human trafficking, sex trafficking, child
21 sexual abuse, and forced marriage on access to
22 health care (including mental health care) and
23 substance use disorder treatment and recovery
24 support;

1 (C) a breakdown (including by race and
2 ethnicity) of categories of individuals who are
3 disproportionately victims of domestic violence,
4 dating violence, sexual assault, stalking, human
5 trafficking, sex trafficking, child sexual abuse,
6 or forced marriage that contributes to, or re-
7 sults in, pregnancy-related death;

8 (D) an analysis of the impact on health,
9 mental health, and substance use resulting from
10 domestic violence, dating violence, sexual as-
11 sault, stalking, human trafficking, sex traf-
12 ficking, child sexual abuse, and forced marriage
13 among Alaskan Natives, Native Hawaiians, and
14 American Indians during the prenatal and
15 postpartum period;

16 (E) an assessment of the factors that in-
17 crease or decrease risks for maternal mortality
18 or severe maternal morbidity among victims of
19 domestic violence, dating violence, sexual as-
20 sault, stalking, human trafficking, sex traf-
21 ficking, child sexual abuse, or forced marriage;

22 (F) an assessment of increased risk of ma-
23 ternal mortality or severe maternal morbidity
24 stemming from suicide, substance use disorders,
25 or drug overdose due to domestic violence, dat-

ing violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage;

(G) recommendations for legislative or policy changes—

(i) to reduce maternal mortality rates;

and

(ii) to address health inequities that contribute to inequities in such rates and deaths;

(H) best practices to reduce maternal mortality and severe maternal morbidity among victims of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, and forced marriage, including—

(i) reducing reproductive coercion, mental health conditions, and substance use coercion; and

(ii) routinely assessing pregnant people for domestic violence and other forms of reproductive violence; and

(I) any other information on maternal mortality or severe maternal morbidity the Sec-

1 retary determines appropriate to include in the
2 report.

3 (b) STUDY BY NATIONAL ACADEMY OF MEDICINE.—

4 (1) IN GENERAL.—The Secretary shall seek to
5 enter into an arrangement with the National Acad-
6 emy of Medicine (or, if the Academy declines to
7 enter into such arrangement, another appropriate
8 entity) to study—

9 (A) the impact of domestic violence, dating
10 violence, sexual assault, stalking, human traf-
11 ficking, sex trafficking, child sexual abuse, and
12 forced marriage on an individual's health; rel-
13 ative to

14 (B) maternal mortality and severe mater-
15 nal morbidity.

16 (2) TOPICS.—The study under paragraph (1)
17 shall—

18 (A) examine—

19 (i) whether domestic violence, dating
20 violence, sexual assault, stalking, human
21 trafficking, sex trafficking, child sexual
22 abuse, or forced marriage, or generational
23 intimate partner violence, trauma, and psy-
24 chiatric disorders, increase the risk of sui-
25 cide, substance use, and drug overdose

1 among pregnant and postpartum persons;

2 and

3 (ii) the intersection of domestic vio-
 4 lence, dating violence, sexual assault, stalk-
 5 ing, human trafficking, sex trafficking,
 6 child sexual abuse, and forced marriage as
 7 a social determinant of health; and

8 (B) give particular focus to impacts among
 9 African American, American Indian, Native Ha-
 10 waiian, Alaskan Native, and LGBTQ birthing
 11 persons.

12 (c) GRANTS FOR INNOVATIVE APPROACHES.—

13 (1) IN GENERAL.—The Secretary, acting
 14 through the Administrator of the Health Resources
 15 and Services Administration, and in collaboration
 16 with the Administration for Children and Families,
 17 the Indian Health Service, and the Substance Abuse
 18 and Mental Health Services Administration, shall
 19 award grants to eligible entities for developing and
 20 implementing innovative approaches to improve ma-
 21 ternal and child health outcomes of victims of do-
 22 mestic violence, dating violence, sexual assault,
 23 stalking, human trafficking, sex trafficking, child
 24 sexual abuse, or forced marriage.

1 (2) ELIGIBLE ENTITY.—To seek a grant under
2 this subsection, an entity shall be—

3 (A) a State, local, or federally recognized
4 Tribal government;

5 (B) a nonprofit organization or commu-
6 nity-based organization that provides prevention
7 or intervention services related to domestic vio-
8 lence, dating violence, sexual assault, stalking,
9 human trafficking, sex trafficking, child sexual
10 abuse, or forced marriage;

11 (C) a tribal organization or Urban Indian
12 organization (as such terms are defined in sec-
13 tion 4 of the Indian Health Care Improvement
14 Act (25 U.S.C. 1603));

15 (D) an entity, the principal purpose of
16 which is to provide health care, such as a hos-
17 pital, clinic, health department, freestanding
18 birthing center, perinatal health worker, or ma-
19 ternity care provider;

20 (E) an institution of higher education; or

21 (F) a comprehensive substance use dis-
22 order parenting program.

23 (3) PRIORITY.—In awarding grants under this
24 subsection, the Secretary shall give priority to appli-
25 cants proposing to address—

1 (A) mental health and substance use dis-
 2 orders among pregnant persons; or

3 (B) pregnant and postpartum persons ex-
 4 perienicing intimate partner violence.

5 (4) FREESTANDING BIRTH CENTER DEFINED.—

6 In this subsection, the term “freestanding birth cen-
 7 ter” has the meaning given that term in section
 8 1905(l) of the Social Security Act (42 U.S.C.
 9 1396d(l)).

10 (5) AUTHORIZATION OF APPROPRIATIONS.—To

11 carry out this subsection, there is authorized to be
 12 appropriated \$25,000,000 for the period of fiscal
 13 years 2027 through 2029.

14 (d) GUIDANCE.—Not later than 2 years after the
 15 date of enactment of this Act, the Secretary shall issue
 16 and disseminate guidance to States, Tribes, territories,
 17 maternity care providers, and managed care entities on—

18 (1) providing universal education on healthy re-
 19 lationships and intimate partner violence;

20 (2) developing protocols on—

21 (A) routine assessment of intimate partner
 22 violence; and

23 (B) health promotion and strategies for
 24 trauma-informed care plans; and

1 (3) creating sustainable partnerships with com-
 2 munity-based organizations that address domestic vi-
 3 olence, dating violence, sexual assault, stalking,
 4 human trafficking, sex trafficking, child sexual
 5 abuse, or forced marriage.

6 (e) DEFINITIONS.—In this section:

7 (1) MATERNAL MORTALITY.—The term “mater-
 8 nal mortality”—

9 (A) means death that—

10 (i) occurs during, or within the 1-year
 11 period after, pregnancy; and

12 (ii) is attributed to or aggravated by
 13 pregnancy-related or childbirth complica-
 14 tions; and

15 (B) includes a suicide, drug overdose
 16 death, homicide (including a domestic violence-
 17 related homicide), or other death resulting from
 18 a mental health or substance use disorder at-
 19 tributed to or aggravated by pregnancy-related
 20 or childbirth complications.

21 (2) MATERNITY CARE PROVIDER.—The term
 22 “maternity care provider” means a health care pro-
 23 vider who—

24 (A) is a physician, physician assistant,
 25 nurse, midwife who meets at a minimum the

1 international definition of the midwife and glob-
2 al standards for midwifery education as estab-
3 lished by the International Confederation of
4 Midwives, nurse practitioner, or clinical nurse
5 specialist; and

6 (B) has a focus on maternal or perinatal
7 health.

8 (3) PERINATAL HEALTH WORKER.—The term
9 “perinatal health worker” means a worker who—

10 (A) is a doula, community health worker,
11 peer supporter, breastfeeding and lactation edu-
12 cator or counselor, nutritionist or dietitian,
13 childbirth educator, social worker, home visitor,
14 language interpreter, or navigator; and

15 (B) provides assistance with perinatal
16 health.

17 (4) POSTPARTUM.—The term “postpartum”
18 means the 12-month period following childbirth.

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

21 (6) SEVERE MATERNAL MORBIDITY.—The term
22 “severe maternal morbidity” means a health condi-
23 tion, including a mental health condition or sub-
24 stance use disorder, that—

1 (A) is attributed to or aggravated by preg-
 2 nancy or childbirth; and

3 (B) results in significant short-term or
 4 long-term consequences to the health of the in-
 5 dividual who was pregnant.

6 **SEC. 5213. MIDWIVES SCHOOLS AND PROGRAMS EXPAN-**
 7 **SION.**

8 (a) MIDWIFERY SCHOOLS AND PROGRAMS.—

9 (1) IN GENERAL.—Title VII of the Public
 10 Health Service Act is amended by inserting after
 11 section 760 (42 U.S.C. 294k) the following:

12 **“SEC. 760A. MIDWIFERY SCHOOLS AND PROGRAMS.**

13 “(a) IN GENERAL.—The Secretary may award grants
 14 to institutions of higher education (as defined in sub-
 15 sections (a) and (b) of section 101 of the Higher Edu-
 16 cation Act of 1965) for the following:

17 “(1) Direct support of students in an accredited
 18 midwifery school or program.

19 “(2) Establishment or expansion of an accred-
 20 ited midwifery school or program.

21 “(3) Securing, preparing, or providing support
 22 for increasing the number of qualified preceptors for
 23 training the students of an accredited midwifery
 24 school or program.

1 “(b) SPECIAL CONSIDERATIONS.—In awarding
2 grants under subsection (a), the Secretary shall give spe-
3 cial consideration to any institution of higher education
4 that—

5 “(1) agrees to prioritize students who plan to
6 practice in a health professional shortage area des-
7 ignated under section 332; and

8 “(2) demonstrates a focus on increasing racial
9 and ethnic minority representation in midwifery edu-
10 cation.

11 “(c) RESTRICTION.—The Secretary shall not provide
12 any assistance under this section to be used with respect
13 to a midwifery school or program within a school of nurs-
14 ing (as defined in section 801).

15 “(d) AUTHORIZATION OF APPROPRIATIONS.—

16 “(1) IN GENERAL.—There is authorized to be
17 appropriated to carry out this section \$15,000,000
18 for the period of fiscal years 2027 through 2031.

19 “(2) ALLOCATION.—Of the amounts made
20 available to carry out this section for any fiscal year,
21 the Secretary shall use—

22 “(A) 50 percent to award grants for pur-
23 poses specified in subsection (a)(1);

24 “(B) 25 percent to award grants for pur-
25 poses specified in subsection (a)(2); and

1 “(C) 25 percent to award grants for pur-
2 poses specified in subsection (a)(3).”.

3 (2) DEFINITIONS.—

4 (A) MIDWIFERY SCHOOL OR PROGRAM.—
5 Section 799B(1)(A) of the Public Health Serv-
6 ice Act (42 U.S.C. 295p(1)(A)) is amended—

7 (i) by inserting “‘midwifery school or
8 program’,” before “and ‘school of chiro-
9 practic’ ”;

10 (ii) by inserting “a degree or certifi-
11 cate in midwifery or an equivalent degree
12 or certificate,” before “and a degree of
13 doctor of chiropractic or an equivalent de-
14 gree”; and

15 (iii) by striking “any such school” and
16 inserting “any such school or program”.

17 (B) ACCREDITED.—Section 799B(1)(E) of
18 the Public Health Service Act (42 U.S.C.
19 295p(1)(E)) is amended by inserting “a mid-
20 wifery school or program,” before “or a grad-
21 uate program in health administration”.

22 (b) NURSE-MIDWIVES.—Title VIII of the Public
23 Health Service Act is amended by inserting after section
24 812 (as added by section 5205(c)), the following:

1 **“SEC. 812A. MIDWIFERY EXPANSION PROGRAM.**

2 “(a) IN GENERAL.—The Secretary may award grants
3 to schools of nursing for the following:

4 “(1) Direct support of students in an accredited
5 nurse-midwifery school or program.

6 “(2) Establishment or expansion of an accred-
7 ited nurse-midwifery school or program.

8 “(3) Securing, preparing, or providing support
9 for increasing the number of qualified preceptors at
10 clinical training sites to precept students training to
11 become certified nurse-midwives.

12 “(b) SPECIAL CONSIDERATIONS.—In awarding
13 grants under subsection (a), the Secretary shall give spe-
14 cial consideration to any school of nursing that—

15 “(1) agrees to prioritize students who choose to
16 pursue an advanced education degree in nurse-mid-
17 wifery to practice in a health professional shortage
18 area designated under section 332; and

19 “(2) demonstrates a focus on increasing racial
20 and ethnic minority representation in nurse-mid-
21 wifery education.

22 “(c) AUTHORIZATION OF APPROPRIATIONS.—

23 “(1) IN GENERAL.—To carry out this section,
24 there is authorized to be appropriated \$20,000,000
25 for the period of fiscal years 2027 through 2031.

1 “(2) ALLOCATION.—Of the amounts made
2 available to carry out this section for any fiscal year,
3 the Secretary shall use—

4 “(A) 50 percent to award grants for pur-
5 poses specified in subsection (a)(1);

6 “(B) 25 percent to award grants for pur-
7 poses specified in subsection (a)(2); and

8 “(C) 25 percent to award grants for pur-
9 poses specified in subsection (a)(3).”.

10 **SEC. 5214. GESTATIONAL DIABETES.**

11 Part B of title III of the Public Health Service Act
12 (42 U.S.C. 243 et seq.) is amended by adding after section
13 317H (42 U.S.C. 247b–9) the following:

14 **“SEC. 317H–1. GESTATIONAL DIABETES.**

15 “(a) UNDERSTANDING AND MONITORING GESTA-
16 TIONAL DIABETES.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Director of the Centers for Disease
19 Control and Prevention, in consultation with the Di-
20 abetes Mellitus Interagency Coordinating Committee
21 established under section 429 and representatives of
22 appropriate national health organizations, shall de-
23 velop a multisite gestational diabetes research
24 project within the diabetes program of the Centers
25 for Disease Control and Prevention to expand and

1 enhance surveillance data and public health research
2 on gestational diabetes.

3 “(2) AREAS TO BE ADDRESSED.—The research
4 project developed under paragraph (1) shall ad-
5 dress—

6 “(A) procedures to establish accurate and
7 efficient systems for the collection of gestational
8 diabetes data within each State and common-
9 wealth, territory, or possession of the United
10 States;

11 “(B) the progress of collaborative activities
12 with the National Vital Statistics System, the
13 National Center for Health Statistics, and
14 State health departments with respect to the
15 standard birth certificate, in order to improve
16 surveillance of gestational diabetes;

17 “(C) postpartum methods of tracking indi-
18 viduals with gestational diabetes after delivery
19 as well as targeted interventions proven to
20 lower the incidence of type 2 diabetes in that
21 population;

22 “(D) variations in the distribution of diag-
23 nosed and undiagnosed gestational diabetes,
24 and of impaired fasting glucose tolerance and

1 impaired fasting glucose, within and among
2 groups of pregnant individuals; and

3 “(E) factors and culturally sensitive inter-
4 ventions that influence risks and reduce the in-
5 cidence of gestational diabetes and related com-
6 plications during childbirth, including cultural,
7 behavioral, racial, ethnic, geographic, demo-
8 graphic, socioeconomic, and genetic factors.

9 “(3) REPORT.—Not later than 2 years after the
10 date of enactment of this section, and annually
11 thereafter, the Secretary shall generate a report on
12 the findings and recommendations of the research
13 project including prevalence of gestational diabetes
14 in the multisite area and disseminate the report to
15 the appropriate Federal and non-Federal agencies.

16 “(b) EXPANSION OF GESTATIONAL DIABETES RE-
17 SEARCH.—

18 “(1) IN GENERAL.—The Secretary shall expand
19 and intensify public health research regarding gesta-
20 tional diabetes. Such research may include—

21 “(A) developing and testing novel ap-
22 proaches for improving postpartum diabetes
23 testing or screening and for preventing type 2
24 diabetes in individuals who can become preg-
25 nant with a history of gestational diabetes; and

1 “(B) conducting public health research to
2 further understanding of the epidemiologic,
3 socioenvironmental, behavioral, translation, and
4 biomedical factors and health systems that in-
5 fluence the risk of gestational diabetes and the
6 development of type 2 diabetes in individuals
7 who can become pregnant with a history of ges-
8 tational diabetes.

9 “(2) AUTHORIZATION OF APPROPRIATIONS.—
10 There is authorized to be appropriated to carry out
11 this subsection \$5,000,000 for each of fiscal years
12 2027 through 2031.

13 “(c) DEMONSTRATION GRANTS TO LOWER THE
14 RATE OF GESTATIONAL DIABETES.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Director of the Centers for Disease
17 Control and Prevention, shall award grants, on a
18 competitive basis, to eligible entities for demonstra-
19 tion projects that implement evidence-based inter-
20 ventions to reduce the incidence of gestational diabe-
21 tes, the recurrence of gestational diabetes in subse-
22 quent pregnancies, and the development of type 2 di-
23 abetes in individuals who can become pregnant with
24 a history of gestational diabetes.

1 “(2) PRIORITY.—In making grants under this
2 subsection, the Secretary shall give priority to
3 projects focusing on—

4 “(A) helping individuals who can become
5 pregnant who have 1 or more risk factors for
6 developing gestational diabetes;

7 “(B) working with individuals who can be-
8 come pregnant with a history of gestational dia-
9 betes during a previous pregnancy;

10 “(C) providing postpartum care for indi-
11 viduals who can become pregnant with gesta-
12 tional diabetes;

13 “(D) tracking cases where individuals who
14 can become pregnant with a history of gesta-
15 tional diabetes developed type 2 diabetes;

16 “(E) educating mothers with a history of
17 gestational diabetes about the increased risk of
18 their child developing diabetes;

19 “(F) working to prevent gestational diabe-
20 tes and prevent or delay the development of
21 type 2 diabetes in individuals who can become
22 pregnant with a history of gestational diabetes;
23 and

24 “(G) achieving outcomes designed to assess
25 the efficacy and cost-effectiveness of interven-

1 tions that can inform decisions on long-term
2 sustainability, including third-party reimburse-
3 ment.

4 “(3) APPLICATION.—An eligible entity desiring
5 to receive a grant under this subsection shall submit
6 to the Secretary—

7 “(A) an application at such time, in such
8 manner, and containing such information as the
9 Secretary may require; and

10 “(B) a plan to—

11 “(i) lower the rate of gestational dia-
12 betes during pregnancy; or

13 “(ii) develop methods of tracking indi-
14 viduals who can become pregnant with a
15 history of gestational diabetes and develop
16 effective interventions to lower the inci-
17 dence of the recurrence of gestational dia-
18 betes in subsequent pregnancies and the
19 development of type 2 diabetes.

20 “(4) USES OF FUNDS.—An eligible entity re-
21 ceiving a grant under this subsection shall use the
22 grant funds to carry out demonstration projects de-
23 scribed in paragraph (1), including—

24 “(A) expanding community-based health
25 promotion education, activities, and incentives

1 focused on the prevention of gestational diabe-
2 tes and development of type 2 diabetes in indi-
3 viduals who can become pregnant with a history
4 of gestational diabetes;

5 “(B) aiding State- and Tribal-based diabe-
6 tes prevention and control programs to collect,
7 analyze, disseminate, and report surveillance
8 data on individuals who can become pregnant
9 with, and at risk for, gestational diabetes, the
10 recurrence of gestational diabetes in subsequent
11 pregnancies, and, for individuals who can be-
12 come pregnant with a history of gestational dia-
13 betes, the development of type 2 diabetes; and

14 “(C) training and encouraging health care
15 providers—

16 “(i) to promote risk assessment, high-
17 quality care, and self-management for ges-
18 tational diabetes and the recurrence of ges-
19 tational diabetes in subsequent preg-
20 nancies; and

21 “(ii) to prevent the development of
22 type 2 diabetes in individuals who can be-
23 come pregnant with a history of gesta-
24 tional diabetes, and its complications in the

1 practice settings of the health care pro-
2 viders.

3 “(5) REPORT.—Not later than 4 years after the
4 date of enactment of this section, the Secretary shall
5 prepare and submit to the Congress a report con-
6 cerning the results of the demonstration projects
7 conducted through the grants awarded under this
8 subsection.

9 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
10 this subsection, the term ‘eligible entity’ means a
11 nonprofit organization (such as a nonprofit academic
12 center or community health center) or a State, Trib-
13 al, or local health agency.

14 “(7) AUTHORIZATION OF APPROPRIATIONS.—
15 There is authorized to be appropriated to carry out
16 this subsection \$5,000,000 for each of fiscal years
17 2027 through 2031.

18 “(d) POSTPARTUM FOLLOWUP REGARDING GESTA-
19 TIONAL DIABETES.—The Secretary, acting through the
20 Director of the Centers for Disease Control and Preven-
21 tion, shall work with the State- and Tribal-based diabetes
22 prevention and control programs assisted by the Centers
23 to encourage postpartum followup after gestational diabe-
24 tes, as medically appropriate, for the purpose of reducing
25 the incidence of gestational diabetes, the recurrence of

1 gestational diabetes in subsequent pregnancies, the devel-
2 opment of type 2 diabetes in individuals with a history
3 of gestational diabetes, and related complications.”.

4 **SEC. 5215. CONSUMER EDUCATION CAMPAIGN.**

5 Section 229(b) of the Public Health Service Act (42
6 U.S.C. 237a(b)) is amended—

7 (1) in paragraph (6), by striking “and” at the
8 end;

9 (2) in paragraph (7), by striking the period at
10 the end and inserting a semicolon; and

11 (3) by adding at the end the following:

12 “(8) not later than 1 year after the date of en-
13 actment of this paragraph, develop and implement a
14 4-year culturally and linguistically appropriate
15 multimedia consumer education campaign that is de-
16 signed to promote understanding and acceptance of
17 evidence-based maternity practices and models of
18 care for optimal maternity outcomes among individ-
19 uals of childbearing ages and families of such indi-
20 viduals and that—

21 “(A) highlights the importance of pro-
22 tecting, promoting, and supporting the innate
23 capacities of childbearing individuals and their
24 newborns for childbirth, breastfeeding, and at-
25 tachment;

1 “(B) promotes understanding of the impor-
2 tance of using obstetric interventions when
3 medically necessary and when supported by
4 strong, high-quality evidence;

5 “(C) highlights the widespread overuse of
6 maternity practices that have been shown to
7 have benefit when used appropriately in situa-
8 tions of medical necessity, but which can expose
9 pregnant individuals, infants, or both to risk of
10 harm if used routinely and indiscriminately;

11 “(D) emphasizes the noninvasive maternity
12 practices that have proven correlation or may
13 be associated with improvement in outcomes
14 with no detrimental side effects, and are signifi-
15 cantly underused in the United States, includ-
16 ing smoking cessation programs in pregnancy,
17 group model prenatal care, continuous labor
18 support, nonsupine positions for birth, and ex-
19 ternal version to turn breech babies at term;

20 “(E) educates consumers about—

21 “(i) the qualifications of licensed pro-
22 viders of maternity care, including obstetri-
23 cian-gynecologists, family physicians, cer-
24 tified nurse-midwives, certified midwives,
25 and certified professional midwives; and

1 “(ii) the best evidence about the safe-
 2 ty, satisfaction, outcomes, and costs of
 3 such providers;

4 “(F) informs consumers about the best
 5 available research comparing birth center
 6 births, planned home births, and hospital
 7 births, including information about each set-
 8 ting’s safety, satisfaction, outcomes, and costs;

9 “(G) fosters participation in high-quality,
 10 evidence-based childbirth education that pro-
 11 motes a healthy and safe approach to preg-
 12 nancy, childbirth, and early parenting; is taught
 13 by certified educators, peer counselors, and
 14 health professionals; and promotes informed de-
 15 cision making by childbearing individuals;

16 “(H) informs consumers about—

17 “(i) the effects of systemic, institu-
 18 tional, and interpersonal racism on the
 19 health, well-being, and outcomes of birth-
 20 ing people;

21 “(ii) the importance of respectful, cul-
 22 turally and linguistically appropriate, and
 23 culturally congruent care; and

1 “(iii) the value of community-based
 2 and community-led maternal care and sup-
 3 port; and

4 “(I) is pilot tested for consumer com-
 5 prehension, cultural sensitivity, and acceptance
 6 of the messages across geographically, racially,
 7 ethnically, and linguistically diverse popu-
 8 lations;”.

9 **SEC. 5216. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
 10 **VIEWS FOR CARE OF CHILDBEARING INDI-**
 11 **VIDUALS AND NEWBORNS.**

12 (a) IN GENERAL.—Not later than 1 year after the
 13 date of enactment of this Act, the Secretary of Health and
 14 Human Services, acting through the Director of the Agen-
 15 cy for Healthcare Research and Quality, shall—

16 (1) make publicly available an online biblio-
 17 graphic database identifying systematic reviews, in-
 18 cluding an explanation of the level and quality of
 19 evidence, for care of childbearing individuals and
 20 newborns; and

21 (2) initiate regular updates that incorporate
 22 newly issued and updated systematic reviews.

23 (b) SOURCES.—To aim for a comprehensive inventory
 24 of systematic reviews relevant to maternal and newborn

1 care, the database shall identify reviews from diverse
 2 sources, including—

- 3 (1) scientific peer-reviewed journals;
- 4 (2) databases, including the Cochrane Database
 5 of Systematic Reviews; and
- 6 (3) internet websites of agencies and organiza-
 7 tions throughout the world that produce such sys-
 8 tematic reviews.

9 (c) FEATURES.—The database shall—

- 10 (1) provide bibliographic citations for each
 11 record within the database, and for each such cita-
 12 tion include an explanation of the level and quality
 13 of evidence;
- 14 (2) include abstracts, as available;
- 15 (3) provide reference to companion documents
 16 as may exist for each review, such as evidence tables
 17 and guidelines or consumer educational materials de-
 18 veloped from the review;
- 19 (4) provide links to the source of the full review
 20 and to any companion documents;
- 21 (5) provide links to the source of a previous
 22 version or update of the review;
- 23 (6) be searchable by intervention or other topic
 24 of the review, reported outcomes, author, title, and
 25 source; and

1 (7) offer to users periodic electronic notification
2 of database updates relating to users' topics of inter-
3 est.

4 (d) OUTREACH.—Not later than the first date the
5 database is made publicly available and periodically there-
6 after, the Secretary of Health and Human Services shall
7 publicize the availability, features, and uses of the data-
8 base under this section to the stakeholders described in
9 subsection (e).

10 (e) CONSULTATION.—For purposes of developing the
11 database under this section and maintaining and updating
12 such database, the Secretary of Health and Human Serv-
13 ices shall convene and consult with an advisory committee
14 composed of relevant stakeholders, including—

15 (1) Federal Medicaid administrators and State
16 agencies administering State plans under title XIX
17 of the Social Security Act pursuant to section
18 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

19 (2) providers of maternity and newborn care
20 from both academic and community-based settings,
21 including obstetrician-gynecologists, family physi-
22 cians, certified nurse midwives, certified midwives,
23 certified professional midwives, physician assistants,
24 perinatal nurses, pediatricians, and nurse practi-
25 tioners;

1 (3) maternal-fetal medicine specialists;

2 (4) neonatologists;

3 (5) childbearing individuals and advocates for
4 such individuals, including childbirth educators cer-
5 tified by a nationally accredited program, rep-
6 resenting communities that are diverse in terms of
7 race, ethnicity, indigenous status, and geographic
8 area;

9 (6) employers and purchasers;

10 (7) health facility and system leaders, including
11 both hospital and birth center facilities;

12 (8) journalists; and

13 (9) bibliographic informatics specialists.

14 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated \$2,500,000 for each of fis-
16 cal years 2027 through 2029 for the purpose of developing
17 the database and such sums as may be necessary for each
18 subsequent fiscal year for updating the database and pro-
19 viding outreach and notification to users, as described in
20 this section.

21 **SEC. 5217. DEVELOPMENT OF INTERPROFESSIONAL MA-**
22 **TERNITY CARE EDUCATIONAL MODELS AND**
23 **TOOLS.**

24 (a) IN GENERAL.—Not later than 180 days after the
25 date of enactment of this Act, the Secretary of Health and

1 Human Services, acting in conjunction with the Adminis-
2 trator of the Health Resources and Services Administra-
3 tion, shall convene, for a 1-year period, an Interprofes-
4 sional Maternity Provider Education Commission (re-
5 ferred to in this section as the “Commission”) to discuss
6 and make recommendations for—

7 (1) a consensus standard physiologic maternity
8 care curriculum that takes into account the core
9 competencies for basic midwifery practice such as
10 those developed by the American College of Nurse-
11 Midwives and the North American Registry of Mid-
12 wives, and the educational objectives for physicians
13 practicing in obstetrics and gynecology as deter-
14 mined by the Council on Resident Education in Ob-
15 stetrics and Gynecology;

16 (2) suggestions for multidisciplinary use of the
17 consensus physiologic curriculum;

18 (3) strategies to integrate and coordinate edu-
19 cation across maternity care disciplines, including
20 recommendations to increase medical and midwifery
21 student exposure to out-of-hospital birth;

22 (4) curriculum and strategies for continuing
23 education of practicing perinatal professionals who
24 have completed their undergraduate and graduate
25 education; and

1 (5) pilot demonstrations of interprofessional
2 educational models.

3 (b) PARTICIPANTS.—

4 (1) PROFESSIONS.—The Commission shall in-
5 clude maternity care educators, curriculum devel-
6 opers, service leaders, certification leaders, and ac-
7 creditation leaders from the various professions that
8 provide or support maternity care in the United
9 States. Such professions shall include obstetrician
10 gynecologists, certified nurse midwives or certified
11 midwives, family practice physicians, nurse practi-
12 tioners, physician assistants, certified professional
13 midwives, perinatal nurses, doulas, lactation per-
14 sonnel, and community health workers.

15 (2) CONSUMER ADVOCATES.—The Commission
16 shall also include representation from maternity care
17 consumer advocates.

18 (c) CURRICULUM.—The consensus standard physio-
19 logic maternity care curriculum described in subsection
20 (a)(1) shall—

21 (1) have a public health focus with a foundation
22 in health promotion and disease prevention;

23 (2) foster physiologic childbearing and person
24 and family centered care;

1 (3) reflect the extensive, growing research evi-
2 dence about—

3 (A) the innate abilities and processes of
4 the birthing person and the fetus or newborn
5 for labor, birth, postpartum transition,
6 breastfeeding, and attachment, when promoted,
7 supported, and protected; and

8 (B) the effects of factors that disturb and
9 disrupt these processes;

10 (4) integrate strategies to reduce maternal and
11 infant morbidity and mortality;

12 (5) incorporate recommendations to ensure re-
13 spectful, safe, and seamless consultation, referral,
14 transport, and transfer of care when necessary;

15 (6) include cultural sensitivity and strategies to
16 decrease inequities in maternity outcomes; and

17 (7) include implicit bias training.

18 (d) REPORT.—Not later than 180 days after the final
19 meeting of the Commission, the Secretary of Health and
20 Human Services shall—

21 (1) submit to Congress a report containing the
22 recommendations made by the Commission under
23 this section; and

24 (2) make such report publicly available.

1 (e) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this sec-
3 tion—

4 (1) \$1,000,000 for each of fiscal years 2027
5 and 2028; and

6 (2) such sums as are necessary for each of fis-
7 cal years 2029 through 2031.

8 **SEC. 5218. DISSEMINATION OF THE QUALITY FAMILY PLAN-**
9 **NING GUIDELINES.**

10 (a) IN GENERAL.—Not later than 180 days after the
11 date of enactment of this Act, the Secretary of Health and
12 Human Services and the Director of the Centers for Dis-
13 ease Control and Prevention shall—

14 (1) develop a plan for outreach to publicly fund-
15 ed health care providers, including federally qualified
16 health centers (as defined in section 1861(aa)(4) of
17 the Social Security Act (42 U.S.C. 1395x(aa)(4)))
18 and branches of the Indian Health Service, about
19 the quality family planning guidelines referred to in
20 section 5304; and

21 (2) award grants to eligible entities to imple-
22 ment such guidelines for all patients seeking family
23 planning services.

1 (b) DEFINITION.—In this section, the term “eligible
2 entity” means a publicly funded health care provider that
3 serves persons of reproductive age.

4 **Subtitle D—Federal Agency** 5 **Coordination on Maternal Health**

6 **SEC. 5301. INTERAGENCY COORDINATING COMMITTEE ON** 7 **THE PROMOTION OF OPTIMAL MATERNITY** 8 **OUTCOMES.**

9 (a) IN GENERAL.—Part A of title II of the Public
10 Health Service Act (42 U.S.C. 202 et seq.) is amended
11 by adding at the end the following:

12 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON** 13 **THE PROMOTION OF OPTIMAL MATERNITY** 14 **OUTCOMES.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Deputy Assistant Secretary for Women’s Health under
17 section 229 and in collaboration with the Federal officials
18 specified in subsection (b), shall establish the Interagency
19 Coordinating Committee on the Promotion of Optimal Ma-
20 ternity Outcomes (referred to in this section as the
21 ‘ICCPOM’).

22 “(b) OTHER AGENCIES.—The officials specified in
23 this subsection are the Secretary of Labor, the Secretary
24 of Defense, the Secretary of Veterans Affairs, the Surgeon
25 General, the Director of the Centers for Disease Control

1 and Prevention, the Administrator of the Health Re-
2 sources and Services Administration, the Administrator of
3 the Centers for Medicare & Medicaid Services, the Direc-
4 tor of the Indian Health Service, the Assistant Secretary
5 for Mental Health and Substance Use, the Director of the
6 National Institute of Child Health and Human Develop-
7 ment, the Director of the Agency for Healthcare Research
8 and Quality, the Assistant Secretary for Children and
9 Families, the Deputy Assistant Secretary for Minority
10 Health, the Director of the Office of Personnel Manage-
11 ment, and such other Federal officials as the Secretary
12 of Health and Human Services determines to be appro-
13 priate.

14 “(c) CHAIR.—The Deputy Assistant Secretary for
15 Women’s Health shall serve as the chair of the ICCPOM.

16 “(d) DUTIES.—The ICCPOM shall guide policy and
17 program development across the Federal Government with
18 respect to promotion of optimal maternity care. Nothing
19 in this section shall be construed as transferring regu-
20 latory or program authority from an agency to the
21 ICCPOM.

22 “(e) CONSULTATIONS.—The ICCPOM shall actively
23 seek the input of, and shall consult with, all appropriate
24 and interested stakeholders, including State health depart-
25 ments, public health research and interest groups, founda-

1 tions, childbearing individuals and their advocates, and
 2 maternity care professional associations and organiza-
 3 tions, reflecting racially, ethnically, demographically, and
 4 geographically diverse communities.

5 “(f) ANNUAL REPORT.—

6 “(1) IN GENERAL.—The Secretary, on behalf of
 7 the ICCPOM, shall annually submit to Congress a
 8 report that summarizes—

9 “(A) all programs and policies of Federal
 10 agencies (including the Medicare program
 11 under title XVIII of the Social Security Act and
 12 the Medicaid program under title XIX of such
 13 Act) designed to promote optimal maternity
 14 care, focusing particularly on programs and
 15 policies that support the adoption of evidence-
 16 based maternity care, as defined by timely, sci-
 17 entifically sound systematic reviews;

18 “(B) all programs and policies of Federal
 19 agencies (including the Medicare program
 20 under title XVIII of the Social Security Act and
 21 the Medicaid program under title XIX of such
 22 Act) designed to address the problems of mater-
 23 nal mortality and morbidity, infant mortality,
 24 prematurity, and low birth weight, including
 25 such programs and policies designed to address

1 racial and ethnic inequities with respect to each
 2 of such problems;

3 “(C) the extent of progress in reducing
 4 maternal mortality and infant mortality, low
 5 birth weight, and prematurity at State and na-
 6 tional levels; and

7 “(D) such other information regarding op-
 8 timal maternity care (such as quality and per-
 9 formance measures) as the Secretary deter-
 10 mines to be appropriate.

11 “(2) REDUCING INEQUITIES WITH RESPECT TO
 12 INDIGENOUS STATUS.—The information specified in
 13 paragraph (1)(C) shall be included in each such re-
 14 port in a manner that disaggregates such informa-
 15 tion by race, ethnicity, and indigenous status in
 16 order to determine the extent of progress in reduc-
 17 ing racial and ethnic inequities and inequities related
 18 to indigenous status.

19 “(3) CERTAIN INFORMATION.—Each report
 20 under paragraph (1) shall include information
 21 (disaggregated by race, ethnicity, and indigenous
 22 status, as applicable) on the following rates, trends,
 23 and costs by State:

24 “(A) The rate and trend of primary cesar-
 25 ean deliveries and repeat cesarean deliveries.

1 “(B) The rate and trend of vaginal births
2 after cesarean.

3 “(C) The rate and trend of vaginal breech
4 births.

5 “(D) The rate and trend of induction of
6 labor.

7 “(E) The rate and trend of freestanding
8 birth center births.

9 “(F) The rate and trend of planned and
10 unplanned home birth.

11 “(G) The rate and trends of attended
12 births by different types of maternity care pro-
13 viders, including by an obstetrician-gyne-
14 cologist, family practice physician, obstetrician-
15 gynecologist, physician assistant, certified
16 nurse-midwife, certified midwife, and certified
17 professional midwife.

18 “(H) The rate and trend of severe mater-
19 nal morbidity.

20 “(I) The rates and trends of prenatal and
21 postpartum anxiety and depression.

22 “(J) The rate and trend of preterm birth.

23 “(K) The rate and trend of low birth
24 weight.

1 “(L) The cost of maternity care
2 disaggregated by place of birth and provider of
3 care, including—

4 “(i) uncomplicated vaginal birth;

5 “(ii) complicated vaginal birth;

6 “(iii) uncomplicated cesarean birth;

7 and

8 “(iv) complicated cesarean birth.

9 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
10 is authorized to be appropriated, in addition to amounts
11 authorized to be appropriated under section 229(e), to
12 carry out this section \$1,000,000 for each of the fiscal
13 years 2027 through 2031.”.

14 (b) CONFORMING AMENDMENTS.—

15 (1) INCLUSION AS DUTY OF HHS OFFICE ON
16 WOMEN’S HEALTH.—Section 229(b) of the Public
17 Health Service Act (42 U.S.C. 237a(b)) (as amend-
18 ed by section 5215) is amended by adding at the end
19 the following:

20 “(9) establish the Interagency Coordinating
21 Committee on the Promotion of Optimal Maternity
22 Outcomes in accordance with section 229A; and”.

23 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
24 tion 229(d) of such Act (42 U.S.C. 237a(d)) is

1 amended by inserting “(other than under subsection
2 (b)(9))” after “under this section”.

3 **SEC. 5302. EXPANSION OF CDC PREVENTION RESEARCH**
4 **CENTERS PROGRAM TO INCLUDE CENTERS**
5 **ON OPTIMAL MATERNITY OUTCOMES.**

6 (a) IN GENERAL.—Not later than 1 year after the
7 date of enactment of this Act, the Secretary of Health and
8 Human Services shall support the establishment of addi-
9 tional Prevention Research Centers under the Prevention
10 Research Center Program administered by the Centers for
11 Disease Control and Prevention. Such additional centers
12 shall each be known as a Center for Excellence on Optimal
13 Maternity Outcomes.

14 (b) RESEARCH.—Each Center for Excellence on Opti-
15 mal Maternity Outcomes shall—

16 (1) conduct at least one focused program of re-
17 search to improve maternity outcomes, including the
18 reduction of cesarean birth rates, early elective in-
19 ductions, prematurity rates, and low birth weight
20 rates within an underserved population that has a
21 disproportionately large burden of suboptimal mater-
22 nity outcomes, including maternal mortality and
23 morbidity, infant mortality, prematurity, or low
24 birth weight, which such program shall include de-

1 veloping performance and quality measures for ac-
 2 countability;

3 (2) work with partners on special interest
 4 projects, as specified by the Centers for Disease
 5 Control and Prevention and other relevant agencies
 6 within the Department of Health and Human Serv-
 7 ices, and on projects funded by other sources; and
 8 (3) involve a minimum of two distinct birth set-
 9 ting models, such as—

10 (A) a hospital labor and delivery model
 11 and freestanding birth center model; or

12 (B) a hospital labor and delivery model
 13 and planned home birth model.

14 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
 15 for Excellence on Optimal Maternity Outcomes shall in-
 16 clude the following interdisciplinary providers of maternity
 17 care:

18 (1) Obstetrician-gynecologists.

19 (2) At least two of the following providers:

20 (A) Family practice physicians.

21 (B) Nurse practitioners.

22 (C) Physician assistants.

23 (D) Certified professional midwives, cer-
 24 tified nurse-midwives, or certified midwives.

1 (d) SERVICES.—Research conducted by each Center
2 for Excellence on Optimal Maternity Outcomes shall in-
3 clude at least 2 (and preferably more) of the following sup-
4 portive provider services:

- 5 (1) Mental health.
- 6 (2) Doula labor support.
- 7 (3) Nutrition education.
- 8 (4) Childbirth education.
- 9 (5) Social work.
- 10 (6) Physical therapy or occupation therapy.
- 11 (7) Substance use disorder services.
- 12 (8) Home visiting.

13 (e) COORDINATION.—The programs of research at
14 each of the Centers of Excellence on Optimal Maternity
15 Outcomes shall complement and not replicate the work of
16 the other.

17 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
18 authorized to be appropriated to carry out this section
19 \$2,000,000 for each of fiscal years 2027 through 2031.

1 **SEC. 5303. EXPANDING MODELS TO BE TESTED BY CENTER**
2 **FOR MEDICARE AND MEDICAID INNOVATION**
3 **TO EXPLICITLY INCLUDE MATERNITY CARE**
4 **AND CHILDREN'S HEALTH MODELS.**

5 Section 1115A(b)(2) of the Social Security Act (42
6 U.S.C. 1315a(b)(2)), as amended by section 5209(b), is
7 amended—

8 (1) in subparagraph (B), by adding at the end
9 the following:

10 “(xxix) Promoting evidence-based
11 models of care that have been associated
12 with reductions in pregnancy-related and
13 infant health inequities, including incor-
14 porating the use of and payment for
15 doulas, particularly community-based
16 doulas, and promoting support for people
17 during pregnancy and for the one-year pe-
18 riod after the last day of such person's
19 pregnancy, through evidence-based models
20 of antepartum, birth, postpartum care, and
21 two-generation birthing person and new-
22 born care models, and supporting the risk-
23 appropriate use of out-of-hospital birth
24 models, including births at home and in
25 freestanding birth centers. Such models
26 shall be selected and evaluated based on

1 their impact on quality, equity, and devel-
 2 opmental outcomes, notwithstanding any
 3 other provision of this section.”;

4 (2) in subparagraph (C), by adding at the end
 5 the following:

6 “(ix) Whether the model includes a
 7 regular process for ensuring the provision
 8 of culturally and linguistically appropriate
 9 services.

10 “(x) Whether health care services and
 11 supportive services included in the model
 12 are tailored to community health and
 13 health-related social needs and provided by
 14 community-based and community-led pro-
 15 viders.

16 “(xi) Whether the model is designed
 17 to mitigate harmful effects of discrimina-
 18 tion on the basis of race, sex, disability,
 19 ethnicity, language, and age.”; and

20 (3) by adding at the end the following:

21 “(D) MANDATORY HEALTH EQUITY MOD-
 22 ELS TO BE TESTED.—The Secretary shall se-
 23 lect—

24 “(i) Medicaid payment models for cul-
 25 turally and linguistically appropriate

1 antepartum, labor and delivery, and
 2 postpartum doula services, including com-
 3 munity-based doula services, that are—

4 “(I) structured to provide pay-
 5 ment to doulas as individuals, health
 6 care entity staff, or members of a
 7 doula group or collective, or through a
 8 third-party administrator;

9 “(II) designed to reduce racial
 10 and intersecting health inequities;

11 “(III) designed to provide doulas
 12 providing support with an equitable
 13 and sustainable reimbursement rate;

14 “(IV) designed to reduce barriers
 15 to workforce entry for culturally and
 16 linguistically competent and racially
 17 congruent doulas to provide services
 18 to Medicaid enrollees; and

19 “(V) designed with input from
 20 community-based doulas, maternal
 21 health advocates, reproductive justice
 22 advocates, and Medicaid beneficiaries;

23 “(ii) a Medicaid episode-based pay-
 24 ment model for pregnancy-related services,
 25 including health care services and sup-

1 portive services to address health-related
2 social needs, during the prenatal,
3 intrapartum, and postpartum periods, to
4 improve health outcomes and reduce racial
5 health inequities, and to be designed with
6 input from maternity care providers, ma-
7 ternal health advocates, reproductive jus-
8 tice advocates, and Medicaid beneficiaries;

9 “(iii) a Medicaid alternative payment
10 model for a pregnancy-related health home
11 service to improve health outcomes during
12 and for one year after pregnancy and dur-
13 ing the newborn period, and to reduce ra-
14 cial health inequities, designed with input
15 from maternity care providers, maternal
16 health advocates, reproductive justice advo-
17 cates, and Medicaid beneficiaries;

18 “(iv) a Medicaid perinatal health
19 worker service delivery model for culturally
20 and linguistically appropriate and respect-
21 ful health care and supportive services that
22 are tailored to community health and
23 health-related social needs, designed to im-
24 prove health outcomes and mitigate harm-
25 ful effects of racism and other forms of

discrimination, and provided by community-based and community-led providers; and

“(v) one or more models exclusively focused on early intervention and prevention for children enrolled in a State plan (or waiver of such plan) under title XIX or a State child health plan under title XXI using evidence-based interventions including parenting support programs, home-visiting services, and dyadic therapy treatment for children and adolescents at risk.

Such models shall be selected and evaluated based on their impact on quality, equity, and developmental outcomes, notwithstanding any other provision of this section.”.

SEC. 5304. INTERAGENCY UPDATE TO THE QUALITY FAMILY PLANNING GUIDELINES.

(a) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention and the Office of Population Affairs shall review and expand the 2014 Quality Family Planning Guidelines to address—

(1) health inequities; and

1 (2) the importance of patient-directed contra-
2 ceptive decision making.

3 (b) CONSULTATION.—In carrying out subsection (a),
4 the Director of the Centers for Disease Control and Pre-
5 vention and the Office of Population Affairs shall convene
6 a meeting, and solicit the views of, stakeholders including
7 experts on health inequities, experts on reproductive coer-
8 cion, representatives of provider organizations, patient ad-
9 vocates, reproductive justice organizations, organizations
10 that represent racial and ethnic minority communities, or-
11 ganizations that represent people with disabilities, organi-
12 zations that represent LGBTQ persons, and organizations
13 that represent people with limited English proficiency.

14 **Subtitle E—Reproductive and**
15 **Sexual Health**

16 **SEC. 5401. SENSE OF CONGRESS ON URGENT ISSUES CON-**
17 **CERNING BARRIERS TO ABORTION ACCESS**
18 **AND VITAL SOLUTIONS.**

19 It is the sense of Congress that eliminating the Hyde
20 amendment, enacting the Equal Access to Abortion Cov-
21 erage in Health Insurance Act of 2025, and enacting the
22 Women’s Health Protection Act of 2025, are critical to—

23 (1) promoting equitable abortion access, includ-
24 ing coverage, for all who seek care;

1 (2) creating enforceable rights to receive, and
2 receive coverage for, such care;

3 (3) advancing equitable access to comprehensive
4 health coverage, which cannot be achieved without
5 abortion coverage; and

6 (4) alleviating urgent racial, gender, and other
7 inequities in health and health care and cor-
8 responding reproductive injustices.

9 **SEC. 5402. EMERGENCY CONTRACEPTION EDUCATION AND**
10 **INFORMATION PROGRAMS.**

11 (a) EMERGENCY CONTRACEPTION PUBLIC EDU-
12 CATION PROGRAM.—

13 (1) IN GENERAL.—The Secretary, acting
14 through the Director of the Centers for Disease
15 Control and Prevention, shall develop and dissemi-
16 nate to the public medically accurate and complete
17 information on emergency contraceptives.

18 (2) DISSEMINATION.—The Secretary may dis-
19 seminate medically accurate and complete informa-
20 tion under paragraph (1) directly or through ar-
21 rangements with nonprofit organizations, community
22 health workers, including patient advocates, con-
23 sumer groups, institutions of higher education, clin-
24 ics, the media, and Federal, State, and local agen-
25 cies.

1 (3) INFORMATION.—The information dissemi-
2 nated under paragraph (1) shall—

3 (A) include, at a minimum, a description
4 of emergency contraceptives and an explanation
5 of the use, safety, efficacy, affordability, and
6 availability, including over-the-counter access,
7 of such contraceptives and options for access to
8 such contraceptives without cost-sharing
9 through insurance and other programs; and

10 (B) be pilot tested for consumer com-
11 prehension, cultural and linguistic appropriate-
12 ness, and acceptance of the messages across
13 geographically, racially, ethnically, and linguis-
14 tically diverse populations.

15 (b) EMERGENCY CONTRACEPTION INFORMATION
16 PROGRAM FOR HEALTH CARE PROVIDERS.—

17 (1) IN GENERAL.—The Secretary, acting
18 through the Administrator of the Health Resources
19 and Services Administration and in consultation
20 with major medical and public health organizations,
21 shall develop and disseminate to health care pro-
22 viders, including pharmacists, information on emer-
23 gency contraceptives.

1 (2) INFORMATION.—The information dissemi-
2 nated under paragraph (1) shall include, at a min-
3 imum—

4 (A) information describing the use, safety,
5 efficacy, and availability of emergency contra-
6 ceptives, and options for access without cost-
7 sharing through insurance and other programs;

8 (B) a recommendation regarding the use of
9 such contraceptives; and

10 (C) information explaining how to obtain
11 copies of the information developed under sub-
12 section (a) for distribution to the patients of
13 the providers.

14 (c) DEFINITIONS.—In this section:

15 (1) HEALTH CARE PROVIDER.—The term
16 “health care provider” means an individual who is li-
17 censed or certified under State law to provide health
18 care services and who is operating within the scope
19 of such license. Such term shall include a phar-
20 macist.

21 (2) INSTITUTION OF HIGHER EDUCATION.—The
22 term “institution of higher education” has the
23 meaning given such term in section 101(a) of the
24 Higher Education Act of 1965 (20 U.S.C. 1001(a)).

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

3 (d) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2027 through 2031.

7 **SEC. 5403. DUTIES OF PHARMACIES TO ENSURE PROVISION**
8 **OF FDA-APPROVED CONTRACEPTION.**

9 Part B of title II of the Public Health Service Act
10 (42 U.S.C. 238 et seq.) is amended by adding at the end
11 the following:

12 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
13 **OF FDA-APPROVED CONTRACEPTION.**

14 “(a) IN GENERAL.—Subject to subsection (c), a
15 pharmacy that receives Food and Drug Administration-
16 approved drugs or devices in interstate commerce shall
17 maintain compliance with each of the following:

18 “(1) If a customer requests a contraceptive or
19 a medication related to a contraceptive, including
20 emergency contraception, that is in stock, the phar-
21 macy shall ensure that the requested contraceptive
22 or medication is provided to the customer without
23 delay.

24 “(2) If a customer requests a contraceptive or
25 a medication related to a contraceptive that is not

1 in stock and the pharmacy in the normal course of
2 business stocks contraception, the pharmacy shall
3 immediately inform the customer that the requested
4 contraceptive or medication is not in stock and with-
5 out delay offer the customer the following options:

6 “(A) If the customer prefers to obtain the
7 requested contraceptive or medication through a
8 referral or transfer, the pharmacy shall—

9 “(i) locate a pharmacy of the cus-
10 tomer’s choice or the closest pharmacy
11 confirmed to have the requested contracep-
12 tive or medication in stock; and

13 “(ii) refer the customer or transfer
14 the prescription to that pharmacy.

15 “(B) If the customer prefers for the phar-
16 macy to order the requested contraceptive or
17 medication, the pharmacy shall obtain the con-
18 traceptive or medication under the pharmacy’s
19 standard procedure for expedited ordering of
20 medication and notify the customer when the
21 contraceptive or medication arrives.

22 “(3) The pharmacy shall ensure that—

23 “(A) the pharmacy does not operate an en-
24 vironment in which customers are intimidated,
25 threatened, or harassed in the delivery of serv-

1 ices relating to a request for contraception or a
2 medication related to a contraceptive;

3 “(B) the pharmacy’s employees do not
4 interfere with or obstruct the delivery of serv-
5 ices relating to a request for contraception or a
6 medication related to a contraceptive;

7 “(C) the pharmacy’s employees do not in-
8 tentionally misrepresent or deceive customers
9 about the availability of a contraceptive or a
10 medication related to a contraceptive, or the
11 mechanism of action of such contraceptive or
12 medication;

13 “(D) the pharmacy’s employees do not
14 breach medical confidentiality with respect to a
15 request for a contraceptive or a medication re-
16 lated to a contraceptive or threaten to breach
17 such confidentiality; or

18 “(E) the pharmacy’s employees do not
19 refuse to return a valid, lawful prescription for
20 a contraceptive or a medication related to a
21 contraceptive upon customer request.

22 “(b) CONTRACEPTIVES NOT ORDINARILY
23 STOCKED.—Nothing in subsection (a)(2) shall be con-
24 strued to require any pharmacy to comply with such sub-
25 section if the pharmacy does not ordinarily stock contra-

1 ceptives or medications related to contraceptives, as the
2 case may be, in the normal course of business.

3 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
4 MACY PRACTICE.—This section does not prohibit a phar-
5 macy from refusing to provide a contraceptive or a medi-
6 cation related to a contraceptive to a customer in accord-
7 ance with any of the following:

8 “(1) If it is unlawful to dispense the requested
9 contraceptive or medication to the customer without
10 a valid, lawful prescription and no such prescription
11 is presented.

12 “(2) If the customer is unable to pay for the re-
13 quested contraceptive or medication.

14 “(3) If the employee of the pharmacy refuses to
15 provide the requested contraceptive or medication on
16 the basis of a professional clinical judgment.

17 “(d) RELATION TO OTHER LAW.—

18 “(1) RULE OF CONSTRUCTION.—Nothing in
19 this section shall be construed to invalidate or limit
20 rights, remedies, procedures, or legal standards
21 under title VII of the Civil Rights Act of 1964.

22 “(2) CERTAIN CLAIMS.—The Religious Free-
23 dom Restoration Act of 1993 shall not provide a
24 basis for a claim concerning, or a defense to a claim

1 under, this section, or provide a basis for challenging
2 the application or enforcement of this section.

3 “(e) PREEMPTION.—This section does not preempt
4 any provision of State law or affect any professional obli-
5 gation made applicable by a State board or other entity
6 responsible for licensing or discipline of pharmacies or
7 pharmacists, to the extent that such State law or profes-
8 sional obligation provides protections for customers that
9 are greater than the protections provided by this section.

10 “(f) ENFORCEMENT.—

11 “(1) CIVIL PENALTY.—A pharmacy that vio-
12 lates a requirement of subsection (a) is liable to the
13 United States for a civil penalty in an amount not
14 exceeding \$1,000 per day of violation, not to exceed
15 \$100,000 for all violations adjudicated in a single
16 proceeding.

17 “(2) PRIVATE CAUSE OF ACTION.—Any person
18 aggrieved as a result of a violation of a requirement
19 of subsection (a) may, in any court of competent ju-
20 risdiction, commence a civil action against the phar-
21 macy involved to obtain appropriate relief, including
22 actual and punitive damages, injunctive relief, and a
23 reasonable attorney’s fee and costs.

24 “(3) LIMITATIONS.—A civil action under para-
25 graph (1) or (2) may not be commenced against a

1 pharmacy after the expiration of the 5-year period
2 beginning on the date on which the pharmacy alleg-
3 edly engaged in the violation involved.

4 “(g) DEFINITIONS.—In this section:

5 “(1) CONTRACEPTION.—The term ‘contracep-
6 tion’ or ‘contraceptive’ means any drug or device ap-
7 proved by the Food and Drug Administration to pre-
8 vent pregnancy.

9 “(2) EMPLOYEE.—The term ‘employee’ means
10 a person hired, by contract or any other form of an
11 agreement, by a pharmacy.

12 “(3) MEDICATION RELATED TO A CONTRACEP-
13 TIVE.—The term ‘medication related to a contracep-
14 tive’ means any drug or device approved by the Food
15 and Drug Administration that a medical professional
16 determines necessary to use before or in conjunction
17 with use of a contraceptive.

18 “(4) PHARMACY.—The term ‘pharmacy’ means
19 an entity that—

20 “(A) is authorized by a State to engage in
21 the business of selling prescription drugs at re-
22 tail; and

23 “(B) employs one or more employees.

1 “(5) PRODUCT.—The term ‘product’ means a
2 Food and Drug Administration-approved drug or de-
3 vice.

4 “(6) PROFESSIONAL CLINICAL JUDGMENT.—
5 The term ‘professional clinical judgment’ means a
6 clinical judgment, formed with the use of profes-
7 sional knowledge and skills, in accordance with pre-
8 vailing medical standards.

9 “(7) WITHOUT DELAY.—The term ‘without
10 delay’, with respect to a pharmacy providing, pro-
11 viding a referral for, or ordering contraception, or
12 transferring the prescription for contraception,
13 means within the usual and customary timeframe at
14 the pharmacy for providing, providing a referral for,
15 or ordering other products, or transferring the pre-
16 scription for other products, respectively.

17 “(h) EFFECTIVE DATE.—This section shall take ef-
18 fect on the 31st day after the date of the enactment of
19 this section, without regard to whether the Secretary has
20 issued any guidance or final rule regarding this section.”.

21 **SEC. 5404. REAL EDUCATION AND ACCESS FOR HEALTHY**
22 **YOUTH ACT.**

23 (a) SHORT TITLE.—This section may be cited as the
24 “Real Education and Access for Healthy Youth Act”.

25 (b) DEFINITIONS.—In this section:

1 (1) AGE AND DEVELOPMENTALLY APPRO-
 2 PRIATE.—The term “age and developmentally appro-
 3 priate” means topics, messages, and teaching meth-
 4 ods suitable to particular ages, age groups, or devel-
 5 opmental levels, based on cognitive, emotional, so-
 6 cial, and behavioral capacity of most young people at
 7 that age level.

8 (2) CONSENT.—The term “consent” means af-
 9 firmative, conscious, and voluntary agreement to en-
 10 gage in interpersonal, physical, or sexual activity.

11 (3) CULTURALLY RESPONSIVE.—The term “cul-
 12 turally responsive” means education and services
 13 that—

14 (A) embrace and actively engage and ad-
 15 just to young people and their various cultural
 16 identities;

17 (B) recognize the ways in which many
 18 marginalized young people face unique barriers
 19 in society that result in increased adverse
 20 health outcomes and associated stereotypes; and

21 (C) may address the ways in which racism
 22 has shaped national health care policy, the last-
 23 ing historical trauma associated with reproduc-
 24 tive health experiments and forced sterilizations
 25 of Black, Latine, and Indigenous communities,

1 or sexual stereotypes assigned to young People
2 of Color or LGBTQ+ people.

3 (4) EVIDENCE-INFORMED.—The term “evi-
4 dence-informed” means incorporates characteristics,
5 content, or skills that have been proven to be effec-
6 tive through evaluation in changing sexual behavior.

7 (5) GENDER EXPRESSION.—The term “gender
8 expression” means the expression of one’s gender,
9 such as through behavior, clothing, haircut, or voice,
10 and which may or may not conform to socially de-
11 fined behaviors and characteristics typically associ-
12 ated with being either masculine or feminine.

13 (6) GENDER IDENTITY.—The term “gender
14 identity” means the gender-related identity, appear-
15 ance, mannerisms, or other gender-related character-
16 istics of an individual, regardless of the individual’s
17 designated sex at birth.

18 (7) INCLUSIVE.—The term “inclusive” means
19 content and skills that ensure marginalized young
20 people are valued, respected, centered, and sup-
21 ported in sex education instruction and materials.

22 (8) INSTITUTION OF HIGHER EDUCATION.—The
23 term “institution of higher education” has the
24 meaning given the term in section 101 of the Higher
25 Education Act of 1965 (20 U.S.C. 1001).

1 (9) INTERPERSONAL VIOLENCE.—The term
 2 “interpersonal violence” means abuse, assault, bul-
 3 lying, dating violence, domestic violence, harassment,
 4 intimate partner violence, or stalking.

5 (10) LOCAL EDUCATIONAL AGENCY.—The term
 6 “local educational agency” has the meaning given
 7 the term in section 8101 of the Elementary and Sec-
 8 ondary Education Act of 1965 (20 U.S.C. 7801).

9 (11) MARGINALIZED YOUNG PEOPLE.—The
 10 term “marginalized young people” means young peo-
 11 ple who are disadvantaged by underlying structural
 12 barriers and social inequities, including young people
 13 who are—

14 (A) Black, Indigenous, Latine, Asian
 15 American, Native Hawaiian, Pacific Islander,
 16 and other People of Color;

17 (B) immigrants;

18 (C) in contact with the foster care system;

19 (D) in contact with the juvenile justice sys-
 20 tem;

21 (E) experiencing homelessness;

22 (F) pregnant or parenting;

23 (G) lesbian, gay, bisexual, transgender, or
 24 queer;

25 (H) living with HIV;

1 (I) living with disabilities;

2 (J) from families with low-incomes; or

3 (K) living in rural areas.

4 (12) MEDICALLY ACCURATE AND COMPLETE.—

5 The term “medically accurate and complete” means
6 that—

7 (A) the information provided through the
8 education is verified or supported by the weight
9 of research conducted in compliance with ac-
10 cepted scientific methods and is published in
11 peer-reviewed journals, where applicable; or

12 (B) the education contains information
13 that leading professional organizations and
14 agencies with relevant expertise in the field rec-
15 ognize as accurate, objective, and complete.

16 (13) RESILIENCE.—The term “resilience”
17 means the ability to adapt to trauma and tragedy.

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

20 (15) SEX EDUCATION.—The term “sex edu-
21 cation” means high quality teaching and learning
22 that—

23 (A) is delivered, to the maximum extent
24 practicable, following the National Sexuality

1 Education Standards of the Future of Sex Ed
 2 Initiative;

3 (B) is about a broad variety of topics re-
 4 lated to sex and sexuality, including—

5 (i) puberty and adolescent develop-
 6 ment;

7 (ii) sexual and reproductive anatomy
 8 and physiology;

9 (iii) sexual orientation, gender iden-
 10 tity, and gender expression;

11 (iv) contraception, pregnancy, preg-
 12 nancy options, and reproduction;

13 (v) HIV and other STIs;

14 (vi) consent and healthy relationships;

15 and

16 (vii) interpersonal violence;

17 (C) explores values and beliefs about such
 18 topics; and

19 (D) helps young people in gaining the
 20 skills that are needed to navigate relationships
 21 and manage one's own sexual health.

22 (16) SEXUAL HEALTH SERVICES.—The term
 23 “sexual health services” includes—

24 (A) sexual health information, education,
 25 and counseling;

1 (B) all methods of contraception approved
2 by the Food and Drug Administration;

3 (C) routine gynecological care, including
4 human papillomavirus (HPV) vaccines and can-
5 cer screenings;

6 (D) pre-exposure prophylaxis or post-expo-
7 sure prophylaxis;

8 (E) substance use and mental health serv-
9 ices;

10 (F) interpersonal violence survivor services;
11 and

12 (G) other pregnancy and STI prevention,
13 care, or treatment services.

14 (17) SEXUAL ORIENTATION.—The term “sexual
15 orientation” means an individual’s romantic, emo-
16 tional, or sexual attraction to other people.

17 (18) STATE EDUCATIONAL AGENCY.—The term
18 “State educational agency” has the meaning given
19 the term in section 8101 of the Elementary and Sec-
20 ondary Education Act of 1965 (20 U.S.C. 7801).

21 (19) TRAUMA.—The term “trauma” means a
22 response to an event, series of events, or set of cir-
23 cumstances that is experienced or witnessed by an
24 individual or group of people as physically or emo-
25 tionally harmful or life-threatening with lasting ad-

1 verse effects on their functioning and mental, phys-
2 ical, social, emotional, or spiritual well-being.

3 (20) TRAUMA-INFORMED AND RESILIENCE-ORI-
4 ENTED.—The term “trauma-informed and resil-
5 ience-oriented” means an approach that realizes the
6 prevalence of trauma, recognizes the various ways
7 individuals, organizations, and communities may re-
8 spond to trauma differently, recognizes that resil-
9 ience can be built, and responds by putting this
10 knowledge into practice.

11 (21) YOUNG PEOPLE.—The term “young peo-
12 ple” means individuals who are ages 10 through 29
13 at the time of commencement of participation in a
14 project supported under this section.

15 (22) YOUTH-FRIENDLY SEXUAL HEALTH SERV-
16 ICES.—The term “youth-friendly sexual health serv-
17 ices” means sexual health services that are provided
18 in a confidential, equitable, and accessible manner
19 that makes it easy and comfortable for young people
20 to seek out and receive services.

21 (c) GRANTS FOR SEX EDUCATION AT ELEMENTARY
22 AND SECONDARY SCHOOLS AND YOUTH-SERVING ORGA-
23 NIZATIONS.—

24 (1) PROGRAM AUTHORIZED.—The Secretary, in
25 coordination with the Secretary of Education, shall

1 award grants, on a competitive basis, to eligible enti-
2 ties to enable such eligible entities to carry out
3 projects that provide young people with sex edu-
4 cation.

5 (2) DURATION.—Grants awarded under this
6 section shall be for a period of 5 years.

7 (3) ELIGIBLE ENTITY.—In this section, the
8 term “eligible entity” means a public or private enti-
9 ty that delivers evidence-based sex education to
10 young people.

11 (4) APPLICATIONS.—An eligible entity desiring
12 a grant under this section shall submit an applica-
13 tion to the Secretary at such time, in such manner,
14 and containing such information as the Secretary
15 may require.

16 (5) PRIORITY.—In awarding grants under this
17 section, the Secretary shall give priority to eligible
18 entities that are—

19 (A) State educational agencies or local
20 educational agencies; or

21 (B) Indian Tribes or Tribal organizations,
22 as defined in section 4 of the Indian Self-Deter-
23 mination and Education Assistance Act (25
24 U.S.C. 5304).

1 (6) USE OF FUNDS.—Each eligible entity that
2 receives a grant under this section shall use the
3 grant funds to carry out a project that provides
4 young people with sex education.

5 (d) GRANTS FOR SEX EDUCATION AT INSTITUTIONS
6 OF HIGHER EDUCATION.—

7 (1) PROGRAM AUTHORIZED.—The Secretary, in
8 coordination with the Secretary of Education, shall
9 award grants, on a competitive basis, to institutions
10 of higher education or consortia of such institutions
11 to enable such institutions to provide students with
12 age and developmentally appropriate sex education.

13 (2) DURATION.—Grants awarded under this
14 section shall be for a period of 5 years.

15 (3) APPLICATIONS.—An institution of higher
16 education or consortium of such institutions desiring
17 a grant under this section shall submit an applica-
18 tion to the Secretary at such time, in such manner,
19 and containing such information as the Secretary
20 may require.

21 (4) PRIORITY.—In awarding grants under this
22 section, the Secretary shall give priority to an insti-
23 tution of higher education that—

1 (A) has an enrollment of needy students,
2 as defined in section 318(b) of the Higher Edu-
3 cation Act of 1965 (20 U.S.C. 1059e(b));

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

7 (C) is a Tribal College or University, as
8 defined in section 316(b) of such Act (20
9 U.S.C. 1059c(b));

10 (D) is an Alaska Native-serving institution,
11 as defined in section 317(b) of such Act (20
12 U.S.C. 1059d(b));

13 (E) is a Native Hawaiian-serving institu-
14 tion, as defined in section 317(b) of such Act
15 (20 U.S.C. 1059d(b));

16 (F) is a Predominantly Black Institution,
17 as defined in section 318(b) of such Act (20
18 U.S.C. 1059e(b));

19 (G) is a Native American-serving, non-
20 tribal institution, as defined in section 319(b)
21 of such Act (20 U.S.C. 1059f(b));

22 (H) is an Asian American and Native
23 American Pacific Islander-serving institution, as
24 defined in section 320(b) of such Act (20
25 U.S.C. 1059g(b)); or

1 (I) is a minority institution, as defined in
2 section 365 of such Act (20 U.S.C. 1067k),
3 with an enrollment of needy students, as de-
4 fined in section 312 of such Act (20 U.S.C.
5 1058).

6 (5) USES OF FUNDS.—An institution of higher
7 education or consortium of such institutions receiv-
8 ing a grant under this section shall use grant funds
9 to develop and implement a project to integrate sex
10 education into the institution of higher education in
11 order to reach a large number of students, by car-
12 rying out 1 or more of the following activities:

13 (A) Adopting and incorporating age and
14 developmentally appropriate sex education into
15 student orientation, general education, or
16 courses.

17 (B) Developing or adopting and imple-
18 menting educational programming outside of
19 class that delivers age and developmentally ap-
20 propriate sex education to students.

21 (C) Developing or adopting and imple-
22 menting innovative technology-based approaches
23 to deliver age and developmentally appropriate
24 sex education to students.

(D) Developing or adopting and implementing peer-led activities to generate discussion, educate, and raise awareness among students about age and developmentally appropriate sex education.

(E) Developing or adopting and implementing policies and practices to link students to sexual health services.

(e) GRANTS FOR EDUCATOR TRAINING.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Secretary of Education, shall award grants, on a competitive basis, to eligible entities to enable such eligible entities to carry out the activities described in paragraph (5).

(2) DURATION.—Grants awarded under this section shall be for a period of 5 years.

(3) ELIGIBLE ENTITY.—In this section, the term “eligible entity” means—

(A) a State educational agency or local educational agency;

(B) an Indian Tribe or Tribal organization, as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304);

(C) a State or local department of health;

1 (D) an educational service agency, as de-
2 fined in section 8101 of the Elementary and
3 Secondary Education Act of 1965 (20 U.S.C.
4 7801);

5 (E) a nonprofit institution of higher edu-
6 cation or a consortium of such institutions; or

7 (F) a national or statewide nonprofit orga-
8 nization or consortium of nonprofit organiza-
9 tions that has as its primary purpose the im-
10 provement of provision of sex education through
11 training and effective teaching of sex education.

12 (4) APPLICATION.—An eligible entity desiring a
13 grant under this section shall submit an application
14 to the Secretary at such time, in such manner, and
15 containing such information as the Secretary may
16 require.

17 (5) AUTHORIZED ACTIVITIES.—

18 (A) REQUIRED ACTIVITY.—Each eligible
19 entity receiving a grant under this section shall
20 use grant funds for professional development
21 and training of relevant teachers, health edu-
22 cators, faculty, administrators, and staff, in
23 order to increase effective teaching of sex edu-
24 cation to young people.

1 (B) PERMISSIBLE ACTIVITIES.—Each eligi-
2 ble entity receiving a grant under this section
3 may use grant funds to—

4 (i) provide training and support for
5 educators about the content, skills, and
6 professional disposition needed to imple-
7 ment sex education effectively;

8 (ii) develop and provide training and
9 support to educators on incorporating anti-
10 racist and gender inclusive policies and
11 practices in sex education;

12 (iii) support the dissemination of in-
13 formation on effective practices and re-
14 search findings concerning the teaching of
15 sex education;

16 (iv) support research on—

17 (I) effective sex education teach-
18 ing practices; and

19 (II) the development of assess-
20 ment instruments and strategies to
21 document—

22 (aa) young people’s under-
23 standing of sex education; and

24 (bb) the effects of sex edu-
25 cation;

1 (v) convene conferences on sex edu-
2 cation, in order to effectively train edu-
3 cators in the provision of sex education;
4 and

5 (vi) develop and disseminate appro-
6 priate research-based materials to foster
7 sex education.

8 (C) SUBGRANTS.—Each eligible entity re-
9 ceiving a grant under this section may award
10 subgrants to nonprofit organizations that pos-
11 sess a demonstrated record of providing train-
12 ing to teachers, health educators, faculty, ad-
13 ministrators, and staff on sex education to—

14 (i) train educators in sex education;

15 (ii) support internet or distance learn-
16 ing related to sex education;

17 (iii) promote rigorous academic stand-
18 ards and assessment techniques to guide
19 and measure student performance in sex
20 education;

21 (iv) encourage replication of best
22 practices and model programs to promote
23 sex education;

1 (v) develop and disseminate effective,
 2 research-based sex education learning ma-
 3 terials; or

4 (vi) develop academic courses on the
 5 pedagogy of sex education at institutions
 6 of higher education.

7 (f) AUTHORIZATION OF GRANTS TO SUPPORT THE
 8 DELIVERY OF SEXUAL HEALTH SERVICES TO
 9 MARGINALIZED YOUNG PEOPLE.—

10 (1) PROGRAM AUTHORIZED.—The Secretary
 11 shall award grants, on a competitive basis, to eligible
 12 entities to enable such entities to provide youth-
 13 friendly sexual health services to marginalized young
 14 people.

15 (2) DURATION.—Grants awarded under this
 16 section shall be for a period of 5 years.

17 (3) ELIGIBLE ENTITY.—In this section, the
 18 term “eligible entity” means—

19 (A) a public or private youth-serving orga-
 20 nization; or

21 (B) a covered entity, as defined in section
 22 340B of the Public Health Service Act (42
 23 U.S.C. 256b).

24 (4) APPLICATIONS.—An eligible entity desiring
 25 a grant under this section shall submit an applica-

1 tion to the Secretary at such time, in such manner,
2 and containing such information as the Secretary
3 may require.

4 (5) USES OF FUNDS.—Each eligible entity that
5 receives a grant under this section may use the
6 grant funds to—

7 (A) develop and implement an evidence-in-
8 formed project to deliver sexual health services
9 to marginalized young people;

10 (B) establish, alter, or modify staff posi-
11 tions, service delivery policies and practices,
12 service delivery locations, service delivery envi-
13 ronments, service delivery schedules, or other
14 services components in order to increase youth-
15 friendly sexual health services to marginalized
16 young people;

17 (C) conduct outreach to marginalized
18 young people to invite them to participate in
19 the eligible entity's sexual health services and to
20 provide feedback to inform improvements in the
21 delivery of such services;

22 (D) establish and refine systems of referral
23 to connect marginalized young people to other
24 sexual health services and supportive services;

1 (E) establish partnerships and collabora-
2 tions with entities providing services to
3 marginalized young people to link such young
4 people to sexual health services, such as by de-
5 livering health services at locations where they
6 congregate, providing transportation to loca-
7 tions where sexual health services are provided,
8 or other linkages to services approaches;

9 (F) provide evidence-informed, comprehen-
10 sive in scope, confidential, equitable, accessible,
11 medically accurate and complete, age and devel-
12 opmentally appropriate, culturally responsive,
13 and trauma-informed and resilience-oriented
14 sexual health information to marginalized
15 young people in the languages and cultural con-
16 texts that are most appropriate for the
17 marginalized young people to be served by the
18 eligible entity;

19 (G) promote effective communication re-
20 garding sexual health among marginalized
21 young people; and

22 (H) provide training and support for eligi-
23 ble entity personnel and community members
24 who work with marginalized young people about
25 the content, skills, and professional disposition

1 needed to provide youth-friendly sex education
2 and youth-friendly sexual health services.

3 (g) REPORTING AND IMPACT EVALUATION.—

4 (1) GRANTEE REPORT TO SECRETARY.—For
5 each year a grantee receives grant funds under sub-
6 section (c), (d), (e), or (f) the grantee shall submit
7 to the Secretary a report that includes—

8 (A) a description of the use of grant funds
9 by the grantee;

10 (B) a description of how the use of grant
11 funds has increased the access of young people
12 to sex education or sexual health services; and

13 (C) such other information as the Sec-
14 retary may require.

15 (2) SECRETARY'S REPORT TO CONGRESS.—Not
16 later than 1 year after the date of the enactment of
17 this section, and annually thereafter for a period of
18 5 years, the Secretary shall prepare and submit to
19 Congress a report on the activities funded under this
20 section. The Secretary's report to Congress shall in-
21 clude—

22 (A) a statement of how grants awarded by
23 the Secretary meet the purposes of the grants;
24 and

25 (B) information about—

(i) the number of grantees that are receiving grant funds under subsections (c), (d), (e), and (f);

(ii) the specific activities supported by grant funds awarded under subsections (c), (d), (e), and (f);

(iii) the number of young people served by projects funded under subsections (c),(d), and (f), in the aggregate and disaggregated and cross-tabulated by grant program, race and ethnicity, sex, sexual orientation, gender identity, and other characteristics determined by the Secretary (except that such disaggregation or cross-tabulation shall not be required in a case in which the results would reveal personally identifiable information about an individual young person);

(iv) the number of teachers, health educators, faculty, school administrators, and staff trained under subsection (e); and

(v) the status of the evaluation required under paragraph (3).

(3) MULTI-YEAR EVALUATION.—

1 (A) IN GENERAL.—Not later than 6
2 months after the date of the enactment of this
3 section, the Secretary shall enter into a contract
4 with a nonprofit organization with experience in
5 conducting impact evaluations to conduct a
6 multi-year evaluation on the impact of the
7 projects funded under subsections (c), (d), (e),
8 and (f) and to report to Congress and the Sec-
9 retary on the findings of such evaluation.

10 (B) EVALUATION.—The evaluation con-
11 ducted under this subsection shall—

12 (i) be conducted in a manner con-
13 sistent with relevant, nationally recognized
14 professional and technical evaluation
15 standards;

16 (ii) use sound statistical methods and
17 techniques relating to the behavioral
18 sciences, including quasi-experimental de-
19 signs, inferential statistics, and other
20 methodologies and techniques that allow
21 for conclusions to be reached;

22 (iii) be carried out by an independent
23 organization that has not received a grant
24 under subsection (c), (d), (e), or (f); and

1 (iv) be designed to provide informa-
2 tion on output measures and outcome
3 measures to be determined by the Sec-
4 retary.

5 (C) REPORT.—Not later than 6 years after
6 the date of enactment of this section, the orga-
7 nization conducting the evaluation under this
8 paragraph shall prepare and submit to the ap-
9 propriate committees of Congress and the Sec-
10 retary an evaluation report. Such report shall
11 be made publicly available, including on the
12 website of the Department of Health and
13 Human Services.

14 (h) NONDISCRIMINATION.—Activities funded under
15 this section shall not discriminate on the basis of actual
16 or perceived sex (including sexual orientation and gender
17 identity), age, parental status, race, color, ethnicity, na-
18 tional origin, disability, or religion. Nothing in this section
19 shall be construed to invalidate or limit rights, remedies,
20 procedures, or legal standards available under any other
21 Federal law or any law of a State or a political subdivision
22 of a State, including the Civil Rights Act of 1964 (42
23 U.S.C. 2000a et seq.), title IX of the Education Amend-
24 ments of 1972 (20 U.S.C. 1681 et seq.), section 504 of
25 the Rehabilitation Act of 1973 (29 U.S.C. 794), the Amer-

1 icans with Disabilities Act of 1990 (42 U.S.C. 12101 et
2 seq.), and section 1557 of the Patient Protection and Af-
3 fordable Care Act (42 U.S.C. 18116).

4 (i) LIMITATION.—No Federal funds provided under
5 this section may be used for sex education or sexual health
6 services that—

7 (1) withhold health-promoting or life-saving in-
8 formation about sexuality-related topics, including
9 HIV;

10 (2) are medically inaccurate or incomplete;

11 (3) promote gender or racial stereotypes or are
12 unresponsive to gender or racial inequities;

13 (4) fail to address the needs of sexually active
14 young people;

15 (5) fail to address the needs of pregnant or par-
16 enting young people;

17 (6) fail to address the needs of survivors of
18 interpersonal violence;

19 (7) fail to address the needs of young people of
20 all physical, developmental, or mental abilities;

21 (8) fail to be inclusive of individuals with vary-
22 ing gender identities, gender expressions, and sexual
23 orientations; or

24 (9) are inconsistent with the ethical imperatives
25 of medicine and public health.

1 (j) AMENDMENTS TO OTHER LAWS.—

2 (1) AMENDMENT TO THE PUBLIC HEALTH
3 SERVICE ACT.—Section 2500 of the Public Health
4 Service Act (42 U.S.C. 300ee) is amended by strik-
5 ing subsections (b) through (d) and inserting the fol-
6 lowing:

7 “(b) CONTENTS OF PROGRAMS.—All programs of
8 education and information receiving funds under this sub-
9 chapter shall include information about the potential ef-
10 fects of intravenous substance use.”.

11 (2) AMENDMENTS TO THE ELEMENTARY AND
12 SECONDARY EDUCATION ACT OF 1965.—Section 8526
13 of the Elementary and Secondary Education Act of
14 1965 (20 U.S.C. 7906) is amended—

15 (A) by striking paragraphs (3), (5), and
16 (6);

17 (B) by redesignating paragraph (4) as
18 paragraph (3);

19 (C) in paragraph (3), as redesignated by
20 paragraph (2), by inserting “or” after the semi-
21 colon; and

22 (D) by redesignating paragraph (7) as
23 paragraph (4).

24 (k) FUNDING.—

1 (1) AUTHORIZATION.—For the purpose of car-
2 rying out this section, there is authorized to be ap-
3 propriated \$100,000,000 for each of fiscal years
4 2027 through 2032. Amounts appropriated under
5 this subsection shall remain available until expended.

6 (2) RESERVATIONS OF FUNDS.—

7 (A) IN GENERAL.—The Secretary—

8 (i) shall reserve not more than 30 per-
9 cent of the amount authorized under para-
10 graph (1) for the purposes of awarding
11 grants for sex education at elementary and
12 secondary schools and youth-serving orga-
13 nizations under subsection (c);

14 (ii) shall reserve not more than 10
15 percent of the amount authorized under
16 paragraph (1) for the purpose of awarding
17 grants for sex education at institutions of
18 higher education under subsection (d);

19 (iii) shall reserve not more than 15
20 percent of the amount authorized under
21 paragraph (1) for the purpose of awarding
22 grants for educator training under sub-
23 section (e);

24 (iv) shall reserve not more than 30
25 percent of the amount authorized under

1 paragraph (1) for the purpose of awarding
2 grants for sexual health services for
3 marginalized youth under subsection (f);
4 and

5 (v) shall reserve not less than 5 per-
6 cent of the amount authorized under para-
7 graph (1) for the purpose of carrying out
8 the reporting and impact evaluation re-
9 quired under subsection (g).

10 (B) RESEARCH, TRAINING, AND TECH-
11 NICAL ASSISTANCE.—The Secretary shall re-
12 serve not less than 10 percent of the amount
13 authorized under paragraph (1) for expendi-
14 tures by the Secretary to provide, directly or
15 through a competitive grant process, research,
16 training, and technical assistance, including dis-
17 semination of research and information regard-
18 ing effective and promising practices, providing
19 consultation and resources, and developing re-
20 sources and materials to support the activities
21 of recipients of grants. In carrying out such
22 functions, the Secretary shall collaborate with a
23 variety of entities that have expertise in sex
24 education and sexual health services standards

1 setting, design, development, delivery, research,
 2 monitoring, and evaluation.

3 (3) REPROGRAMMING OF ABSTINENCE ONLY
 4 UNTIL MARRIAGE PROGRAM FUNDING.—The unobli-
 5 gated balance of funds made available to carry out
 6 section 510 of the Social Security Act (42 U.S.C.
 7 710) (as in effect on the day before the date of en-
 8 actment of this section) are transferred and shall be
 9 used by the Secretary to carry out this section. The
 10 amounts transferred and made available to carry out
 11 this section shall remain available until expended.

12 (4) REPEAL OF ABSTINENCE ONLY UNTIL MAR-
 13 RIAGE PROGRAM.—Section 510 of the Social Secu-
 14 rity Act (42 U.S.C. 710 et seq.) is repealed.

15 **SEC. 5405. COMPASSIONATE ASSISTANCE FOR RAPE EMER-**
 16 **GENCIES.**

17 (a) MEDICARE.—

18 (1) LIMITATION ON PAYMENT.—Section
 19 1866(a)(1) of the Social Security Act (42 U.S.C.
 20 1395cc(a)(1)), as amended by section 5201(e), is
 21 amended—

22 (A) in subparagraph (W), by moving the
 23 indentation 2 ems to the left;

24 (B) in subparagraph (X), by moving the
 25 indentation 2 ems to the left;

1 (C) in subparagraph (Y)(ii)(V), by striking
2 “and” at the end;

3 (D) in subparagraph (Z)(iii), by striking
4 the period and inserting “, and”; and

5 (E) by inserting after subparagraph (Z)
6 the following new subparagraph:

7 “(AA) in the case of a hospital, critical access
8 hospital, or rural emergency hospital, to adopt and
9 enforce a policy to ensure compliance with the re-
10 quirements of subsection (l) and to meet the require-
11 ments of such subsection.”.

12 (2) ASSISTANCE TO VICTIMS.—Section 1866 of
13 the Social Security Act (42 U.S.C. 1395cc) is
14 amended by adding at the end the following new
15 subsection:

16 “(l) COMPASSIONATE ASSISTANCE FOR RAPE EMER-
17 GENCIES.—

18 “(1) IN GENERAL.—For purposes of subsection
19 (a)(1)(AA), a hospital meets the requirements of
20 this subsection if the hospital provides each of the
21 services described in paragraph (2) to each indi-
22 vidual, whether or not eligible for benefits under this
23 title or under any other form of health insurance,
24 who comes to the hospital on or after January 1,
25 2027, and—

1 “(A) who states to hospital personnel that
2 they are victims of sexual assault;

3 “(B) who is accompanied by an individual
4 who states to hospital personnel that the indi-
5 vidual is a victim of sexual assault; or

6 “(C) whom hospital personnel, during the
7 course of treatment and care for the individual,
8 have reason to believe is a victim of sexual as-
9 sault.

10 “(2) REQUIRED SERVICES DESCRIBED.—For
11 purposes of paragraph (1), the services described in
12 this subparagraph are the following:

13 “(A) Provision of medically and factually
14 accurate and unbiased written and oral infor-
15 mation about emergency contraception that—

16 “(i) is written in clear and concise
17 language;

18 “(ii) is readily comprehensible;

19 “(iii) includes an explanation that
20 emergency contraceptives—

21 “(I) have been approved by the
22 Food and Drug Administration for in-
23 dividuals and are a safe and effective
24 way to prevent pregnancy after unpro-

1 tected intercourse or contraceptive
2 failure if taken in a timely manner;

3 “(II) are more effective the soon-
4 er it is taken; and

5 “(III) do not cause an abortion
6 and cannot interrupt an established
7 pregnancy;

8 “(iv) meet such conditions regarding
9 the provision of such information in lan-
10 guages other than English as the Secretary
11 may establish; and

12 “(v) are provided without regard to
13 the ability of the individual or their family
14 to pay costs associated with the provision
15 of such information to the individual.

16 “(B) Immediate offer to provide emergency
17 contraception to the individual at the hospital
18 and, in the case that such individual accepts
19 such offer, immediate provision to such indi-
20 vidual of such contraception on the same day it
21 is requested without regard to the inability of
22 the individual or their family to pay costs asso-
23 ciated with the offer and provision of such con-
24 traception.

1 “(C) Development and implementation of a
2 written policy to ensure that an individual is
3 present at the hospital, or on-call, who—

4 “(i) has authority to dispense or pre-
5 scribe emergency contraception, independ-
6 ently, or under a protocol prepared by a
7 physician for the administration of emer-
8 gency contraception at the hospital to a
9 victim of sexual assault; and

10 “(ii) is trained to comply with the re-
11 quirements of this section.

12 “(D) Provision of medically and factually
13 accurate and unbiased written and oral infor-
14 mation and counseling about post-exposure pro-
15 phylaxis (referred to in this paragraph as
16 ‘PEP’) protocol for the prevention of HIV.

17 “(E) Immediate offer to begin PEP to the
18 individual at the hospital except in cases where
19 the medical professional’s best judgement is
20 that further evaluation is required or that such
21 a regimen will be substantially detrimental to
22 the health of such individual. Such provision
23 shall be offered regardless of the individual’s
24 ability to pay. Hospitals shall be responsible for

1 ensuring adequate supply of PEP medications
2 to provide to patients.

3 “(3) HOSPITAL DEFINED.—In this subsection,
4 the term ‘hospital’ has the meaning given such term
5 in section 1861(e), except that for purposes of this
6 subsection, such term shall include a critical access
7 hospital (as defined in section 1861(mm)(1)) and a
8 rural emergency hospital (as defined in section
9 1861(kkk)).”.

10 (b) LIMITATION ON PAYMENT UNDER MEDICAID.—
11 Section 1903(i) of the Social Security Act (42 U.S.C.
12 1396b(i)), as amended by section 4106(b)(2), is further
13 amended—

14 (1) in paragraph (27), by striking “or” after
15 the semicolon;

16 (2) in paragraph (28), by striking the period
17 and inserting “; or”; and

18 (3) by inserting after paragraph (28) the fol-
19 lowing new paragraph:

20 “(29) with respect to any amount expended for
21 care or services furnished under the plan by a hos-
22 pital on or after January 1, 2027, unless such hos-
23 pital meets the requirements specified in section
24 1866(l) for purposes of title XVIII.”.

1 **SEC. 5406. MENSTRUAL EQUITY FOR ALL ACT.**

2 (a) SHORT TITLE.—This section may be cited as the
3 “Menstrual Equity For All Act”.

4 (b) MENSTRUAL PRODUCTS FOR STUDENTS AT ELE-
5 MENTARY AND SECONDARY SCHOOLS.—

6 (1) IN GENERAL.—Section 4108(5)(C) of the
7 Elementary and Secondary Education Act of 1965
8 (20 U.S.C. 7118(5)(C)) is amended—

9 (A) in clause (vi), by striking “or” after
10 the semicolon;

11 (B) in clause (vii), by inserting “or” after
12 the semicolon; and

13 (C) by adding at the end the following:

14 “(viii) provide free menstrual products
15 to students who use menstrual products;”.

16 (2) DEFINITIONS.—Section 4102 of the Ele-
17 mentary and Secondary Education Act of 1965 (20
18 U.S.C. 7112) is amended—

19 (A) by redesignating paragraphs (6)
20 through (8) as paragraphs (7) through (9), re-
21 spectively; and

22 (B) by inserting after paragraph (5) the
23 following:

24 “(6) MENSTRUAL PRODUCTS.—The term ‘men-
25 strual products’ means sanitary napkins and tam-

1 pons that conform to applicable industry stand-
 2 ards.”.

3 (3) RULEMAKING.—Not later than 1 year after
 4 the date of enactment of this section, the Secretary
 5 of Education, in consultation with the Secretary of
 6 Health and Human Services, shall promulgate rules
 7 with respect to the definition of “menstrual prod-
 8 ucts” in paragraph (6) of section 4102 of the Ele-
 9 mentary and Secondary Education Act of 1965 (20
 10 U.S.C. 7112), as amended by paragraph (2).

11 (c) MENSTRUAL PRODUCTS FOR STUDENTS AT IN-
 12 STITUTIONS OF HIGHER EDUCATION.—

13 (1) PURPOSE.—The purpose of this subsection
 14 is to alleviate—

15 (A) the barriers to academic success faced
 16 by many college and graduate students due to
 17 the inability of such students to afford to pur-
 18 chase menstrual products; and

19 (B) the unique set of burdens that college
 20 and graduate students experiencing period pov-
 21 erty face that can be compounded by lack of ac-
 22 cess to basic needs such as housing, food, trans-
 23 portation, and access to physical and mental
 24 health services.

1 (2) IN GENERAL.—The Secretary of Education
2 shall establish a program to award grants, on a com-
3 petitive basis, to not less than 4 institutions of high-
4 er education to—

5 (A) support programs that provide free
6 menstrual products to students; and

7 (B) report on best practices of such pro-
8 grams.

9 (3) APPLICATION.—To apply for a grant under
10 this subsection, an institution of higher education
11 shall submit to the Secretary an application in such
12 form, at such time, and containing such information
13 as the Secretary determines appropriate, including
14 an assurance that such grant will be used to carry
15 out the activities described in paragraph (5).

16 (4) COMMUNITY COLLEGES.—Not less than 50
17 percent of the grants awarded under this subsection
18 shall be awarded to community colleges.

19 (5) GRANT USES.—A grant awarded under this
20 subsection may only be used to—

21 (A) carry out or expand activities that
22 fund programs that support direct provision of
23 free menstrual products to students in appro-
24 priate campus locations, including—

25 (i) campus restroom facilities;

1 (ii) wellness centers; and

2 (iii) on-campus residential buildings;

3 (B) report on best practices of such pro-
4 grams;

5 (C) conduct outreach to students to en-
6 courage participation in menstrual equity pro-
7 grams and services;

8 (D) help eligible students apply for and en-
9 roll in local, State, and Federal public assist-
10 ance programs; and

11 (E) coordinate and collaborate with gov-
12 ernment or community-based organizations to
13 carry out the activities described in subpara-
14 graphs (A) through (D).

15 (6) PRIORITY.—In awarding grants under this
16 subsection, the Secretary shall prioritize—

17 (A) institutions with respect to which not
18 less than 25 percent of the enrolled students re-
19 ceive a Federal Pell Grant; and

20 (B) historically Black colleges and univer-
21 sities, Hispanic-serving institutions, Asian
22 American and Native American Pacific Is-
23 lander-serving institutions, and other minority
24 serving institutions.

25 (7) DEFINITIONS.—In this subsection:

1 (A) INSTITUTION OF HIGHER EDU-
 2 CATION.—The term “institution of higher edu-
 3 cation” has the meaning given that term in sec-
 4 tion 101 of the Higher Education Act of 1965
 5 (20 U.S.C. 1001).

6 (B) MENSTRUAL PRODUCT DEFINED.—
 7 The term “menstrual product” means a sani-
 8 tary napkin or tampon that conforms to indus-
 9 try standards.

10 (8) AUTHORIZATION OF APPROPRIATIONS.—
 11 There are authorized to be appropriated \$5,000,000
 12 out of funds appropriated for a fiscal year to the
 13 Fund for the Improvement of Postsecondary Edu-
 14 cation under section 741 of the Higher Education
 15 Act of 1965 (20 U.S.C. 1138) to carry out the grant
 16 program under this subsection.

17 (d) MENSTRUAL PRODUCTS FOR INCARCERATED IN-
 18 DIVIDUALS AND DETAINEES.—

19 (1) MENSTRUAL PRODUCTS DEFINED.—In this
 20 subsection, the term “menstrual products” means
 21 sanitary napkins and tampons that conform to appli-
 22 cable industry standards.

23 (2) REQUIREMENT FOR STATES.—Beginning on
 24 the date that is 180 days after the date of the enact-
 25 ment of this Act, and annually thereafter, the chief

1 executive officer of each State that receives a grant
2 under subpart 1 of part E of title I of the Omnibus
3 Crime Control and Safe Streets Act of 1968 (34
4 U.S.C. 10151 et seq.) shall submit to the Attorney
5 General a certification, in such form and containing
6 such information as the Attorney General may re-
7 quire, that—

8 (A) all incarcerated individuals and detain-
9 ees in the State have access to menstrual prod-
10 ucts—

11 (i) on demand; and

12 (ii) at no cost to the incarcerated indi-
13 viduals and detainees; and

14 (B) no visitor of an incarcerated individual
15 or detainee of the State is prohibited from vis-
16 iting an incarcerated individual or detainee due
17 to the visitor's use of menstrual products.

18 (3) REDUCTION IN GRANT FUNDING.—In the
19 case of a State of which the chief executive officer
20 fails to submit a certification required under para-
21 graph (2) in a fiscal year, the Attorney General shall
22 reduce the amount that the State would otherwise
23 receive under section 505 of title I of the Omnibus
24 Crime Control and Safe Streets Act of 1968 (34

1 U.S.C. 10156) by 20 percent for the following fiscal
2 year.

3 (4) REALLOCATION.—Amounts not allocated to
4 a State under section 505 of title I of the Omnibus
5 Crime Control and Safe Streets Act of 1968 (34
6 U.S.C. 10156) for a fiscal year pursuant to para-
7 graph (3) shall be reallocated under such section to
8 States that submit certifications under paragraph
9 (2).

10 (5) AVAILABILITY FOR FEDERAL PRISONERS.—
11 The Attorney General shall make rules requiring,
12 and the Director of the Bureau of Prisons shall take
13 such actions as may be necessary to ensure, the dis-
14 tribution and accessibility without charge of men-
15 strual products to prisoners in the custody of the
16 Bureau of Prisons, including any prisoner in a Fed-
17 eral penal or correctional institution, any Federal
18 prisoner in a State penal or correctional institution,
19 and any Federal prisoner in a facility administered
20 by a private detention entity, to ensure that each
21 prisoner who requires menstrual products may re-
22 ceive them in sufficient quantity.

23 (6) AVAILABILITY FOR DETAINEES.—The Sec-
24 retary of Homeland Security shall take such actions
25 as may be necessary to ensure that menstrual prod-

1 ucts are distributed and made accessible to each
2 alien detained by the Secretary of Homeland Secu-
3 rity, including any alien in a facility administered by
4 a private detention entity, at no expense to the alien.

5 (e) MENSTRUAL PRODUCTS AVAILABILITY FOR
6 HOMELESS INDIVIDUALS UNDER EMERGENCY FOOD AND
7 SHELTER GRANT PROGRAM.—Subsection (a) of section
8 316 of the McKinney-Vento Homeless Assistance Act (42
9 U.S.C. 11346(a)) is amended—

10 (1) in paragraph (5), by striking “and” at the
11 end;

12 (2) in paragraph (6), by striking the period at
13 the end and inserting “; and”; and

14 (3) by adding at the end the following new
15 paragraph:

16 “(7) guidelines that ensure that amounts pro-
17 vided under the program to private nonprofit organi-
18 zations and local governments may be used to pro-
19 vide sanitary napkins and tampons that conform to
20 applicable industry standards.”.

21 (f) MENSTRUAL PRODUCTS COVERED BY MED-
22 ICAID.—

23 (1) IN GENERAL.—Section 1905 of the Social
24 Security Act (42 U.S.C. 1396d), as amended by sec-
25 tion 5201, is further amended—

1 (A) in subsection (a)—

2 (i) in paragraph (32), by striking “;
3 and” and inserting a semicolon;

4 (ii) by redesignating paragraph (33)
5 as paragraph (34); and

6 (iii) by inserting after paragraph (32)
7 the following new paragraph:

8 “(33) menstrual products (as defined in sub-
9 section (qq)); and”; and

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

12 “(qq) MENSTRUAL PRODUCTS.—For purposes of
13 subsection (a)(33), the term ‘menstrual products’ means
14 menstrual cups, menstrual discs, menstrual underwear,
15 and sanitary napkins and tampons, that conform to appli-
16 cable industry standards.”.

17 (2) EFFECTIVE DATE.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (B), the amendments made by this sub-
20 section shall apply with respect to medical as-
21 sistance furnished during or after the first cal-
22 endar quarter beginning on or after the date
23 that is 1 year after the date of the enactment
24 of this Act.

1 (B) EXCEPTION FOR STATE LEGISLA-
2 TION.—In the case of a State plan under title
3 XIX of the Social Security Act (42 U.S.C. 1396
4 et seq.) that the Secretary of Health and
5 Human Services determines requires State leg-
6 islation in order for the respective plan to meet
7 any requirement imposed by amendments made
8 by this subsection, the respective plan shall not
9 be regarded as failing to comply with the re-
10 quirements of such title solely on the basis of
11 its failure to meet such an additional require-
12 ment before the first day of the first calendar
13 quarter beginning after the close of the first
14 regular session of the State legislature that be-
15 gins after the date of the enactment of this Act.
16 For purposes of the previous sentence, in the
17 case of a State that has a 2-year legislative ses-
18 sion, each year of the session shall be consid-
19 ered to be a separate regular session of the
20 State legislature.

21 (g) MENSTRUAL PRODUCTS FOR EMPLOYEES.—Sec-
22 tion 6 of the Occupational Safety and Health Act of 1970
23 (29 U.S.C. 655) is amended by adding at the end the fol-
24 lowing:

1 “(h) The Secretary shall by rule promulgate a re-
 2 quirement that each employer with not less than 100 em-
 3 ployees provide menstrual products free of charge for em-
 4 ployees of the employer. For purposes of the preceding
 5 sentence, ‘menstrual products’ means sanitary napkins
 6 and tampons that conform to applicable industry stand-
 7 ards.”.

8 (h) MENSTRUAL PRODUCTS IN FEDERAL BUILD-
 9 INGS.—

10 (1) DEFINITIONS.—In this subsection:

11 (A) APPROPRIATE AUTHORITY.—The term
 12 “appropriate authority” means the head of a
 13 Federal agency, the Architect of the Capitol, or
 14 any other official authority responsible for the
 15 operation of a covered public building.

16 (B) COVERED PUBLIC BUILDING.—

17 (i) IN GENERAL.—The term “covered
 18 public building” means a public building
 19 (as defined in section 3301(a) of title 40,
 20 United States Code) that is open to the
 21 public and contains a public restroom.

22 (ii) INCLUSIONS.—The term “covered
 23 public building” includes specified build-
 24 ings and grounds (as defined in section
 25 6301 of title 40, United States Code) and

1 the Capitol Buildings (as defined in section
2 5101 of that title).

3 (C) COVERED RESTROOM.—The term “cov-
4 ered restroom” means a restroom in a covered
5 public building.

6 (D) MENSTRUAL PRODUCTS.—The term
7 “menstrual products” means sanitary napkins
8 and tampons that conform to applicable indus-
9 try standards.

10 (2) REQUIREMENT.—Each appropriate author-
11 ity shall ensure that menstrual products are stocked
12 in, and available free of charge in, each covered rest-
13 room in each covered public building under the juris-
14 diction of that authority.

15 (i) MENSTRUAL PRODUCTS IN THE SOCIAL SERVICES
16 BLOCK GRANT PROGRAM.—

17 (1) INCREASE IN FUNDING FOR SOCIAL SERV-
18 ICES BLOCK GRANT PROGRAM.—

19 (A) IN GENERAL.—The amount specified
20 in subsection (c) of section 2003 of the Social
21 Security Act (42 U.S.C. 1397b) for purposes of
22 subsections (a) and (b) of such section is
23 deemed to be \$1,900,000,000 for each of fiscal
24 years 2027 through 2030, of which, the amount
25 equal to \$200,000,000, reduced by the amounts

1 reserved under subparagraph (B)(ii) for each
2 such fiscal year, shall be obligated by States in
3 accordance with paragraph (2).

4 (B) APPROPRIATION.—

5 (i) IN GENERAL.—Out of any money
6 in the Treasury of the United States not
7 otherwise appropriated, there is appro-
8 priated \$200,000,000 for each of fiscal
9 years 2027 through 2030, to carry out this
10 subsection.

11 (ii) RESERVATIONS.—

12 (I) PURPOSES.—The Secretary
13 shall reserve, from the amount appro-
14 priated under clause (i) to carry out
15 this subsection—

16 (aa) for each of fiscal years
17 2027 through 2030, not more
18 than 2 percent of the amount ap-
19 propriated for the fiscal year for
20 purposes of entering into an
21 agreement with an eligible entity
22 described in clause (iii) to assist
23 in providing technical assistance
24 and training, to support effective
25 policy, practice, research, and

1 cross-system collaboration among
2 grantees and subgrantees, and to
3 assist in the administration of
4 the program described in this
5 subsection; and

6 (bb) for fiscal year 2027, an
7 amount, not to exceed
8 \$2,000,000, for purposes of con-
9 ducting an evaluation under
10 paragraph (4).

11 (II) NO STATE ENTITLEMENT TO
12 RESERVED FUNDS.—The State enti-
13 tlement under section 2002(a) of the
14 Social Security Act (42 U.S.C.
15 1397a(a)) shall not apply to the
16 amounts reserved under subclause (I).

17 (iii) ELIGIBLE ENTITY DESCRIBED.—
18 An eligible entity described in this clause is
19 a nonprofit organization described in sec-
20 tion 501(c)(3) of the Internal Revenue
21 Code of 1986 and exempt from taxation
22 under section 501(a) of such Code, that—

23 (I) has experience in more than 1
24 State in the area of community dis-
25 tributions of basic need services, in-

cluding experience collecting,
warehousing, and distributing basic
necessities such as menstrual prod-
ucts;

(II) demonstrates competency to
implement a project, provide fiscal ac-
countability, collect data, and prepare
reports and other necessary docu-
mentation; and

(III) demonstrates a willingness
to share information with researchers,
practitioners, and other interested
parties.

(2) RULES GOVERNING USE OF ADDITIONAL
FUNDS.—

(A) IN GENERAL.—Funds are used in ac-
cordance with this paragraph if—

(i) the State, in consultation with rel-
evant stakeholders, including agencies, pro-
fessional associations, and nonprofit orga-
nizations, distributes the funds to eligible
entities to—

(I) decrease the unmet need for
menstrual products by low-income
menstruating individuals through—

1 (aa) the distribution of free
2 menstrual products;

3 (bb) community outreach to
4 assist in participation in existing
5 menstrual product distribution
6 programs; or

7 (cc) improving access to
8 menstrual products among low-
9 income individuals; and

10 (II) increase the ability of com-
11 munities and low-income families in
12 such communities to provide for the
13 need for menstrual products of low-in-
14 come adults; and

15 (ii) the funds are used subject to the
16 limitations in section 2005 of the Social
17 Security Act (42 U.S.C. 1397d).

18 (B) ALLOWABLE USES BY ELIGIBLE ENTI-
19 TIES.—

20 (i) IN GENERAL.—An eligible entity
21 receiving funds made available under para-
22 graph (1) shall use the funds for any of
23 the following:

1 (I) To pay for the purchase and
2 distribution of menstrual products
3 among low-income individuals.

4 (II) To integrate activities car-
5 ried out under subclause (I) with
6 other basic needs assistance programs
7 serving low-income families, including
8 the following:

9 (aa) Programs funded by
10 the temporary assistance for
11 needy families program under
12 part A of title IV of the Social
13 Security Act (42 U.S.C. 601 et
14 seq.), including the State mainte-
15 nance of effort provisions of such
16 program.

17 (bb) Programs designed to
18 support the health of eligible chil-
19 dren, such as the Children's
20 Health Insurance Program under
21 title XXI of the Social Security
22 Act, the Medicaid program under
23 title XIX of such Act, or State
24 funded health care programs.

1 (cc) Programs funded
2 through the special supplemental
3 nutrition program for women, in-
4 fants, and children under section
5 17 of the Child Nutrition Act of
6 1966.

7 (dd) Programs that offer
8 early home visiting services, in-
9 cluding the maternal, infant, and
10 early childhood home visiting
11 program (including the Tribal
12 home visiting program) under
13 section 511 of the Social Security
14 Act (42 U.S.C. 711).

15 (III) To provide training or tech-
16 nical assistance in carrying out activi-
17 ties under this subsection.

18 (IV) To cover administrative
19 costs.

20 (ii) LIMITATION ON USE OF FUNDS
21 FOR ADMINISTRATIVE COSTS.—An eligible
22 entity receiving funds made available under
23 this subsection shall not use more than 9
24 percent of the funds for administrative
25 costs incurred pursuant to this subsection.

1 (C) AVAILABILITY OF FUNDS.—

2 (i) FUNDS DISTRIBUTED TO ELIGIBLE
3 ENTITIES.—Funds made available under
4 paragraph (1) that are distributed to an el-
5 igible entity by a State for a fiscal year
6 may be expended by the eligible entity only
7 in such fiscal year or the succeeding fiscal
8 year.

9 (ii) EVALUATION.—Funds reserved
10 under paragraph (1)(B)(ii)(I)(aa) to carry
11 out the evaluation under paragraph (4)
12 shall be available for expenditure through
13 September 30, 2031.

14 (D) NO EFFECT ON OTHER PROGRAMS.—

15 Any assistance or benefits received by a family
16 through funds made available under paragraph
17 (1) shall be disregarded for purposes of deter-
18 mining the family's eligibility for, or amount of,
19 benefits under any other Federal needs-based
20 programs.

21 (3) ANNUAL REPORTS.—Section 2004 of the
22 Social Security Act shall apply with respect to pay-
23 ments made to a State under this section in the
24 same way it applies with respect to payments made
25 to a State under section 2002 of such Act.

1 (4) EVALUATION.—The Secretary, in consulta-
2 tion with States, the eligible entities described in
3 paragraph (1)(B)(iii) receiving funds made available
4 under this subsection, shall—

5 (A) not later than December 30, 2031,
6 complete an evaluation of the effectiveness of
7 the assistance program carried out pursuant to
8 this subsection, such as the effect of activities
9 carried out under this Act on mitigating the
10 health risks of unmet menstrual products need
11 among individuals in low-income families;

12 (B) not later than March 31, 2032, submit
13 to the Committees on Energy and Commerce
14 and on Ways and Means of the House of Rep-
15 resentatives and the Committee on Finance of
16 the Senate a report on the results of the evalua-
17 tion; and

18 (C) not later than April 30, 2032, publish
19 the results of the evaluation on the internet
20 website of the Department of Health and
21 Human Services.

22 (5) GUIDANCE.—Not later than 180 days after
23 the date of the enactment of this Act, the Secretary
24 shall issue guidance regarding how the provisions of
25 this subsection should be carried out, including in-

1 formation regarding eligible entities, allowable use of
2 funds, and reporting requirements.

3 (6) BEST PRACTICES.—The Secretary of Health
4 and Human Services, in cooperation with the Sec-
5 retary of Education, shall develop best practices for
6 school officials to use in discussing menstruation
7 with students, and shall publish this information on
8 the internet website of the Department of Health
9 and Human Services.

10 (7) DEFINITIONS.—In this subsection:

11 (A) MENSTRUAL PRODUCTS.—The term
12 “menstrual products” means menstrual cups,
13 menstrual discs, menstrual underwear, and san-
14 itary napkins and tampons, that conform to ap-
15 plicable industry standards.

16 (B) ELIGIBLE ENTITIES.—The term “eligi-
17 ble entity” means a State or local governmental
18 entity, an Indian tribe or tribal organization (as
19 defined in section 4 of the Indian Self-Deter-
20 mination and Education Assistance Act), or a
21 nonprofit organization described in section
22 501(c)(3) of the Internal Revenue Code of 1986
23 and exempt from taxation under section 501(a)
24 of such Code that—

1 (i) has experience in the area of com-
 2 munity distributions of basic need services,
 3 including experience collecting,
 4 warehousing, and distributing basic neces-
 5 sities such as diapers, food, or menstrual
 6 products;

7 (ii) demonstrates competency to im-
 8 plement a project, provide fiscal account-
 9 ability, collect data, and prepare reports
 10 and other necessary documentation; and

11 (iii) demonstrates a willingness to
 12 share information with researchers, practi-
 13 tioners, and other interested parties.

14 (C) STATE.—The term “State” has the
 15 meaning given in section 1101(a)(1) of the So-
 16 cial Security Act for purposes of title XX of
 17 such Act.

18 (8) LIMITATION ON AUTHORIZATION OF APPRO-
 19 PRIATIONS.—For the administration of this sub-
 20 section, there are authorized to be appropriated to
 21 the Secretary of Health and Human Services not
 22 more than \$6,000,000 for fiscal years 2027 through
 23 2030.

24 (9) EXEMPTION FROM SEQUESTRATION.—
 25 Funds made available to carry out this subsection

1 shall be exempt from reduction under any order
2 issued under the Balanced Budget and Emergency
3 Deficit Control Act of 1985.

4 (j) MENSTRUAL PRODUCTS AND TAXATION.—

5 (1) IN GENERAL.—It shall be unlawful for a
6 State, or unit of local government of a State, to im-
7 pose a tax on the retail sale of a menstrual product.

8 (2) DEFINITIONS.—For purposes of this sub-
9 section:

10 (A) MENSTRUAL PRODUCT.—The term
11 “menstrual products” means menstrual cups,
12 menstrual discs, menstrual underwear, and san-
13 itary napkins and tampons, that conform to ap-
14 plicable industry standards.

15 (B) STATE.—The term “State” means any
16 of the several States or the District of Colum-
17 bia.

18 (3) EFFECTIVE DATE.—This subsection shall
19 take effect 120 days after the date of the enactment
20 of this subsection.

21 (k) MENSTRUAL PRODUCTS IN TANF.—

22 (1) IN GENERAL.—Section 403(a) of the Social
23 Security Act (42 U.S.C. 603(a)) is amended by add-
24 ing at the end the following:

25 “(6) GRANTS FOR MENSTRUAL PRODUCTS.—

1 “(A) IN GENERAL.—The Secretary may
2 make grants, on a competitive basis, for each
3 fiscal year to eligible applicants for the grants,
4 in such amounts as the Secretary deems appro-
5 priate to enable the eligible applicants to pro-
6 vide, to covered families that include an indi-
7 vidual who is capable of menstruating, such
8 benefits as are needed to ensure that the indi-
9 vidual can purchase menstrual products for per-
10 sonal use.

11 “(B) DEFINITIONS.—In subparagraph (A):

12 “(i) COVERED FAMILIES.—The term
13 ‘covered families’ means families eligible
14 for assistance under a State program fund-
15 ed under this part.

16 “(ii) ELIGIBLE APPLICANT.—The
17 term ‘eligible applicant’ means—

18 “(I) a State to which a grant is
19 made under paragraph (1) for a fiscal
20 year; and

21 “(II) a political subdivision of a
22 State that administers the State pro-
23 gram funded under this part in the
24 political subdivision.

1 “(iii) MENSTRUAL PRODUCTS.—The
2 term ‘menstrual products’ means men-
3 strual cups, menstrual discs, menstrual un-
4 derwear, and sanitary napkins and tam-
5 pons, that conform to applicable industry
6 standards.

7 “(C) CONSIDERATION OF APPLICATIONS.—
8 The Secretary shall award grants under this
9 paragraph on the basis of how effectively the
10 programs proposed by the eligible applicants
11 will help low-income individuals suffering from
12 material deprivation meet their need for men-
13 strual products.

14 “(D) ADMINISTRATION.—A State or polit-
15 ical subdivision to which a grant is made under
16 this paragraph may use the grant to provide
17 benefits under this paragraph in such form and
18 in such manner as the State or political subdivi-
19 sion deems appropriate.

20 “(E) TREATMENT OF ASSISTANCE.—Bene-
21 fits provided using funds made available under
22 this paragraph shall not be considered assist-
23 ance under any State program funded under
24 this part.

1 “(F) APPROPRIATION.—Out of any money
2 in the Treasury of the United States not other-
3 wise appropriated, there are appropriated for
4 fiscal year 2027 and each succeeding fiscal year
5 \$10,000,000 for grants under this paragraph.”.

6 (2) EVALUATIONS.—Section 413 of such Act
7 (42 U.S.C. 613) is amended by redesignating sub-
8 section (h) as subsection (i) and inserting after sub-
9 section (g) the following:

10 “(h) EVALUATIONS OF GRANTS FOR MENSTRUAL
11 PRODUCTS.—

12 “(1) IN GENERAL.—The Secretary shall submit
13 to the Congress reports, in writing, that evaluate the
14 effectiveness of the benefit program provided for in
15 section 403(a)(6). Each such report shall, for the
16 period covered by the report—

17 “(A) describe—

18 “(i) the extent of material deprivation
19 in the population, including lacking suffi-
20 cient funds to regularly purchase neces-
21 sities such as menstrual products; and

22 “(ii) the extent to which the program
23 alleviated such material deprivation;

24 “(B) specify the number and identity of
25 the entities to which a grant has been made

1 under such section, and the amount of the
2 grant made to each such entity;

3 “(C) describe how the grantees used the
4 grants to provide benefits under the program;

5 “(D) specify the number of individuals who
6 received the benefits;

7 “(E) describe how efficacious the program
8 has been in helping low-income individuals meet
9 their need for menstrual products;

10 “(F) describe the extent to which the pro-
11 gram has improved the economic security of the
12 benefit recipients; and

13 “(G) include such other relevant informa-
14 tion as the Secretary deems appropriate.

15 “(2) TIMING.—The Secretary shall submit a re-
16 port that meets the requirements of paragraph (1)
17 within 2 years after the date of the enactment of
18 this paragraph and every 2 years thereafter.”.

19 **SEC. 5407. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
20 **WOMEN’S HEALTH.**

21 Section 229(b) of the Public Health Service Act (42
22 U.S.C. 237a(b)), as amended by section 5301(b), is fur-
23 ther amended by adding at the end the following:

24 “(10) facilitate the understanding of policy-
25 makers, health system leaders and providers, con-

1 sumers, and other stakeholders concerning optimal
2 maternity care and support for the provision of such
3 care, including the priorities of—

4 “(A) protecting, promoting, and supporting
5 the innate capacities of childbearing individuals
6 and their newborns for childbirth,
7 breastfeeding, and attachment;

8 “(B) using obstetric interventions only
9 when such interventions are supported by
10 strong, high-quality evidence, and minimizing
11 overuse of maternity practices that have been
12 shown to have benefit in limited situations and
13 that can expose people, infants, or both to risk
14 of harm if used routinely and indiscriminately,
15 including overuse of continuous electronic fetal
16 monitoring, labor induction, epidural analgesia,
17 primary cesarean section, and routine repeat ce-
18 sarean birth;

19 “(C) reliably incorporating noninvasive,
20 evidence-based practices that have a docu-
21 mented correlation with considerable improve-
22 ment in outcomes with no detrimental side ef-
23 fects, such as incorporation of smoking ces-
24 sation programs in pregnancy, maternal immu-
25 nizations, and proven models (including group

1 prenatal care, midwifery care, and doula sup-
2 port) that integrate health assessment, edu-
3 cation, and support into a unified program, and
4 supporting evidence-based breastfeeding pro-
5 motion efforts with respect for a breastfeeding
6 individual's personal decisionmaking;

7 “(D) a shared understanding of the quali-
8 fications of licensed providers of maternity care
9 and the best evidence about the safety, satisfac-
10 tion, outcomes, and costs of maternity care, and
11 appropriate deployment of such caregivers with-
12 in the maternity care workforce to address the
13 needs of childbearing individuals and newborns
14 and the growing shortage of maternity care-
15 givers;

16 “(E) a shared understanding of the results
17 of the best available research comparing hos-
18 pital, birth center, and planned home births, in-
19 cluding information about each setting's safety,
20 satisfaction, outcomes, and costs;

21 “(F) a shared understanding of the impor-
22 tance for the safety and choices of birthing
23 families of an integrated maternity care system
24 with seamless processes for consultation, shared
25 care, transfer and transport across maternity

1 care settings, and use of providers when birth-
 2 ing people and their newborns require a higher
 3 level of care;

4 “(G) advancing high-quality, evidence-
 5 based childbirth education that—

6 “(i) promotes a healthy and safe ap-
 7 proach to pregnancy, childbirth, and early
 8 parenting;

9 “(ii) is taught by certified educators,
 10 peer counselors, and health professionals;
 11 and

12 “(iii) promotes informed decision-
 13 making by childbearing individuals; and

14 “(H) developing measures that enable a
 15 more robust, balanced set of standardized ma-
 16 ternity care measures, including performance
 17 and quality measures.”.

18 **SEC. 5408. INCLUDING SERVICES FURNISHED BY CERTAIN**
 19 **STUDENTS, INTERNS, AND RESIDENTS SU-**
 20 **PERVISED BY CERTIFIED NURSE MIDWIVES**
 21 **OR CERTIFIED MIDWIVES WITHIN INPATIENT**
 22 **HOSPITAL SERVICES UNDER MEDICARE.**

23 (a) IN GENERAL.—Section 1861(b) of the Social Se-
 24 curity Act (42 U.S.C. 1395x(b)) is amended—

1 (1) in paragraph (6), by striking “; or” at the
2 end and inserting “, or in the case of services in a
3 hospital or osteopathic hospital by a student midwife
4 or an intern or resident-in-training under a teaching
5 program previously described in this paragraph who
6 is in the field of obstetrics and gynecology, if such
7 student midwife, intern, or resident-in-training is su-
8 pervised by a certified nurse-midwife or certified
9 midwife to the extent permitted under applicable
10 State law and as may be authorized by the hos-
11 pital;”;

12 (2) in paragraph (7), by striking the period at
13 the end and inserting “; or”; and

14 (3) by adding at the end the following new
15 paragraph:

16 “(8) a certified nurse-midwife or certified mid-
17 wife where the hospital has a teaching program ap-
18 proved as specified in paragraph (6), if—

19 “(A) the hospital elects to receive any pay-
20 ment due under this title for reasonable costs of
21 such services; and

22 “(B) all certified nurse-midwives or cer-
23 tified midwives in such hospital agree not to bill
24 charges for professional services rendered in

1 such hospital to individuals covered under the
2 insurance program established by this title.”.

3 (b) **EFFECTIVE DATE.**—The amendments made by
4 subsection (a) shall apply to services furnished on or after
5 the date of the enactment of this Act.

6 **SEC. 5409. GRANTS TO PROFESSIONAL ORGANIZATIONS**
7 **AND MINORITY-SERVING INSTITUTIONS TO**
8 **INCREASE DIVERSITY IN MATERNAL, REPRO-**
9 **DUCTIVE, AND SEXUAL HEALTH PROFES-**
10 **SIONALS.**

11 (a) **GRANTS TO HEALTH PROFESSIONAL ORGANIZA-**
12 **TIONS.**—

13 (1) **IN GENERAL.**—The Secretary of Health and
14 Human Services, acting through the Administrator
15 of the Health Resources and Services Administration
16 (referred to in this section as the “Secretary”), shall
17 carry out a grant program under which the Sec-
18 retary may make to eligible organizations—

19 (A) for fiscal year 2027, planning grants
20 described in paragraph (2); and

21 (B) for the subsequent 4-year period, im-
22 plementation grants described in paragraph (3).

23 (2) **PLANNING GRANTS.**—

1 (A) IN GENERAL.—Planning grants de-
2 scribed in this paragraph are grants for each of
3 the following purposes:

4 (i) To collect data and identify any
5 workforce inequalities, with respect to a
6 health profession, at each of the following
7 stages along the health professional con-
8 tinuum:

9 (I) Pipeline availability, with re-
10 spect to students at the high school
11 and college or university levels consid-
12 ering, and working toward, entrance
13 in the profession, including inequal-
14 ities due to barriers triggered by
15 criminal records.

16 (II) Entrance into the training
17 program for the profession.

18 (III) Graduation from such train-
19 ing program.

20 (IV) Entrance into practice, in-
21 cluding inequalities due to barriers
22 triggered by criminal records.

23 (V) Retention in practice for
24 more than a 5-year period.

1 (ii) To develop one or more strategies
2 to address the workforce inequalities with-
3 in the health profession, as identified
4 under (and in response to the findings pur-
5 suant to) clause (i).

6 (B) APPLICATION.—To be eligible to re-
7 ceive a grant under this paragraph, an eligible
8 health professional organization shall submit to
9 the Secretary an application in such form and
10 manner and containing such information as
11 specified by the Secretary.

12 (C) AMOUNT.—Each grant awarded under
13 this paragraph shall be for an amount not to
14 exceed \$300,000.

15 (D) REPORT.—Each recipient of a grant
16 under this paragraph shall submit to the Sec-
17 retary a report containing—

18 (i) information on the extent and dis-
19 tribution of workforce inequalities identi-
20 fied through the grant; and

21 (ii) reasonable objectives and strate-
22 gies developed to address such inequalities
23 within a 5-, 10-, and 25-year period.

24 (3) IMPLEMENTATION GRANTS.—

1 (A) IN GENERAL.—Implementation grants
2 described in this paragraph are grants to imple-
3 ment one or more of the strategies developed
4 pursuant to a planning grant awarded under
5 paragraph (2).

6 (B) APPLICATION.—To be eligible to re-
7 ceive a grant under this paragraph, an eligible
8 health professional organization shall submit to
9 the Secretary an application in such form and
10 manner as specified by the Secretary. Each
11 such application shall contain information on—

12 (i) the capability of the organization
13 to carry out a strategy described in sub-
14 paragraph (A);

15 (ii) the involvement of partners or
16 coalitions;

17 (iii) the organization's plans for devel-
18 oping sustainability of the implementation
19 efforts after the culmination of the grant
20 cycle; and

21 (iv) any other matter specified by the
22 Secretary.

23 (C) AMOUNT; DURATION.—Each grant
24 awarded under this paragraph shall be for an
25 amount not to exceed \$500,000 for each year of

1 the grant. The term of a grant under this para-
2 graph shall not exceed 4 years.

3 (D) REPORTS.—For each of the first 3
4 years for which an eligible health professional
5 organization is awarded a grant under this
6 paragraph, the organization shall submit to the
7 Secretary a report on the activities carried out
8 by such organization through the grant during
9 such year and objectives for the subsequent
10 year. For the fourth year for which an eligible
11 health professional organization is awarded a
12 grant under this paragraph, the organization
13 shall submit to the Secretary a report that in-
14 cludes an analysis of all the activities carried
15 out by the organization through the grant and
16 a detailed plan for the continuation of the orga-
17 nization's implementation efforts.

18 (4) ELIGIBLE HEALTH PROFESSIONAL ORGANI-
19 ZATION DEFINED.—For purposes of this subsection,
20 the term “eligible health professional organization”
21 means a professional organization representing ob-
22 stetrician-gynecologists, certified nurse midwives,
23 certified midwives, family practice physicians, nurse
24 practitioners whose scope of practice includes preg-
25 nancy-related or sexual and reproductive health care,

1 physician assistants whose scope of practice includes
 2 obstetrical or sexual and reproductive health care,
 3 certified professional midwives, adolescent medicine
 4 specialists who provide sexual and reproductive
 5 health care, or pediatricians who provide sexual and
 6 reproductive health care.

7 (b) GRANTS TO MINORITY-SERVING INSTITU-
 8 TIONS.—

9 (1) IN GENERAL.—The Secretary shall carry
 10 out a grant program under which the Secretary may
 11 make to eligible minority-serving institutions—

12 (A) for fiscal years 2027 and 2028, plan-
 13 ning grants described in paragraph (2); and

14 (B) for the subsequent 10-year period, im-
 15 plementation grants described in paragraph (3).

16 (2) PLANNING GRANTS.—

17 (A) IN GENERAL.—Planning grants de-
 18 scribed in this paragraph are grants for plans
 19 relating to 1 or more of the following purposes:

20 (i) To develop or expand academic
 21 programs to educate maternity care clini-
 22 cians and maternity care support per-
 23 sonnel, including—

1 (I) nurses who have the intention
 2 of providing maternity, newborn, or
 3 sexual and reproductive health care;

4 (II) nurse practitioners whose
 5 scope of practice includes maternity,
 6 newborn, or sexual and reproductive
 7 health care; and

8 (III) maternity care support per-
 9 sonnel, such as doulas and lactation
 10 counselors.

11 (ii) To develop or expand academic
 12 programs to educate obstetrician-gyne-
 13 cologists.

14 (B) APPLICATION.—To be eligible to re-
 15 ceive a grant under this paragraph, an eligible
 16 minority-serving institution shall submit to the
 17 Secretary an application in such form and man-
 18 ner and containing such information as speci-
 19 fied by the Secretary.

20 (C) AMOUNT.—Each grant awarded under
 21 this paragraph shall be for an amount not to
 22 exceed \$400,000 for each of 2 years.

23 (D) REPORT.—Each recipient of a grant
 24 under this paragraph shall submit to the Sec-
 25 retary an annual report describing the planned

development or expansion of academic programs, including—

(i) the types of clinical or support personnel to be served and the degrees or certificates to be conferred;

(ii) the associated curricula;

(iii) the faculty and their capabilities and commitments, including any plans for recruitment;

(iv) the anticipated number of students to be enrolled and plans for their recruitment and social, emotional, and financial support; and

(v) the objectives and strategies for addressing inequalities and preparing students to provide high-quality culturally congruent care.

(3) IMPLEMENTATION GRANTS.—

(A) IN GENERAL.—Implementation grants described in this paragraph are grants to implement the plans developed under paragraph (2).

(B) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible minority-serving institution shall submit to the Secretary an application in such form and man-

ner as specified by the Secretary. Each such application shall contain information on the capability of the institution to carry out a plan described in paragraph (2), plans for sustainability of the academic program involved after the culmination of the grant cycle, and any other matter specified by the Secretary.

(C) AMOUNT.—Each grant under this paragraph shall be for an amount not to exceed \$1,000,000 for each year during the 10-year period of the grant.

(D) REPORTS.—

(i) INITIAL PERIOD.—For each of the first 9 years for which an eligible minority-serving institution is awarded a grant under this paragraph, the institution shall submit a report to the Secretary on the activities carried out by such institution through the grant during such year and objectives for the subsequent year.

(ii) FINAL YEAR.—For the tenth year for which an eligible minority-serving institution is awarded a grant under this paragraph, the organization shall submit to the Secretary a report that includes an anal-

1 ysis of all the activities carried out by the
2 institution through the grant and a de-
3 tailed plan for continuation of the aca-
4 demic program.

5 (4) MINORITY-SERVING INSTITUTION.—For the
6 purposes of this subsection, the term “minority-serv-
7 ing institution” means any of the following:

8 (A) A Hispanic-serving institution, as that
9 term is defined in section 502(a) of the Higher
10 Education Act of 1965 (20 U.S.C. 1101a(a)).

11 (B) A Tribal College or University, as that
12 term is defined in section 316(b) of the Higher
13 Education Act of 1965 (20 U.S.C. 1059c(b)).

14 (C) An Alaska Native-serving institution,
15 as that term is defined in section 317(b) of the
16 Higher Education Act of 1965 (20 U.S.C.
17 1059d(b)).

18 (D) A Native Hawaiian-serving institution,
19 as that term is defined in section 317(b) of the
20 Higher Education Act of 1965 (20 U.S.C.
21 1059d(b)).

22 (E) A Predominantly Black Institution, as
23 that term is defined in section 318(b) of the
24 Higher Education Act of 1965 (20 U.S.C.
25 1059e(b)).

1 (F) A Native American-serving, nontribal
 2 institution, as that term is defined in section
 3 319(b) of the Higher Education Act of 1965
 4 (20 U.S.C. 1059f(b)).

5 (G) An Asian American and Native Amer-
 6 ican Pacific Islander-serving institution, as that
 7 term is defined in section 320(b) of the Higher
 8 Education Act of 1965 (20 U.S.C. 1059g(b)).

9 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
 10 authorized to be appropriated to carry out—

11 (1) subsection (a), \$2,000,000 for fiscal year
 12 2027 and \$3,000,000 for each of the fiscal years
 13 2028 through 2031; and

14 (2) subsection (b), \$4,000,000 for each of fiscal
 15 years 2027 and 2028 and \$10,000,000 for each of
 16 fiscal years 2029 through 2038.

17 **Subtitle F—Children’s Health**

18 **SEC. 5501. CARING FOR KIDS ACT.**

19 (a) PERMANENT EXTENSION OF CHILDREN’S
 20 HEALTH INSURANCE PROGRAM.—

21 (1) IN GENERAL.—Section 2104(a)(28) of the
 22 Social Security Act (42 U.S.C. 1397dd(a)(28)) is
 23 amended to read as follows:

1 “(28) for fiscal year 2029 and each subsequent
 2 year, such sums as are necessary to fund allotments
 3 to States under subsections (c) and (m).”.

4 (2) ALLOTMENTS.—

5 (A) IN GENERAL.—Section 2104(m) of the
 6 Social Security Act (42 U.S.C. 1397dd(m)) is
 7 amended—

8 (i) in paragraph (2)(B)—

9 (I) in the matter preceding clause
 10 (i), by striking “through (27)” and in-
 11 serting “through (28)”; and

12 (II) in clause (i), by striking
 13 “2023, and 2029” and inserting “and
 14 2023”;

15 (ii) in paragraph (7)—

16 (I) in subparagraph (A), by strik-
 17 ing “and ending with fiscal year
 18 2029,”; and

19 (II) in the flush left matter at
 20 the end, by striking “fiscal year 2026,
 21 or fiscal year 2028” and inserting
 22 “fiscal year 2026, or a subsequent
 23 even-numbered fiscal year”;

24 (iii) in paragraph (9)—

1 (I) by striking “(10), or (11)”
 2 and inserting “or (10)”; and
 3 (II) by striking “2023, or 2029,”
 4 and inserting “or 2023”; and
 5 (iv) by striking paragraph (11).

6 (B) CONFORMING AMENDMENT.—Section
 7 50101(b)(2) of the Bipartisan Budget Act of
 8 2018 (Public Law 115–123) is repealed.

9 (b) PERMANENT EXTENSIONS OF OTHER PROGRAMS
 10 AND DEMONSTRATION PROJECTS.—

11 (1) PEDIATRIC QUALITY MEASURES PRO-
 12 GRAM.—Section 1139A(i)(1) of the Social Security
 13 Act (42 U.S.C. 1320b–9a(i)(1)) is amended—

14 (A) in subparagraph (D), by striking “;
 15 and” and inserting a semicolon;

16 (B) in subparagraph (E), by striking the
 17 period at the end and inserting “; and”; and

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

20 “(F) for a subsequent fiscal year, the
 21 amount appropriated under this paragraph for
 22 the previous fiscal year, increased by the per-
 23 centage increase in the consumer price index for
 24 all urban consumers (all items; United States
 25 city average) over such previous fiscal year, for

1 the purpose of carrying out this section (other
 2 than subsections (e), (f), and (g)).”.

3 (2) EXPRESS LANE ELIGIBILITY OPTION.—Sec-
 4 tion 1902(e)(13) of the Social Security Act (42
 5 U.S.C. 1396a(e)(13)) is amended by striking sub-
 6 paragraph (I).

7 (3) ASSURANCE OF AFFORDABILITY STANDARD
 8 FOR CHILDREN AND FAMILIES.—

9 (A) IN GENERAL.—Section 2105(d)(3) of
 10 the Social Security Act (42 U.S.C.
 11 1397ee(d)(3)) is amended—

12 (i) in the paragraph heading, by strik-
 13 ing “THROUGH SEPTEMBER 30, 2029”; and

14 (ii) in subparagraph (A), in the mat-
 15 ter preceding clause (i)—

16 (I) by striking “During the pe-
 17 riod that begins on the date of enact-
 18 ment of the Patient Protection and
 19 Affordable Care Act and ends on Sep-
 20 tember 30, 2029” and inserting “Be-
 21 ginning on the date of the enactment
 22 of the Patient Protection and Afford-
 23 able Care Act”;

24 (II) by striking “During the pe-
 25 riod that begins on October 1, 2019,

1 and ends on September 30, 2029”
 2 and inserting “Beginning on October
 3 1, 2019”; and

4 (III) by striking “The preceding
 5 sentences shall not be construed as
 6 preventing a State during any such
 7 periods from” and inserting “The pre-
 8 ceding sentences shall not be con-
 9 strued as preventing a State from”.

10 (B) CONFORMING AMENDMENTS.—Section
 11 1902(gg)(2) of the Social Security Act (42
 12 U.S.C. 1396a(gg)(2)) is amended—

13 (i) in the paragraph heading, by strik-
 14 ing “THROUGH SEPTEMBER 30, 2029”; and

15 (ii) by striking “through September
 16 30” and all that follows through “ends on
 17 September 30, 2029” and inserting “(but
 18 beginning on October 1, 2019”.

19 (4) QUALIFYING STATES OPTION.—Section
 20 2105(g)(4) of the Social Security Act (42 U.S.C.
 21 1397ee(g)(4)) is amended—

22 (A) in the paragraph heading, by striking
 23 “FOR FISCAL YEARS 2009 THROUGH 2029” and
 24 inserting “AFTER FISCAL YEAR 2008”; and

1 (B) in subparagraph (A), by striking “for
2 any of fiscal years 2009 through 2029” and in-
3 serting “for any fiscal year after fiscal year
4 2008”.

5 (5) OUTREACH AND ENROLLMENT PROGRAM.—
6 Section 2113 of the Social Security Act (42 U.S.C.
7 1397mm) is amended—

8 (A) in subsection (a)—

9 (i) in paragraph (1), by striking “dur-
10 ing the period of fiscal years 2009 through
11 2029” and inserting “, beginning with fis-
12 cal year 2009,”;

13 (ii) in paragraph (2)—

14 (I) by striking “10 percent of
15 such amounts” and inserting “10 per-
16 cent of such amounts for the period or
17 the fiscal year for which such amounts
18 are appropriated”; and

19 (II) by striking “during such pe-
20 riod” and inserting “, during such pe-
21 riod or such fiscal year,”; and

22 (iii) in paragraph (3), by striking
23 “For the period of fiscal years 2024
24 through 2029, an amount equal to 10 per-
25 cent of such amounts” and inserting “Be-

ginning with fiscal year 2024, an amount
equal to 10 percent of such amounts for
the period or the fiscal year for which such
amounts are appropriated”; and

(B) in subsection (g)—

(i) by striking “and \$40,000,000” and
inserting “\$40,000,000”; and

(ii) by inserting after “fiscal years
2028 and 2029,” the following:
“\$12,000,000 for fiscal year 2030, and,
for each fiscal year after fiscal year 2030,
the amount appropriated under this sub-
section for the previous fiscal year, in-
creased by the percentage increase in the
consumer price index for all urban con-
sumers (all items; United States city aver-
age) over such previous fiscal year,”.

(6) CHILD ENROLLMENT CONTINGENCY
FUND.—Section 2104(n) of the Social Security Act
(42 U.S.C. 1397dd(n)) is amended—

(A) in paragraph (2)—

(i) in subparagraph (A)(ii)—

(I) by striking “and 2024
through 2028” and inserting “and for

1 each fiscal year after fiscal year
2 2023”; and

3 (II) by striking “2023, and
4 2029” and inserting “and 2023”; and
5 (ii) in subparagraph (B)—

6 (I) by striking “2024 through
7 2028” and inserting “and for each
8 fiscal year after fiscal year 2023”;
9 and

10 (II) by striking “2023, and
11 2029” and inserting “and 2023”; and
12 (B) in paragraph (3)(A)—

13 (i) by striking “fiscal years 2024
14 through 2028” and inserting “a fiscal year
15 after fiscal year 2023”; and

16 (ii) by striking “2023, or 2027” and
17 inserting “or 2023”.

18 **SEC. 5502. END DIAPER NEED ACT.**

19 (a) TARGETED FUNDING FOR DIAPER ASSISTANCE
20 (INCLUDING DIAPERING SUPPLIES AND ADULT INCONTI-
21 NENCE MATERIALS AND SUPPLIES) THROUGH THE SO-
22 CIAL SERVICES BLOCK GRANT PROGRAM.—

23 (1) INCREASE IN FUNDING FOR SOCIAL SERV-
24 ICES BLOCK GRANT PROGRAM.—

1 (A) IN GENERAL.—The amount specified
2 in subsection (c) of section 2003 of the Social
3 Security Act (42 U.S.C. 1397b) for purposes of
4 subsections (a) and (b) of such section is
5 deemed to be \$1,900,000,000 for each of fiscal
6 years 2027 through 2030, of which, the amount
7 equal to \$200,000,000, reduced by the amounts
8 reserved under subparagraph (B)(ii) for each
9 such fiscal year, shall be obligated by States in
10 accordance with paragraph (2).

11 (B) APPROPRIATION.—

12 (i) IN GENERAL.—Out of any money
13 in the Treasury of the United States not
14 otherwise appropriated, there is appro-
15 priated \$200,000,000 for each of fiscal
16 years 2027 through 2030, to carry out this
17 subsection.

18 (ii) RESERVATIONS.—

19 (I) PURPOSES.—The Secretary
20 shall reserve, from the amount appro-
21 priated under clause (i) to carry out
22 this subsection—

23 (aa) for each of fiscal years
24 2027 through 2030, not more
25 than 2 percent of the amount ap-

1 appropriated for the fiscal year for
2 purposes of entering into an
3 agreement with a national entity
4 described in clause (iii) to assist
5 in providing technical assistance
6 and training, to support effective
7 policy, practice, research, and
8 cross-system collaboration among
9 grantees and subgrantees, and to
10 assist in the administration of
11 the program described in this
12 subsection; and

13 (bb) for fiscal year 2027, an
14 amount, not to exceed
15 \$2,000,000, for purposes of con-
16 ducting an evaluation under
17 paragraph (4).

18 (II) NO STATE ENTITLEMENT TO
19 RESERVED FUNDS.—The State enti-
20 tlement under section 2002(a) of the
21 Social Security Act (42 U.S.C.
22 1397a(a)) shall not apply to the
23 amounts reserved under subclause (I).

24 (iii) NATIONAL ENTITY DESCRIBED.—

25 A national entity described in this clause is

1 a nonprofit organization described in sec-
2 tion 501(c)(3) of the Internal Revenue
3 Code of 1986 and exempt from taxation
4 under section 501(a) of such Code, that—

5 (I) has experience in more than 1
6 State in the area of—

7 (aa) community distribu-
8 tions of basic need services, in-
9 cluding experience collecting,
10 warehousing, and distributing
11 basic necessities such as diapers,
12 food, or menstrual products;

13 (bb) child care;

14 (cc) child development ac-
15 tivities in low-income commu-
16 nities; or

17 (dd) motherhood, father-
18 hood, or parent education efforts
19 serving low-income parents of
20 young children;

21 (II) demonstrates competency to
22 implement a project, provide fiscal ac-
23 countability, collect data, and prepare
24 reports and other necessary docu-
25 mentation; and

1 (III) demonstrates a willingness
2 to share information with researchers,
3 practitioners, and other interested
4 parties.

5 (2) RULES GOVERNING USE OF ADDITIONAL
6 FUNDS.—

7 (A) IN GENERAL.—Funds are used in ac-
8 cordance with this paragraph if—

9 (i) the State, in consultation with rel-
10 evant stakeholders, including agencies, pro-
11 fessional associations, and nonprofit orga-
12 nizations, distributes the funds to eligible
13 entities to—

14 (I) decrease the need for diapers
15 and diapering supplies and adult in-
16 continence materials and supplies in
17 low-income families and meet such
18 unmet needs of infants and toddlers,
19 medically complex children, and low-
20 income adults and adults with disabil-
21 ities in such families through—

22 (aa) the distribution of free
23 diapers and diapering supplies,
24 medically necessary diapers, and

1 adult incontinence materials and
2 supplies;

3 (bb) community outreach to
4 assist in participation in existing
5 diaper distribution programs or
6 programs that distribute medi-
7 cally necessary diapers or adult
8 incontinence materials and sup-
9 plies; or

10 (cc) improving access to dia-
11 pers and diapering supplies,
12 medically necessary diapers, and
13 adult incontinence materials and
14 supplies; and

15 (II) increase the ability of com-
16 munities and low-income families in
17 such communities to provide for the
18 need for diapers and diapering sup-
19 plies, medically necessary diapers, and
20 adult incontinence materials and sup-
21 plies, of infants and toddlers, medi-
22 cally complex children, and low-income
23 adults and adults with disabilities;

1 (ii) the funds are used subject to the
2 limitations in section 2005 of the Social
3 Security Act (42 U.S.C. 1397d);

4 (iii) the funds are used to supplement,
5 not supplant, State general revenue funds
6 provided for the purposes described in
7 clause (i); and

8 (iv) the funds are not used for costs
9 that are reimbursable by the Federal
10 Emergency Management Agency, under a
11 contract for insurance, or by self-insur-
12 ance.

13 (B) ALLOWABLE USES BY ELIGIBLE ENTI-
14 TIES.—An eligible entity receiving funds made
15 available under paragraph (1) shall use the
16 funds for any of the following:

17 (i) To pay for the purchase and dis-
18 tribution of diapers and diapering supplies,
19 medically necessary diapers, and funding
20 diaper (including medically necessary dia-
21 pers) distribution that serves low-income
22 families with—

23 (I) 1 or more children 3 years of
24 age or younger; or

1 (II) 1 or more medically complex
2 children.

3 (ii) To pay for the purchase and dis-
4 tribution of adult incontinence materials
5 and supplies and funding distribution of
6 such materials and supplies that serves
7 low-income families with 1 or more low-in-
8 come adults or adults with disabilities who
9 rely on adult incontinence materials and
10 supplies.

11 (iii) To integrate activities carried out
12 under clause (i) with other basic needs as-
13 sistance programs serving eligible children
14 and their families, including the following:

15 (I) Programs funded by the tem-
16 porary assistance for needy families
17 program under part A of title IV of
18 the Social Security Act (42 U.S.C.
19 601 et seq.), including the State
20 maintenance of effort provisions of
21 such program.

22 (II) Programs designed to sup-
23 port the health of eligible children,
24 such as the Children's Health Insur-
25 ance Program under title XXI of the

1 Social Security Act, the Medicaid pro-
2 gram under title XIX of such Act, or
3 State-funded health care programs.

4 (III) Programs funded through
5 the special supplemental nutrition
6 program for women, infants, and chil-
7 dren under section 17 of the Child
8 Nutrition Act of 1966.

9 (IV) Programs that offer early
10 home visiting services, including the
11 maternal, infant, and early childhood
12 home visiting program (including the
13 Tribal home visiting program) under
14 section 511 of the Social Security Act
15 (42 U.S.C. 711).

16 (V) Programs to provide im-
17 proved and affordable access to child
18 care, including programs funded
19 through the Child Care and Develop-
20 ment Fund, the temporary assistance
21 for needy families program under part
22 A of title IV of the Social Security
23 Act (42 U.S.C. 601 et seq.), or a
24 State-funded program.

25 (C) AVAILABILITY OF FUNDS.—

1 (i) FUNDS DISTRIBUTED TO ELIGIBLE
2 ENTITIES.—Funds made available under
3 paragraph (1) that are distributed to an el-
4 igible entity by a State for a fiscal year
5 may be expended by the eligible entity only
6 in such fiscal year or the succeeding fiscal
7 year.

8 (ii) EVALUATION.—Funds reserved
9 under paragraph (1)(B)(ii)(I)(aa) to carry
10 out the evaluation under paragraph (4)
11 shall be available for expenditure during
12 the 3-year period that begins on the date
13 of enactment of this Act.

14 (D) NO EFFECT ON OTHER PROGRAMS.—
15 Any assistance or benefits received by a family
16 through funds made available under paragraph
17 (1) shall be disregarded for purposes of deter-
18 mining the family's eligibility for, or amount of,
19 benefits under any other Federal needs-based
20 programs.

21 (3) ANNUAL REPORTS.—A State shall include
22 in the annual report required under section 2006 of
23 the Social Security Act (42 U.S.C. 1397e) covering
24 each of fiscal years 2027 through 2030, information
25 detailing how eligible entities, including subgrantees,

1 used funds made available under paragraph (1) to
2 distribute diapers and diapering supplies and adult
3 incontinence materials and supplies to families in
4 need. Each such report shall include the following:

5 (A) The number and age of infants, tod-
6 dlers, medically complex children, and low-in-
7 come adults and adults with disabilities who re-
8 ceived assistance or benefits through such
9 funds.

10 (B) The number of families that have re-
11 ceived assistance or benefits through such
12 funds.

13 (C) The number of diapers, medically nec-
14 essary diapers, or adult incontinence materials
15 and supplies (such as adult diapers, briefs, pro-
16 tective underwear, pull-ons, pull-ups, liners,
17 shields, guards, pads, undergarments), and the
18 number of each type of diapering or adult in-
19 continence supply, distributed through the use
20 of such funds.

21 (D) The ZIP Code or ZIP Codes where the
22 eligible entity (or subgrantee) distributed dia-
23 pers and diapering supplies and adult inconti-
24 nence materials and supplies.

1 (E) The method or methods the eligible en-
2 tity (or subgrantee) uses to distribute diapers
3 and diapering supplies and, adult incontinence
4 materials and supplies.

5 (F) Such other information as the Sec-
6 retary may specify.

7 (4) EVALUATION.—The Secretary, in consulta-
8 tion with States, the national entity described in
9 paragraph (1)(B)(iii), and eligible entities receiving
10 funds made available under this subsection, shall—

11 (A) not later than 2 years after the date
12 of enactment of this Act—

13 (i) complete an evaluation of the effec-
14 tiveness of the assistance program carried
15 out pursuant to this subsection, such as
16 the effect of activities carried out under
17 this section on mitigating the health and
18 developmental risks of unmet diaper need
19 among infants, toddlers, medically complex
20 children, and other family members in low-
21 income families, including the risks of dia-
22 per dermatitis, urinary tract infections,
23 and parental and child depression and anx-
24 iety;

1 (ii) submit to the relevant congres-
2 sional committees a report on the results
3 of such evaluation; and

4 (iii) publish the results of the evalua-
5 tion on the internet website of the Depart-
6 ment of Health and Human Services;

7 (B) not later than 3 years after the date
8 of enactment of this Act, update the evaluation
9 required by subparagraph (A)(i); and

10 (C) not later than 90 days after completion
11 of the updated evaluation under subparagraph
12 (B)—

13 (i) submit to the relevant congres-
14 sional committees a report describing the
15 results of such updated evaluation; and

16 (ii) publish the results of such evalua-
17 tion on the internet website of the Depart-
18 ment of Health and Human Services.

19 (5) GUIDANCE.—Not later than 180 days after
20 enactment of this Act, the Secretary shall issue
21 guidance regarding how the provisions of this sub-
22 section should be carried out, including information
23 regarding eligible entities, allowable use of funds,
24 and reporting requirements.

25 (6) DEFINITIONS.—In this subsection:

1 (A) ADULT INCONTINENCE MATERIALS
2 AND SUPPLIES.—The term “adult incontinence
3 materials and supplies” means those supplies
4 that are used to assist low-income adults or
5 adults with disabilities and includes adult dia-
6 pers, briefs, protective underwear, pull-ons,
7 pull-ups, liners, shields, guards, pads, undergar-
8 ments, disposable wipes, over-the-counter adult
9 diaper rash cream products, intermittent cath-
10 eterization, indwelling catheters, condom cath-
11 eters, urinary drainage bags, external collection
12 devices, wearable urinals, and penile clamps.

13 (B) ADULTS WITH DISABILITIES.—The
14 term “adults with disabilities” means individ-
15 uals who—

- 16 (i) have attained age 18; and
17 (ii) have a disability (as such term is
18 defined, with respect to an individual, in
19 section 3 of the Americans with Disabil-
20 ities Act of 1990 (42 U.S.C. 12102)).

21 (C) DIAPER.—The term “diaper” means
22 an absorbent garment that—

- 23 (i) is washable or disposable that may
24 be worn by an infant or toddler who is not
25 toilet-trained; and

1 (ii) if disposable—

2 (I) does not use any latex or
3 common allergens; and

4 (II) meets or exceeds the quality
5 standards for diapers commercially
6 available through retail sale in the fol-
7 lowing categories:

8 (aa) Absorbency (with ac-
9 ceptable rates for first and sec-
10 ond wetting).

11 (bb) Waterproof outer cover.

12 (cc) Flexible leg openings.

13 (dd) Refastening closures.

14 (D) DIAPERING SUPPLIES.—The term
15 “diapering supplies” means items, including di-
16 aper wipes and diaper cream, necessary to en-
17 sure that—

18 (i) an eligible child using a diaper is
19 properly cleaned and protected from diaper
20 rash; or

21 (ii) a medically complex child who
22 uses a medically necessary diaper is prop-
23 erly cleaned and protected from diaper
24 rash.

1 (E) ELIGIBLE CHILD.—The term “eligible
2 child” means a child who—

- 3 (i) has not attained 4 years of age;
4 and
5 (ii) is a member of a low-income fam-
6 ily.

7 (F) ELIGIBLE ENTITIES.—The term “eligi-
8 ble entity” means a State or local governmental
9 entity, an Indian tribe or tribal organization (as
10 defined in section 4 of the Indian Self-Deter-
11 mination and Education Assistance Act), or a
12 nonprofit organization described in section
13 501(c)(3) of the Internal Revenue Code of 1986
14 and exempt from taxation under section 501(a)
15 of such Code that—

- 16 (i) has experience in the area of—

17 (I) community distributions of
18 basic need services, including experi-
19 ence collecting, warehousing, and dis-
20 tributing basic necessities such as dia-
21 pers, food, or menstrual products;

22 (II) child care;

23 (III) child development activities
24 in low-income communities; or

1 (IV) motherhood, fatherhood, or
2 parent education efforts serving low-
3 income parents of young children;

4 (ii) demonstrates competency to im-
5 plement a project, provide fiscal account-
6 ability, collect data, and prepare reports
7 and other necessary documentation; and

8 (iii) demonstrates a willingness to
9 share information with researchers, practi-
10 tioners, and other interested parties.

11 (G) FEDERAL POVERTY LINE.—The term
12 “Federal poverty line” means the Federal pov-
13 erty line as defined by the Office of Manage-
14 ment and Budget and revised annually in ac-
15 cordance with section 673(2) of the Omnibus
16 Budget Reconciliation Act of 1981 applicable to
17 a family of the size involved.

18 (H) LOW-INCOME.—The term “low-in-
19 come”, with respect to a family, means a family
20 whose self-certified income is not more than
21 200 percent of the Federal poverty line.

22 (I) MEDICALLY COMPLEX CHILD.—The
23 term “medically complex child” means an indi-
24 vidual who has attained age 3 and for whom a
25 licensed health care provider has provided a di-

1 agnosis of bowel or bladder incontinence, a
2 bowel or bladder condition that causes excess
3 urine or stool (such as short gut syndrome or
4 diabetes insipidus), or a severe skin condition
5 that causes skin erosions (such as epidermolysis
6 bullosa).

7 (J) MEDICALLY NECESSARY DIAPER.—The
8 term “medically necessary diaper” means an
9 absorbent garment that is—

10 (i) washable or disposable;

11 (ii) worn by a medically complex child
12 who has been diagnosed with bowel or
13 bladder incontinence, a bowel or bladder
14 condition that causes excess urine or stool
15 (such as short gut syndrome or diabetes
16 insipidus), or a severe skin condition that
17 causes skin erosions (such as epidermolysis
18 bullosa) and needs such garment to correct
19 or ameliorate such condition; and

20 (iii) if disposable—

21 (I) does not use any latex or
22 common allergens; and

23 (II) meets or exceeds the quality
24 standards for diapers commercially

1 available through retail sale in the fol-
 2 lowing categories:

3 (aa) Absorbency (with ac-
 4 ceptable rates for first and sec-
 5 ond wetting).

6 (bb) Waterproof outer cover.

7 (cc) Flexible leg openings.

8 (dd) Refastening closures.

9 (7) EXEMPTION OF PROGRAM FROM SEQUES-
 10 TRATION.—

11 (A) IN GENERAL.—Section 255(h) of the
 12 Balanced Budget and Emergency Deficit Con-
 13 trol Act of 1985 (2 U.S.C. 905(h)) is amended
 14 by inserting after “Supplemental Security In-
 15 come Program (28–0406–0–1–609).” the fol-
 16 lowing:

17 “Targeted funding for States for diaper assist-
 18 ance (including diapering supplies and adult inconti-
 19 nence materials and supplies) through the Social
 20 Services Block Grant Program.”.

21 (B) APPLICABILITY.—The amendment
 22 made by this paragraph shall apply to any se-
 23 questration order issued under the Balanced
 24 Budget and Emergency Deficit Control Act of

1 1985 (2 U.S.C. 900 et seq.) on or after the
2 date of enactment of this Act.

3 (b) IMPROVING ACCESS TO DIAPERS FOR MEDICALLY
4 COMPLEX CHILDREN.—Section 1915(c) of the Social Se-
5 curity Act (42 U.S.C. 1396n(c)) is amended by adding at
6 the end the following new paragraph:

7 “(12)(A) In the case of any waiver under this sub-
8 section that provides medical assistance to a medically
9 complex child who has been diagnosed with bowel or blad-
10 der incontinence, a bowel or bladder condition that causes
11 excess urine or stool (such as short gut syndrome or diabe-
12 tes insipidus), or a severe skin condition that causes skin
13 erosions (such as epidermolysis bullosa), such medical as-
14 sistance shall include, for the duration of the waiver, the
15 provision of 200 medically necessary diapers per month
16 and diapering supplies. Such medical assistance may in-
17 clude the provision of medically necessary diapers in
18 amounts greater than 200 if a licensed health care pro-
19 vider (such as a physician, nurse practitioner, or physician
20 assistant) specifies that such greater amounts are nec-
21 essary for such medically complex child.

22 “(B) For purposes of this paragraph:

23 “(i) The term ‘medically complex child’ means
24 an individual who has attained age 3 and for whom

1 a licensed health care provider has provided a diag-
 2 nosis of 1 or more significant chronic conditions.

3 “(ii) The term ‘medically necessary diaper’
 4 means an absorbent garment that is—

5 “(I) washable or disposable;

6 “(II) worn by a medically complex child
 7 who has been diagnosed with a condition de-
 8 scribed in subparagraph (A) and needs such
 9 garment to correct or ameliorate such condition;
 10 and

11 “(III) if disposable—

12 “(aa) does not use any latex or com-
 13 mon allergens; and

14 “(bb) meets or exceeds the quality
 15 standards for diapers commercially avail-
 16 able through retail sale in the following
 17 categories:

18 “(AA) Absorbency (with accept-
 19 able rates for first and second wet-
 20 ting).

21 “(BB) Waterproof outer cover.

22 “(CC) Flexible leg openings.

23 “(DD) Refastening closures.

24 “(iii) The term ‘diapering supplies’ means
 25 items, including diaper wipes and diaper creams,

1 necessary to ensure that a medically complex child
 2 who has been diagnosed with a condition described
 3 in subparagraph (A) and uses a medically necessary
 4 diaper is properly cleaned and protected from diaper
 5 rash.”.

6 (c) INCLUSION OF DIAPERS AND DIAPERING SUP-
 7 PLIES AS QUALIFIED MEDICAL EXPENSES.—

8 (1) HEALTH SAVINGS ACCOUNTS.—Section
 9 223(d)(2) of the Internal Revenue Code of 1986 is
 10 amended—

11 (A) by inserting “, medically necessary dia-
 12 pers, and diapering supplies” after “menstrual
 13 care products” in the last sentence of subpara-
 14 graph (A); and

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

17 “(E) MEDICALLY NECESSARY DIAPERS
 18 AND DIAPERING SUPPLIES.—For purposes of
 19 this paragraph—

20 “(i) MEDICALLY NECESSARY DIA-
 21 PERS.—The term ‘medically necessary dia-
 22 per’ means an absorbent garment which is
 23 washable or disposable and which is worn
 24 by an individual who has attained 3 years
 25 of age because of medical necessity, such

1 as someone who has been diagnosed with
2 bowel or bladder incontinence, a bowel or
3 bladder condition that causes excess urine
4 or stool (such as short gut syndrome or di-
5 abetes insipidus), or a severe skin condi-
6 tion that causes skin erosions (such as
7 epidermolysis bullosa) and needs such gar-
8 ment to correct or ameliorate such condi-
9 tion, to serve a preventative medical pur-
10 pose, or to correct or ameliorate defects or
11 physical or mental illnesses or conditions
12 diagnosed by a licensed health care pro-
13 vider, and, if disposable—

14 “(I) does not use any latex or
15 common allergens; and

16 “(II) meets or exceeds the quality
17 standards for diapers commercially
18 available through retail sale in the fol-
19 lowing categories:

20 “(aa) Absorbency (with ac-
21 ceptable rates for first and sec-
22 ond wetting).

23 “(bb) Waterproof outer
24 cover.

25 “(cc) Flexible leg openings.

1 “(dd) Refastening closures.

2 “(ii) DIAPERING SUPPLIES.—The
3 term ‘diapering supplies’ means items, in-
4 cluding diaper wipes and diaper creams,
5 necessary to ensure that an individual
6 wearing medically necessary diapers is
7 properly cleaned and protected from diaper
8 rash.”.

9 (2) ARCHER MSAS.—The last sentence of sec-
10 tion 220(d)(2)(A) of such Code is amended by in-
11 serting “, medically necessary diapers (as defined in
12 section 223(d)(2)(E)), and diapering supplies (as de-
13 fined in section 223(d)(2)(E))” after “menstrual
14 care products (as defined in section 223(d)(2)(D))”.

15 (3) HEALTH FLEXIBLE SPENDING ARRANGE-
16 MENTS AND HEALTH REIMBURSEMENT ARRANGE-
17 MENTS.—Section 106(f) of such Code is amended—

18 (A) by inserting “, medically necessary dia-
19 pers (as defined in section 223(d)(2)(E)), and
20 diapering supplies (as defined in section
21 223(d)(2)(E))” after “menstrual care products
22 (as defined in section 223(d)(2)(D))”; and

23 (B) in the heading, by inserting “, MEDI-
24 CALLY NECESSARY DIAPERS, AND DIAPERING

1 SUPPLIES” after “MENSTRUAL CARE PROD-
2 UCTS”.

3 (4) EFFECTIVE DATES.—

4 (A) DISTRIBUTIONS FROM CERTAIN AC-
5 COUNTS.—The amendments made by para-
6 graphs (1) and (2) shall apply to amounts paid
7 after December 31, 2026.

8 (B) REIMBURSEMENTS.—The amendment
9 made by paragraph (3) shall apply to expenses
10 incurred after December 31, 2026.

11 **SEC. 5503. DECREASING THE RISK FACTORS FOR SUDDEN**
12 **UNEXPECTED INFANT DEATH AND SUDDEN**
13 **UNEXPLAINED DEATH IN CHILDHOOD.**

14 (a) ESTABLISHMENT.—The Secretary of Health and
15 Human Services, acting through the Administrator of the
16 Health Resources and Services Administration and in con-
17 sultation with the Director of the Centers for Disease Con-
18 trol and Prevention and the Director of the National Insti-
19 tutes of Health (in this section referred to as the “Sec-
20 retary”), shall establish and implement a culturally and
21 linguistically competent public health awareness and edu-
22 cation campaign to provide information that is focused on
23 decreasing the risk factors for sudden unexpected infant
24 death and sudden unexplained death in childhood, includ-
25 ing educating individuals about safe sleep environments,

1 sleep positions, and reducing exposure to smoking during
2 pregnancy and after birth.

3 (b) TARGETED POPULATIONS.—The campaign under
4 subsection (a) shall be designed to reduce health inequal-
5 ities through the targeting of populations with high rates
6 of sudden unexpected infant death or of sudden unex-
7 plained death in childhood.

8 (c) CONSULTATION.—In establishing and imple-
9 menting the campaign under subsection (a), the Secretary
10 shall consult with national organizations representing (col-
11 lectively) health care providers, including nurses and phy-
12 sicians, parents, child care providers, children’s advocacy
13 and safety organizations, maternal and child health pro-
14 grams, nutrition professionals focusing on (collectively)
15 people, infants, and children, and other individuals and
16 groups determined necessary by the Secretary for such es-
17 tablishment and implementation.

18 (d) GRANTS.—

19 (1) IN GENERAL.—In carrying out the cam-
20 paign under subsection (a), the Secretary shall
21 award grants to national organizations, State and
22 local health departments, and community-based or-
23 ganizations for the conduct of education and out-
24 reach programs for nurses, parents, child care pro-

1 viders, community health workers, public health
2 agencies, and community organizations.

3 (2) APPLICATION.—To be eligible to receive a
4 grant under paragraph (1), an entity shall submit to
5 the Secretary an application at such time, in such
6 manner, and containing such information as the Sec-
7 retary may require.

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2027 through 2031.

12 **Subtitle G—Elder Care**

13 **SEC. 5601. EXPENSES FOR HOUSEHOLD AND ELDER CARE** 14 **SERVICES NECESSARY FOR GAINFUL EM-** 15 **PLOYMENT.**

16 (a) IN GENERAL.—Subpart A of part IV of sub-
17 chapter A of chapter 1 of the Internal Revenue Code of
18 1986 is amended by inserting after section 25F the fol-
19 lowing new section:

20 **“SEC. 25G. EXPENSES FOR HOUSEHOLD AND ELDER CARE** 21 **SERVICES NECESSARY FOR GAINFUL EM-** 22 **PLOYMENT.**

23 “(a) ALLOWANCE OF CREDIT.—

24 “(1) IN GENERAL.—In the case of an individual
25 for which there are one or more qualifying individ-

1 uals (as defined in subsection (b)(1)) with respect to
 2 such individual, there shall be allowed as a credit
 3 against the tax imposed by this chapter for the tax-
 4 able year an amount equal to the applicable percent-
 5 age of the employment-related expenses (as defined
 6 in subsection (b)(3)) paid by such individual during
 7 the taxable year.

8 “(2) APPLICABLE PERCENTAGE DEFINED.—For
 9 purposes of paragraph (1), the term ‘applicable per-
 10 centage’ means 35 percent reduced (but not below
 11 20 percent) by 1 percentage point for each \$2,000
 12 (or fraction thereof) by which the taxpayer’s ad-
 13 justed gross income for the taxable year exceeds
 14 \$15,000.

15 “(b) DEFINITIONS OF QUALIFYING INDIVIDUAL AND
 16 EMPLOYMENT-RELATED EXPENSES.—For purposes of
 17 this section—

18 “(1) QUALIFYING INDIVIDUAL.—The term
 19 ‘qualifying individual’ means an individual who—

20 “(A) has attained age 50, and

21 “(B) satisfies the requirements of any of
 22 the following clauses:

23 “(i) An individual who bears a rela-
 24 tionship to the taxpayer described in sub-
 25 paragraph (C) or (D) of section 152(d)(2)

1 (relating to fathers, mothers, and ances-
2 tors).

3 “(ii) An individual who would be a de-
4 pendent of the taxpayer (as defined in sec-
5 tion 152, determined without regard to
6 subsections (b)(1) and (b)(2)) as a quali-
7 fying relative described in section
8 152(d)(1) if—

9 “(I) in lieu of the requirements
10 under subparagraphs (B) and (C) of
11 such section, with respect to such in-
12 dividual—

13 “(aa) the taxpayer has pro-
14 vided over one-half of the individ-
15 ual’s support for the calendar
16 year in which such taxable year
17 begins and each of the preceding
18 4 taxable years, and

19 “(bb) the individual’s modi-
20 fied adjusted gross income for
21 the calendar year in which such
22 taxable year begins is less than
23 the exemption amount (as de-
24 fined in section 151(d)),

1 “(II) the individual is physically
2 or mentally incapable of caring for
3 himself or herself, and

4 “(III) the individual has the
5 same principal place of abode as the
6 taxpayer for more than one-half of
7 such taxable year.

8 “(iii) The spouse of the taxpayer, if
9 such spouse is physically or mentally in-
10 capable of caring for himself or herself.

11 “(2) MODIFIED ADJUSTED GROSS INCOME.—
12 The term ‘modified adjusted gross income’ means
13 adjusted gross income determined without regard to
14 section 86.

15 “(3) EMPLOYMENT-RELATED EXPENSES.—

16 “(A) IN GENERAL.—The term ‘employ-
17 ment-related expenses’ means amounts paid for
18 the following expenses, but only if such ex-
19 penses are incurred to enable the taxpayer to be
20 gainfully employed for any period for which
21 there are one or more qualifying individuals
22 with respect to the taxpayer:

23 “(i) Expenses for household services
24 with respect to the qualifying individual.

1 “(ii) Expenses for the care of a quali-
2 fying individual, including expenses for res-
3 pite care and hospice care.

4 “(B) EXCEPTION.—The term ‘employ-
5 ment-related expenses’ shall not include services
6 provided outside the taxpayer’s household un-
7 less such expenses are incurred for the care
8 of—

9 “(i) a qualifying individual described
10 in paragraph (1)(A), or

11 “(ii) a qualifying individual (not de-
12 scribed in paragraph (1)(A)) who regularly
13 spends at least 8 hours each day in the
14 taxpayer’s household.

15 “(C) DEPENDENT CARE CENTERS.—The
16 term ‘employment-related expenses’ shall not
17 include services provided outside the taxpayer’s
18 household by a dependent care center (as de-
19 fined in subparagraph (D)) unless—

20 “(i) such center complies with all ap-
21 plicable laws and regulations of the State
22 and local government in which such center
23 is located, and

24 “(ii) the requirements of subpara-
25 graph (B) are met.

1 “(D) DEPENDENT CARE CENTER DE-
2 FINED.—For purposes of this paragraph, the
3 term ‘dependent care center’ means any facility
4 which—

5 “(i) provides care for more than 6 in-
6 dividuals (other than individuals who re-
7 side at the facility), and

8 “(ii) receives a fee, payment, or grant
9 for providing services for any of the indi-
10 viduals (regardless of whether such facility
11 is operated for profit).

12 “(c) DOLLAR LIMIT ON AMOUNT CREDITABLE.—The
13 amount of the employment-related expenses incurred dur-
14 ing any taxable year which may be taken into account
15 under subsection (a) shall not exceed—

16 “(1) if there is 1 qualifying individual with re-
17 spect to the taxpayer for such taxable year, \$3,000,
18 or

19 “(2) if there are 2 or more qualifying individ-
20 uals with respect to the taxpayer for such taxable
21 year, \$6,000.

22 The amount determined under this subsection shall be re-
23 duced by the aggregate amount excludable from gross in-
24 come under section 129 for the taxable year.

1 “(d) EARNED INCOME LIMITATION.—The amount of
2 the employment-related expenses incurred during any tax-
3 able year which may be taken into account under sub-
4 section (a) shall not exceed—

5 “(1) in the case of an individual who is not
6 married at the close of such year, such individual’s
7 earned income for such year, or

8 “(2) in the case of an individual who is married
9 at the close of such year, the lesser of such individ-
10 ual’s earned income or the earned income of the in-
11 dividual’s spouse for such year.

12 “(e) SPECIAL RULES.—For purposes of this sec-
13 tion—

14 “(1) PLACE OF ABODE.—An individual shall
15 not be treated as having the same principal place of
16 abode of the taxpayer if at any time during the tax-
17 able year of the taxpayer the relationship between
18 the individual and the taxpayer is in violation of
19 local law.

20 “(2) MARRIED COUPLES MUST FILE JOINT RE-
21 TURN.—In the case of an individual who is married
22 as of the close of the taxable year, the credit shall
23 be allowed under subsection (a) only if a joint return
24 is filed for the taxable year under section 6013.

1 “(3) MARITAL STATUS.—An individual legally
2 separated from the individual’s spouse under a de-
3 cree of divorce or of separate maintenance shall not
4 be considered as married.

5 “(4) CERTAIN MARRIED INDIVIDUALS LIVING
6 APART.—In the case of an individual who is married
7 and does not file a joint return for the taxable year,
8 if—

9 “(A) such individual—

10 “(i) maintains as such individual’s
11 home a household which constitutes for
12 more than one-half of the taxable year the
13 principal place of abode of a qualifying in-
14 dividual, and

15 “(ii) furnishes over half of the cost of
16 maintaining such household during the
17 taxable year, and

18 “(B) during the last 6 months of such tax-
19 able year, such individual’s spouse is not a
20 member of such household,
21 such individual shall not be considered as married.

22 “(5) PAYMENTS TO RELATED INDIVIDUALS.—
23 No credit shall be allowed under subsection (a) for
24 any amount paid by the taxpayer to an individual—

1 “(A) with respect to whom, for the taxable
2 year, a deduction under section 151(c) (relating
3 to deduction for personal exemptions for de-
4 pendents) is allowable either to the taxpayer or
5 the taxpayer’s spouse, or

6 “(B) who—

7 “(i) is a child of the taxpayer (within
8 the meaning of section 152(f)(1)), and

9 “(ii) has not attained the age of 19 at
10 the close of the taxable year.

11 For purposes of this paragraph, the term ‘taxable
12 year’ means the taxable year of the taxpayer in
13 which the service (as described in clause (i) of sub-
14 section (b)(3)(A)) is performed or the care (as de-
15 scribed in clause (ii) of such subsection) is provided.

16 “(6) IDENTIFYING INFORMATION REQUIRED
17 WITH RESPECT TO SERVICE PROVIDER.—No credit
18 shall be allowed under subsection (a) for any amount
19 paid to any person unless—

20 “(A) the name, address, and taxpayer
21 identification number of such person are in-
22 cluded on the return of tax for the taxable year
23 in which the credit under this section is being
24 claimed, or

1 “(B) if such person is an organization de-
 2 scribed in section 501(c)(3) and exempt from
 3 tax under section 501(a), the name and address
 4 of such person are included on the return of tax
 5 for the taxable year in which the credit under
 6 this section is being claimed.

7 In the case of a failure to provide the information
 8 required under the preceding sentence, the preceding
 9 sentence shall not apply if it is shown that the tax-
 10 payer exercised due diligence in attempting to pro-
 11 vide the information so required.

12 “(7) IDENTIFYING INFORMATION REQUIRED
 13 WITH RESPECT TO QUALIFYING INDIVIDUALS.—No
 14 credit shall be allowed under this section with re-
 15 spect to any qualifying individual unless the TIN of
 16 such individual is included on the return of tax for
 17 the taxable year in which the credit under this sec-
 18 tion is being claimed.

19 “(f) REGULATIONS.—The Secretary shall prescribe
 20 such regulations as may be necessary to carry out the pur-
 21 poses of this section.”.

22 (b) CLERICAL AMENDMENT.—The table of sections
 23 for subpart A of part IV of subchapter A of chapter 1
 24 of the Internal Revenue Code of 1986 is amended by in-

1 serting after the item relating to section 25F the following
 2 new item:

“Sec. 25G. Expenses for household and elder care services necessary for gainful employment.”.

3 (c) **EFFECTIVE DATE.**—The amendments made by
 4 this section shall apply to taxable years beginning after
 5 the date of the enactment of this Act.

6 **Subtitle H—Miscellaneous** 7 **Provisions**

8 **SEC. 5701. CLARIFICATION SUPPORTING PERMISSIBLE USE** 9 **OF FUNDS FOR STILLBIRTH PREVENTION AC-** 10 **TIVITIES.**

11 Section 501(a) of the Social Security Act (42 U.S.C.
 12 701(a)) is amended—

13 (1) in paragraph (1)(B), by inserting “to re-
 14 duce the incidence of stillbirth,” after “among chil-
 15 dren,”; and

16 (2) in paragraph (2), by inserting after “follow-
 17 up services” the following: “, and for evidence-based
 18 programs and activities and outcome research to re-
 19 duce the incidence of stillbirth (including tracking
 20 and awareness of fetal movements, improvement of
 21 birth timing for pregnancies with risk factors, initia-
 22 tives that encourage safe sleeping positions during
 23 pregnancy, screening and surveillance for fetal
 24 growth restriction, efforts to achieve smoking ces-

1 sation during pregnancy, community-based programs
 2 that provide home visits or other types of support,
 3 and any other research or evidence-based program-
 4 ming to prevent stillbirths)’’.

5 **TITLE VI—MENTAL HEALTH AND** 6 **SUBSTANCE USE DISORDERS**

7 **SEC. 6001. SENSE OF CONGRESS.**

8 It is the sense of the Congress that it is imperative
 9 that a comprehensive public health approach to addressing
 10 trauma and mental health care be focused on care delivery
 11 that is culturally and linguistically appropriate.

12 **Subtitle A—Access to Care and** 13 **Funding Streams**

14 **SEC. 6101. COVERAGE OF SUBSTANCE USE DISORDER** 15 **COUNSELOR SERVICES AND PEER SUPPORT** 16 **SPECIALIST SERVICES UNDER PART B OF** 17 **THE MEDICARE PROGRAM.**

18 (a) COVERAGE OF SERVICES.—

19 (1) IN GENERAL.—Section 1861(s)(2) of the
 20 Social Security Act (42 U.S.C. 1395x(s)(2)), as
 21 amended by section 4251(c)(1), is amended—

22 (A) in subparagraph (KK), by striking
 23 “and” at the end;

24 (B) by inserting “and” at the end of sub-
 25 paragraph (LL); and

1 (C) by adding at the end the following new
 2 subparagraph:

3 “(MM) substance use disorder counselor serv-
 4 ices (as defined in subsection (rrr)(1)), and peer
 5 support specialist services (as defined in subsection
 6 (rrr)(3));”.

7 (2) DEFINITIONS.—Section 1861 of the Social
 8 Security Act (42 U.S.C. 1395x), as amended by sec-
 9 tions 2007(b), 4221(a), and 4251(c)(2), is amended
 10 by adding at the end the following new subsection:

11 “Substance Use Disorder Counselor Services; Substance
 12 Use Disorder Counselor; Peer Support Specialist
 13 Services; Peer Support Specialist

14 “(rrr)(1) The term ‘substance use disorder counselor
 15 services’ means services performed by a substance use dis-
 16 order counselor (as defined in paragraph (2)) for the diag-
 17 nosis and treatment of substance use disorder and addic-
 18 tion that the substance use disorder counselor is legally
 19 authorized to perform under State law (or the State regu-
 20 latory mechanism provided by the State law) of the State
 21 in which such services are performed, as would otherwise
 22 be covered if furnished by a physician or as incident to
 23 a physician’s professional service, but only if no facility
 24 or other provider charges or is paid any amounts with re-
 25 spect to the furnishing of such services.

1 “(2) The term ‘substance use disorder counselor’
2 means an individual who—

3 “(A) has performed at least 2 years of super-
4 vised substance use disorder counselor practice;

5 “(B) in the case of an individual performing
6 services in a State that provides for licensure or cer-
7 tification of substance use disorder counselors or
8 professional counselors, is licensed or certified as a
9 substance use disorder counselor or professional
10 counselor in such State; or

11 “(C) is a drug and alcohol counselor as de-
12 scribed in section 40.281(a)(6) of title 49, Code of
13 Federal Regulations.

14 “(3) The term ‘peer support specialist services’
15 means services performed by a peer support specialist (as
16 defined in paragraph (4)) for the well-being of individuals
17 needing mental health support that the peer support spe-
18 cialist is legally authorized to perform under State law (or
19 the State regulatory mechanism provided by the State
20 law) of the State in which such services are performed,
21 as would otherwise be covered if furnished by a physician
22 or as incident to a physician’s professional service, but
23 only if no facility or other provider charges or is paid any
24 amounts with respect to the furnishing of such services.

1 “(4) The term ‘peer support specialist’ means an in-
2 dividual who—

3 “(A) is an individual living in recovery with
4 mental illness, addiction, or justice system involve-
5 ment;

6 “(B) has skills learned in formal training;

7 “(C) uses assets-based framing in speaking
8 about mental health, recovery, and well-being; and

9 “(D) delivers services in behavioral health set-
10 tings to promote mind-body recovery and resil-
11 iency.”.

12 (3) PROVISION FOR PAYMENT UNDER PART
13 B.—Section 1832(a)(2)(B) of the Social Security
14 Act (42 U.S.C. 1395k(a)(2)(B)) is amended by add-
15 ing at the end the following new clause:

16 “(v) substance use disorder counselor
17 services and peer support specialist serv-
18 ices;”.

19 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
20 of the Social Security Act (42 U.S.C. 1395l(a)(1)),
21 as amended by section 4251(c)(3), is amended—

22 (A) by striking “and” before “(II)”; and

23 (B) by inserting before the semicolon at
24 the end the following: “, and (JJ) with respect
25 to substance use disorder counselor services and

peer support specialist services under section 1861(s)(2)(MM), 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 PEER SUPPORT SPECIALIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting “peer support specialist services (as defined in section 1861(rrr)(3)),” after “mental health counselor services (as defined in section 1861(lll)(3))”.

(6) INCLUSION OF SUBSTANCE USE DISORDER COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

“(ix) A substance use disorder counselor (as defined in section 1861(rrr)(2)).

“(x) A peer support specialist (as defined in section 1861(rrr)(4)).”.

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDER-

1 ALLY QUALIFIED HEALTH CENTERS.—Section
 2 1861(aa)(1)(B) of the Social Security Act (42 U.S.C.
 3 1395x(aa)(1)(B)) is amended by striking “or by a mental
 4 health counselor (as defined in subsection (lll)(4))” and
 5 inserting “by a mental health counselor (as defined in sub-
 6 section (lll)(4)), by a substance use disorder counselor (as
 7 defined in subsection (rrr)(2)), or by a peer support spe-
 8 cialist (as defined in subsection (rrr)(4))”.

9 (c) EFFECTIVE DATE.—The amendments made by
 10 this section shall apply with respect to services furnished
 11 on or after January 1, 2027.

12 **SEC. 6102. REAUTHORIZATION OF MINORITY FELLOWSHIP**
 13 **PROGRAM.**

14 Section 597(c) of the Public Health Service Act (42
 15 U.S.C. 290ll(c)) is amended by striking “\$25,000,000 for
 16 each of fiscal years 2023 through 2027” and inserting
 17 “\$36,700,000 for each of fiscal years 2027 through
 18 2031”.

19 **SEC. 6103. ADDITIONAL FUNDS FOR NATIONAL INSTITUTES**
 20 **OF HEALTH.**

21 (a) IN GENERAL.—In addition to amounts otherwise
 22 authorized to be appropriated to the National Institutes
 23 of Health, there is authorized to be appropriated to such
 24 Institutes \$150,000,000 for each of fiscal years 2027
 25 through 2032—

1 (1) to build relations with communities and
 2 conduct or support clinical research, including clin-
 3 ical research on racial or ethnic disparities in phys-
 4 ical and mental health; and

5 (2) to carry out the Strategic Framework For
 6 Addressing Youth Mental Health Disparities devel-
 7 oped by the National Institute of Mental Health.

8 (b) DEFINITION.—In this section, the term “clinical
 9 research” has the meaning given to such term in section
 10 409 of the Public Health Service Act (42 U.S.C. 284d).

11 **SEC. 6104. ADDITIONAL FUNDS FOR NATIONAL INSTITUTE**
 12 **ON MINORITY HEALTH AND HEALTH DISPARI-**
 13 **TIES.**

14 In addition to amounts otherwise authorized to be ap-
 15 propriated to the National Institute on Minority Health
 16 and Health Disparities, there is authorized to be appro-
 17 priated to such Institute \$750,000,000 for each of fiscal
 18 years 2027 through 2032.

19 **SEC. 6105. GRANTS FOR INCREASING RACIAL AND ETHNIC**
 20 **MINORITY ACCESS TO HIGH-QUALITY TRAU-**
 21 **MA SUPPORT SERVICES AND MENTAL**
 22 **HEALTH CARE.**

23 (a) IN GENERAL.—The Secretary of Health and
 24 Human Services (in this section referred to as the “Sec-
 25 retary”), acting through the Assistant Secretary for Men-

1 tal Health and Substance Use, shall award grants to eligi-
2 ble entities to establish or expand programs for the pur-
3 pose of increasing racial and ethnic minority access to
4 high-quality trauma support services and mental health
5 care.

6 (b) ELIGIBLE ENTITIES.—To seek a grant under this
7 section, an entity shall be a community-based program or
8 organization that—

9 (1) provides culturally and linguistically appro-
10 priate programs and resources that are aligned with
11 evidence-based practices for trauma-informed care;
12 and

13 (2) has demonstrated expertise in serving com-
14 munities of color or can partner with a program that
15 has such demonstrated expertise.

16 (c) USE OF FUNDS.—As a condition on receipt of a
17 grant under this section, a grantee shall agree to use the
18 grant to increase racial and ethnic minority access to high-
19 quality trauma support services and mental health care,
20 such as by—

21 (1) establishing and maintaining community-
22 based programs providing evidence-based services in
23 trauma-informed care and culturally specific services
24 and other resources;

1 (2) developing innovative, culturally specific
2 strategies and projects to enhance access to trauma-
3 informed care and resources for racial and ethnic
4 minorities who face obstacles to using more tradi-
5 tional services and resources (such as obstacles in
6 geographic access to providers, insurance coverage,
7 and access to audio and video technologies);

8 (3) working with State and local governments
9 and social service agencies to develop and enhance
10 effective strategies to provide culturally specific serv-
11 ices to racial and ethnic minorities;

12 (4) increasing communities' capacity to provide
13 culturally specific resources and support for commu-
14 nities of color;

15 (5) working in cooperation with the community
16 to develop education and prevention strategies high-
17 lighting culturally specific issues and resources re-
18 garding racial and ethnic minorities;

19 (6) providing culturally specific programs for
20 racial and ethnic minorities exposed to law enforce-
21 ment violence; and

22 (7) examining the dynamics of culture and its
23 impact on victimization and healing.

24 (d) PRIORITY.—In awarding grants under this sec-
25 tion, the Secretary shall give priority to eligible entities

1 proposing to serve communities that have faced high rates
 2 of community trauma, including from exposure to law en-
 3 forcement violence, intergenerational poverty, civil unrest,
 4 discrimination, or oppression.

5 (e) GRANT PERIOD.—The period of a grant under
 6 this section shall be 4 years.

7 (f) EVALUATION.—Not later than 6 months after the
 8 end of the period of all grants under this section, the Sec-
 9 retary shall—

10 (1) conduct an evaluation of the programs
 11 funded by a grant under this section;

12 (2) include in such evaluation an assessment of
 13 the outcomes of each such program; and

14 (3) submit a report on the results of such eval-
 15 uation to the Congress.

16 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
 17 out this section, there is authorized to be appropriated
 18 \$20,000,000 for each of fiscal years 2027 through 2031.

19 **Subtitle B—Interprofessional Care**

20 **SEC. 6201. HEALTH PROFESSIONS COMPETENCIES TO AD-** 21 **DRESS RACIAL AND ETHNIC MENTAL HEALTH** 22 **INEQUITIES.**

23 (a) IN GENERAL.—The Secretary of Health and
 24 Human Services, acting through the Assistant Secretary

1 for Mental Health and Substance Use, shall award grants
2 to qualified national organizations for the purposes of—

3 (1) developing, and disseminating to health pro-
4 fessional educational programs, culturally and lin-
5 guistically appropriate curricula or core com-
6 petencies addressing mental health inequities among
7 racial and ethnic minority groups for use in the
8 training of students in the professions of social
9 work, psychology, psychiatry, marriage and family
10 therapy, mental health counseling, peer support, and
11 substance use disorder counseling; and

12 (2) certifying community health workers and
13 peer wellness specialists with respect to such cur-
14 ricula and core competencies and integrating and ex-
15 panding the use of such workers and specialists into
16 health care and community-based settings to address
17 mental health inequities among racial and ethnic mi-
18 nority groups.

19 (b) CURRICULA; CORE COMPETENCIES.—Organiza-
20 tions receiving funds under subsection (a) may use the
21 funds to engage in the following activities related to the
22 development and dissemination of curricula or core com-
23 petencies described in subsection (a)(1):

24 (1) Formation of committees or working groups
25 composed of experts from accredited health profes-

sions schools to identify core competencies relating to mental health inequities among racial and ethnic minority groups.

(2) Planning of workshops in collaboration with community-based organizations and communities of color in national fora to directly facilitate public input, including input from communities of color with lived experience, into the educational needs associated with mental health inequities among racial and ethnic minority groups.

(3) Dissemination and promotion of the use of curricula or core competencies in undergraduate and graduate health professions training programs nationwide.

(4) Establishing external stakeholder advisory boards to provide meaningful input into policy and program development and best practices to reduce mental health inequities among racial and ethnic groups, including participation and leadership from communities of color with lived experience of the impacts of mental health inequities.

(c) DEFINITIONS.—In this section:

(1) QUALIFIED NATIONAL ORGANIZATION.—The term “qualified national organization” means a national organization that focuses on the education of

1 students in programs of social work, occupational
 2 therapy, psychology, psychiatry, substance use coun-
 3 seling, and marriage and family therapy.

4 (2) RACIAL AND ETHNIC MINORITY GROUP.—
 5 The term “racial and ethnic minority group” has the
 6 meaning given to such term in section 1707(g) of
 7 the Public Health Service Act (42 U.S.C. 300u–
 8 6(g)).

9 (d) AUTHORIZATION OF APPROPRIATIONS.—There
 10 are authorized to be appropriated to carry out this section
 11 such sums as may be necessary for each of fiscal years
 12 2027 through 2031.

13 **SEC. 6202. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
 14 **BEHAVIORAL HEALTH CARE.**

15 Part D of title V of the Public Health Service Act
 16 (42 U.S.C. 290dd et seq.) is amended by adding at the
 17 end the following:

18 **“SEC. 554. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
 19 **PROVISION OF BEHAVIORAL HEALTH CARE**
 20 **IN PRIMARY CARE SETTINGS.**

21 “(a) GRANTS.—The Secretary, acting through the
 22 Assistant Secretary, shall award grants to eligible entities
 23 for the purpose of establishing interprofessional health
 24 care teams that provide behavioral health care.

1 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
2 a grant under this section, an entity shall be a Federally
3 qualified health center (as defined in section 1861(aa) of
4 the Social Security Act), rural health clinic, women’s
5 health clinic, or behavioral health program (including any
6 such program operated by a community-based organiza-
7 tion) serving a high proportion of individuals from racial
8 and ethnic minority groups (as defined in section
9 1707(g)).

10 “(c) LOAN FORGIVENESS.—To encourage qualified
11 and diverse allied health professionals to enter the mental
12 health field, an eligible entity receiving a grant under this
13 section shall agree to use not less than \$10,000 of the
14 grant funds on a loan forgiveness program for practi-
15 tioners who commit to working in the mental health field
16 for a period of 2 years.

17 “(d) SCIENTIFICALLY AND CULTURALLY BASED.—
18 Integrated health care funded through this section shall
19 be scientifically and culturally based, taking into consider-
20 ation the results of the most recent peer-reviewed research
21 available, including information on language accessibility,
22 cultural humility, diversity of practitioners, and consider-
23 ation of social determinants of health.

24 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
25 carry out this section, there is authorized to be appro-

1 priated \$20,000,000 for each of fiscal years 2027 through
2 2031.”.

3 **SEC. 6203. INTEGRATED HEALTH CARE DEMONSTRATION**
4 **PROGRAM.**

5 Part D of title V of the Public Health Service Act
6 (42 U.S.C. 290dd et seq.), as amended by section 6202,
7 is amended by adding at the end the following:

8 **“SEC. 555. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
9 **PROVISION OF BEHAVIORAL HEALTH CARE**
10 **IN PRIMARY CARE SETTINGS.**

11 “(a) GRANTS.—The Secretary shall award grants to
12 eligible entities for the purpose of establishing interprofes-
13 sional health care teams that provide behavioral health
14 care.

15 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
16 a grant under this section, an entity shall be a Federally
17 qualified health center (as defined in section 1861(aa) of
18 the Social Security Act), rural health clinic, or behavioral
19 health program, serving a high proportion of individuals
20 from racial and ethnic minority groups (as defined in sec-
21 tion 1707(g)).

22 “(c) SCIENTIFICALLY BASED.—Integrated health
23 care funded through this section shall be scientifically
24 based, taking into consideration the results of the most
25 recent peer-reviewed research available.

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
 2 carry out this section, there is authorized to be appro-
 3 priated \$20,000,000 for each of the first 5 fiscal years
 4 following the date of enactment of the Health Equity and
 5 Accountability Act 2026.”.

6 **Subtitle C—Workforce** 7 **Development**

8 **SEC. 6301. BUILDING AN EFFECTIVE WORKFORCE IN MEN-** 9 **TAL HEALTH.**

10 (a) IN GENERAL.—The Secretary of Health and
 11 Human Services, in coordination with the Assistant Sec-
 12 retary for Mental Health and Substance Use, the Adminis-
 13 trator of the Health Resources and Services Administra-
 14 tion, the Secretary of Labor, and advocacy and behavioral
 15 and mental health organizations serving vulnerable popu-
 16 lations, including youth and young adults, people with low
 17 incomes, and people of color, shall—

18 (1) develop, strengthen, and implement strate-
 19 gies to bolster career pathways for diverse mental
 20 health professionals;

21 (2) identify the breadth of settings where men-
 22 tal health care and behavioral health care can take
 23 place; and

1 (3) identify current mental health professional
2 workforce shortages, inclusive of shortages of diverse
3 mental health professionals.

4 (b) CONTENTS.—Strategies under subsection (a)
5 shall include—

6 (1) the variety of settings where mental health
7 professionals are needed, including community-based
8 organizations, women’s centers, shelters, organiza-
9 tions focused on youth development, workforce agen-
10 cies, job placement and development centers, emer-
11 gency rooms, the special supplemental nutrition pro-
12 gram for women, infants, and children under section
13 17 of the Child Nutrition Act of 1966 (42 U.S.C.
14 1786), food banks, legal aid, and benefit issuers (as
15 defined in section 3 of the Food and Nutrition Act
16 of 2008 (7 U.S.C. 2012));

17 (2) defining career pathways in mental and be-
18 havioral health, to help diverse communities under-
19 stand the variety of careers in mental and behavioral
20 health that are available;

21 (3) building career pathways in mental and be-
22 havioral health as part of the curriculum at the
23 postsecondary education level;

24 (4) providing accessible training and certifi-
25 cation pathways for diverse lay health workers such

1 as community health workers and other peer support
2 specialists to ensure that careers pay a living wage;

3 (5) creating incentives for students in the fields
4 of occupational therapy, social work, psychology,
5 medicine, and nursing to learn more about mental
6 health, and to include a mental health rotation, with
7 a particular focus in racially and ethnically diverse
8 communities, as a part of the health professional
9 curricula;

10 (6) including training and education for teach-
11 ers about the basics of section 504 of the Rehabilita-
12 tion Act of 1973 (29 U.S.C. 794) and individualized
13 education programs (as defined in section 614(d) of
14 the Individuals with Disabilities Education Act (20
15 U.S.C. 1414(d)));

16 (7) researching, developing, and implementing
17 programs for mental and behavioral health profes-
18 sionals to prevent burnout; and

19 (8) finding better and increased avenues to en-
20 sure equity by providing better loan forgiveness pro-
21 grams, including a focus area within the National
22 Health Service Corps focused on community trauma.

23 (c) USE OF FUNDS.—Programs and activities funded
24 under this section shall be consistent with subsection
25 (a)(1) and shall include the following:

1 (1) Subgrants to entities serving youth and
 2 young adults which demonstrate a need for an in-
 3 creased mental health workforce, using strategies de-
 4 scribed in subsection (a)(1).

5 (2) Funding towards the Health Resources and
 6 Services Administration's Behavioral Health Work-
 7 force Education and Training Program.

8 (3) Funding towards the development and im-
 9 plementation of a National Health Service Corps
 10 program focused on community trauma.

11 (d) AUTHORIZATION OF APPROPRIATIONS.—There
 12 are authorized to be appropriated to carry out this section
 13 \$50,000,000 for each of fiscal years 2027 through 2037.

14 **SEC. 6302. DEMONSTRATION PROGRAM TO INCREASE LAN-**
 15 **GUAGE ACCESS AT ELIGIBLE HEALTH CEN-**
 16 **TERS.**

17 (a) GRANTS.—The Secretary shall carry out a dem-
 18 onstration program consisting of awarding grants to eligi-
 19 ble health centers to recruit, hire, employ, and supervise
 20 qualified behavioral health professionals who—

21 (1) are proficient in speaking and under-
 22 standing both spoken English and at least one other
 23 spoken language, including any necessary specialized
 24 vocabulary, terminology, and phraseology;

1 (2) are able to effectively, accurately, and im-
2 partially communicate directly with limited English
3 proficient individuals in their primary language; and

4 (3) are, or will be, employed—

5 (A) directly by the eligible health center; or

6 (B) through a contract between the eligible
7 health center and the qualified behavioral
8 health professional under which such profes-
9 sional provides services as part of the eligible
10 health center's workforce or under supervision
11 by the health center, in order to provide behav-
12 ioral health services in another language.

13 (b) PREFERENCE.—In selecting grant recipients
14 under subsection (a), the Secretary shall give preference
15 to eligible health centers at which at least 10 percent of
16 the patients are best served in a language other than
17 English, as indicated by data in the Uniform Data System
18 of the Health Resources and Services Administration (or
19 any successor database).

20 (c) OUTREACH.—An eligible health center receiving
21 a grant under this section shall use a portion of the grant
22 funds to disseminate information about the behavioral
23 health services supported through the grant.

24 (d) REPORTS.—

1 (1) INITIAL REPORT.—Not later than 6 months
2 after the first grants are awarded under subsection
3 (a), the Secretary shall submit to the Committee on
4 Appropriations and the Committee on Energy and
5 Commerce of the House of Representatives, the
6 Committee on Appropriations and the Committee on
7 Health, Education, Labor, and Pensions of the Sen-
8 ate, and other appropriate congressional committees,
9 a report on the implementation of the program
10 under this section. Such report shall include—

11 (A) the languages spoken by the qualified
12 behavioral health professionals recruited pursu-
13 ant to a grant under subsection (a);

14 (B) the eligible health center at which each
15 such professional was placed;

16 (C) how many eligible health centers re-
17 ceived grants under subsection (a);

18 (D) an analysis, conducted in consultation
19 with the eligible health centers receiving grants
20 under subsection (a), of the effectiveness of
21 such grants at increasing language access to be-
22 havioral health services; and

23 (E) best practices, developed in consulta-
24 tion with eligible health centers receiving grants
25 under subsection (a), for the recruitment and

1 retention of qualified behavioral health profes-
 2 sionals at such health centers.

3 (2) FINAL REPORT.—Not later than the end of
 4 fiscal year 2028, the Secretary shall submit to the
 5 Committee on Appropriations and the Committee on
 6 Energy and Commerce of the House of Representa-
 7 tives, the Committee on Appropriations and the
 8 Committee on Health, Education, Labor, and Pen-
 9 sions of the Senate, and other appropriate congres-
 10 sional committees, a final report on the implementa-
 11 tion of the program under this section, including the
 12 information, analysis, and best practices described in
 13 subparagraphs (A) through (E) of paragraph (1).

14 (e) DEFINITIONS.—In this section:

15 (1) The term “eligible health center” means a
 16 health center (as defined in section 330 of the Pub-
 17 lic Health Service Act (42 U.S.C. 254b)) that is al-
 18 ready receiving assistance pursuant to one or more
 19 grants under such section 330 at the time of the
 20 award to such health center of a supplemental grant
 21 under subsection (a).

22 (2) The term “qualified behavioral health pro-
 23 fessional” means—

24 (A) a behavioral and mental health profes-
 25 sional (as defined in section 331(a)(3)(E)(i) of

1 the Public Health Service Act (42 U.S.C.
2 254d(a)(3)(E)(i));

3 (B) a substance use disorder counselor;

4 (C) an occupational therapist; or

5 (D) an individual who—

6 (i) has not yet been licensed or cer-
7 tified to serve as a professional listed in
8 any of subparagraphs (A) through (C);
9 and

10 (ii) will serve at the eligible health
11 center under the supervision of a licensed
12 individual or certified professional so list-
13 ed.

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

16 (f) FUNDING.—Subject to the availability of appro-
17 priations, out of amounts otherwise appropriated under
18 section 760(g) of the Public Health Service Act (42 U.S.C.
19 294k(g)), the Secretary is authorized to use up to
20 \$10,000,000 for each of fiscal years 2027 through 2032
21 to carry out this section.

1 **SEC. 6303. HEALTH PROFESSIONS COMPETENCIES TO AD-**
2 **DRESS RACIAL AND ETHNIC MINORITY MEN-**
3 **TAL HEALTH DISPARITIES.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services may award grants to qualified national
6 organizations for the purposes of—

7 (1) developing, and disseminating to health pro-
8 fessional educational programs, best practices or
9 core competencies addressing mental health dispari-
10 ties among racial and ethnic minority groups for use
11 in the training of students in the professions of so-
12 cial work, psychology, psychiatry, marriage and fam-
13 ily therapy, mental health counseling, and substance
14 use disorder counseling; and

15 (2) certifying community health workers and
16 peer wellness specialists with respect to such best
17 practices and core competencies and integrating and
18 expanding the use of such workers and specialists
19 into health care to address mental health disparities
20 among racial and ethnic minority groups.

21 (b) BEST PRACTICES; CORE COMPETENCIES.—Orga-
22 nizations receiving funds under subsection (a) may use the
23 funds to engage in the following activities related to the
24 development and dissemination of best practices or core
25 competencies described in subsection (a)(1):

1 (1) Formation of committees or working groups
 2 composed of experts from accredited health profes-
 3 sions schools to identify best practices and core com-
 4 petencies relating to mental health disparities among
 5 racial and ethnic minority groups.

6 (2) Planning of workshops at the national level
 7 to allow for public input into the educational needs
 8 associated with mental health disparities among ra-
 9 cial and ethnic minority groups.

10 (3) Dissemination and promotion of the use of
 11 best practices or core competencies for culturally
 12 and linguistically appropriate mental health services
 13 in undergraduate and graduate health professions
 14 training programs nationwide.

15 (4) Establishing external stakeholder advisory
 16 boards to provide meaningful input into policy and
 17 program development and best practices to reduce
 18 mental health disparities among racial and ethnic
 19 minority groups.

20 (c) DEFINITIONS.—In this section:

21 (1) QUALIFIED NATIONAL ORGANIZATION.—The
 22 term “qualified national organization” means a na-
 23 tional organization that focuses on the education of
 24 students in one or more of the professions of social
 25 work, psychology, psychiatry, marriage and family

1 therapy, mental health counseling, and substance
2 misuse counseling.

3 (2) RACIAL AND ETHNIC MINORITY GROUP.—
4 The term “racial and ethnic minority group” has the
5 meaning given to such term in section 1707(g) of
6 the Public Health Service Act (42 U.S.C. 300u–
7 6(g)).

8 **Subtitle D—Children’s Mental** 9 **Health**

10 **SEC. 6401. GRANT PROGRAMS TO SUPPORT PEDIATRIC BE-** 11 **HAVIORAL HEALTH CARE.**

12 Part D of title III of the Public Health Service Act
13 (42 U.S.C. 254b et seq.) is amended by inserting after
14 subpart V the following new subpart:

15 **“Subpart VI—Pediatric Behavioral Health Programs** 16 **“SEC. 340A-1. PROGRAM TO IMPROVE ACCESS TO COMMU-** 17 **NITY-BASED PEDIATRIC BEHAVIORAL** 18 **HEALTH CARE.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Administrator of the Health Resources and Services
21 Administration, shall award grants, contracts, or coopera-
22 tive agreements to eligible entities for the purpose of sup-
23 porting pediatric behavioral health care integration and
24 coordination within communities to meet local community
25 needs.

1 “(b) ELIGIBLE ENTITIES.—Entities eligible for
2 grants under subsection (a) include—

3 “(1) health care providers, including family
4 physicians, pediatric medical sub-specialists, and
5 surgical specialists;

6 “(2) children’s hospitals;

7 “(3) facilities that are eligible to receive funds
8 under section 340E or 340H;

9 “(4) nonprofit medical facilities that predomi-
10 nantly treat individuals under the age of 21;

11 “(5) rural health clinics and Federally qualified
12 health centers (as such terms are defined in section
13 1861(aa) of the Social Security Act);

14 “(6) pediatric mental health and substance use
15 disorder providers, such as child and adolescent psy-
16 chiatrists, psychologists, developmental and behav-
17 ioral pediatricians, general pediatricians, advanced
18 practice nurses, social workers, licensed professional
19 counselors, and other licensed professionals that pro-
20 vide mental health and substance use disorder serv-
21 ices to patients under 21 years of age;

22 “(7) children’s advocacy centers described in
23 section 214(c)(2)(B) of the Victims of Child Abuse
24 Act of 1990;

25 “(8) school-based health centers; and

1 “(9) other entities as determined appropriate by
2 the Secretary.

3 “(c) PRIORITIZATION.—In making awards under sub-
4 section (a), the Secretary shall prioritize—

5 “(1) applicants that provide children and ado-
6 lescents from high-need, rural, or under-resourced
7 communities with services across the continuum of
8 children’s mental health and substance use disorder
9 care; and

10 “(2) applicants that predominantly provide care
11 to children and adolescents that demonstrate plans
12 to utilize funds to expand provision of care to chil-
13 dren, adolescents, and youth under age 21.

14 “(d) USE OF FUNDS.—Activities that may be funded
15 through an award under subsection (a) include—

16 “(1) increasing the capacity of pediatric prac-
17 tices, family medicine practices, and school-based
18 health centers to integrate pediatric mental, emo-
19 tional, and behavioral health services into their prac-
20 tices including through co-location of mental, emo-
21 tional, and behavioral health providers;

22 “(2) training for non-clinical pediatric health
23 care workers, including care coordinators and navi-
24 gators, on child and adolescent mental health and

1 substance use disorder, trauma-informed care, and
2 local resources to support children and caregivers;

3 “(3) expanding evidence-based, integrated mod-
4 els of care for pediatric mental health and substance
5 use disorder services;

6 “(4) pediatric practice integration for the provi-
7 sion of pediatric mental health and substance use
8 disorder services;

9 “(5) addressing surge capacity for pediatric
10 mental health and substance use disorder needs;

11 “(6) providing pediatric mental, emotional, and
12 behavioral health services to children as delivered by
13 mental health and substance use disorder profes-
14 sionals utilizing telehealth services;

15 “(7) establishing or maintaining initiatives to
16 allow more children to access care outside of emer-
17 gency departments, including partial hospitalization,
18 step down residency programs, and intensive out-
19 patient programs;

20 “(8) supporting, enhancing, or expanding pedi-
21 atric mental health and substance use disorder pre-
22 ventive and crisis intervention services;

23 “(9) establishing or maintaining pediatric men-
24 tal health and substance use disorder urgent care or
25 walk-in clinics;

“(12) supporting the collection of data on children and adolescents’ mental health needs, service utilization and availability, and demographic data, to capture community needs and identify gaps and barriers in children’s access to care, in a manner that protects personal privacy, consistent with applicable Federal and State privacy laws.

15 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
16 carry out this section, there is authorized to be appro-
17 priated such sums as may be necessary for each of fiscal
18 years 2027 through 2031.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants, contracts, or cooperative agreements to eligible entities for the purpose of sup-

1 porting evidence-based pediatric mental health and sub-
2 stance use disorder workforce training.

3 “(b) ELIGIBLE ENTITIES.—Entities eligible for
4 grants under subsection (a) include—

5 “(1) children’s hospitals;

6 “(2) facilities that are eligible to receive funds
7 under section 340E or 340H;

8 “(3) nonprofit medical facilities that predomi-
9 nantly treat individuals under the age of 21;

10 “(4) rural health clinics and Federally qualified
11 health centers (as such terms are defined in section
12 1861(aa) of the Social Security Act);

13 “(5) entities that employ mental health and
14 substance use disorder professionals, such as child
15 and adolescent psychiatrists, psychologists, develop-
16 mental and behavioral pediatricians, general pedia-
17 tricians, advanced practice nurses, social workers, li-
18 censed professional counselors, or other licensed pro-
19 fessionals that provide mental health or substance
20 use disorder services to patients under 21 years of
21 age; and

22 “(6) other pediatric health care providers as de-
23 termined appropriate by the Secretary.

1 “(c) USE OF FUNDS.—Activities that may be sup-
2 ported through an award under subsection (a) include the
3 following:

4 “(1) Training to enhance the capabilities of the
5 existing pediatric workforce, including pediatricians,
6 primary care physicians, advanced practice reg-
7 istered nurses, and other pediatric health care pro-
8 viders, including expanded training in pediatric men-
9 tal health and substance use disorders, and cul-
10 turally and developmentally appropriate care for
11 children with mental health conditions.

12 “(2) Training to support multi-disciplinary
13 teams to provide pediatric mental health and sub-
14 stance use disorder treatment, including through in-
15 tegrated care models.

16 “(3) Initiatives to accelerate the time to licen-
17 sure within the pediatric mental health or substance
18 use disorder workforce.

19 “(4) Activities to expand recruitment and reten-
20 tion, increase workforce diversity, or enhance work-
21 force training for critical pediatric mental health
22 professions, including—

23 “(A) child and adolescent psychiatrists;

24 “(B) psychiatric nurses;

25 “(C) psychologists;

- 1 “(D) family therapists;
 2 “(E) social workers;
 3 “(F) mental health counselors;
 4 “(G) developmental and behavioral pedia-
 5 tricians;
 6 “(H) pediatric substance use disorder spe-
 7 cialists; and
 8 “(I) other mental health care providers as
 9 determined appropriate by the Secretary.

10 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
 11 carry out this section, there is authorized to be appro-
 12 priated such sums as may be necessary for each of fiscal
 13 years 2027 through 2031.”.

14 **SEC. 6402. INCREASING FEDERAL INVESTMENT IN PEDI-**
 15 **ATRIC BEHAVIORAL HEALTH SERVICES.**

16 The Public Health Service Act (42 U.S.C. 201 et
 17 seq.) (as amended by section 2004) is amended by adding
 18 at the end the following:

1 **“TITLE XXXV—ASSISTANCE FOR**
2 **CONSTRUCTION AND MOD-**
3 **ERNIZATION OF CHILDREN’S**
4 **MENTAL HEALTH AND SUB-**
5 **STANCE USE DISORDER IN-**
6 **FRASTRUCTURE**

7 **“SEC. 3501. INCREASING FEDERAL INVESTMENT IN PEDI-**
8 **ATRIC BEHAVIORAL HEALTH SERVICES.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Administrator of the Health Resources and Services
11 Administration, shall award grants, contracts, or coopera-
12 tive agreements to eligible entities for the purpose of im-
13 proving their ability to provide pediatric behavioral health
14 services, including by—

15 “(1) constructing or modernizing sites of care
16 for pediatric behavioral health services;

17 “(2) expanding capacity to provide pediatric be-
18 havioral health services, including enhancements to
19 digital infrastructure, telehealth capabilities, or other
20 improvements to patient care infrastructure;

21 “(3) supporting the reallocation of existing re-
22 sources to accommodate pediatric behavioral health
23 patients, including by converting or adding a suffi-
24 cient number of beds to establish or increase the
25 hospital’s inventory of licensed and operational,

1 short-term psychiatric and substance use inpatient
2 beds; and

3 “(4) addressing gaps in the continuum of care
4 for children, by expanding capacity to provide inter-
5 mediate levels of care, such as intensive outpatient
6 services, partial hospitalization programs, and day
7 programs that can prevent hospitalizations and sup-
8 port children as they transition back to their homes
9 and communities.

10 “(b) ELIGIBILITY.—To be eligible to seek an award
11 under this section, an entity shall be a hospital or rural
12 health clinic that predominantly treats individuals under
13 the age of 21, including any hospital that receives funds
14 under section 340E.

15 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
16 carry out this section, there is authorized to be appro-
17 priated such sums as may be necessary for each of fiscal
18 years 2027 through 2031.

19 “(d) SUPPLEMENT, NOT SUPPLANT.—Funds pro-
20 vided under this section shall be used to supplement, not
21 supplant Federal and non-Federal funds available for car-
22 rying out the activities described in this section.

23 “(e) REPORTING.—

24 “(1) REPORTS FROM AWARD RECIPIENTS.—Not
25 later than 180 days after the completion of activities

1 funded by an award under this section, the entity
2 that received such award shall submit a report to
3 the Secretary on the activities conducted using funds
4 from such award, and other information as the Sec-
5 retary may require.

6 “(2) REPORTS TO CONGRESS.—Not later than
7 one year after the completion of activities funded by
8 an award under this section, the Secretary shall sub-
9 mit to the Committee on Energy and Commerce of
10 the House of Representatives and the Committee on
11 Health, Education, Labor, and Pensions of the Sen-
12 ate a report on the projects and activities conducted
13 with funds awarded under this section, and the out-
14 come of such projects and activities. Such report
15 shall include—

16 “(A) the number of projects supported by
17 awards made under this section;

18 “(B) an overview of the impact, if any, of
19 such projects on pediatric health care infra-
20 structure, including any impact on access to pe-
21 diatric mental health and substance use dis-
22 order services;

23 “(C) recommendations for improving the
24 investment program under this section; and

1 “(D) any other considerations as the Sec-
2 retary determines appropriate.”.

3 **SEC. 6403. MENTAL HEALTH IN SCHOOLS.**

4 (a) SCHOOL-BASED MENTAL HEALTH AND CHIL-
5 DREN.—Section 581 of the Public Health Service Act (42
6 U.S.C. 290hh) is amended to read as follows:

7 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN**
8 **AND ADOLESCENTS.**

9 “(a) IN GENERAL.—The Secretary, in consultation
10 with the Secretary of Education, shall, through grants,
11 contracts, or cooperative agreements awarded to eligible
12 entities described in subsection (c), provide comprehensive
13 school-based mental health services and supports to assist
14 children in local communities and schools (including
15 schools funded by the Bureau of Indian Education) deal-
16 ing with traumatic experiences, grief, bereavement, risk of
17 suicide, and violence. Such services and supports shall—

18 “(1) be developmentally, linguistically, and cul-
19 turally appropriate;

20 “(2) be trauma-informed; and

21 “(3) incorporate positive behavioral interven-
22 tions and supports.

23 “(b) ACTIVITIES.—Grants, contracts, or cooperative
24 agreements awarded under subsection (a), shall, as appro-
25 priate, be used for—

1 “(1) implementation of school- and community-
2 based mental health programs that—

3 “(A) build awareness of individual trauma
4 and the intergenerational, continuum of impacts
5 of trauma on populations;

6 “(B) train appropriate staff to identify,
7 and screen for, signs of trauma exposure, men-
8 tal health disorders, or risk of suicide; and

9 “(C) incorporate positive behavioral inter-
10 ventions, family engagement, student treatment,
11 and multigenerational supports to foster the
12 health and development of children, prevent
13 mental health disorders, and ameliorate the im-
14 pact of trauma;

15 “(2) technical assistance to local communities
16 with respect to the development of programs de-
17 scribed in paragraph (1);

18 “(3) facilitating community partnerships among
19 families, students, law enforcement agencies, edu-
20 cation agencies, mental health and substance use
21 disorder service systems, family-based mental health
22 service systems, child welfare agencies, health care
23 providers (including primary care physicians, mental
24 health professionals, and other professionals who
25 specialize in children’s mental health such as child

1 and adolescent psychiatrists), institutions of higher
 2 education, faith-based programs, trauma networks,
 3 and other community-based systems to address child
 4 and adolescent trauma, mental health issues, and vi-
 5 olence; and

6 “(4) establishing mechanisms for children and
 7 adolescents to report incidents of violence or plans
 8 by other children, adolescents, or adults to commit
 9 violence.

10 “(c) REQUIREMENTS.—

11 “(1) IN GENERAL.—To be eligible for a grant,
 12 contract, or cooperative agreement under subsection
 13 (a), an entity shall be a partnership that includes—

14 “(A) a State educational agency, as de-
 15 fined in section 8101 of the Elementary and
 16 Secondary Education Act of 1965, in coordina-
 17 tion with one or more local educational agen-
 18 cies, as defined in section 8101 of the Elemen-
 19 tary and Secondary Education Act of 1965, or
 20 a consortium of any entities described in sub-
 21 paragraph (B), (C), (D), or (E) of section
 22 8101(30) of such Act; and

23 “(B) at least 1 community-based mental
 24 health provider, including a public or private
 25 mental health entity, health care entity, family-

1 based mental health entity, trauma network, or
2 other community-based entity, as determined by
3 the Secretary (and which may include addi-
4 tional entities such as a human services agency,
5 law enforcement or juvenile justice entity, child
6 welfare agency, an institution of higher edu-
7 cation, or another entity, as determined by the
8 Secretary).

9 “(2) COMPLIANCE WITH HIPAA.—Any patient
10 records developed by covered entities through activi-
11 ties under the grant shall meet the regulations pro-
12 mulgated under section 264(c) of the Health Insur-
13 ance Portability and Accountability Act of 1996.

14 “(3) COMPLIANCE WITH FERPA.—Section 444
15 of the General Education Provisions Act (commonly
16 known as the ‘Family Educational Rights and Pri-
17 vacy Act of 1974’) shall apply to any entity that is
18 a member of the partnership in the same manner
19 that such section applies to an educational agency or
20 institution (as that term is defined in such section).

21 “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary
22 shall ensure that grants, contracts, or cooperative agree-
23 ments under subsection (a) will be distributed equitably
24 among the regions of the country and among urban and
25 rural areas.

1 “(e) DURATION OF AWARDS.—With respect to a
2 grant, contract, or cooperative agreement under sub-
3 section (a), the period during which payments under such
4 an award will be made to the recipient shall be 5 years,
5 with options for renewal.

6 “(f) EVALUATION AND MEASURES OF OUTCOMES.—

7 “(1) DEVELOPMENT OF PROCESS.—The Assist-
8 ant Secretary shall develop a fiscally appropriate
9 process for evaluating activities carried out under
10 this section. Such process shall include—

11 “(A) the development of guidelines for the
12 submission of program data by grant, contract,
13 or cooperative agreement recipients;

14 “(B) the development of measures of out-
15 comes (in accordance with paragraph (2)) to be
16 applied by such recipients in evaluating pro-
17 grams carried out under this section; and

18 “(C) the submission of annual reports by
19 such recipients concerning the effectiveness of
20 programs carried out under this section.

21 “(2) MEASURES OF OUTCOMES.—The Assistant
22 Secretary shall develop measures of outcomes to be
23 applied by recipients of assistance under this section
24 to evaluate the effectiveness of programs carried out
25 under this section, including outcomes related to the

1 student, family, and local educational systems sup-
2 ported by this Act.

3 “(3) SUBMISSION OF ANNUAL DATA.—An eligi-
4 ble entity described in subsection (c) that receives a
5 grant, contract, or cooperative agreement under this
6 section shall annually submit to the Assistant Sec-
7 retary a report that includes data to evaluate the
8 success of the program carried out by the entity
9 based on whether such program is achieving the pur-
10 poses of the program. Such reports shall utilize the
11 measures of outcomes under paragraph (2) in a rea-
12 sonable manner to demonstrate the progress of the
13 program in achieving such purposes.

14 “(4) EVALUATION BY ASSISTANT SECRETARY.—
15 Based on the data submitted under paragraph (3),
16 the Assistant Secretary shall annually submit to
17 Congress a report concerning the results and effec-
18 tiveness of the programs carried out with assistance
19 received under this section.

20 “(5) LIMITATION.—An eligible entity shall use
21 not more than 20 percent of amounts received under
22 a grant under this section to carry out evaluation
23 activities under this subsection.

24 “(g) INFORMATION AND EDUCATION.—The Sec-
25 retary shall disseminate best practices based on the find-

1 ings of the knowledge development and application under
2 this section.

3 “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF
4 APPROPRIATIONS.—

5 “(1) AMOUNT OF GRANTS.—A grant under this
6 section shall be in an amount that is not more than
7 \$2,000,000 for each of the first 5 fiscal years fol-
8 lowing the date of enactment of the Health Equity
9 and Accountability Act 2026. The Secretary shall
10 determine the amount of each such grant based on
11 the population of children up to age 21 of the area
12 to be served under the grant.

13 “(2) AUTHORIZATION OF APPROPRIATIONS.—
14 There is authorized to be appropriated to carry out
15 this section, \$300,000,000 for each of fiscal years
16 2027 through 2030.”.

17 (b) CONFORMING AMENDMENT.—Part G of title V
18 of the Public Health Service Act (42 U.S.C. 290hh et
19 seq.), as amended by subsection (a), is amended by strik-
20 ing the part designation and heading and inserting the
21 following:

1 **“PART G—SCHOOL-BASED MENTAL HEALTH”.**

2 **SEC. 6404. ADDITIONAL SUPPORT FOR YOUTH AND YOUNG**
 3 **ADULT MENTAL HEALTH SERVICE PROVI-**
 4 **SION.**

5 Section 1903 of the Social Security Act (42 U.S.C.
 6 1396b) is amended by adding at the end the following new
 7 subsection:

8 “(cc) YOUTH AND YOUNG ADULT INTERVENTION
 9 SERVICES.—

10 “(1) IN GENERAL.—Notwithstanding section
 11 1902(a)(1) (relating to Statewideness), section
 12 1902(a)(10)(B) (relating to comparability), section
 13 1902(a)(23)(A) (relating to freedom of choice of
 14 providers), or section 1902(a)(27) (relating to pro-
 15 vider agreements), a State may, during the 5-year
 16 period beginning on the first day of the fiscal year
 17 quarter that begins on or after January 1, 2027,
 18 provide medical assistance for qualifying youth and
 19 young adult mental health and substance use inter-
 20 vention services (as defined in paragraph (2)(C))
 21 under a State plan amendment or waiver approved
 22 under section 1115 or 1915(c).

23 “(2) DEFINITIONS.—For the purposes of this
 24 subsection:

25 “(A) PRIORITY SERVICE.—The term ‘pri-
 26 ority service’ means any of the following, if vol-

1 untarily received and provided in a manner that
 2 maintains the privacy and confidentiality of pa-
 3 tient information consistent with Federal and
 4 State requirements:

5 “(i) Qualifying community-based mo-
 6 bile crisis intervention services, as defined
 7 in section 1947.

8 “(ii) Telehealth.

9 “(iii) Youth peer support.

10 “(iv) Screening for adverse childhood
 11 experiences.

12 “(v) Trauma responsive care.

13 “(vi) Other priority services for youth,
 14 as defined by the Secretary.

15 “(B) QUALIFIED MENTAL HEALTH PRO-
 16 VIDER.—The term ‘qualified mental health pro-
 17 vider’ means a behavioral health care profes-
 18 sional who is capable of conducting an assess-
 19 ment of an individual described in subpara-
 20 graph (C)(i), in accordance with the profes-
 21 sional’s permitted scope of practice under State
 22 law, and any other professional or paraprofes-
 23 sional with appropriate expertise in youth and
 24 young adult behavioral health or mental health,
 25 including a social worker, peer support spe-

1 cialist, recovery coach, community health work-
 2 er, mental health clinician, and any other pro-
 3 vider designated by the State and approved by
 4 the Secretary.

5 “(C) QUALIFYING YOUTH AND YOUNG
 6 ADULT MENTAL HEALTH AND SUBSTANCE USE
 7 INTERVENTION SERVICES DEFINED.—The term
 8 ‘qualifying youth and young adult mental health
 9 and substance use intervention services’ means,
 10 with respect to a State, items and services for
 11 which medical assistance is available under the
 12 State plan under this title or a waiver of such
 13 plan, that are—

14 “(i) furnished to an individual 16 to
 15 25 years of age who is—

16 “(I) experiencing a mental health
 17 or substance use disorder crisis;

18 “(II) an offender, as defined in
 19 section 3 of the Workforce Innovation
 20 and Opportunity Act;

21 “(III)(aa) experiencing homeless-
 22 ness (as defined in section 41403(6)
 23 of the Violence Against Women Act of
 24 1994);

1 “(bb) a homeless child or youth
2 (as defined in section 725(2) of the
3 McKinney-Vento Homeless Assistance
4 Act);

5 “(cc) a runaway, is in foster
6 care, or has aged out of the foster
7 care system;

8 “(dd) a child eligible for assist-
9 ance under section 477; or

10 “(ee) in an out-of-home place-
11 ment;

12 “(IV) an individual who is preg-
13 nant or parenting, including—

14 “(aa) a custodial or non-cus-
15 todial mother or father; or

16 “(bb) an expectant mother;

17 “(V) a youth who is an individual
18 with a disability (as defined in section
19 3 of the Americans with Disabilities
20 Act of 1990);

21 “(VI) a low-income youth requir-
22 ing additional assistance to enter or
23 complete an educational program or
24 to secure or hold employment; or

1 “(VII) living in a community that
2 has faced acute or long-term exposure
3 to substantial discrimination, histor-
4 ical oppression, intergenerational pov-
5 erty, civil unrest, or a high rate of vio-
6 lence or drug overdose deaths, as de-
7 termined by the Secretary;

8 “(ii) furnished by a qualified mental
9 health provider; and

10 “(iii) a priority service.

11 “(D) TELEHEALTH.—The term ‘telehealth’
12 means use of electronic information and tele-
13 communications technologies, including voice
14 only audio, text, remote patient monitoring, and
15 mHealth through applications, to support clin-
16 ical mental health care, patient and professional
17 health-related education, public health, and
18 health administration.

19 “(3) PAYMENTS.—Notwithstanding section
20 1905(b), beginning January 1, 2027, during each of
21 the first 20 fiscal quarters that a State meets the
22 requirements described in paragraph (4), the Fed-
23 eral medical assistance percentage applicable to
24 amounts expended by the State for medical assist-
25 ance for qualifying youth and young adult mental

1 health and substance use intervention services fur-
2 nished during such quarter shall be equal to 100
3 percent.

4 “(4) REQUIREMENTS.—The requirements de-
5 scribed in this paragraph are the following:

6 “(A) The State demonstrates, to the satis-
7 faction of the Secretary, that the State will be
8 able to support—

9 “(i) the provision of qualifying youth
10 and young adult mental health and sub-
11 stance use intervention services in accord-
12 ance with paragraph (1); and

13 “(ii) coordination between qualified
14 mental health providers and substance use
15 teams and community partners, including
16 health care providers, to enable the provi-
17 sion of services, needed referrals, and other
18 activities identified by the Secretary.

19 “(B) The State provides assurances satis-
20 factory to the Secretary that—

21 “(i) any additional Federal funds re-
22 ceived by the State for qualifying youth
23 and young adult mental health and sub-
24 stance use intervention services provided
25 under this subsection that are attributable

1 to the increased Federal medical assistance
2 percentage under paragraph (3) will be
3 used to supplement, and not supplant, the
4 level of State funds expended for such
5 services for fiscal year 2027;

6 “(ii) if the State made qualifying
7 youth and young adult mental health and
8 substance use intervention services avail-
9 able in a region of the State in fiscal year
10 2026 the State will continue to make such
11 services available in such region under this
12 subsection at the same level that the State
13 made such services available in such fiscal
14 year; and

15 “(iii) the State will conduct the eval-
16 uation and assessment, and submit the re-
17 port, required under paragraph (5).

18 “(5) STATE EVALUATION AND REPORT.—

19 “(A) STATE EVALUATION.—Not later than
20 4 fiscal quarters after a State begins providing
21 qualifying youth and young adult mental health
22 and substance use intervention services in ac-
23 cordance with this subsection, the State shall
24 enter into a contract with an independent entity

1 or organization to conduct an evaluation for the
2 purposes of—

3 “(i) determining the effect of the pro-
4 vision of such services on—

5 “(I) emergency room visits;

6 “(II) use of ambulatory services;

7 “(III) hospitalizations;

8 “(IV) the involvement of law en-
9 forcement in mental health or sub-
10 stance use disorder crisis events; and

11 “(V) the diversion of individuals
12 from jails or similar settings; and

13 “(ii) assessing—

14 “(I) the types of services pro-
15 vided to individuals;

16 “(II) the types of events to which
17 such services responded;

18 “(III) cost savings or cost-effec-
19 tiveness attributable to such services;

20 “(IV) the experiences of individ-
21 uals who receive such services;

22 “(V) the successful connection of
23 individuals with follow-up services;
24 and

1 “(VI) other relevant outcomes
2 identified by the Secretary.

3 “(B) COMPARISON TO HISTORICAL MEAS-
4 URES.—The contract described in subparagraph
5 (A) shall specify that the evaluation conducted
6 under such contract is based on a comparison
7 of the historical measures of State performance
8 with respect to the outcomes specified under
9 such subparagraph to the State’s performance
10 with respect to such outcomes during the period
11 beginning with the first quarter in which the
12 State begins providing qualifying youth and
13 young adult mental health and substance use
14 intervention services in accordance with this
15 subsection.

16 “(C) REPORT.—Not later than 2 years
17 after a State begins to provide qualifying youth
18 and young adult mental health and substance
19 use intervention services in accordance with this
20 subsection, the State shall submit a report to
21 the Secretary on the following:

22 “(i) The results of the evaluation con-
23 ducted under subparagraph (A).

24 “(ii) The number of individuals who
25 received qualifying youth and young adult

1 mental health and substance use interven-
2 tion services.

3 “(iii) Demographic information re-
4 garding such individuals when available,
5 including the race and ethnicity, age, sex,
6 sexual orientation, gender identity, and ge-
7 ographic location of such individuals.

8 “(iv) The processes and models devel-
9 oped by the State to provide qualifying
10 youth and young adult mental health and
11 substance use intervention services under
12 the State plan or a waiver of such plan, in-
13 cluding the processes developed to provide
14 referrals for, or coordination with, follow-
15 up care and services.

16 “(v) Lessons learned regarding the
17 provision of such services.

18 “(D) PUBLIC AVAILABILITY.—The State
19 shall make the report required under subpara-
20 graph (C) publicly available, including on the
21 website of the appropriate State agency, upon
22 submission of such report to the Secretary.

23 “(6) BEST PRACTICES REPORT.—

24 “(A) IN GENERAL.—Not later than 3 years
25 after the first State begins to provide qualifying

1 youth and young adult mental health and sub-
2 stance use intervention services in accordance
3 with this subsection, the Secretary shall submit
4 a report to Congress that—

5 “(i) identifies the States that elected
6 to provide such services in accordance with
7 this subsection;

8 “(ii) summarizes the information re-
9 ported by such States under paragraph
10 (5)(C); and

11 “(iii) identifies best practices for the
12 effective delivery of youth and young adult
13 mental health and substance use interven-
14 tion services.

15 “(B) PUBLIC AVAILABILITY.—The report
16 required under subparagraph (A) shall be made
17 publicly available, including on the website of
18 the Department of Health and Human Services,
19 upon submission to Congress.

20 “(7) NONDISCRIMINATION.—

21 “(A) FEDERALLY FUNDED ACTIVITIES.—

22 (i) For the purpose of applying the prohibitions
23 against discrimination on the basis of age under
24 the Age Discrimination Act of 1975, on the
25 basis of handicap under section 504 of the Re-

1 habilitation Act of 1973, on the basis of sex
2 under title IX of the Education Amendments of
3 1972, or on the basis of race, color, or national
4 origin under title VI of the Civil Rights Act of
5 1964, programs and activities funded in whole
6 or in part with funds made available under this
7 subsection are considered to be programs and
8 activities receiving Federal financial assistance.

9 “(ii) No person shall on the ground of sex
10 or religion be excluded from participation in, be
11 denied the benefits of, or be subjected to dis-
12 crimination under any program or activity
13 funded in whole or in part with funds made
14 available under this subsection.

15 “(B) COMPLIANCE.—

16 “(i) IN GENERAL.—Whenever the Sec-
17 retary finds that a State, or an entity that
18 has received a payment from an allotment
19 to a State for medical assistance for quali-
20 fying youth and young adult mental health
21 and substance use intervention services
22 furnished under this subsection, has failed
23 to comply with a provision of law referred
24 to in subparagraph (A)(i), with subpara-
25 graph (A)(ii), or with an applicable regula-

tion (including one prescribed to carry out subparagraph (A)(ii)), the Secretary shall notify the chief executive officer of the State and shall request such chief executive officer to secure compliance.

“(ii) FAILURE OR REFUSAL TO SECURE COMPLIANCE.—If the chief executive officer of a State fails or refuses to secure compliance within a reasonable period of time, not to exceed 60 days, as requested under clause (i), the Secretary may—

“(I) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted;

“(II) exercise the powers and functions provided by title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, as may be applicable; or

“(III) take such other action as may be provided by law.

“(C) AUTHORITY OF ATTORNEY GENERAL; CIVIL ACTIONS.—When a matter is referred to

1 the Attorney General pursuant to subparagraph
 2 (B)(ii)(I), or whenever the Attorney General
 3 has reason to believe that an entity is engaged
 4 in a pattern or practice in violation of a provi-
 5 sion of law referred to in clause (i) or (ii) of
 6 subparagraph (A), the Attorney General may
 7 bring a civil action in any appropriate district
 8 court of the United States for such relief as
 9 may be appropriate, including injunctive re-
 10 lief.”.

11 **SEC. 6405. EARLY INTERVENTION AND PREVENTION PRO-**
 12 **GRAMS FOR TRANSITION-AGE YOUTH.**

13 (a) IN GENERAL.—Section 1912(b)(1) of the Public
 14 Health Service Act (42 U.S.C. 300x–1(b)(1)) is amend-
 15 ed—

16 (1) by redesignating subparagraph (E) as sub-
 17 paragraph (F); and

18 (2) by inserting after subparagraph (D) the fol-
 19 lowing:

20 “(E) EARLY INTERVENTION AND PREVEN-
 21 TION PROGRAMS FOR TRANSITION-AGE
 22 YOUTH.—The plan shall describe the State’s
 23 plans to carry out demonstration grants or con-
 24 tracts for early intervention and prevention pro-
 25 grams for transition-age youth of 16 to 25

1 years of age who meet one or more of the cri-
 2 teria specified in section 129(a)(1)(B) of the
 3 Workforce Innovation and Opportunity Act to
 4 be considered out-of-school youth.”.

5 (b) SET-ASIDE.—Section 1920 of the Public Health
 6 Service Act (42 U.S.C. 300x–9) is amended by adding at
 7 the end the following:

8 “(e) EARLY INTERVENTION AND PREVENTION PRO-
 9 GRAMS FOR TRANSITION-AGE YOUTH.—

10 “(1) IN GENERAL.—Except as provided in para-
 11 graph (2), a State shall expend at least 15 percent
 12 of the amount of the allotment of the State pursuant
 13 to a funding agreement under section 1911 for each
 14 fiscal year to support programs described in section
 15 1912(b)(1)(E).

16 “(2) STATE FLEXIBILITY.—In lieu of expending
 17 15 percent of the amount of the allotment for a fis-
 18 cal year as required by paragraph (1), a State may
 19 elect to expend not less than 30 percent of such
 20 amount to support such programs by the end of two
 21 consecutive fiscal years.”.

22 **SEC. 6406. STRATEGIES TO INCREASE ACCESS TO TELE-**
 23 **HEALTH UNDER MEDICAID AND THE CHIL-**
 24 **DREN’S HEALTH INSURANCE PROGRAM.**

25 (a) GUIDANCE.—

1 (1) IN GENERAL.—Not later than 1 year after
2 the date of the enactment of this Act, the Secretary
3 of Health and Human Services shall issue and dis-
4 seminate guidance to States to clarify strategies to
5 overcome existing barriers and increase access to
6 telehealth under the Medicaid program under title
7 XIX of the Social Security Act (42 U.S.C. 1396 et
8 seq.) and the Children’s Health Insurance Program
9 under title XXI of such Act (42 U.S.C. 1397aa et
10 seq.).

11 (2) CONTENTS.—The guidance described in
12 paragraph (1) shall include technical assistance and
13 best practices regarding—

14 (A) telehealth delivery of services furnished
15 under such programs;

16 (B) recommended voluntary billing codes,
17 modifiers, and place-of-service designations for
18 telehealth and other virtual health care services;

19 (C) the simplification or alignment (includ-
20 ing through reciprocity) of provider licensing,
21 credentialing, and enrollment protocols with re-
22 spect to telehealth across States, State Med-
23 icaid plans under such title XIX, and Medicaid
24 managed care organizations, including during
25 national public health emergencies;

1 (D) existing strategies States can use to
 2 integrate telehealth and other virtual health
 3 care services into value-based health care mod-
 4 els; and

5 (E) examples of States that have used
 6 waivers under the Medicaid program to test ex-
 7 panded access to telehealth, including during
 8 the emergency period described in section
 9 1135(g)(1)(B) of the Social Security Act (42
 10 U.S.C. 1320b–5(g)(1)(B)).

11 (b) STUDIES AND REPORTS TO CONGRESS.—

12 (1) TELEHEALTH IMPACT ON HEALTH CARE
 13 ACCESS.—

14 (A) IN GENERAL.—Not later than 1 year
 15 after the date of the enactment of this Act, the
 16 Medicaid and CHIP Payment and Access Com-
 17 mission shall conduct a study, and submit to
 18 Congress a report, on the impact of telehealth
 19 on health care access, utilization, cost, and out-
 20 comes, broken down by race, ethnicity, sex, age,
 21 disability status, and ZIP Code, with respect to
 22 a minimum of 10 States across geographic re-
 23 gions of the United States.

24 (B) REPORT CONTENTS.—The report re-
 25 quired under subparagraph (A) shall—

1 (i) evaluate cost, access, utilization,
2 outcomes, and patient experience data
3 from across the health care field, including
4 States, Medicaid managed care organiza-
5 tions, provider organizations, and other or-
6 ganizations that provide or pay for tele-
7 health under the Medicaid program under
8 title XIX of the Social Security Act (42
9 U.S.C. 1396 et seq.) and the Children’s
10 Health Insurance Program under title XXI
11 of such Act (42 U.S.C. 1397aa et seq.);

12 (ii) identify barriers and potential so-
13 lutions to provider entry and participation
14 in telehealth that States are experiencing,
15 as well as barriers to providing telehealth
16 across State lines, including during times
17 of public health crisis or public health
18 emergency;

19 (iii) determine the frequency at which
20 out-of-State telehealth is provided to pa-
21 tients enrolled in the Medicaid program
22 under such title XIX and the potential im-
23 pact on access to telehealth if State Med-
24 icaid policies were more aligned; and

1 (iv) identify and evaluate opportuni-
2 ties for more alignment among such poli-
3 cies to promote access to telehealth across
4 all States, State Medicaid plans under
5 such title XIX, State child health plans
6 under such title XXI, and Medicaid man-
7 aged care organizations, including the po-
8 tential for regional compacts or reciprocity
9 agreements.

10 (2) FEDERAL AGENCY TELEHEALTH COLLABO-
11 RATION.—

12 (A) IN GENERAL.—Not later than 1 year
13 after the date of the enactment of this Act, the
14 Comptroller General of the United States shall
15 conduct a study, and submit to Congress a re-
16 port, evaluating collaboration between Federal
17 agencies with respect to telehealth services fur-
18 nished under the Medicaid program under title
19 XIX of the Social Security Act (42 U.S.C. 1396
20 et seq.) or the Children’s Health Insurance Pro-
21 gram under title XXI of such Act (42 U.S.C.
22 1397aa et seq.) to individuals under the age of
23 18, including such services furnished to such in-
24 dividuals in early care and education settings.

1 (B) REPORT CONTENTS.—The report re-
2 quired under subparagraph (A) shall include
3 recommendations on—

4 (i) opportunities for Federal agencies
5 to improve collaboration with respect to
6 the telehealth services described in such
7 subparagraph; and

8 (ii) opportunities for collaboration be-
9 tween Federal agencies to expand tele-
10 health access to individuals under the age
11 of 18 that are enrolled in the programs de-
12 scribed in such subparagraph, including in
13 early care and education settings.

14 **SEC. 6407. YOUTH AND YOUNG ADULT MENTAL HEALTH**
15 **PROMOTION, PREVENTION, INTERVENTION,**
16 **AND TREATMENT.**

17 Part Q of title III of the Public Health Service Act
18 (as amended by section 5001) is amended by adding at
19 the end the following:

20 **“SEC. 399Z–4. YOUTH AND YOUNG ADULT MENTAL HEALTH**
21 **PROMOTION, PREVENTION, INTERVENTION,**
22 **AND TREATMENT.**

23 “(a) GRANTS.—The Secretary shall—

24 “(1) award grants to eligible entities to develop,
25 maintain, or enhance youth and young adult mental

1 health promotion, prevention, intervention, and
 2 treatment programs, including—

3 “(A) programs for youth and young adults
 4 who may be likely to develop, are showing early
 5 signs of, or have been diagnosed with a mental
 6 health condition, including a serious emotional
 7 disturbance; and

8 “(B) infrastructure and organization
 9 change at a State, tribal, or territorial level to
 10 improve cross-system collaboration, service ca-
 11 pacity, and expertise related to youth and
 12 young adults; and

13 “(2) ensure that programs funded through
 14 grants under this section use community-driven, evi-
 15 dence-informed, or evidence-based models, practices,
 16 and methods that are, as appropriate, culturally and
 17 linguistically appropriate, and can be replicated in
 18 other appropriate settings.

19 “(b) ELIGIBLE TRANSITION AGE YOUTH AND ENTI-
 20 TIES.—In this section:

21 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
 22 tity’ means—

23 “(A) a local educational agency;

24 “(B) a State educational agency;

1 “(C) an institution of higher education (or
2 consortium of such institutions), which may in-
3 clude a recovery program at an institution of
4 higher education;

5 “(D) a local board, or a one-stop operator,
6 as defined in section 3 of the Workforce Inno-
7 vation and Opportunity Act;

8 “(E) a nonprofit organization with appro-
9 priate expertise in providing services or pro-
10 grams for children, adolescents, or young
11 adults, excluding a school;

12 “(F) a State, political subdivision of a
13 State, Indian tribe, or tribal organization; or

14 “(G) a high school or dormitory serving
15 high school students that receives funding from
16 the Bureau of Indian Education.

17 “(2) ELIGIBLE TRANSITION AGE YOUTH.—The
18 term ‘eligible transition age youth’ means a youth or
19 young adult from age 16 to not more than 25 years
20 of age who is—

21 “(A) an out-of-school youth as defined in
22 section 129(a)(1)(B) of the Workforce Innova-
23 tion and Opportunity Act;

24 “(B) a homeless individual (as defined in
25 section 41403(6) of the Violence Against

1 Women Act of 1994), a homeless child or youth
2 (as defined in section 725(2) of the McKinney-
3 Vento Homeless Assistance Act) a runaway, in
4 foster care or has aged out of the foster care
5 system, a child eligible for assistance under sec-
6 tion 477 of the Social Security Act, or in an
7 out-of-home placement;

8 “(C) an individual who is pregnant or par-
9 enting, as referred to in section 129(a)(1)(B) of
10 the Workforce Innovation and Opportunity Act;

11 “(D) a youth who is an individual with a
12 disability, as referred to in section 129(a)(1)(B)
13 of the Workforce Innovation and Opportunity
14 Act;

15 “(E) a low-income individual who requires
16 additional assistance to enter or complete an
17 educational program or to secure or hold em-
18 ployment, as referred to in section 129(a)(1)(B)
19 of the Workforce Innovation and Opportunity
20 Act; or

21 “(F) living in a community that has faced
22 acute or long-term exposure to substantial dis-
23 crimination, historical oppression, intergenera-
24 tional poverty, civil unrest, a high rate of vio-
25 lence, or drug overdose deaths.

1 “(c) APPLICATION.—An eligible entity seeking a
2 grant under subsection (a) shall submit to the Secretary
3 an application at such time, in such manner, and con-
4 taining such information as the Secretary may require.

5 “(d) USE OF FUNDS FOR MENTAL HEALTH PRO-
6 MOTION, PREVENTION, INTERVENTION AND TREATMENT
7 PROGRAMS.—An eligible entity may use amounts awarded
8 under a grant under subsection (a)(1) to carry out the
9 following:

10 “(1) Creation, implementation, and expansion
11 of services and supports that are culturally and lin-
12 guistically appropriate and youth guided, involve and
13 include family and community members (including
14 business leaders and faith-based organizations), and
15 provide for continuity of care between child- and
16 adult-serving systems to ensure seamless transition.

17 “(2) Infrastructure and organization change at
18 a State, Tribal, or territorial level to improve cross-
19 system collaboration, service capacity, and expertise
20 related to youth and young adults with, or at risk
21 of, mental health conditions and substance use dis-
22 orders as they transition into adult roles and respon-
23 sibilities.

24 “(3) Public awareness and cross-system pro-
25 vider training for individuals employed at institu-

1 tions of higher education and community colleges,
2 behavioral health providers, individuals working in
3 the criminal justice system, primary care providers,
4 vocational service providers, and child welfare work-
5 ers.

6 “(e) MATCHING FUNDS.—The Secretary may not
7 award a grant under this section to an eligible entity un-
8 less the eligible entity agrees, with respect to the costs to
9 be incurred by the eligible entity in carrying out the activi-
10 ties described in subsection (d), to make available non-
11 Federal contributions (in cash or in kind) toward such
12 costs in an amount that is not less than 10 percent of
13 the total amount of Federal funds provided in the grant.

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
15 carry out this section, there are authorized to be appro-
16 priated \$25,000,000 for each of fiscal years 2027 through
17 2036.”.

1 **Subtitle E—Community-Based Care**

2 **SEC. 6501. ASIAN AMERICAN, AFRICAN AMERICAN, NATIVE**
 3 **HAWAIIAN, PACIFIC ISLANDER, INDIGENOUS,**
 4 **MIDDLE EASTERN AND NORTH AFRICAN, AND**
 5 **HISPANIC AND LATINO BEHAVIORAL HEALTH**
 6 **OUTREACH AND EDUCATION STRATEGY.**

7 Part D of title V of the Public Health Service Act
 8 (42 U.S.C. 290dd et seq.), as amended by section 6203,
 9 is amended by adding at the end the following:

10 **“SEC. 556. BEHAVIORAL OUTREACH AND EDUCATION**
 11 **STRATEGY.**

12 “(a) IN GENERAL.—The Secretary, acting through
 13 the Assistant Secretary for Mental Health and Substance
 14 Use, shall, in coordination with advocacy and behavioral
 15 organizations serving populations of Asian American, Afri-
 16 can American, Native Hawaiian, Pacific Islander, Indige-
 17 nous, Middle Eastern and North African (in this section
 18 referred to as ‘MENA’), and Hispanic and Latino/a/x indi-
 19 viduals or communities, develop and implement an out-
 20 reach and education strategy to promote behavioral
 21 health, emphasize that behavioral health conditions are
 22 treatable and that reasonable accommodations under sec-
 23 tion 504 of the Rehabilitation Act of 1973 and titles II
 24 and III of the Americans with Disabilities Act of 1990
 25 are necessary and may help, as well as reduce stigma asso-

1 ciated with mental health conditions and substance use
2 disorder among the Asian American, African American,
3 Native Hawaiian, Pacific Islander, Indigenous, MENA,
4 and Hispanic and Latino/a/x populations. Such strategy
5 shall—

6 “(1) be designed to—

7 “(A) meet the diverse cultural and lan-
8 guage needs of the various Asian American, Af-
9 rican American, Indigenous, MENA, Native
10 Hawaiian, Pacific Islander, and Hispanic and
11 Latino/a/x populations; and

12 “(B) ensure that approaches recommended
13 in the strategy are developmentally (with re-
14 spect to the beneficiary’s relative age and expe-
15 rience) and age appropriate, as well as cog-
16 nitively accessible to persons with cognitive dis-
17 abilities;

18 “(2) increase awareness of symptoms of mental
19 illnesses common among such populations, taking
20 into account differences within subgroups (such as
21 gender, gender identity, age, sexual orientation, dis-
22 ability, and ethnicity) of such populations;

23 “(3) provide information on evidence-based, cul-
24 turally and linguistically appropriate and adapted
25 interventions and treatments;

1 “(4) ensure full participation of, and engage,
2 both consumers and community members rep-
3 resenting the communities of focus in the develop-
4 ment and implementation of materials; and

5 “(5) seek to broaden the perspective among
6 both individuals in such communities and stake-
7 holders serving such communities to use a com-
8 prehensive public health approach to promoting be-
9 havioral health that addresses a holistic view of
10 health by focusing on the intersection between be-
11 havioral and physical health.

12 “(b) REPORTS.—Beginning not later than 1 year
13 after the date of the enactment of this section and annu-
14 ally thereafter, the Secretary, acting through the Assistant
15 Secretary, shall submit to the Congress, and make publicly
16 available, a report on the extent to which the strategy de-
17 veloped and implemented under subsection (a) increased
18 behavioral health outcomes associated with mental health
19 conditions and substance use disorder among Asian Amer-
20 ican, African American, Native Hawaiian, Pacific Is-
21 lander, Indigenous, MENA, and Hispanic and Latino/a/
22 x populations.

23 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section
25 \$15,000,000 for each of fiscal years 2027 through 2032.”.

Subtitle F—Reports

2 SEC. 6601. ADDRESSING RACIAL AND ETHNIC MINORITY 3 MENTAL HEALTH DISPARITIES RESEARCH 4 GAPS.

5 Not later than 9 months after the date of the enact-
6 ment of this Act, the Director of the National Institutes
7 of Health, in consultation with the Director of the Na-
8 tional Institute of Mental Health and the Assistant Sec-
9 retary of Substance Use and Mental Health, shall enter
10 into an arrangement with the National Academies of
11 Sciences, Engineering, and Medicine (or, if the National
12 Academies of Sciences, Engineering, and Medicine decline
13 to enter into such an arrangement, the Patient-Centered
14 Outcomes Research Institute, the Agency for Healthcare
15 Research and Quality, or another appropriate entity)—

16 (1) to conduct a study with respect to mental
17 health disparities research gaps in racial and ethnic
18 minority groups (as defined in section 1707(g) of
19 the Public Health Service Act (42 U.S.C. 300u-
20 6(g))); and

21 (2) to submit to the Congress a report on the
22 results of such study, including—

23 (A) a compilation of information on the
24 prevalence of mental health outcomes in such
25 racial and ethnic minority groups; and

1 (B) an assessment of information on the
2 impact of exposure to community violence, ad-
3 verse childhood experiences, structural bias, and
4 other psychological traumas on mental health
5 outcomes in such racial and minority groups.

6 **SEC. 6602. RESEARCH ON ADVERSE HEALTH EFFECTS AS-**
7 **SOCIATED WITH INTERACTIONS WITH LAW**
8 **ENFORCEMENT.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services, acting through the Director of the Office
11 of Minority Health of the Centers for Disease Control and
12 Prevention (established pursuant to section 1707A of the
13 Public Health Service Act (42 U.S.C. 300u–6a)) (in this
14 section referred to as the “Secretary”), shall conduct re-
15 search on the adverse health effects associated with inter-
16 actions with law enforcement.

17 (b) EFFECTS AMONG RACIAL AND ETHNIC MINORI-
18 TIES.—The research under subsection (a) shall include re-
19 search on—

20 (1) the health consequences, both individual
21 and community-wide, of trauma related to violence
22 committed by law enforcement among racial and
23 ethnic minorities; and

24 (2) the disproportionate burden of morbidity
25 and mortality associated with such trauma.

1 (c) REPORT.—Not later than 1 year after the date
2 of enactment of this Act, the Secretary shall—

3 (1) complete the research under this section;
4 and

5 (2) submit to the Congress a report on the find-
6 ings, conclusions, and recommendations resulting
7 from such research.

8 **SEC. 6603. GEOACCESS STUDY.**

9 Not later than 180 days after the date of enactment
10 of this Act, the Assistant Secretary for Mental Health and
11 Substance Use shall—

12 (1) conduct a study to—

13 (A) determine which geographic areas of
14 the United States have shortages of racially and
15 ethnically diverse mental health providers, as
16 well as mental health providers trained to work
17 with racially and ethnically diverse clients and
18 clients with multiple mental health, cognitive,
19 and developmental disabilities; and

20 (B) assess the preparedness of mental
21 health providers to deliver culturally and lin-
22 guistically appropriate, affordable, and acces-
23 sible services; and

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

1 **SEC. 6604. CO-OCCURRING CONDITIONS.**

2 (a) GAO REPORT.—Not later than 2 years after the
3 date of enactment of this Act, the Comptroller General
4 of the United States shall submit to Congress a report
5 on barriers to care for persons with co-occurring condi-
6 tions and access to care in the United States. Such report
7 shall include the information and recommendations de-
8 scribed in subsection (b).

9 (b) CONTENT OF REPORT.—The report under sub-
10 section (a) shall include—

11 (1) an assessment of current barriers to behav-
12 ioral health and substance use disorder treatment
13 for low-income, uninsured, and Medicaid-enrolled
14 adults, and recommendations for addressing such
15 barriers, particularly for women and diverse racial
16 and ethnic groups;

17 (2) an assessment of—

18 (A) how many adults have a behavioral
19 health condition and options for adults to re-
20 ceive behavioral health and substance use dis-
21 order treatment in nonexpansion States;

22 (B) Medicaid expansion States who provide
23 behavioral health coverage for newly eligible en-
24 rollees;

25 (C) how enrollment in coverage affects
26 treatment availability; and

1 (D) the impacts of COVID–19 to receiving
2 and accessing treatment for behavioral health,
3 substance use disorders, and diverse racial and
4 ethnic groups, and recommendations for ad-
5 dressing such barriers;

6 (3) an assessment of current barriers, inclusive
7 of social determinants of health and cultural bar-
8 riers, that prevent adults from receiving behavioral
9 health and substance use disorder treatment, and
10 recommendations for addressing such barriers, par-
11 ticularly for low-income women and adults from ra-
12 cial and ethnic groups;

13 (4) an assessment of disparities in access to ad-
14 diction counselors and mental or behavioral health
15 care providers acting in accordance with State law,
16 stratified by race, ethnicity, gender identity, geo-
17 graphic location, and insurance type, and rec-
18 ommendations to promote greater access equity; and

19 (5) recommendations to promote greater equity
20 in access to care for behavioral services and sub-
21 stance use disorders, particularly for low-income
22 women and adults from diverse racial and ethnic
23 groups.

1 **SEC. 6605. STUDY AND REPORT ON THE AANHPI YOUTH**
2 **MENTAL HEALTH CRISIS.**

3 (a) STUDY.—

4 (1) IN GENERAL.—The Secretary, acting
5 through the Assistant Secretary for Mental Health
6 and Substance Use (referred to in this section as the
7 “Secretary”), in coordination with the Director of
8 the National Institutes of Health, the Director of
9 the Centers for Disease Control and Prevention, and
10 the Director of the Office of Minority Health, shall
11 conduct a study on behavioral health among
12 AANHPI youth.

13 (2) ELEMENTS.—Such study required under
14 paragraph (1) shall include an assessment of—

15 (A) the prevalence, risk factors, and root
16 causes of mental health challenges, substance
17 misuse, and mental health and substance use
18 disorders among AANHPI youth;

19 (B) the prevalence among AANHPI youth
20 of attempted suicide, nonfatal substance use
21 overdose, and death by suicide or substance use
22 overdose; and

23 (C) AANHPI youth that received treat-
24 ment for mental health and substance use dis-
25 orders.

1 (b) REPORT.—Not later than 1 year after the date
2 of the enactment of this Act, the Secretary shall submit
3 to the Committee on Health, Education, Labor, and Pen-
4 sions of the Senate and the Committee on Energy and
5 Commerce of the House of Representatives, and make
6 publicly available, a report on the findings of the study
7 conducted under subsection (a), including—

8 (1) identification of the barriers to accessing
9 behavioral health services for AANHPI youth;

10 (2) identification of root causes of mental
11 health challenges and substance misuse among
12 AANHPI youth;

13 (3) recommendations for actions to be taken by
14 the Secretary to improve behavioral health among
15 AANHPI youth;

16 (4) recommendations for legislative or adminis-
17 trative action to improve the behavioral health of
18 AANHPI youth experiencing depression, suicide,
19 and overdose, and to reduce the prevalence of de-
20 pression, suicide, and overdose among AANHPI
21 youth; and

22 (5) such other recommendations as the Sec-
23 retary determines appropriate.

24 (c) DATA.—Any data included in the study or report
25 under this section shall be disaggregated by race, eth-

1 nicity, age, sex, gender identity, sexual orientation, geo-
 2 graphic region, disability status, and other relevant fac-
 3 tors, in a manner that protects personal privacy and that
 4 is consistent with applicable Federal and State privacy
 5 law.

6 (d) AUTHORIZATION OF APPROPRIATIONS.—For pur-
 7 poses of carrying out this section, there is authorized to
 8 be appropriated \$1,500,000 for fiscal year 2027.

9 **SEC. 6606. STUDY AND REPORT ON STRATEGIES ON THE**
 10 **AANHPI BEHAVIORAL HEALTH WORKFORCE**
 11 **SHORTAGE.**

12 (a) STUDY.—

13 (1) IN GENERAL.—The Secretary, acting
 14 through the Assistant Secretary for Mental Health
 15 and Substance Use (referred to in this section as the
 16 “Secretary”), in coordination with the Administrator
 17 of the Health Resources and Services Administra-
 18 tion, the Secretary of Labor, and the Director of the
 19 Office of Minority Health, shall conduct a study on
 20 strategies for increasing the behavioral health pro-
 21 fessional workforce that identify as AANHPI.

22 (2) ELEMENTS.—Such study required under
 23 paragraph (1) shall consider—

1 (A) the total number of licensed behavioral
2 health providers in the United States who iden-
3 tify as AANHPI;

4 (B) with respect to each such provider, in-
5 formation regarding the current type of license,
6 geographic area of practice, and type of em-
7 ployer (such as hospital, Federally qualified
8 health center, school, or private practice);

9 (C) information regarding the cultural and
10 linguistic capabilities of such providers, includ-
11 ing languages spoken proficiently; and

12 (D) the relevant barriers to enrollment in
13 behavioral health professional education pro-
14 grams and entering the behavioral workforce
15 for AANHPI individuals.

16 (b) REPORT.—Not later than 1 year after the date
17 of the enactment of this Act, the Secretary shall submit
18 to the Committee on Health, Education, Labor, and Pen-
19 sions of the Senate and the Committee on Energy and
20 Commerce of the House of Representatives, and make
21 publicly available, a report on the findings of the study
22 conducted under subsection (a), including—

23 (1) identification of AANHPI licensed behav-
24 ioral health providers' knowledge and awareness of
25 the barriers to quality behavioral health care services

1 faced by AANHPI individuals, including stigma, lim-
2 ited English proficiency, and lack of health insur-
3 ance coverage;

4 (2) recommendations for actions to be taken by
5 the Secretary to increase the number of AANHPI li-
6 censed behavioral health professionals;

7 (3) recommendations for legislative or adminis-
8 trative action to improve the enrollment of AANHPI
9 individuals in behavioral health professional edu-
10 cation programs; and

11 (4) such other recommendations as the Sec-
12 retary determines appropriate.

13 (c) DATA.—Any data included in the study or report
14 under this section shall be disaggregated by race, eth-
15 nicity, age, sex, gender identity, sexual orientation, geo-
16 graphic region, disability status, and other relevant fac-
17 tors, in a manner that protects personal privacy and that
18 is consistent with applicable Federal and State privacy
19 law.

20 (d) DEFINITION.—In this section the term “licensed
21 behavioral health provider” means any individual licensed
22 to provide mental health or substance use disorder serv-
23 ices, including in the professions of social work, psy-
24 chology, psychiatry, marriage and family therapy, mental
25 health counseling, and substance use disorder counseling.

1 (e) AUTHORIZATION OF APPROPRIATIONS.—For pur-
 2 poses of carrying out this section, there is authorized to
 3 be appropriated \$1,500,000 for fiscal year 2027.

4 **Subtitle G—Miscellaneous**
 5 **Provisions**

6 **SEC. 6701. STRENGTHENING MENTAL HEALTH SUPPORTS**
 7 **FOR BIPOC COMMUNITIES.**

8 (a) IN GENERAL.—Section 1942(a) of the Public
 9 Health Service Act (42 U.S.C. 300x–52(a)) is amended—

10 (1) by redesignating paragraphs (2) and (3) as
 11 paragraphs (5) and (6), respectively; and

12 (2) by inserting after paragraph (1) the fol-
 13 lowing:

14 “(2) services provided by the State to adults
 15 with a serious mental illness and children with a se-
 16 rious emotional disturbance who are members of ra-
 17 cial and ethnic minority groups, including—

18 “(A) the extent to which such services are
 19 provided to such adults and children; and

20 “(B) the outcomes experienced by such
 21 adults and children as a result of the provision
 22 of such services, including with respect to—

23 “(i) diversions from hospitalization
 24 and criminal justice system involvement;

1 “(ii) treatment for first episode psy-
2 chosis or undefined psychosis;

3 “(iii) reductions in suicide and in-
4 creased utilization of appropriate treat-
5 ments and interventions for suicidal idea-
6 tion;

7 “(iv) response through crisis services,
8 including mobile crisis services;

9 “(v) treatment of individuals who are
10 experiencing homelessness or housing inse-
11 curity and individuals residing in rural
12 communities; and

13 “(vi) increased patient family and
14 caregiver engagement and education on se-
15 rious mental illness to reduce social stigma
16 and promote healthy social support for pa-
17 tients;

18 “(3) any outreach by the State to, and the hir-
19 ing of, providers of mental health services from mul-
20 tiple disciplines (such as a psychologist, psychiatrist,
21 peer support provider, or social worker) who are
22 members of racial and ethnic minority groups;

23 “(4) any outreach by the State to providers
24 from multiple disciplines of mental health services—

1 “(A) to provide training on culturally ef-
 2 fective, culturally affirming, and linguistically
 3 competent services; and

4 “(B) to increase awareness of community-
 5 defined practices by practitioners of racial and
 6 ethnic minority groups;”.

7 (b) APPLICABILITY.—The amendments made by sub-
 8 section (a) shall apply with respect to funding agreements
 9 entered into under section 1911 or 1921 of the Public
 10 Health Service Act (42 U.S.C. 300x; 42 U.S.C. 300x–21)
 11 on or after the date of the enactment of this Act.

12 **SEC. 6702. STRONG SUPPORT FOR CHILDREN.**

13 (a) DATA ANALYSIS AND STRATEGY IMPLEMENTA-
 14 TION TO PREVENT AND MITIGATE CHILDHOOD TRAU-
 15 MA.—Title XXXI of the Public Health Service Act (42
 16 U.S.C. 300kk) is amended by adding at the end the fol-
 17 lowing:

18 **“SEC. 3102. DATA ANALYSIS AND STRATEGY IMPLEMENTA-**
 19 **TION TO PREVENT AND MITIGATE CHILD-**
 20 **HOOD TRAUMA.**

21 “(a) IN GENERAL.—The Secretary shall establish a
 22 program—

23 “(1) to support the development and implemen-
 24 tation of programs that use data analysis methods
 25 to identify and facilitate strategies for early inter-

1 vention and prevention, in order to prevent and miti-
2 gate childhood trauma and support communities and
3 families, including—

4 “(A) improving connections through care
5 coordination;

6 “(B) aligning community initiatives in tar-
7 geted areas of need; and

8 “(C) expanding community capacity
9 through cross-sector collaboration; and

10 “(2) to evaluate the effectiveness of these pro-
11 grams in improving outcomes for children.

12 “(b) GRANTS.—The Secretary shall award grants to
13 up to 5 eligible entities to carry out the activities described
14 in subsection (a).

15 “(c) USE OF FUNDS.—A grant for activities under
16 this section shall be used to support the development and
17 implementation of programs that use data analysis meth-
18 ods to identify and facilitate strategies for early interven-
19 tion and prevention, in order to prevent and mitigate
20 childhood trauma and support communities and families,
21 including as follows:

22 “(1) Utilize data analysis methods to—

23 “(A) identify specific geographic areas,
24 such as census tracts, with a high prevalence of
25 adverse childhood experiences and significant

1 risk factors for poor outcomes for children
 2 (such as increased risk of experiencing adverse
 3 childhood experiences), including areas with
 4 high rates of—

5 “(i) poor public health outcomes in-
 6 cluding illness, disease, suicide, and mor-
 7 tality;

8 “(ii) exclusionary discipline practices,
 9 including suspensions, expulsions, and re-
 10 ferrals to law enforcement, as well as low
 11 graduation rates;

12 “(iii) substance use disorders;

13 “(iv) poverty;

14 “(v) foster system involvement or re-
 15 ferrals;

16 “(vi) housing instability and homeless-
 17 ness;

18 “(vii) food insecurity;

19 “(viii) inequity, including disparities
 20 in income, wealth, employment, educational
 21 attainment, health care access, and public
 22 health outcomes, along lines of race, sex,
 23 sexuality and gender identity, ethnicity, or
 24 nationality;

25 “(ix) incarceration rates; or

1 “(x) other indicators of adversity as
2 defined by the Secretary; and

3 “(B) identify strategies to improve out-
4 comes for children aged 0 through 17 that build
5 on strengths in communities that could be fur-
6 ther supported, including—

7 “(i) existing support networks for
8 families; and

9 “(ii) enhanced connections to commu-
10 nity-based organizations.

11 “(2) Implement strategies identified pursuant
12 to paragraph (1)(B) to facilitate outreach and in-
13 volvement of children and their caregivers in Fed-
14 eral, State, or local programs that provide repar-
15 ative, gender-responsive, culturally specific, and
16 trauma-informed prevention services, and for which
17 children and their caregivers are eligible, including—

18 “(A) home visiting programs;

19 “(B) training and education on parenting
20 skills;

21 “(C) substance use disorder prevention and
22 treatment that is voluntary and noncoercive;

23 “(D) mental health supports and care that
24 is voluntary and noncoercive;

1 “(E) family and intimate partner violence
2 prevention services;

3 “(F) child advocacy center programming;

4 “(G) economic and nutrition support serv-
5 ices;

6 “(H) housing support services, including
7 emergency and temporary shelter for those ex-
8 perencing homelessness and housing insecurity,
9 as well as stable, long-term housing;

10 “(I) voluntary, noncoercive, gender-respon-
11 sive, and culturally specific mental health sup-
12 ports in school and early childhood education
13 center-based settings;

14 “(J) wraparound programs for
15 transitioning youth and youth currently in the
16 foster system;

17 “(K) programming to support the health
18 and well-being of lesbian, gay, bisexual,
19 transgender, and intersex children and their
20 families; and

21 “(L) family resource center services.

22 “(d) SPECIAL RULES.—

23 “(1) PRIMARY PAYER RESTRICTION.—The Sec-
24 retary may not award a grant under this section to
25 an eligible entity for a service if the service to be

1 provided is available pursuant to the State plan ap-
2 proved under title XIX of the Social Security Act for
3 the State in which the program funded by the grant
4 is being conducted unless the State and all eligible
5 subdivisions involved—

6 “(A) will enter into agreements with public
7 or nonprofit private entities under which the
8 entities will provide the service; and

9 “(B) demonstrate that the State and all el-
10 igible subdivisions will ensure that the entities
11 providing the service—

12 “(i) will seek payment for each such
13 service rendered in accordance with the
14 usual payment schedule under the State
15 plan; and

16 “(ii) the entities have entered into a
17 participation agreement and are qualified
18 to receive payments under such plan.

19 “(2) IMPLEMENTATION.—An eligible entity that
20 receives a grant under this section may use—

21 “(A) not more than 25 percent of the
22 amounts made available through the grant for
23 the first 24 months of the grant period to uti-
24 lize data analysis methods to—

1 “(i) identify specific geographic areas
2 where care coordination, prevention and
3 early intervention, and facilitation services
4 will be provided; and

5 “(ii) identify support and intervention
6 services to improve outcomes for children
7 located in a geographic area identified
8 under subsection (c)(1)(A); and

9 “(B) not more than 10 percent of the
10 grant in each subsequent year to continue data
11 analysis activities.

12 “(3) ADMINISTRATION.—An eligible entity that
13 receives a grant under this section may not use more
14 than 5 percent of amounts received through the
15 grant for administration, reporting, and program
16 oversight functions, including the development of
17 systems to improve data collection and data sharing
18 for the purposes of improving services and the provi-
19 sion of care.

20 “(4) PRIORITY.—

21 “(A) IN GENERAL.—In awarding grants
22 under this section, the Secretary shall give pri-
23 ority, to the extent practical, to eligible entities
24 that use community-based system dynamic
25 modeling as the primary data analysis method.

“(B) SYSTEM DYNAMIC MODELING DEFINED.—The term ‘system dynamic modeling’ means a method of data analysis and predictive modeling that includes—

“(i) utilization of community-based participatory research methods for involving community in the process of understanding and changing systems and evaluating outcomes of grants;

“(ii) consideration of a multitude of environmental risk factors and ascertainment of the significance of contributing community risk factors for purposes of identifying strategies to reduce adverse child outcomes, including—

“(I) maltreatment cases;

“(II) involvement with the juvenile criminal legal system or foster system;

“(III) exclusionary school discipline; or

“(IV) exposure to violence; and

“(iii) identification of cross-sector responses involving reparative, trauma-informed, culturally specific, gender-respon-

1 sive, and community-based organizations
2 to reduce adverse child outcomes.

3 “(5) SUBGRANT.—

4 “(A) IN GENERAL.—An eligible entity that
5 receives a grant under this section shall use at
6 least 25 percent of the total amount of the
7 grant to make subgrants to organizations that
8 aid in implementing the strategy identified
9 under subsection (c)(1)(B) for preventing and
10 mitigating childhood trauma and supporting
11 communities and families.

12 “(B) ELIGIBILITY.—To be eligible to re-
13 ceive a subgrant under this paragraph, an orga-
14 nization shall prepare and submit to the eligible
15 entity an application in such form, and con-
16 taining such information, as the eligible entity
17 may require, including evidence that the—

18 “(i) needs of the population to be
19 served are urgent and are not met by the
20 services currently available in the geo-
21 graphic area; and

22 “(ii) organization has the capacity to
23 provide the services listed in subsection
24 (c)(2).

1 “(C) SUPPLEMENT, NOT SUPPLANT.—
2 Subgrant funds received pursuant to this para-
3 graph by an organization shall be used to sup-
4 plement and not supplant State or local funds
5 provided to the partnership organization for
6 services listed in subsection (c)(2).

7 “(e) APPLICATION.—To be eligible to receive a grant
8 under this section, an eligible entity shall submit to the
9 Secretary an application in such form, and containing
10 such information, as the Secretary may require, to include
11 the following:

12 “(1) A demonstration that—

13 “(A) the applicant utilizes trauma-in-
14 formed, culturally specific, and gender-respon-
15 sive practices, including a demonstration of the
16 extent to which the applicant has trained staff
17 in these practices;

18 “(B) the applicant has the capacity to ad-
19 minister the grant, including conducting all re-
20 quired data analysis activities; and

21 “(C) services will be provided to children
22 and families in an accessible, culturally rel-
23 evant, and linguistically specific manner con-
24 sistent with local needs.

1 “(2) A preliminary analysis of how the appli-
2 cant will use the grant to—

3 “(A) identify the geographic area or areas
4 to be served using data analysis methods;

5 “(B) utilize data analysis methods to iden-
6 tify strategies to improve outcomes for children
7 in the geographic area;

8 “(C) facilitate strategies identified through
9 care coordination efforts; and

10 “(D) track data for evaluation of out-
11 comes.

12 “(3) A detailed project plan for the use of the
13 grant that includes anticipated technical assistance
14 needs.

15 “(4) Additional funding sources, including State
16 and local funds, supporting the prevention and miti-
17 gation of adverse childhood experiences.

18 “(f) GRANT AMOUNT.—The amount of a grant under
19 this section shall not exceed \$9,500,000.

20 “(g) PERIOD OF A GRANT.—The period of a grant
21 under this section shall not exceed 7 years.

22 “(h) SERVICE PROVISION WITHOUT REGARD TO
23 ABILITY TO PAY.—As a condition on receipt of a grant
24 under this section, an eligible entity shall agree that any

1 assistance provided to an individual through the grant will
2 be provided without regard to—

3 “(1) the ability of the individual to pay for such
4 services;

5 “(2) the current or past health condition of the
6 individual to be served;

7 “(3) the immigration status of the individual to
8 be served;

9 “(4) the sexual orientation and gender identity
10 of the individual to be served; and

11 “(5) any prior involvement of the individual in
12 the criminal legal system.

13 “(i) PROHIBITIONS.—In addition to any other prohi-
14 bitions determined by the Secretary, an eligible entity may
15 not use a grant under this section to—

16 “(1) use data analysis methods to inform indi-
17 vidual case decisions, including child removal or
18 placement decisions, or to target services at certain
19 individuals or families;

20 “(2) require any individual or family to partici-
21 pate in any service or program as a condition of re-
22 ceipt of a benefit to which the individual or family
23 is otherwise eligible;

24 “(3) increase the presence or funding of law en-
25 forcement surveillance, involvement, or activity in

1 implementing the strategies identified under sub-
2 section (c)(1)(B); or

3 “(4) enable the practice of conversion therapy.

4 “(j) EVALUATION.—

5 “(1) DATA MODEL EVALUATION.—Not later
6 than 36 months after the date of enactment of this
7 section, the Assistant Secretary for Planning and
8 Evaluation of the Department of Health and Human
9 Services, in coordination with the grantees receiving
10 a grant under this section, shall complete an evalua-
11 tion of the effectiveness of the data model accuracy
12 of the grant program under this section to address
13 each of the following:

14 “(A) Determining the effectiveness of the
15 grantees’ use of data analysis methods to iden-
16 tify geographic areas pursuant to subsection
17 (c)(1).

18 “(B) Examining the grantees’ development
19 and utilization of data analysis methods.

20 “(C) Examining the grantees’ ability to ef-
21 fectively utilize data analysis methods in future
22 prevention work.

23 “(D) Establishing a method for rigorously
24 evaluating the activities of grantees and com-
25 paring the reduction of child and family expo-

1 sure to adverse experiences in other commu-
2 nities with similar demographics.

3 “(E) Examining the grantees’ utilization of
4 community-based system dynamics modeling
5 methods and other community engagement
6 methods.

7 “(2) PROGRAM EVALUATION.—Not later than 6
8 years after the date of enactment of this section, the
9 Assistant Secretary for Planning and Evaluation of
10 the Department of Health and Human Services, in
11 coordination with eligible entities receiving grants
12 under this section, shall complete an evaluation of
13 the effectiveness of the grant program under this
14 section.

15 “(3) DATA COLLECTION.—

16 “(A) IN GENERAL.—The Assistant Sec-
17 retary for Planning and Evaluation of the De-
18 partment of Health and Human Services and
19 each eligible entity receiving a grant under this
20 section shall collect any relevant data necessary
21 to complete the evaluations required by para-
22 graphs (1) and (2) to include—

23 “(i) the activities funded by the grant
24 under this section, including development
25 and implementation data analysis methods;

1 “(ii) the number of children and of
 2 families receiving coordination and facilita-
 3 tion of care and services; and

4 “(iii) the effect of activities supported
 5 by the grant under this section on the local
 6 area serviced by the program, including
 7 such effects on—

8 “(I) children and adolescents’
 9 health and well-being;

10 “(II) the number of children who
 11 enter into or depart from foster serv-
 12 ices; and

13 “(III) homelessness and housing
 14 insecurity.

15 “(B) STUDY.—

16 “(i) IN GENERAL.—Not later than 7
 17 years after the date of enactment of this
 18 section, the Assistant Secretary for Plan-
 19 ning and Evaluation of the Department of
 20 Health and Human Services shall—

21 “(I) complete a study on the re-
 22 sults of the grant program under this
 23 section using the community-based
 24 participatory action research method,
 25 which focuses on social, structural,

1 and physical environmental inequities
2 through active involvement of commu-
3 nity members, clients, organizational
4 representatives, and researchers in all
5 aspects of the research process; and

6 “(II) submit a report on the re-
7 sults of the study to the Congress.

8 “(ii) PARTNERS.—In conducting the
9 study under clause (i), the Assistant Sec-
10 retary for Planning and Evaluation of the
11 Department of Health and Human Serv-
12 ices shall ensure that partners and persons
13 that have participated in the grant pro-
14 gram under this section on every level, es-
15 pecially those such partners or persons re-
16 ceiving services and support through the
17 program, have an opportunity to contribute
18 their expertise to evaluating the strategy
19 and outcomes.

20 “(k) REPORT.—Not later than 3 months after the
21 completion of the evaluation required by subsection (j)(2),
22 the Assistant Secretary for Planning and Evaluation of
23 the Department of Health and Human Services shall sub-
24 mit to Congress and make available to the public on the
25 internet website of the Department of Health and Human

1 Services a report based upon the evaluation under sub-
 2 section (j)(2), to include—

3 “(1) the impact of the program under this sec-
 4 tion on homelessness and housing insecurity, sub-
 5 stance use disorder and drug deaths, incarceration,
 6 foster system involvement, and other child and fam-
 7 ily outcomes as identified by the Assistant Secretary
 8 for Planning and Evaluation of the Department of
 9 Health and Human Services;

10 “(2) an analysis of which elements of the pro-
 11 gram should be replicated and scaled by govern-
 12 mental or non-governmental entities; and

13 “(3) such recommendations for legislation and
 14 administrative action as the Secretary determines
 15 appropriate.

16 “(l) DEFINITIONS.—In this section:

17 “(1) The term ‘adverse childhood experience’
 18 means a potentially traumatic experience that occurs
 19 in childhood and can have a tremendous impact on
 20 the child’s lifelong health and opportunity outcomes,
 21 such as any of the following:

22 “(A) Abuse, such as any of the following:

23 “(i) Emotional and psychological
 24 abuse.

25 “(ii) Physical abuse.

1 “(iii) Sexual abuse.

2 “(B) Household challenges such as any of
3 the following:

4 “(i) A household member is treated
5 violently.

6 “(ii) A household member has a sub-
7 stance use disorder.

8 “(iii) A household member has a men-
9 tal health condition.

10 “(iv) Parental separation or divorce.

11 “(v) A household member is incarcer-
12 ated, is placed in immigrant detention, or
13 has been deported.

14 “(vi) A household member has a life-
15 threatening illness such as COVID-19.

16 “(C) Neglect.

17 “(D) Living in—

18 “(i) impoverished communities that
19 lack access to human services;

20 “(ii) areas of high unemployment
21 neighborhoods; or

22 “(iii) communities experiencing de
23 facto segregation.

24 “(E) Experiencing food insecurity and
25 poor nutrition.

1 “(F) Witnessing violence.

2 “(G) Involvement with the foster system.

3 “(H) Experiencing discrimination.

4 “(I) Dealing with historical and ongoing
5 traumas due to systemic and interpersonal rac-
6 ism.

7 “(J) Dealing with historical and ongoing
8 traumas regarding systemic and interpersonal
9 sexism, homophobia, biphobia, and transphobia.

10 “(K) Dealing with the threat of deporta-
11 tion or detention as a result of immigration sta-
12 tus.

13 “(L) The impacts of multigenerational pov-
14 erty resulting from limited educational and eco-
15 nomic opportunities.

16 “(M) Living through natural disasters
17 such as earthquakes, forest fires, floods, or hur-
18 ricanes.

19 “(2) The term ‘eligible entity’ means a State or
20 local health department.

21 “(3) The term ‘practice of conversion ther-
22 apy’—

23 “(A) means any practice or treatment by
24 any person that seeks to change another indi-
25 vidual’s sexual orientation or gender identity,

1 including efforts to change behaviors or gender
2 expressions, or to eliminate or reduce sexual or
3 romantic attractions or feelings toward individ-
4 uals of the same gender, if such person receives
5 monetary compensation in exchange for any
6 such practice or treatment; and

7 “(B) does not include any practice or
8 treatment that does not seek to change sexual
9 orientation or gender identity and—

10 “(i) provides assistance to an indi-
11 vidual undergoing a gender transition; or

12 “(ii) provides acceptance, support,
13 and understanding of a client or facilita-
14 tion of a client’s coping, social support,
15 and identity exploration and development.

16 “(m) AUTHORIZATION OF APPROPRIATIONS.—There
17 is authorized to be appropriated to carry out this section
18 for the period of fiscal years 2027 through 2033—

19 “(1) to carry out subsection (a)(1) through the
20 award of grants under subsection (b)—

21 “(A) \$47,500,000 for grants; and

22 “(B) such sums as may be necessary for
23 the administrative costs of carrying out such
24 subsection; and

1 “(2) \$7,500,000 to carry out the evaluation
2 under subsection (a)(2).”.

3 (b) CARE COORDINATION GRANTS.—Part E of title
4 XII of the Public Health Service Act (42 U.S.C. 300d–
5 51 et seq.) is amended by adding at the end the following
6 new section:

7 **“SEC. 1255. CARE COORDINATION GRANTS.**

8 “(a) IN GENERAL.—The Secretary shall award
9 grants to eligible entities to establish or expand trauma-
10 informed care coordination services to support—

11 “(1) children aged 0 through 5 at risk of ad-
12 verse childhood experiences; and

13 “(2) their caregivers, including prenatal people
14 of any age.

15 “(b) NUMBER OF GRANTS.—Subject to the avail-
16 ability of appropriations, the Secretary shall award not
17 fewer than 9 and not more than 40 grants under this sec-
18 tion.

19 “(c) AMOUNT OF GRANTS.—Subject to the avail-
20 ability of appropriations, the amount of a grant under this
21 section for a fiscal year shall be—

22 “(1) not less than \$250,000; and

23 “(2) not more than \$1,000,000.

24 “(d) ELIGIBLE ENTITIES.—To be eligible to receive
25 a grant under this section, an entity shall be a local gov-

1 ernment or Indian Tribe, acting through the public health
2 department thereof if such government or Tribe has a
3 public health department.

4 “(e) PRIORITY.—

5 “(1) IN GENERAL.—In awarding grants under
6 this section, the Secretary shall give priority to eligi-
7 ble entities proposing to serve communities with a
8 high need for trauma-informed care coordination
9 services, as demonstrated by indicators such as—

10 “(A) pregnant people who face barriers to
11 prenatal care;

12 “(B) mortality or morbidity of people giv-
13 ing birth or infants;

14 “(C) caretakers and parents who are living
15 with a mental health condition or substance use
16 disorder;

17 “(D) a high prevalence of community vio-
18 lence, including domestic violence, as dem-
19 onstrated by instances of homicide and public
20 health statistics, including treatment of injury
21 or trauma;

22 “(E) high proportions of low-income chil-
23 dren;

1 “(F) a high prevalence of child fatalities or
 2 near fatalities related to child abuse and ne-
 3 glect;

4 “(G) significant disparities in health out-
 5 comes for people giving birth and infants;

6 “(H) a high rate of exclusionary discipline
 7 and referrals to law enforcement; and

8 “(I) a high rate of homelessness and hous-
 9 ing instability.

10 “(2) DATA FROM TRIBAL AREAS.—The Sec-
 11 retary, acting through the Director of the Indian
 12 Health Service, shall consult with Indian Tribes to
 13 establish criteria to measure indicators of need, for
 14 purposes of paragraph (1), with respect to Tribal
 15 areas.

16 “(f) USE OF FUNDS.—

17 “(1) REQUIRED USES.—

18 “(A) IN GENERAL.—A grant received
 19 under this section shall be used to establish or
 20 expand gender-responsive, culturally specific,
 21 trauma-informed care coordination services, in-
 22 cluding by instituting and conducting risk and
 23 needs assessments including—

24 “(i) using strengths-based approaches
 25 focused on protective factors for children

1 and their caregivers, including prenatal
2 people of any age; and

3 “(ii) inputting screening results into a
4 centralized intake system to promote a sin-
5 gle point of access system across providers
6 and services.

7 “(B) TRAINING.—A grant received under
8 this section shall be used to ensure that individ-
9 uals employed through the grant funds, in
10 whole or in part, have received sufficient and
11 up-to-date training on trauma-informed care
12 and strategies that are reparative, culturally
13 sensitive, gender responsive, and healing cen-
14 tered.

15 “(2) PERMISSIBLE USES.—A grant received
16 under this section may be used for any of the fol-
17 lowing:

18 “(A) Employing care coordinators, case
19 managers, community health workers, certified
20 infant mental health specialists, and outreach
21 and engagement specialists to work with chil-
22 dren and their caregivers, including prenatal in-
23 dividuals, to prevent and respond to adverse
24 childhood experiences by connecting clients with
25 culturally specific, trauma-informed care treat-

1 ment services, including economic, social, food,
2 and housing supports.

3 “(B) Providing training described in para-
4 graph (1)(B) to community health providers
5 and community partners.

6 “(C) Expanding, enhancing, modifying,
7 and connecting the existing network of commu-
8 nity programs and services to achieve a more
9 comprehensive and coordinated system of care
10 approach, including—

11 “(i) developing local infrastructure to
12 bolster and shape community support sys-
13 tems and map and build access to services
14 in a coordinated and comprehensive way;
15 and

16 “(ii) creating infrastructure to con-
17 duct outreach to children and families, in-
18 cluding those experiencing homelessness
19 and housing instability, so they acquire ac-
20 cess to the services and supports they need
21 and the benefits to which they are entitled.

22 “(D) Compiling information on resources
23 (including any referral services) available
24 through community-based organizations and
25 local, State, and Federal agencies, such as—

- 1 “(i) programs addressing social deter-
2 minants of health, including—
3 “(I) emergency, temporary, and
4 long-term housing;
5 “(II) programs that offer free or
6 affordable and nutritious food;
7 “(III) vocational and workforce
8 development; and
9 “(IV) transportation supports;
10 “(ii) home visiting programs for new
11 parents and their infants;
12 “(iii) workforce development programs
13 to support caregivers in skill building;
14 “(iv) trauma-responsive, parenting
15 skills-building programs;
16 “(v) the continuum of substance use
17 prevention, intervention, and treatment
18 programs and mental health support pro-
19 grams, including programs with trauma-in-
20 formed, gender-responsive, and culturally
21 specific counseling; and
22 “(vi) childcare support and early
23 childhood education, including Head Start
24 and Early Head Start programs.

1 “(E) Subject to subsection (g)(1), estab-
2 lishing or updating a database that compiles
3 data used to track the effectiveness of the care
4 coordination services funded through the grant.

5 “(F) Developing and implementing referral
6 partnership agreements with community-based
7 organizations, parent organizations, substance
8 use disorder treatment providers and facilities,
9 housing and shelter providers, health care pro-
10 viders, mental health care providers, and Fed-
11 eral and State offices and programs that imple-
12 ment practices to support children ages 0
13 through 5 who are at risk of adverse childhood
14 experiences and their caregivers, including pre-
15 natal people. Such practices shall include—

16 “(i) a bilateral ‘warm handoff’ system
17 whereby a grantee understands the needs
18 of the children and their families, and fam-
19 ilies are involved in addressing these needs;
20 and

21 “(ii) an active service connection
22 whereby the children and families are each
23 actively connected with a resource in a
24 well-coordinated way that ensures avail-
25 ability and direct contact.

1 “(G) Supporting cross-system planning
2 and collaboration among employees who may
3 work in emergency medical services, health care
4 services, public health, early childhood edu-
5 cation, and substance use disorder treatment
6 and recovery support.

7 “(H) Providing or subsidizing services to
8 address barriers that children, prenatal individ-
9 uals, and caregivers face to utilizing community
10 resources and services, such as by providing or
11 subsidizing transportation or childcare costs as
12 applicable and within reasonable amounts.

13 “(I) Creating or expanding infrastructure
14 and investing in technology, including the provi-
15 sion of communications technology and internet
16 service to children and their caregivers, to en-
17 able increased telemedicine capabilities to reach
18 participants.

19 “(3) INDIAN TRIBES.—In the case of an eligible
20 entity that is an Indian Tribe, the Secretary may
21 waive such provisions of this subsection as the Sec-
22 retary determines appropriate.

23 “(4) PROHIBITIONS.—In addition to any other
24 prohibitions determined by the Secretary, an eligible
25 entity may not use a grant under this section to—

1 “(A) use data analysis methods to inform
 2 individual case decisions, including child re-
 3 moval or placement decisions, or to target serv-
 4 ices at certain individuals or families;

5 “(B) require any individual or family to
 6 participate in any service or program as a con-
 7 dition of receipt of a benefit to which the indi-
 8 vidual or family is otherwise eligible; or

9 “(C) increase the presence or funding of
 10 law enforcement surveillance, involvement, or
 11 activity in connection with trauma-informed
 12 care coordination services supported pursuant
 13 to this section.

14 “(g) REQUIREMENTS.—As a condition on receipt of
 15 a grant under this section, an eligible entity shall agree
 16 to each of the following funding conditions:

17 “(1) RESTRICTION OF FUNDING ALLOCATION.—
 18 The eligible entity will not use more than 30 percent
 19 of the funds made available to the entity through the
 20 grant (for the total grant period) to establish or up-
 21 date a database pursuant to subsection (f)(2)(E).

22 “(2) ACCESSIBLE SETTING.—

23 “(A) IN GENERAL.—The eligible entity will
 24 ensure that all care coordination services pro-
 25 vided through the grant are provided in a set-

1 ting that is accessible, including through mobile
2 settings, to—

3 “(i) low-income or no-income individ-
4 uals, including individuals experiencing
5 homelessness or housing instability; and

6 “(ii) individuals in rural areas.

7 “(B) COMMUNITY OUTREACH.—In com-
8 plying with subparagraph (A), the eligible entity
9 will ensure that at least 50 percent of the care
10 coordination services provided through the
11 grant occur in community settings that are con-
12 venient to the children and caregivers who are
13 being served, such as homes, schools, and shel-
14 ters, whether for initial outreach or as part of
15 long-term care.

16 “(3) SUPPLEMENT, NOT SUPPLANT.—The
17 grant will be used to supplement, not supplant other
18 Federal, State, or local funds available for care co-
19 ordination services.

20 “(4) CONFIDENTIALITY.—The eligible entity
21 will maintain the confidentiality of individuals receiv-
22 ing services through the grant in a manner con-
23 sistent with applicable law.

1 “(5) PARTNERING; RISK STRATIFICATION.—In
2 providing care coordination services through the
3 grant, the eligible entity will—

4 “(A) partner with community-based orga-
5 nizations with experience serving child popu-
6 lations prenatally through age 5;

7 “(B) coordinate with the local agency re-
8 sponsible for administering the State plan ap-
9 proved under title XIX of the Social Security
10 Act; and

11 “(C) employ risk stratification to develop
12 different effective models of care for different
13 populations based on their needs.

14 “(h) APPLICATION.—

15 “(1) IN GENERAL.—To seek a grant under this
16 section, an eligible entity shall submit an application
17 to the Secretary at such time, in such manner, and
18 containing such information, as the Secretary may
19 require.

20 “(2) CONTENTS.—An application under para-
21 graph (1) shall, at a minimum, contain each of the
22 following:

23 “(A) Goals to be achieved through the
24 grant, including the activities that will be un-
25 dertaken to achieve those goals.

1 “(B) The number of individuals likely to
2 be served through the grant, including demo-
3 graphic data on the populations to be served.

4 “(C) Existing programs and services that
5 can be used to significantly increase the propor-
6 tion of children and families who receive needed
7 supports and services.

8 “(D) A plan for expanding, coordinating,
9 or modifying the existing network of programs
10 and services to meet the needs of children and
11 families for preventing and mitigating the trau-
12 matic impact of adverse childhood experiences.

13 “(E) A demonstration of the ability of the
14 eligible entity to reach the individuals to be
15 served, including by partnering with local stake-
16 holders.

17 “(F) An indication of how the personnel
18 involved are reflective of the communities to be
19 served.

20 “(G) A list of stakeholders with whom the
21 entity plans to partner or consult.

22 “(i) REPORTING BY GRANTEES.—Not later than 4
23 years after the date of enactment of this section, an eligi-
24 ble entity receiving a grant under this section shall submit
25 to the Secretary a report on the activities funded through

1 the grant. Such report shall include, at a minimum, a de-
2 scription of—

3 “(1) the number of individuals served through
4 activities funded through the grant, including demo-
5 graphics as applicable;

6 “(2) the number of referrals made through the
7 grant and the rate of such referrals successfully
8 linked or closed;

9 “(3) a qualitative analysis or number of collabo-
10 rative partnerships with other organizations in car-
11 rying out the activities funded through the grant;

12 “(4) the number of services provided to individ-
13 uals through the grant;

14 “(5) aggregated and de-identified outcomes ex-
15 perienceed by individuals served through the grant
16 such as—

17 “(A) the rate of successful service connec-
18 tions;

19 “(B) any increases in development of pro-
20 tective factors for children;

21 “(C) any increase in development of pro-
22 tective factors for the caregivers;

23 “(D) any mitigation of the negative out-
24 comes associated with adverse childhood experi-
25 ences or decreased likelihood of children experi-

1 encing an adverse childhood experience as evi-
 2 denced by—

3 “(i) decreased presence of law en-
 4 forcement or other punitive State surveil-
 5 lance in the community;

6 “(ii) a parent completing substance
 7 use treatment;

8 “(iii) a parent receiving voluntary
 9 treatment for mental health-related condi-
 10 tions;

11 “(iv) a family entering into or main-
 12 taining a stable housing situation;

13 “(v) a family achieving or maintaining
 14 economic security;

15 “(vi) a parent achieving or maintain-
 16 ing job stability; or

17 “(vii) a child meeting developmental
 18 markers for school readiness; and

19 “(E) reports of satisfaction with the co-
 20 ordination of care by people served; and

21 “(6) any other information required by the Sec-
 22 retary.

23 “(j) CONVENING PARTICIPANTS FOR SHARING LES-
 24 SONS LEARNED.—After the period of all grants awarded
 25 under this section has concluded, the Assistant Secretary

1 for Planning and Evaluation of the Department of Health
 2 and Human Services shall provide an in-person or online
 3 opportunity for persons participating in the programs
 4 funded through this section to share with each other—

5 “(1) lessons learned;

6 “(2) challenges experienced; and

7 “(3) ideas for next steps and solutions.

8 “(k) COMPILING FINDINGS AND CONCLUSIONS.—

9 After providing the opportunity required by subsection (j),
 10 the Secretary shall—

11 “(1) compile the findings and conclusions of
 12 grantees under this section on the provision of care
 13 coordination services described in subsection (a);

14 “(2) submit a report on such findings and con-
 15 clusions to the appropriate congressional commit-
 16 tees; and

17 “(3) make such report publicly available.

18 “(l) DEFINITIONS.—In this section:

19 “(1) ADVERSE CHILDHOOD EXPERIENCE.—The
 20 term ‘adverse childhood experience’ means a poten-
 21 tially traumatic experience that occurs in childhood
 22 and can have a tremendous impact on the child’s
 23 lifelong health and opportunity outcomes, such as
 24 any of the following:

25 “(A) Abuse, such as any of the following:

1 “(i) Emotional and psychological
2 abuse.

3 “(ii) Physical abuse.

4 “(iii) Sexual abuse.

5 “(B) Household challenges such as any of
6 the following:

7 “(i) A household member is treated
8 violently.

9 “(ii) A household member has a sub-
10 stance use disorder.

11 “(iii) A household member has a men-
12 tal health condition.

13 “(iv) Parental separation or divorce.

14 “(v) A household member is incarcer-
15 ated, is placed in immigrant detention, or
16 has been deported.

17 “(vi) A household member has a life-
18 threatening illness such as COVID-19.

19 “(C) Neglect.

20 “(D) Living in—

21 “(i) impoverished communities that
22 lack access to human services;

23 “(ii) areas of high unemployment
24 neighborhoods; or

1 “(iii) communities experiencing de
2 facto segregation.

3 “(E) Experiencing food insecurity and
4 poor nutrition.

5 “(F) Witnessing violence.

6 “(G) Involvement with the foster system.

7 “(H) Experiencing discrimination.

8 “(I) Dealing with historical and ongoing
9 traumas due to systemic and interpersonal rac-
10 ism.

11 “(J) Dealing with historical and ongoing
12 traumas regarding systemic and interpersonal
13 sexism, homophobia, biphobia, and transphobia.

14 “(K) Dealing with the threat of deporta-
15 tion or detention as a result of immigration sta-
16 tus.

17 “(L) The impacts of multigenerational pov-
18 erty resulting from limited educational and eco-
19 nomic opportunities.

20 “(M) Living through natural disasters
21 such as earthquakes, forest fires, floods, or hur-
22 ricanes.

23 “(2) CARE COORDINATION.—The term ‘care co-
24 ordination’ means an active, ongoing process that—

1 “(A) assists children ages 0 through 5 at
2 risk of, or who have experienced, an adverse
3 childhood experience, and their caregivers, in-
4 cluding prenatal people of any age, to identify,
5 access, and use community resources and serv-
6 ices;

7 “(B) is client centered and comprehensive
8 of the services a child or caregiver may need;

9 “(C) ensures a closed loop referral by ob-
10 taining feedback from the families served; and

11 “(D) works across systems and services to
12 promote collaboration to effectively meet the
13 needs of community members.

14 “(3) INDIAN TRIBE.—The term ‘Indian Tribe’
15 has the meaning given such term in section 4 of the
16 Indian Self-Determination and Education Assistance
17 Act.

18 “(4) PROTECTIVE FACTORS.—The term ‘protec-
19 tive factors’ refers to any supportive element in a
20 child or caretaker’s life that helps the child or care-
21 taker to withstand trauma such as a stable school
22 environment or supportive peer relationships.

23 “(m) AUTHORIZATION OF APPROPRIATIONS.—

24 “(1) IN GENERAL.—To carry out this section,
25 there is authorized to be appropriated \$15,000,000

1 for each of the 5 fiscal years following the fiscal year
 2 in which this section is enacted.

3 “(2) GRANTS TO INDIAN TRIBES.—Of the
 4 amount made available to carry out this section for
 5 a fiscal year, the Secretary shall use not less than
 6 10 percent of such amount for grants to eligible en-
 7 tities that are Indian Tribes.

8 “(3) ADMINISTRATIVE EXPENSES.—Of the
 9 amount made available to carry out this section for
 10 a fiscal year, the Secretary may use not more than
 11 15 percent of such amount for administrative ex-
 12 penses, including the expenses of the Assistant Sec-
 13 retary for Planning and Evaluation of the Depart-
 14 ment of Health and Human Services for compiling
 15 and reporting information.

16 “(4) TECHNICAL ASSISTANCE.—Of the amount
 17 made available to carry out this section for a fiscal
 18 year, the Secretary may reserve up to 5 percent of
 19 such amount to provide technical assistance to eligi-
 20 ble entities in preparing and submitting applications
 21 under this section.”.

22 **SEC. 6703. IMPROVING ACCESS TO MENTAL HEALTH.**

23 (a) ACCESS TO CLINICAL SOCIAL WORKERS.—Sec-
 24 tion 1833(a)(1) of the Social Security Act (42 U.S.C.
 25 1395l(a)(1)) is amended—

1 (1) in subparagraph (D)(ii), by striking “such
 2 negotiated rate,,” and inserting “such negotiated
 3 rate,”; and

4 (2) in subparagraph (F)(ii) by striking “75 per-
 5 cent of the amount determined for payment of a
 6 psychologist under clause (L)” and inserting “85
 7 percent of the fee schedule amount provided under
 8 section 1848”.

9 (b) ACCESS TO CLINICAL SOCIAL WORKER SERVICES
 10 PROVIDED TO RESIDENTS OF SKILLED NURSING FACILI-
 11 TIES.—

12 (1) IN GENERAL.—Section 1888(e)(2)(A)(ii) of
 13 the Social Security Act (42 U.S.C.
 14 1395yy(e)(2)(A)(ii)), as amended by section
 15 6101(a)(5), is amended by inserting “clinical social
 16 worker services,” after “peer support specialist serv-
 17 ices (as defined in section 1861(rrr)(3)),”.

18 (2) CONFORMING AMENDMENT.—Section
 19 1861(hh)(2) of the Social Security Act (42 U.S.C.
 20 1395x(hh)(2)) is amended by striking “and other
 21 than services furnished to an inpatient of a skilled
 22 nursing facility which the facility is required to pro-
 23 vide as a requirement for participation”.

24 (c) ACCESS TO THE COMPLETE SET OF CLINICAL SO-
 25 CIAL WORKER SERVICES.—Section 1861(hh)(2) of the So-

1 cial Security Act (42 U.S.C. 1395x(hh)(2)) is amended by
 2 striking “for the diagnosis and treatment of mental ill-
 3 nesses (other than services” and inserting “(including
 4 services for the diagnosis and treatment of mental ill-
 5 nesses or services for health and behavior assessment and
 6 intervention (identified as of January 1, 2022, by HCPCS
 7 codes 96150 through 96161 (and any succeeding codes)),
 8 but not including services”.

9 (d) EFFECTIVE DATE.—The amendments made by
 10 this section shall apply to items and services furnished on
 11 or after January 1, 2027.

12 **SEC. 6704. PROGRAM TO ESTABLISH PUBLIC-PRIVATE CON-**
 13 **TRIBUTIONS TO INCREASE THE AVAILABLE**
 14 **WORKFORCE OF SCHOOL-BASED MENTAL**
 15 **HEALTH SERVICE PROVIDERS.**

16 (a) PROGRAM AUTHORIZED.—The Secretary shall
 17 carry out a program under which eligible graduate institu-
 18 tions may enter into an agreement with the Secretary to
 19 cover a portion of the cost of attendance of a participating
 20 student, which contributions shall be matched by equiva-
 21 lent contributions towards such cost of attendance by the
 22 Secretary.

23 (b) DESIGNATION OF PROGRAM.—The program
 24 under this section shall be known as the “Mental Health
 25 Excellence in Schools Program”.

1 (c) AGREEMENTS.—The Secretary shall enter into an
2 agreement with each eligible graduate institution seeking
3 to participate in the program under this section. Each
4 agreement shall specify the following:

5 (1) The manner (whether by direct grant, schol-
6 arship, or otherwise) in which the eligible graduate
7 institution will contribute to the cost of attendance
8 of a participating student.

9 (2) The maximum amount of the contribution
10 to be made by the eligible graduate institution with
11 respect to any particular participating student in
12 any given academic year.

13 (3) The maximum number of individuals for
14 whom the eligible graduate institution will make con-
15 tributions in any given academic year.

16 (4) That the eligible graduate institution, in se-
17 lecting participating students to receive assistance
18 under the program, shall prioritize the participating
19 students described in subsection (d)(2).

20 (5) That the eligible graduate institution shall
21 require, as a condition for receiving assistance under
22 the program, participating students to agree to re-
23 main in a school-based mental health field for a pe-
24 riod of not less than 3 years.

1 (6) Such other matters as the Secretary and
2 the eligible graduate institution determine appro-
3 priate.

4 (d) OUTREACH.—The Secretary shall—

5 (1) make publicly available and periodically up-
6 date on the internet website of the Department of
7 Education a list of the eligible graduate institutions
8 participating in the program under this section that
9 shall specify, for each such graduate institution, ap-
10 propriate information on the agreement between the
11 Secretary and such eligible graduate institution
12 under subsection (c); and

13 (2) conduct outreach about the program under
14 this section to participating students who, as under-
15 graduates—

16 (A) received a Federal Pell Grant under
17 section 401 of the Higher Education Act of
18 1965 (20 U.S.C. 1070a); or

19 (B) attended an institution listed in section
20 371(a) of the Higher Education Act of 1965
21 (20 U.S.C. 1067q(a)).

22 (e) MATCHING CONTRIBUTIONS.—The Secretary may
23 provide a contribution of not more than 50 percent of the
24 cost of attendance of a participating student if the eligible
25 graduate institution at which such student is enrolled en-

1 ters into an agreement under subsection (c) with the Sec-
2 retary to match such contribution.

3 (f) MONITORING AND EVALUATION.—As a condition
4 of participation in the program under this section, each
5 eligible graduate institution shall agree to submit an an-
6 nual report to the Secretary describing—

7 (1) the number of students served by the pro-
8 gram;

9 (2) the percentage of tuition cost covered by the
10 program;

11 (3) the number of participating students who
12 were also recipients of a Federal Pell Grant; and

13 (4) as applicable, the graduation rates and
14 post-graduate employment of participating students.

15 (g) INTERIM REPORT.—Not later than 2 years after
16 the first contributions are provided under this section, the
17 Secretary shall submit an interim report to Congress
18 based on the annual reports required by subsection (f).

19 (h) INDEPENDENT NATIONAL EVALUATION.—

20 (1) IN GENERAL.—Not later than 4 years after
21 the date of enactment of this Act, the Secretary
22 shall provide for the commencement of an inde-
23 pendent national evaluation of the outcomes and ef-
24 fectiveness of the program under this section.

1 (2) REPORT TO CONGRESS.—Not later than 90
2 days after receiving the results of such independent
3 national evaluation, the Secretary shall submit a re-
4 port to Congress containing the findings of the eval-
5 uation and the Secretary’s recommendations for im-
6 provements to the program.

7 (i) DEFINITIONS.—In this section:

8 (1) COST OF ATTENDANCE.—The term “cost of
9 attendance” has the meaning given the term in sec-
10 tion 472 of the Higher Education Act of 1965 (20
11 U.S.C. 1087ll).

12 (2) ELIGIBLE GRADUATE INSTITUTION.—The
13 term “eligible graduate institution” means an insti-
14 tution of higher education that offers a program of
15 study that leads to a graduate degree—

16 (A) in school psychology that is accredited
17 or approved by the National Association of
18 School Psychologists’ Program Accreditation
19 Board or the Commission on Accreditation of
20 the American Psychological Association and
21 that prepares students in such program for the
22 State licensing or certification examination in
23 school psychology at the specialist level;

24 (B) in an accredited school counseling pro-
25 gram that prepares students in such program

1 for the State licensing or certification examina-
 2 tion in school counseling;

3 (C) in school social work that is accredited
 4 by the Council on Social Work Education and
 5 that prepares students in such program for the
 6 State licensing or certification examination in
 7 school social work;

8 (D) in another school-based mental health
 9 field that prepares students in such program
 10 for the State licensing or certification examina-
 11 tion in such field, if applicable; or

12 (E) in any combination of study described
 13 in subparagraphs (A) through (D).

14 (3) INSTITUTION OF HIGHER EDUCATION.—The
 15 term “institution of higher education” has the
 16 meaning given the term in section 101 of the Higher
 17 Education Act of 1965 (20 U.S.C. 1001).

18 (4) PARTICIPATING STUDENT.—The term “par-
 19 ticipating student” means an individual who is en-
 20 rolled in a graduate degree program in a school-
 21 based mental health field at a participating eligible
 22 graduate institution.

23 (5) SCHOOL-BASED MENTAL HEALTH FIELD.—
 24 The term “school-based mental health field” means
 25 any of the following fields:

1 (A) School counseling.

2 (B) School social work.

3 (C) School psychology.

4 (D) Any other field of study that leads to
5 employment as a school-based mental health
6 services provider, as determined by the Sec-
7 retary.

8 (6) SCHOOL-BASED MENTAL HEALTH SERVICES
9 PROVIDER.—The term “school-based mental health
10 services provider” has the meaning given the term in
11 section 4102 of the Elementary and Secondary Edu-
12 cation Act of 1965 (20 U.S.C. 7112).

13 (7) SECRETARY.—The term “Secretary” means
14 the Secretary of Education.

15 (j) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this sec-
17 tion—

18 (1) \$20,000,000 for fiscal year 2027;

19 (2) \$30,000,000 for fiscal year 2028; and

20 (3) \$50,000,000 for each of fiscal years 2029
21 through 2031.

22 **SEC. 6705. SCHOOL SOCIAL WORKERS IMPROVING STU-**
23 **DENT SUCCESS.**

24 (a) SCHOOL SOCIAL WORKER GRANTS.—

1 (1) PURPOSES.—The purpose of this section is
2 to assist States and local educational agencies in hir-
3 ing additional school social workers in order to in-
4 crease access to mental health and other student
5 support services to students in elementary schools
6 and secondary schools in the United States to the
7 minimum ratios recommended by the National Asso-
8 ciation of Social Workers and the School Social
9 Work Association of America of 1 school social
10 worker for every 250 students, and 1 school social
11 worker for every 50 students when a social worker
12 is providing services to students with intensive
13 needs.

14 (2) ESEA AMENDMENTS.—

15 (A) IN GENERAL.—Subpart 4 of part F of
16 title IV of the Elementary and Secondary Edu-
17 cation Act of 1965 (20 U.S.C. 7291 et seq.) is
18 amended by adding at the end the following:

19 **“SEC. 4645. GRANTS FOR SCHOOL SOCIAL WORKERS.**

20 “(a) GRANTS AUTHORIZED.—

21 “(1) IN GENERAL.—From the amounts appro-
22 priated under subsection (h), the Secretary shall
23 award grants to high-need local educational agencies
24 to enable such agencies to retain school social work-

1 ers employed by such agencies or to hire additional
2 school social workers.

3 “(2) DURATION.—A grant awarded under this
4 section shall be awarded for a period not to exceed
5 4 years.

6 “(3) SUPPLEMENT, NOT SUPPLANT.—Funds
7 made available under this section shall be used to
8 supplement, and not to supplant, other Federal,
9 State, or local funds used for hiring and retaining
10 school social workers.

11 “(b) APPLICATION.—

12 “(1) IN GENERAL.—To be eligible to receive a
13 grant under this section, a high-need local edu-
14 cational agency shall submit to the Secretary an ap-
15 plication at such time, in such manner, and con-
16 taining such information as the Secretary may re-
17 quire.

18 “(2) CONTENTS.—An application submitted
19 under paragraph (1) shall include an assurance that
20 each school social worker who receives assistance
21 under the grant will provide the services described in
22 subsection (d), and a description of the specific serv-
23 ices to be provided by such social worker.

24 “(c) USE OF FUNDS.—A high-need local educational
25 agency receiving a grant under this section—

1 “(1) shall use the grant—

2 “(A) to achieve a ratio of not less than 1
3 school social worker for every 250 students
4 served by the agency, by—

5 “(i) retaining school social workers
6 employed by such agency; or

7 “(ii)(I) employing additional school
8 social workers; or

9 “(II) hiring contractors to serve as
10 school social workers only in a case in
11 which—

12 “(aa) the local educational agen-
13 cy demonstrates to the Secretary that
14 the agency—

15 “(AA) has not been able to
16 employ a sufficient number of
17 school social workers under sub-
18 clause (I) to achieve such ratio
19 despite strong and continuing ef-
20 forts to recruit and employ school
21 social workers; and

22 “(BB) hiring contractors is
23 the only viable option to ensure
24 students have adequate access to
25 school social work services; and

1 “(bb) each such contractor meets
2 the requirements of subparagraphs
3 (A) and (B) of subsection (g)(2); and

4 “(B) to ensure that each school social
5 worker who receives assistance under such
6 grant provides the services described in sub-
7 section (d); and

8 “(2) may use the grant to reimburse school so-
9 cial workers who receive assistance under such grant
10 for—

11 “(A) in the case of a school served by the
12 agency in which the majority of students are
13 higher risk students, to hire or retain additional
14 school social workers in accordance with clauses
15 (i) and (ii) of paragraph (1)(A) to achieve a
16 ratio of not less than 1 school social worker for
17 every 50 students;

18 “(B) travel expenses incurred during home
19 visits and other school-related trips;

20 “(C) any additional expenses incurred by
21 such social workers in rendering any service de-
22 scribed in subsection (d); and

23 “(D) the cost of clinical social work super-
24 vision for such social workers.

1 “(d) RESPONSIBILITIES OF A SCHOOL SOCIAL WORK-
2 ER.—A school social worker who receives assistance under
3 a grant under this section shall provide the following serv-
4 ices:

5 “(1) Identifying high-need students in each
6 school that the social worker serves, and targeting
7 services provided at the school to such students.

8 “(2) Providing students, in each school that the
9 school social worker serves, social work services to
10 promote school engagement and improve academic
11 outcomes, including—

12 “(A) counseling and crisis intervention;

13 “(B) trauma-informed services;

14 “(C) evidence-based educational, behav-
15 ioral, and mental health services (such as imple-
16 menting multi-tiered programs and practices,
17 monitoring progress, and evaluating service ef-
18 fectiveness);

19 “(D) addressing the social and emotional
20 learning needs of students;

21 “(E) promoting a school climate and cul-
22 ture conducive to student learning and teaching
23 excellence (such as promoting effective school
24 policies and administrative procedures, enhanc-
25 ing the professional capacity of school per-

1 sonnel, and facilitating engagement between
2 student, family, school, and community);

3 “(F) providing access to school-based and
4 community-based resources (such as promoting
5 a continuum of services, mobilizing resources
6 and promoting assets, and providing leadership,
7 interdisciplinary collaboration, systems coordi-
8 nation, professional consultation, and con-
9 necting students and families to resource sys-
10 tems);

11 “(G) working with students, families,
12 schools, and communities to address barriers to
13 educational attainment (such as homelessness
14 and housing insecurity, lack of transportation,
15 food insecurity, equity, social justice issues, ac-
16 cess to quality education, and school, family,
17 and community risk factors);

18 “(H) providing assistance to schools and
19 teachers to design social-emotional, educational,
20 behavioral, and mental health interventions;

21 “(I) case management activities to coordi-
22 nate the delivery of and access to the appro-
23 priate social work services to the highest-need
24 students;

1 “(J) home visits to meet the family of stu-
 2 dents in need of social work services in the
 3 home environment;

4 “(K) supervising or coordinating school so-
 5 cial work services at the local educational agen-
 6 cy level; and

7 “(L) other services the Secretary deter-
 8 mines, in partnership with students, educators,
 9 and community member voices, are necessary to
 10 be carried out by such a social worker.

11 “(e) GRANT RENEWAL.—

12 “(1) IN GENERAL.—A grant awarded under
 13 this section may be renewed for additional periods
 14 with the same duration as the original grant period.

15 “(2) CONTINUING ELIGIBILITY APPLICATION.—

16 To be eligible for a renewal under this section, a
 17 high-need local educational agency shall submit to
 18 the Secretary, for each renewal, a report on the
 19 progress of such agency in retaining and hiring
 20 school social workers to achieve the ratio of not less
 21 than 1 school social worker for every 250 students
 22 served by the agency, and shall include—

23 “(A) a description of the staffing expan-
 24 sion of school social workers funded through the
 25 original grant received under this section; and

1 “(B) a description of the work conducted
2 by such social workers for higher risk students.

3 “(f) TECHNICAL ASSISTANCE.—

4 “(1) IN GENERAL.—The Secretary shall provide
5 technical assistance to high-need local educational
6 agencies, including such agencies that do not have
7 adequate staff, in applying for grants under this sec-
8 tion.

9 “(2) EXTENSION OF APPLICATION PERIOD.—

10 The Secretary shall extend any application period
11 for a grant under this section for any high-need local
12 educational agency that—

13 “(A) submits to the Secretary a written
14 notification of the intent to apply for a grant
15 under this section before requesting technical
16 assistance under paragraph (1); and

17 “(B) after submitting the notification
18 under paragraph (1), requests such technical
19 assistance.

20 “(g) DEFINITIONS.—In this section:

21 “(1) HIGH-NEED LOCAL EDUCATIONAL AGEN-
22 CY.—The term ‘high-need local educational agency’
23 has the meaning given the term in section 200 of the
24 Higher Education Act of 1965 (20 U.S.C. 1021).

1 “(2) SCHOOL SOCIAL WORKER.—The term
2 ‘school social worker’ means an individual who—

3 “(A) has a graduate degree in social work
4 from a social work program that is accredited
5 by the Council on Social Work Education; and

6 “(B) meets all other State and local
7 credentialing requirements for practicing as a
8 social worker in an elementary school or sec-
9 ondary school.

10 “(h) AUTHORIZATION FOR APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section,
12 \$100,000,000 for each of fiscal years 2027 through
13 2031.”.

14 (B) TABLE OF CONTENTS.—The table of
15 contents in section 2 of the Elementary and
16 Secondary Education Act of 1965 is amended
17 by inserting after the item relating to section
18 4644 the following:

“Sec. 4645. Grants for school social workers.”.

19 (b) NATIONAL TECHNICAL ASSISTANCE CENTER FOR
20 SCHOOL SOCIAL WORK.—

21 (1) IN GENERAL.—The Secretary of Education,
22 acting through the Assistant Secretary, shall estab-
23 lish an evaluation, documentation, dissemination,
24 and technical assistance resource center to provide
25 appropriate information, training, and technical as-

1 sistance to States, political subdivisions of States,
2 federally recognized Indian Tribes, Tribal organiza-
3 tions, institutions of higher education, State and
4 local educational agencies, and individual students
5 and educators with respect to hiring and retaining
6 school social workers at elementary schools and sec-
7 ondary schools served by local educational agencies.

8 (2) RESPONSIBILITIES OF THE CENTER.—The
9 center established under paragraph (1) shall conduct
10 activities for the purpose of—

11 (A) developing and continuing statewide or
12 Tribal strategies for improving the effectiveness
13 of the school social work workforce;

14 (B) studying the costs and effectiveness of
15 school social work programs at institutions of
16 higher education to identify areas of improve-
17 ment and provide information on relevant issues
18 of importance to national, Tribal, and State
19 policymakers;

20 (C) working with Federal agencies and
21 other national, Tribal, and State stakeholders
22 to collect, evaluate, and disseminate data re-
23 garding school social work ratios, outcomes and
24 best practices of school-based mental health
25 services, and the impact of expanding the num-

ber of school social workers within elementary schools and secondary schools; and

(D) establishing partnerships among national, Tribal, State, and local governments, and local educational agencies, institutions of higher education, non-profit organizations, and State and national trade associations, for the purposes of—

(i) data collection and dissemination;

(ii) establishing a school social work workforce development program;

(iii) documenting the success of school social work methods on a national level; and

(iv) conducting other activities determined appropriate by the Secretary.

(3) DEFINITIONS.—In this subsection:

(A) ESEA TERMS.—Except as otherwise provided, any term used in this subsection that is defined in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801) shall have the meaning given that term in such section.

(B) SCHOOL SOCIAL WORKER.—The term “school social worker” has the meaning given

1 the term in section 4645(g) of the Elementary
2 and Secondary Education Act of 1965.

3 **SEC. 6706. OPIOID GRANTS TO SUPPORT CAREGIVERS, KIN-**
4 **SHIP CARE FAMILIES, AND KINSHIP CARE-**
5 **GIVERS.**

6 (a) OPIOID GRANTS.—Section 1003(b)(4) of the 21st
7 Century Cures Act (42 U.S.C. 290ee–3a(b)(4)) is amend-
8 ed—

9 (1) by redesignating subparagraph (F) as sub-
10 paragraph (G); and

11 (2) by inserting after subparagraph (E) the fol-
12 lowing:

13 “(F) Supporting opioid abuse prevention
14 and treatment services within a State provided
15 by State and local agencies for children and
16 caregivers, kinship care families, and kinship
17 caregivers through—

18 “(i) workforce recruitment and train-
19 ing;

20 “(ii) health care services (including
21 such services described in subparagraph
22 (D)); and

23 “(iii) foster and adoptive parent re-
24 cruitment and training.”.

1 (b) DEFINITIONS.—Section 1003(h) of the 21st Cen-
 2 tury Cures Act (42 U.S.C. 290ee–3a(h)) is amended—

3 (1) by redesignating paragraphs (2) through
 4 (4) as paragraphs (4) through (6), respectively; and
 5 (2) by inserting after paragraph (1) the fol-
 6 lowing:

7 “(2) KINSHIP CARE FAMILY.—The term ‘kin-
 8 ship care family’ means a family with a kinship care-
 9 giver.

10 “(3) KINSHIP CAREGIVER.—The term ‘kinship
 11 caregiver’ means a relative of a child by blood, mar-
 12 riage, or adoption, who—

13 “(A) lives with the child;

14 “(B) is the primary caregiver of the child
 15 because the biological or adoptive parent of the
 16 child is unable or unwilling to serve as the pri-
 17 mary caregiver of the child; and

18 “(C) has a legal relationship to the child or
 19 is raising the child informally.”.

20 (c) AUTHORIZATION OF APPROPRIATIONS.—Section
 21 1003(i)(1) of the 21st Century Cures Act (42 U.S.C.
 22 290ee–3a(i)(1)) is amended by striking “2023 through
 23 2027” and inserting “2027 through 2031”.

24 (d) SET ASIDE.—Section 1003(i)(3) of the 21st Cen-
 25 tury Cures Act (42 U.S.C. 290ee–3a(i)(3)) is amended by

1 inserting before the period at the end “, and set aside 1
2 percent to carry out subsection (b)(4)(F)”.

3 **SEC. 6707. SUBSTANCE USE AND MENTAL HEALTH SERV-**
4 **ICES ADMINISTRATION AND SUBAGENCIES.**

5 (a) SUBSTANCE USE AND MENTAL HEALTH SERV-
6 ICES ADMINISTRATION.—The Public Health Service Act
7 (42 U.S.C. 201 et seq.) is amended—

8 (1) in section 464H(c) (42 U.S.C. 285n(c)),
9 section 464R(c) (42 U.S.C. 285p(c)), and sub-
10 sections (b) and (c)(1) of section 2303 (42 U.S.C.
11 300cc–2), by striking “Administrator of the Sub-
12 stance Abuse and Mental Health Services Adminis-
13 tration” each place it appears and inserting “Assist-
14 ant Secretary for Mental Health and Substance
15 Use”;

16 (2) in title V (42 U.S.C. 290aa et seq.)—

17 (A) in the title heading, by striking
18 “**ABUSE**” and inserting “**USE**”; and

19 (B) in section 501 (42 U.S.C. 290aa)—

20 (i) in the section heading, by striking
21 “**ABUSE**” and inserting “**USE**”; and

22 (ii) in subsection (f)(4), by striking
23 “Substance Abuse and Mental Health Ad-
24 ministration” and inserting “Substance

1 Use and Mental Health Services Adminis-
2 tration”; and

3 (3) by striking “Substance Abuse and Mental
4 Health Services Administration” each place it ap-
5 pears and inserting “Substance Use and Mental
6 Health Services Administration”.

7 (b) CENTER FOR SUBSTANCE USE SERVICES; CEN-
8 TER FOR SUBSTANCE USE PREVENTION SERVICES.—

9 (1) IN GENERAL.—The Public Health Service
10 Act (42 U.S.C. 201 et seq.) is amended—

11 (A) in part B of title V (42 U.S.C. 290bb
12 et seq.)—

13 (i) in subpart 1, in the subpart head-
14 ing, by striking “**Abuse Treatment**”
15 and inserting “**Use Services**”;

16 (ii) in subpart 2, in the subpart head-
17 ing, by striking “**Abuse Prevention**”
18 and inserting “**Use Prevention Serv-**
19 **ices**”;

20 (iii) in section 507 (42 U.S.C. 290bb),
21 in the section heading, by striking “**ABUSE**
22 **TREATMENT**” and inserting “**USE SERV-**
23 **ICES**”;

24 (iv) in section 513(a) (42 U.S.C.
25 290bb–6(a)), in the subsection heading, by

striking “ABUSE TREATMENT” and inserting “USE SERVICES”; and

(v) in section 515 (42 U.S.C. 290bb–21), in the section heading, by striking “**ABUSE PREVENTION**” and inserting “**USE PREVENTION SERVICES**”;

(B) in section 1932(b)(3) (42 U.S.C. 300x–32(b)(3)), in the paragraph heading, by striking “ABUSE PREVENTION” and inserting “USE PREVENTION SERVICES”;

(C) in section 1935(b)(2) of the Public Health Service Act (42 U.S.C. 300x–35(b)(2)), in the paragraph heading, by striking “ABUSE PREVENTION” and inserting “USE PREVENTION SERVICES”;

(D) by striking “Center for Substance Abuse Treatment” each place it appears and inserting “Center for Substance Use Services”; and

(E) by striking “Center for Substance Abuse Prevention” each place it appears and inserting “Center for Substance Use Prevention Services”.

(c) **AUTHORITIES.**—The Secretary of Health and Human Services shall delegate to the Substance Use and

1 Mental Health Services Administration, the Center for
2 Substance Use Services, and the Center for Substance Use
3 Prevention Services all duties and authorities that, as of
4 the date of enactment of this Act, were vested in the Sub-
5 stance Abuse and Mental Health Services Administration,
6 the Center for Substance Abuse Treatment, and the Cen-
7 ter for Substance Abuse Prevention, respectively.

8 (d) REFERENCES.—

9 (1) IN GENERAL.—Except as provided in para-
10 graph (2), any reference in any law, regulation, map,
11 document, paper, or other record of the United
12 States—

13 (A) to the Substance Abuse and Mental
14 Health Services Administration shall be deemed
15 to be a reference to the Substance Use and
16 Mental Health Services Administration;

17 (B) to the Center for Substance Abuse
18 Treatment of such Administration shall be
19 deemed to be a reference to the Center for Sub-
20 stance Use Services of such Administration;
21 and

22 (C) to the Center for Substance Abuse
23 Prevention of such Administration shall be
24 deemed to be a reference to the Center for Sub-

1 stance Use Prevention Services of such Admin-
2 istration.

3 (2) EFFECT.—Paragraph (1) shall not be con-
4 strued to alter or affect section 6001(d) of the 21st
5 Century Cures Act (42 U.S.C. 290aa note), pro-
6 viding that a reference to the Administrator of the
7 Substance Abuse and Mental Health Services Ad-
8 ministration shall be construed to be a reference to
9 the Assistant Secretary for Mental Health and Sub-
10 stance Use.

11 (3) REFERENCES TO SAMHSA.—Notwith-
12 standing this section or the amendments made by
13 this section, the Secretary of Health and Human
14 Services may continue to use the acronym
15 “SAMHSA” to refer to the Substance Use and Men-
16 tal Health Services Administration in regulations,
17 maps, documents, papers, and other records of the
18 United States.

19 **SEC. 6708. MENTAL HEALTH FOR LATINOS ACT.**

20 Part D of title V of the Public Health Service Act
21 (42 U.S.C. 290dd et seq.), as amended by section 6501,
22 is amended by adding at the end the following new section:

1 **“SEC. 557. BEHAVIORAL AND MENTAL HEALTH OUTREACH**
2 **AND EDUCATION STRATEGY.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Assistant Secretary, shall, in coordination with advo-
5 cacy and behavioral and mental health organizations serv-
6 ing populations of Hispanic and Latino individuals or
7 communities, develop and implement an outreach and edu-
8 cation strategy to promote behavioral and mental health
9 and reduce stigma associated with mental health condi-
10 tions and substance abuse among the Hispanic and Latino
11 populations. Such strategy shall—

12 “(1) be designed to—

13 “(A) meet the diverse cultural and lan-
14 guage needs of the various Hispanic and Latino
15 populations; and

16 “(B) be developmentally and age appro-
17 priate;

18 “(2) increase awareness of symptoms of mental
19 illnesses common among such populations, taking
20 into account differences within subgroups, such as
21 gender, gender identity, age, sexual orientation, or
22 ethnicity, of such populations;

23 “(3) provide information on evidence-based, cul-
24 turally and linguistically appropriate and adapted
25 interventions and treatments;

1 “(4) ensure full participation of, and engage,
2 both consumers and community members in the de-
3 velopment and implementation of materials; and

4 “(5) seek to broaden the perspective among
5 both individuals in these communities and stake-
6 holders serving these communities to use a com-
7 prehensive public health approach to promoting be-
8 havioral health that addresses a holistic view of
9 health by focusing on the intersection between be-
10 havioral and physical health.

11 “(b) REPORTS.—Beginning not later than 1 year
12 after the date of the enactment of this section and annu-
13 ally thereafter, the Secretary, acting through the Assistant
14 Secretary, shall submit to Congress, and make publicly
15 available, a report on the extent to which the strategy de-
16 veloped and implemented under subsection (a) improved
17 behavioral and mental health outcomes associated with
18 mental health conditions and substance abuse among His-
19 panic and Latino populations.

20 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section
22 \$1,000,000 for fiscal year 2027.”.

23 **SEC. 6709. SUPPORTING FARMWORKERS’ MENTAL HEALTH.**

24 (a) FINDINGS.—Congress finds that farmworkers—

1 (1) are vital to the economy and food supply of
2 the United States; and

3 (2) who are disproportionately affected by
4 stress and anxiety, often lack access to behavioral
5 health care services.

6 (b) FARM AND RANCH STRESS ASSISTANCE NET-
7 WORK.—Section 7522 of the Food, Conservation, and En-
8 ergy Act of 2008 (7 U.S.C. 5936) is amended—

9 (1) by inserting “farm work,” after “ranching,”
10 each place it appears;

11 (2) in subsection (b)—

12 (A) in paragraph (1)(D), by striking “or”
13 at the end;

14 (B) by redesignating paragraph (2) as
15 paragraph (3);

16 (C) by inserting after paragraph (1) the
17 following:

18 “(2) to initiate, expand, or sustain programs
19 that deliver peer-to-peer mental health support to in-
20 dividuals who are engaged in farming, ranching,
21 farm work, and other occupations relating to agri-
22 culture; or”; and

23 (D) in paragraph (3) (as so redesignated),
24 by striking “paragraph (1) and subsection (a)”

1 and inserting “paragraphs (1) and (2) and sub-
2 section (a)””; and
3 (3) in subsection (d), by striking “2023” and
4 inserting “2031”.

5 **SEC. 6710. CLARIFYING COVERAGE OF OCCUPATIONAL**
6 **THERAPY UNDER MEDICARE.**

7 Not later than 1 year after the date of enactment
8 of this Act, the Secretary of Health and Human Services
9 shall provide education and outreach to stakeholders about
10 the Medicare Benefit Policy Manual with respect to occu-
11 pational therapy services furnished to individuals under
12 the Medicare program for the treatment of a substance
13 use or mental health disorder diagnosis using applicable
14 Healthcare Common Procedure Coding System (HCPCS)
15 codes.

16 **SEC. 6711. TRAINING COMMUNITY MENTAL WELLNESS**
17 **WORKERS.**

18 Part D of title V of the Public Health Service Act
19 (42 U.S.C. 290dd), as amended by section 6708, is
20 amended by adding at the end the following:

21 **“SEC. 558. TRAINING COMMUNITY MENTAL WELLNESS**
22 **WORKERS.**

23 “(a) IN GENERAL.—The Secretary, acting through
24 the Assistant Secretary, may award grants to eligible enti-

1 ties to implement community mental wellness worker
2 training programs.

3 “(b) USE OF FUNDS.—An eligible entity that receives
4 a grant under this section shall use the funds received
5 through such grant to carry out a community mental
6 wellness worker training program, which may include—

7 “(1) supporting training, certification, and su-
8 pervision during and after training of community
9 mental wellness workers and community mental
10 wellness supervisors—

11 “(A) to screen for common mental health
12 and substance use conditions; and

13 “(B) to deliver evidence-informed, cul-
14 turally and linguistically competent counseling
15 and interviewing interventions addressing basic
16 psychosocial or psychotherapeutic treatment
17 needs of persons with or at risk for mental and
18 substance use disorders, including safety plan-
19 ning and interventions to reduce suicide risk;
20 and

21 “(2) covering costs associated with—

22 “(A) the acquisition and use of digital
23 platforms to provide the screening, training, su-
24 pervision, and ongoing quality assurance moni-

1 toring, outcomes evaluation, and delivery of evi-
2 dence-based treatments;

3 “(B) the delivery of counseling and inter-
4 viewing interventions described in paragraph
5 (1)(B); and

6 “(C) the clinical supervision (during and
7 after training) of community mental wellness
8 workers and the certification of such workers
9 upon the completion of required training.

10 “(c) COMMUNITY MENTAL WELLNESS TECHNICAL
11 ASSISTANCE.—

12 “(1) IN GENERAL.—The Secretary may provide
13 appropriate training and technical assistance to eli-
14 gible entities receiving a grant under this section in
15 meeting the requirements of this section, including
16 by—

17 “(A) consulting with such recipients on
18 evidence-based employment practices for com-
19 munity mental wellness workers, including as-
20 sistance with integrating community wellness
21 workers into the workflows of such recipients
22 and other eligible entities;

23 “(B) identifying a diverse array of can-
24 didates for community mental wellness worker
25 training; and

1 “(C) identifying behavioral health pro-
2 viders who may benefit from and employ com-
3 munity mental wellness workers.

4 “(2) ADDITIONAL DISSEMINATION OF TECH-
5 NICAL ASSISTANCE.—The information and resources
6 provided by the Secretary under paragraph (1) shall
7 be made available to States, political subdivisions of
8 States, Indian Tribes and Tribal organizations (as
9 defined in section 4 of the Indian Self-Determination
10 and Education Assistance Act), outpatient and inpa-
11 tient substance use treatment providers, other com-
12 munity-based behavioral health organizations, and
13 other entities as the Secretary determines appro-
14 priate.

15 “(d) PRIORITY.—In awarding grants under this sec-
16 tion, the Secretary shall give priority to eligible entities
17 that are located—

18 “(1) in an area with rates of poverty and unem-
19 ployment that exceed the average in the United
20 States, as determined by the survey conducted by
21 the Secretary of Commerce commonly referred to as
22 the ‘American Community Survey’ (or any successor
23 survey);

24 “(2) in a medically underserved community;

1 “(3) in an area with rates of substance use that
 2 exceed the average in the United States, as deter-
 3 mined by the National Institute on Drug Abuse; or

4 “(4) serving communities with rates of individ-
 5 uals who are dually eligible for both the Medicare
 6 program under title XVIII of the Social Security Act
 7 and the Medicaid program under title XIX of such
 8 Act that exceed the average in the United States.

9 “(e) MALPRACTICE AND NEGLIGENCE SUITS
 10 AGAINST COMMUNITY BEHAVIORAL HEALTH CLINIC AND
 11 COMMUNITY MENTAL HEALTH CENTERS.—

12 “(1) IN GENERAL.—Except as inconsistent with
 13 this subsection, the provisions of section 224, includ-
 14 ing subsections (g), (h), (i), (j), (k), and (l) of such
 15 section, shall apply with respect to acts and omis-
 16 sions of a covered entity that occur during the pe-
 17 riod of the grant under this section, to the same ex-
 18 tent and in the same manner as such provisions
 19 apply with respect to an entity described in sub-
 20 section (g)(4) of such section 224, and any officer,
 21 governing board member, employee, or contractor of
 22 such an entity.

23 “(2) LIST REQUIRED.—Each covered entity de-
 24 scribed in paragraph (3)(A) shall submit to the Sec-
 25 retary, and update as necessary, a list of each offi-

1 cer, governing board member, employee, or con-
2 tractor participating in the entity's program funded
3 through a grant under this section.

4 “(3) COVERED ENTITY DEFINED.—In this sub-
5 section, the term ‘covered entity’ means an entity
6 that—

7 “(A) is an eligible entity (as defined in
8 subsection (g)(3)) in receipt of a grant under
9 this section; and

10 “(B)(i) is an officer, governing board mem-
11 ber, or employee of such an entity or a con-
12 tractor of such an entity who is a physician or
13 other licensed or certified health care practi-
14 tioner; and

15 “(ii) is participating in the entity's pro-
16 gram funded through a grant under this sec-
17 tion, as indicated in a list submitted pursuant
18 to paragraph (2).

19 “(4) DELAYED APPLICABILITY.—This sub-
20 section applies beginning with respect to the first
21 full fiscal year that begins after the date of the en-
22 actment of this section.

23 “(f) REPORT.—

24 “(1) SUBMISSION.—The Secretary shall submit
25 to Congress—

1 “(A) not later than one year after the date
 2 of enactment of this section, an interim report
 3 on the results of the grant program under this
 4 section; and

5 “(B) not later than the end of fiscal year
 6 2031, a final report of such results.

7 “(2) CONTENTS.—The reports required by
 8 paragraph (1) shall each include—

9 “(A) the total number of community men-
 10 tal wellness workers participating in the grant
 11 program under this section; and

12 “(B) the total number of community men-
 13 tal wellness workers who obtained certification
 14 through such participation.

15 “(g) DEFINITIONS.—In this section:

16 “(1) The term ‘community mental wellness
 17 worker’ means an individual trained and certified by
 18 an eligible entity to assist with providing basic
 19 screening and evidence-based treatments to individ-
 20 uals with a mild to moderate mental health or sub-
 21 stance use disorder, including depression, anxiety,
 22 post-traumatic stress disorder, and alcohol use dis-
 23 order.

24 “(2) The term ‘culturally and linguistically
 25 competent’ means, with respect to the provision of

1 counseling and interviewing interventions, providing
2 such services in a manner that acknowledges, and is
3 responsive to, cultural differences that may derive
4 from characteristics of the individual receiving such
5 services, including—

6 “(A) gender;

7 “(B) sex;

8 “(C) sexual orientation;

9 “(D) race or ethnicity;

10 “(E) nationality;

11 “(F) socioeconomic level;

12 “(G) immigration status;

13 “(H) disability;

14 “(I) Tribal affiliation; and

15 “(J) veteran status.

16 “(3) The term ‘eligible entity’ means—

17 “(A) a certified community behavioral
18 health clinic (as described in section 223(a) of
19 the Protecting Access to Medicare Act of 2014);

20 “(B) a community mental health center (as
21 described in section 1913(c));

22 “(C) a hospital that is described in section
23 501(c) of the Internal Revenue Code of 1986
24 and exempt from taxation under section 501(a)
25 of such Code; and

1 “(D) such other community behavioral
2 health organizations as the Secretary may
3 specify, in consultation with—

4 “(i) State authorities responsible for
5 regulating substance use and mental health
6 providers and facilities receiving reim-
7 bursement under a State plan under title
8 XIX of the Social Security Act (or a waiv-
9 er of such plan); and

10 “(ii) other State substance abuse and
11 mental health agencies.

12 “(4) The term ‘medically underserved commu-
13 nity’ has the meaning given such term in section
14 799B.

15 “(h) FUNDING.—

16 “(1) AUTHORIZATION OF APPROPRIATIONS.—
17 There are authorized to be appropriated to carry out
18 this section, \$25,000,000 for each of fiscal years
19 2027 through 2031.

20 “(2) ALLOCATION.—Of the funds authorized to
21 be appropriated to carry out this section for a fiscal
22 year, not less than 20 percent shall be reserved for
23 the provision of training and technical assistance
24 under subsection (c).”.

1 **TITLE VII—ADDRESSING HIGH-**
2 **IMPACT MINORITY DISEASES**
3 **Subtitle A—Cancer**

4 **SEC. 7001. LUNG CANCER MORTALITY REDUCTION.**

5 (a) SENSE OF CONGRESS CONCERNING INVESTMENT
6 IN LUNG CANCER RESEARCH.—It is the sense of the Con-
7 gress that—

8 (1) lung cancer mortality reduction should be
9 made a national public health priority; and

10 (2) a comprehensive mortality reduction pro-
11 gram coordinated by the Secretary of Health and
12 Human Services is justified and necessary to ade-
13 quately address and reduce lung cancer mortality.

14 (b) LUNG CANCER MORTALITY REDUCTION PRO-
15 GRAM.—

16 (1) IN GENERAL.—Subpart 1 of part C of title
17 IV of the Public Health Service Act (42 U.S.C. 285
18 et seq.) is amended by adding at the end the fol-
19 lowing:

20 **“SEC. 417H. LUNG CANCER MORTALITY REDUCTION PRO-**
21 **GRAM.**

22 “(a) IN GENERAL.—Not later than 6 months after
23 the date of the enactment of the Health Equity and Ac-
24 countability Act of 2026, the Secretary, in consultation
25 with the Secretary of Defense, the Secretary of Veterans

1 Affairs, the Director of the National Institutes of Health,
2 the Director of the Centers for Disease Control and Pre-
3 vention, the Commissioner of Food and Drugs, the Admin-
4 istrator of the Centers for Medicare & Medicaid Services,
5 the Director of the National Institute on Minority Health
6 and Health Disparities, the Administrator of the Environ-
7 mental Protection Agency, and other members of the
8 Lung Cancer Advisory Board established under section
9 7001(d) of the Health Equity and Accountability Act of
10 2026, shall implement a comprehensive program, to be
11 known as the Lung Cancer Mortality Reduction Program,
12 to achieve a reduction of at least 25 percent in the mor-
13 tality rate of lung cancer by 2028.

14 “(b) REQUIREMENTS.—The Program shall include at
15 least the following:

16 “(1) With respect to the National Institutes of
17 Health—

18 “(A) a strategic review and prioritization
19 by the National Cancer Institute of research
20 grants to achieve the goal specified in sub-
21 section (a);

22 “(B) the provision of funds to enable the
23 Airway Biology and Disease Branch of the Na-
24 tional Heart, Lung, and Blood Institute to ex-
25 pand its research programs to include pre-

dispositions to lung cancer, the interrelationship between lung cancer and other pulmonary and cardiac disease, the diagnosis and treatment of such diseases, and the investigation of rising rates of lung cancer in populations that have never smoked, such as among Asian American, Native Hawaiian, and Pacific Islander women;

“(C) the provision of funds to enable the National Institute of Biomedical Imaging and Bioengineering to expedite the development of computer-assisted diagnostic, surgical, treatment, and drug-testing innovations to reduce lung cancer mortality, such as through expansion of the Institute’s Quantum Grant Program and Image-Guided Interventions program; and

“(D) the provision of funds to enable the National Institute of Environmental Health Sciences to implement research programs relative to the lung cancer incidence.

“(2) With respect to the Food and Drug Administration—

“(A) activities under section 529B of the Federal Food, Drug, and Cosmetic Act; and

“(B) activities under section 561 of the Federal Food, Drug, and Cosmetic Act to ex-

1 pand access to investigational drugs and devices
2 for the diagnosis, monitoring, or treatment of
3 lung cancer.

4 “(3) With respect to the Centers for Disease
5 Control and Prevention, the establishment of an
6 early disease research and management program
7 under section 1511.

8 “(4) With respect to the Agency for Healthcare
9 Research and Quality, the conduct of a biannual re-
10 view of lung cancer screening, diagnostic, and treat-
11 ment protocols, and the issuance of updated guide-
12 lines.

13 “(5) The promotion (including education) of
14 lung cancer screening within minority and rural pop-
15 ulations and the study of the effectiveness of efforts
16 to increase such screening.

17 “(6) The cooperation and coordination of all
18 minority and health disparity programs within the
19 Department of Health and Human Services to en-
20 sure that all aspects of the Lung Cancer Mortality
21 Reduction Program under this section adequately
22 address the burden of lung cancer on minority and
23 rural populations including among populations who
24 have never smoked, such as Asian American, Native
25 Hawaiian, and Pacific Islander women.

1 “(7) The cooperation and coordination of all to-
 2 bacco control and cessation programs within agen-
 3 cies of the Department of Health and Human Serv-
 4 ices to achieve the goals of the Lung Cancer Mor-
 5 tality Reduction Program under this section with
 6 particular emphasis on the coordination of drug and
 7 other cessation treatments with early detection pro-
 8 tocols.”.

9 (2) FEDERAL FOOD, DRUG, AND COSMETIC
 10 ACT.—Subchapter B of chapter V of the Federal
 11 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
 12 seq.) is amended by adding at the end the following:

13 **“SEC. 529B. DRUGS RELATING TO LUNG CANCER.**

14 “(a) IN GENERAL.—The provisions of this sub-
 15 chapter shall apply to a drug described in subsection (b)
 16 to the same extent and in the same manner as such provi-
 17 sions apply to a drug for a rare disease or condition (as
 18 defined in section 526).

19 “(b) QUALIFIED DRUGS.—A drug described in this
 20 subsection is—

21 “(1) a chemoprevention drug for precancerous
 22 conditions of the lung;

23 “(2) a drug for targeted therapeutic treat-
 24 ments, including any vaccine, for lung cancer; or

1 “(3) a drug to curtail or prevent nicotine addic-
2 tion.

3 “(c) BOARD.—The Board established under section
4 7001(d) of the Health Equity and Accountability Act of
5 2026 shall monitor the program implemented under this
6 section.”.

7 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
8 tion 561(e) of the Federal Food, Drug, and Cos-
9 metic Act (21 U.S.C. 360bbb(e)) is amended by in-
10 serting before the period the following: “and shall
11 include expanding access to drugs under section
12 529B, with substantial consideration being given to
13 whether the totality of information available to the
14 Secretary regarding the safety and effectiveness of
15 an investigational drug, as compared to the risk of
16 morbidity and death from the disease, indicates that
17 a patient may obtain more benefit than risk if treat-
18 ed with the drug”.

19 (4) CDC.—Title XV of the Public Health Serv-
20 ice Act (42 U.S.C. 300k et seq.) is amended by add-
21 ing at the end the following:

22 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
23 **PROGRAM.**

24 “The Secretary shall establish and implement an
25 early disease research and management program targeted

1 at the high incidence and mortality rates of lung cancer
2 among minority and low-income populations.”.

3 (c) DEPARTMENT OF DEFENSE AND DEPARTMENT
4 OF VETERANS AFFAIRS.—The Secretary of Defense and
5 the Secretary of Veterans Affairs, each in coordination
6 with the Secretary of Health and Human Services, shall
7 engage—

8 (1) in the implementation within the Depart-
9 ment of Defense and the Department of Veterans
10 Affairs, as the case may be, of an early detection
11 and disease management research program for mem-
12 bers of the Armed Forces and veterans whose smok-
13 ing history and exposure to carcinogens during serv-
14 ice on active duty in the Armed Forces has increased
15 their risk for lung cancer; and

16 (2) in the implementation of coordinated care
17 programs for members of the Armed Forces and vet-
18 erans diagnosed with lung cancer.

19 (d) LUNG CANCER ADVISORY BOARD.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services shall convene a Lung Cancer Advi-
22 sory Board (referred to in this section as the
23 “Board”)—

1 (A) to monitor the programs established
2 under this section (and the amendments made
3 by this section); and

4 (B) to provide annual reports to the Con-
5 gress concerning benchmarks, expenditures,
6 lung cancer statistics, and the public health im-
7 pact of such programs.

8 (2) COMPOSITION.—The Board shall be com-
9 posed of—

10 (A) the Secretary of Health and Human
11 Services;

12 (B) the Secretary of Defense;

13 (C) the Secretary of Veterans Affairs; and

14 (D) 2 representatives each from the fields
15 of clinical medicine focused on lung cancer,
16 lung cancer research, imaging, drug develop-
17 ment, and lung cancer advocacy, to be ap-
18 pointed by the Secretary of Health and Human
19 Services.

20 (e) AUTHORIZATION OF APPROPRIATIONS.—

21 (1) IN GENERAL.—To carry out this section
22 (and the amendments made by this section), there
23 are authorized to be appropriated \$75,000,000 for
24 fiscal year 2027 and such sums as may be necessary
25 for each of fiscal years 2028 through 2029.

1 (2) LUNG CANCER MORTALITY REDUCTION PRO-
2 GRAM.—The amounts appropriated under paragraph
3 (1) shall be allocated as follows:

4 (A) \$25,000,000 for fiscal year 2027, and
5 such sums as may be necessary for each of fis-
6 cal years 2028 through 2030, for the activities
7 described in section 417H(b)(1)(B) of the Pub-
8 lic Health Service Act, as added by subsection
9 (b);

10 (B) \$25,000,000 for fiscal year 2027, and
11 such sums as may be necessary for each of fis-
12 cal years 2028 through 2030, for the activities
13 described in section 417H(b)(1)(C) of the Pub-
14 lic Health Service Act;

15 (C) \$10,000,000 for fiscal year 2027, and
16 such sums as may be necessary for each of fis-
17 cal years 2028 through 2030, for the activities
18 described in section 417H(b)(1)(D) of the Pub-
19 lic Health Service Act; and

20 (D) \$15,000,000 for fiscal year 2027, and
21 such sums as may be necessary for each of fis-
22 cal years 2028 through 2030, for the activities
23 described in section 417H(b)(3) of the Public
24 Health Service Act.

1 **SEC. 7002. EXPANSION OF PROSTATE CANCER RESEARCH,**
2 **OUTREACH, SCREENING, TESTING, ACCESS,**
3 **AND TREATMENT EFFECTIVENESS.**

4 (a) PROSTATE CANCER COORDINATION AND EDU-
5 CATION.—

6 (1) INTERAGENCY PROSTATE CANCER COORDI-
7 NATION AND EDUCATION TASK FORCE.—Not later
8 than 180 days after the date of the enactment of
9 this Act, the Secretary of Veterans Affairs, in co-
10 operation with the Secretary of Defense and the Sec-
11 retary of Health and Human Services, shall estab-
12 lish an Interagency Prostate Cancer Coordination
13 and Education Task Force (in this section referred
14 to as the “Prostate Cancer Task Force”).

15 (2) DUTIES.—The Prostate Cancer Task Force
16 shall—

17 (A) develop a summary of advances in
18 prostate cancer research supported or con-
19 ducted by Federal agencies relevant to the diag-
20 nosis, prevention, and treatment of prostate
21 cancer, including psychosocial impairments re-
22 lated to prostate cancer treatment, and compile
23 a list of best practices that warrant broader
24 adoption in health care programs;

25 (B) consider establishing, and advocating
26 for, a guidance to enable physicians to allow

1 screening of men who are age 74 or older, on
2 a case-by-case basis, taking into account quality
3 of life and family history of prostate cancer;

4 (C) share and coordinate information on
5 research and health care program activities by
6 the Federal Government, including activities re-
7 lated to—

8 (i) determining how to improve re-
9 search and health care programs, including
10 psychosocial impairments related to pros-
11 tate cancer treatment;

12 (ii) identifying any gaps in the overall
13 research inventory and in health care pro-
14 grams;

15 (iii) identifying opportunities to pro-
16 mote translation of research into practice;
17 and

18 (iv) maximizing the effects of Federal
19 Government efforts by identifying opportu-
20 nities for collaboration and leveraging of
21 resources in research and health care pro-
22 grams that serve individuals who are sus-
23 ceptible to or diagnosed with prostate can-
24 cer;

1 (D) develop a comprehensive interagency
2 strategy and advise relevant Federal agencies in
3 the solicitation of proposals for collaborative,
4 multidisciplinary research and health care pro-
5 grams, including proposals to evaluate factors
6 that may be related to the etiology of prostate
7 cancer, that would—

8 (i) result in innovative approaches to
9 study emerging scientific opportunities or
10 eliminate knowledge gaps in research to
11 improve the prostate cancer research port-
12 folio of the Federal Government; and

13 (ii) outline key research questions,
14 methodologies, and knowledge gaps;

15 (E) develop a coordinated message related
16 to screening and treatment for prostate cancer
17 to be reflected in educational and beneficiary
18 materials for Federal health programs as such
19 materials are updated; and

20 (F) not later than 2 years after the date
21 of the establishment of the Prostate Cancer
22 Task Force, submit to the expert advisory pan-
23 els appointed under paragraph (4) to be re-
24 viewed and returned within 30 days, and then

1 within 90 days submitted to Congress, rec-
2 ommendations—

3 (i) regarding any appropriate changes
4 to research and health care programs, in-
5 cluding recommendations to improve the
6 research portfolio of the Department of
7 Veterans Affairs, the Department of De-
8 fense, the National Institutes of Health,
9 and other Federal agencies to ensure that
10 scientifically based strategic planning is
11 implemented in support of research and
12 health care program priorities;

13 (ii) designed to ensure that the re-
14 search and health care programs and ac-
15 tivities of the Department of Veterans Af-
16 fairs, the Department of Defense, the De-
17 partment of Health and Human Services,
18 and other Federal agencies are free of un-
19 necessary duplication;

20 (iii) regarding public participation in
21 decisions relating to prostate cancer re-
22 search and health care programs to in-
23 crease the involvement of patient advo-
24 cates, community organizations, and med-

1 ical associations representing a broad geo-
2 graphical area;

3 (iv) on how to best disseminate infor-
4 mation on prostate cancer research and
5 progress achieved by health care programs;

6 (v) on how to expand partnerships be-
7 tween public entities, including Federal
8 agencies, and private entities to encourage
9 collaborative, cross-cutting research and
10 health care delivery;

11 (vi) assessing any cost savings and ef-
12 ficiencies realized through the efforts iden-
13 tified in, and supported through, this sub-
14 section and recommending expansion of
15 those efforts that have proved most prom-
16 ising while also ensuring against any con-
17 flicts in directives in law;

18 (vii) identifying key priority action
19 items from among the recommendations
20 specified in clauses (i) through (vi); and

21 (viii) with respect to the level of fund-
22 ing needed by each agency to implement
23 such recommendations.

24 (3) MEMBERS OF THE PROSTATE CANCER TASK
25 FORCE.—The Prostate Cancer Task Force shall be

1 composed of representatives from such Federal agen-
2 cies as the head of each such applicable agency de-
3 termines necessary, so as to coordinate a uniform
4 message relating to prostate cancer screening and
5 treatment where appropriate, including representa-
6 tives of each of the following:

7 (A) The Department of Veterans Affairs,
8 including representatives of each relevant pro-
9 gram area of the Department of Veterans Af-
10 fairs.

11 (B) The Prostate Cancer Research Pro-
12 gram of the Congressionally Directed Medical
13 Research Program of the Department of De-
14 fense.

15 (C) The Department of Health and
16 Human Services, including, at a minimum, rep-
17 resentatives of each of the following:

18 (i) The National Institutes of Health.

19 (ii) National research institutes and
20 centers, including the National Cancer In-
21 stitute, the National Institute of Allergy
22 and Infectious Diseases, and the Office of
23 Minority Health.

24 (iii) The Centers for Medicare & Med-
25 icaid Services.

1 (iv) The Food and Drug Administra-
2 tion.

3 (v) The Centers for Disease Control
4 and Prevention.

5 (vi) The Agency for Healthcare Re-
6 search and Quality.

7 (vii) The Health Resources and Serv-
8 ices Administration.

9 (4) APPOINTING EXPERT ADVISORY PANELS.—
10 The Prostate Cancer Task Force shall appoint ex-
11 pert advisory panels, as the task force determines
12 appropriate, to provide input and concurrence
13 from—

14 (A) individuals and organizations from the
15 medical, prostate cancer patient and advocate,
16 research, and delivery communities with exper-
17 tise in prostate cancer diagnosis, treatment,
18 and research, including practicing urologists,
19 primary care providers, and others; and

20 (B) individuals with expertise in education
21 and outreach to underserved populations af-
22 fected by prostate cancer.

23 (5) MEETINGS.—The Prostate Cancer Task
24 Force shall convene not less frequently than twice

1 each year, or more frequently as the Secretary of
 2 Veterans Affairs determines to be appropriate.

3 (6) FEDERAL ADVISORY COMMITTEE ACT.—The
 4 Federal Advisory Committee Act (5 U.S.C. App.)
 5 shall apply to the Prostate Cancer Task Force.

6 (7) SUNSET DATE.—The Prostate Cancer Task
 7 Force shall terminate on September 30, 2028.

8 (b) PROSTATE CANCER RESEARCH.—

9 (1) RESEARCH COORDINATION PROGRAM.—

10 (A) IN GENERAL.—The Secretary of Vet-
 11 erans Affairs, in coordination with the Sec-
 12 retary of Defense and the Secretary of Health
 13 and Human Services, shall establish and carry
 14 out a program to coordinate and intensify pros-
 15 tate cancer research.

16 (B) ELEMENTS.—The program established
 17 under subparagraph (A) shall—

18 (i) develop advances in diagnostic and
 19 prognostic methods and tests, including
 20 biomarkers and an improved prostate can-
 21 cer screening blood test, including improve-
 22 ments or alternatives to the prostate spe-
 23 cific antigen test and additional tests to
 24 distinguish indolent from aggressive dis-
 25 ease;

(ii) develop a better understanding of the etiology of the disease (including an analysis of lifestyle factors proven to be involved in higher rates of prostate cancer, such as obesity and diet, and in different ethnic, racial, and socioeconomic groups, such as the African-American, Latino or Hispanic, Asian American, Native Hawaiian, Pacific Islander, and American Indian populations and men with a family history of prostate cancer) to improve prevention efforts;

(iii) expand basic research into prostate cancer, including studies of fundamental molecular and cellular mechanisms;

(iv) identify and provide clinical testing of novel agents for the prevention and treatment of prostate cancer;

(v) establish clinical registries for prostate cancer;

(vi) use the National Institute of Biomedical Imaging and Bioengineering and the National Cancer Institute for assessment of appropriate imaging modalities; and

1 (vii) address such other matters relat-
2 ing to prostate cancer research as may be
3 identified by the Federal agencies partici-
4 pating in such program.

5 (C) UNDERSERVED MINORITY GRANT PRO-
6 GRAM.—

7 (i) IN GENERAL.—In carrying out the
8 program established under subparagraph
9 (A), the Secretary shall award grants to el-
10 igible entities—

11 (I) to carry out components of
12 the research outlined in subparagraph
13 (B);

14 (II) to integrate and build upon
15 existing knowledge gained from com-
16 parative effectiveness research; and

17 (III) to recognize and address—

18 (aa) the racial and ethnic
19 disparities in the incidence and
20 mortality rates of prostate cancer
21 and men with a family history of
22 prostate cancer;

23 (bb) any barriers in access
24 to care and participation in clin-
25 ical trials that are specific to ra-

1 cial, ethnic, and other under-
2 served minorities and men with a
3 family history of prostate cancer;

4 (cc) outreach and edu-
5 cational efforts to raise aware-
6 ness among the populations de-
7 scribed in item (bb); and

8 (dd) appropriate access and
9 utilization of imaging modalities.

10 (ii) ELIGIBLE ENTITY DEFINED.—In
11 this subparagraph, the term “eligible enti-
12 ty” means any public, private, nonprofit,
13 or for-profit organization that the Sec-
14 retary determines would be capable to con-
15 duct medical research and other require-
16 ments under this paragraph and is other-
17 wise eligible for research funding from the
18 Federal Government.

19 (2) PROSTATE CANCER ADVISORY BOARD.—

20 (A) IN GENERAL.—There is established in
21 the Office of the Chief Scientist of the Food
22 and Drug Administration a Prostate Cancer
23 Scientific Advisory Board.

24 (B) DUTIES.—The board established under
25 subparagraph (A) shall be responsible for accel-

erating real-time sharing of the latest research data and accelerating movement of new medicines for the treatment of prostate cancer to patients.

(c) TELEHEALTH AND RURAL ACCESS PILOT PROJECTS.—

(1) ESTABLISHMENT OF PILOT PROJECTS.—

(A) IN GENERAL.—The Secretary of Veterans Affairs, in cooperation with the Secretary of Defense and the Secretary of Health and Human Services (referred to in this subsection collectively as the “Secretaries”) shall establish four-year telehealth pilot projects for the purpose of analyzing the clinical outcomes and cost-effectiveness associated with telehealth services in a variety of geographic areas that contain high proportions of medically underserved populations, including African Americans, Latinos or Hispanics, Asian Americans, Native Hawaiians, Pacific Islanders, American Indians, and Alaska Natives, and those in rural areas.

(B) EFFICIENT AND EFFECTIVE CARE.—

Pilot projects established under subparagraph (A) shall promote efficient use of specialist care

1 through better coordination of primary care and
2 physician extender teams in underserved areas
3 and more effectively employ tumor boards to
4 better counsel patients.

5 (2) ELIGIBLE ENTITIES.—

6 (A) IN GENERAL.—The Secretaries shall
7 select eligible entities to participate in the pilot
8 projects established under this subsection.

9 (B) PRIORITY.—In selecting eligible enti-
10 ties to participate in the pilot projects under
11 this subsection, the Secretaries shall give pri-
12 ority to entities located in medically under-
13 served areas, particularly those that include Af-
14 rican Americans, Asian Americans, Native Ha-
15 waiians, Pacific Islanders, Latinos and His-
16 panics, and facilities of the Indian Health Serv-
17 ice, including facilities operated by the Indian
18 Health Service, tribally operated facilities, and
19 facilities administered by an Urban Indian or-
20 ganization (as defined in section 4 of the Indian
21 Health Care Improvement Act (25 U.S.C.
22 1603)) pursuant to title V of that Act (25
23 U.S.C. 1651 et seq.), and those in rural areas.

1 (3) EVALUATION.—The Secretaries shall,
2 through the pilot projects established under this sub-
3 section, evaluate—

4 (A) the effective and economic delivery of
5 care in diagnosing and treating prostate cancer
6 with the use of telehealth services in medically
7 underserved and Tribal areas including collabo-
8 rative uses of health professionals and integra-
9 tion of the range of telehealth and other tech-
10 nologies;

11 (B) the effectiveness of improving the ca-
12 pacity of nonmedical providers and nonspecial-
13 ized medical providers to provide health services
14 for prostate cancer in medically underserved
15 and Tribal areas, including the exploration of
16 innovative medical home models with collabora-
17 tion between urologists, other relevant medical
18 specialists, including oncologists, radiologists,
19 and primary care teams, and coordination of
20 care through the efficient use of primary care
21 teams and physician extenders; and

22 (C) the effectiveness of using telehealth
23 services to provide prostate cancer treatment in
24 medically underserved areas, including the use

1 of tumor boards to facilitate better patient
2 counseling.

3 (4) REPORT.—Not later than one year after the
4 completion of the pilot projects under this sub-
5 section, the Secretaries shall submit to Congress a
6 report describing the outcomes of such pilot projects,
7 including any cost savings and efficiencies realized,
8 and providing recommendations, if any, for expand-
9 ing the use of telehealth services.

10 (d) EDUCATION AND AWARENESS.—

11 (1) CAMPAIGN.—

12 (A) IN GENERAL.—The Secretary of Vet-
13 erans Affairs shall develop a national education
14 campaign for prostate cancer.

15 (B) ELEMENTS.—The campaign developed
16 under subparagraph (A) shall involve the use of
17 written educational materials and public service
18 announcements consistent with the findings of
19 the Prostate Cancer Task Force under sub-
20 section (a) that are intended to encourage men
21 to seek prostate cancer screening when appro-
22 priate.

23 (2) RACIAL DISPARITIES AND THE POPULATION
24 OF MEN WITH A FAMILY HISTORY OF PROSTATE
25 CANCER.—In developing the campaign under para-

graph (1), the Secretary of Veterans Affairs shall ensure that educational materials and public service announcements used in the campaign are more readily available in communities experiencing racial disparities in the incidence and mortality rates of prostate cancer and to men of any race classification with a family history of prostate cancer.

(3) GRANTS.—In carrying out the campaign under this subsection, the Secretary of Veterans Affairs shall award grants to nonprofit private entities to enable such entities to test alternative outreach and education strategies.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section for the period of fiscal years 2027 through 2031 an amount equal to the amount of savings for the Federal Government projected to be achieved over such period by implementation of this section.

SEC. 7003. PROSTATE RESEARCH, IMAGING, AND MEN'S EDUCATION.

(a) RESEARCH AND DEVELOPMENT OF PROSTATE CANCER IMAGING TECHNOLOGIES.—

(1) EXPANSION OF RESEARCH.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Di-

1 rector of the National Institutes of Health and the
2 Administrator of the Health Resources and Services
3 Administration, and in consultation with the Sec-
4 retary of Defense, shall carry out a program to ex-
5 pand and intensify research to develop innovative
6 advanced imaging technologies for prostate cancer
7 detection, diagnosis, and treatment comparable to
8 state-of-the-art mammography technologies.

9 (2) EARLY STAGE RESEARCH.—In imple-
10 menting the program under paragraph (1), the Sec-
11 retary, acting through the Administrator of the
12 Health Resources and Services Administration, shall
13 carry out a grant program to encourage the early
14 stages of research in prostate imaging to develop
15 and implement new ideas, proof of concepts, and
16 pilot studies for high-risk technologic innovation in
17 prostate cancer imaging that would have a high po-
18 tential impact for improving patient care, including
19 individualized care, quality of life, and cost-effective-
20 ness.

21 (3) LARGE SCALE LATER STAGE RESEARCH.—
22 In implementing the program under paragraph (1),
23 the Secretary, acting through the Director of the
24 National Institutes of Health, shall utilize the Na-
25 tional Institute of Biomedical Imaging and Bio-

1 engineering and the National Cancer Institute for
2 advanced stages of research in prostate imaging, in-
3 cluding technology development and clinical trials for
4 projects determined by the Secretary to have dem-
5 onstrated promising preliminary results and proof of
6 concept.

7 (4) INTERDISCIPLINARY PRIVATE-PUBLIC PART-
8 NERSHIPS.—In developing the program under para-
9 graph (1), the Secretary, acting through the Admin-
10 istrator of the Health Resources and Services Ad-
11 ministration, shall establish interdisciplinary private-
12 public partnerships to develop and implement re-
13 search strategies for expedited innovation in imaging
14 and image-guided treatment and to conduct such re-
15 search.

16 (5) RACIAL DISPARITIES.—In developing the
17 program under paragraph (1), the Secretary shall
18 recognize and address—

19 (A) the racial disparities in the incidences
20 of prostate cancer and mortality rates with re-
21 spect to such disease; and

22 (B) any barriers in access to care and par-
23 ticipation in clinical trials that are specific to
24 racial minorities.

25 (6) AUTHORIZATION OF APPROPRIATIONS.—

1 (A) IN GENERAL.—Subject to subpara-
 2 graph (B), there is authorized to be appro-
 3 priated to carry out this subsection,
 4 \$100,000,000 for each of fiscal years 2027
 5 through 2031.

6 (B) SPECIFIC ALLOCATIONS.—Of the
 7 amount authorized to be appropriated under
 8 subparagraph (A) for each of the fiscal years
 9 described in such subparagraph—

10 (i) no less than 10 percent may be
 11 used to carry out the grant program under
 12 paragraph (2); and

13 (ii) no more than 1 percent may be
 14 used to carry out paragraph (4).

15 (b) PUBLIC AWARENESS AND EDUCATION CAM-
 16 PAIGN.—

17 (1) NATIONAL CAMPAIGN.—The Secretary shall
 18 carry out a national campaign to increase the aware-
 19 ness and knowledge of individuals in the United
 20 States with respect to the need for prostate cancer
 21 screening and for improved detection technologies.

22 (2) REQUIREMENTS.—The national campaign
 23 conducted under this subsection shall include—

24 (A) roles for the Health Resources Services
 25 Administration, the Office of Minority Health

1 of the Department of Health and Human Serv-
2 ices, the Centers for Disease Control and Pre-
3 vention, and the Office of Minority Health and
4 Health Equity of the Centers for Disease Con-
5 trol and Prevention; and

6 (B) the development and distribution of
7 written educational materials, and the develop-
8 ment and placing of public service announce-
9 ments, that are intended to encourage men to
10 seek prostate cancer screening and to create
11 awareness of the need for improved imaging
12 technologies for prostate cancer screening and
13 diagnosis, including in-vitro blood testing and
14 imaging technologies.

15 (3) RACIAL DISPARITIES.—In developing the
16 national campaign under paragraph (1), the Sec-
17 retary shall recognize and address—

18 (A) the racial disparities in the incidences
19 of prostate cancer and mortality rates with re-
20 spect to such disease; and

21 (B) any barriers in access to care and par-
22 ticipation in clinical trials that are specific to
23 racial minorities.

24 (4) GRANTS.—The Secretary shall establish a
25 program to award grants to nonprofit private enti-

1 ties to enable such entities to test alternative out-
2 reach and education strategies to increase the
3 awareness and knowledge of individuals in the
4 United States with respect to the need for prostate
5 cancer screening and improved imaging technologies.

6 (5) AUTHORIZATION OF APPROPRIATIONS.—

7 There is authorized to be appropriated to carry out
8 this subsection \$10,000,000 for each of fiscal years
9 2027 through 2031.

10 (c) IMPROVING PROSTATE CANCER SCREENING
11 BLOOD TESTS.—

12 (1) IN GENERAL.—The Secretary, in coordina-
13 tion with the Secretary of Defense, shall support re-
14 search to develop an improved prostate cancer
15 screening blood test using in-vitro detection.

16 (2) AUTHORIZATION OF APPROPRIATIONS.—

17 There is authorized to be appropriated to carry out
18 this subsection, \$20,000,000 for each of fiscal years
19 2027 through 2031.

20 (d) REPORTING AND COMPLIANCE.—

21 (1) REPORT AND STRATEGY.—Not later than
22 12 months after the date of the enactment of this
23 Act, the Secretary shall submit to Congress a report
24 that details the strategy of the Secretary for imple-

1 menting the requirements of this section and the
2 status of such efforts.

3 (2) FULL COMPLIANCE.—Not later than 36
4 months after the date of the enactment of this Act,
5 and annually thereafter, the Secretary shall submit
6 to Congress a report that—

7 (A) describes the research and development
8 and public awareness and education campaigns
9 funded under this section;

10 (B) provides evidence that projects involv-
11 ing high-risk, high-impact technologic innova-
12 tion, proof of concept, and pilot studies are
13 prioritized;

14 (C) provides evidence that the Secretary
15 recognizes and addresses any barriers in access
16 to care and participation in clinical trials that
17 are specific to racial minorities in the imple-
18 mentation of this section;

19 (D) contains assurances that all the other
20 provisions of this section are fully implemented;
21 and

22 (E) certifies compliance with the provisions
23 of this section, or in the case of a Federal agen-
24 cy that has not complied with any of such pro-

1 visions, an explanation as to such failure to
2 comply.

3 **SEC. 7004. PROSTATE CANCER DETECTION RESEARCH AND**
4 **EDUCATION.**

5 (a) PLAN TO DEVELOP AND VALIDATE A TEST OR
6 TESTS FOR PROSTATE CANCER.—

7 (1) IN GENERAL.—The Secretary of Health and
8 Human Services (referred to in this section as the
9 “Secretary”), acting through the Director of the Na-
10 tional Institutes of Health, shall establish an advi-
11 sory council on prostate cancer (referred to in this
12 section as the “advisory council”) to draft a plan for
13 the development and validation of an accurate test
14 or tests, such as biomarkers or imaging, to detect
15 and diagnose prostate cancer.

16 (2) ADVISORY COUNCIL.—

17 (A) MEMBERSHIP.—

18 (i) FEDERAL MEMBERS.—The advi-
19 sory council shall be composed of the fol-
20 lowing experts:

21 (I) A designee of the Centers for
22 Disease Control and Prevention.

23 (II) A designee of the Centers for
24 Medicare & Medicaid Services.

1 (III) A designee of the Office of
2 the Director of the National Cancer
3 Institute.

4 (IV) A designee of the Director
5 of the Department of Defense Con-
6 gressionally Directed Medical Re-
7 search Programs.

8 (V) A designee of the Director of
9 the National Institute of Biomedical
10 Imaging and Bioengineering.

11 (VI) A designee of the Director
12 of the National Institute of General
13 Medical Sciences.

14 (VII) A designee of the Director
15 of the National Institute on Minority
16 Health and Health Disparities.

17 (VIII) A designee of the Director
18 of the National Institutes of Health.

19 (IX) A designee of the Commis-
20 sioner of Food and Drugs.

21 (X) A designee of the Director of
22 the Agency for Healthcare Research
23 and Quality.

24 (XI) A designee of the Director
25 of the Telemedicine and Advanced

1 Technology Research Center of the
2 Department of Defense.

3 (ii) NON-FEDERAL MEMBERS.—In ad-
4 dition to the members described in clause
5 (i), the advisory council shall include 8 ex-
6 pert members from outside the Federal
7 Government to be appointed by the Sec-
8 retary, which shall include—

9 (I) 2 prostate cancer patient ad-
10 vocates;

11 (II) 2 health care providers with
12 a range of expertise and experience in
13 prostate cancer; and

14 (III) 4 leading researchers with
15 prostate cancer-related expertise in a
16 range of clinical disciplines.

17 (B) MEETINGS.—The advisory council
18 shall meet quarterly and such meetings shall be
19 open to the public.

20 (C) ADVICE.—The advisory council shall
21 advise the Secretary, or the Secretary's des-
22 ignee.

23 (D) ANNUAL REPORT.—Not later than 1
24 year after the date of enactment of this Act, the

1 advisory council shall provide to the Secretary,
2 or the Secretary's designee, and Congress—

3 (i) an initial evaluation of all federally
4 funded efforts in prostate cancer research
5 relating to the development and validation
6 of an accurate test or tests to detect and
7 diagnose prostate cancer;

8 (ii) a plan for the development and
9 validation of a reliable test or tests for the
10 detection and accurate diagnosis of pros-
11 tate cancer; and

12 (iii) a set of standards for prostate
13 cancer screening, developed in coordination
14 with the United States Preventive Services
15 Task Force, to ensure that any tools for
16 screening, detection, and diagnosis devel-
17 oped in accordance with the plan under
18 clause (ii) will meet the requirements of
19 the Task Force for recommendation as a
20 proven preventive or diagnostic service.

21 (E) TERMINATION.—The advisory council
22 shall terminate on December 31, 2028.

23 (3) FUNDING.—Notwithstanding any other pro-
24 vision of law, the Secretary may make available
25 \$1,000,000, from any unobligated amounts appro-

1 priated to the National Institutes of Health, for each
2 of fiscal years 2027 through 2031 to carry out this
3 subsection.

4 (b) COORDINATION AND INTENSIFICATION OF PROS-
5 TATE CANCER RESEARCH.—

6 (1) IN GENERAL.—The Director of the National
7 Institutes of Health, in consultation with the Sec-
8 retary of Defense, shall coordinate and intensify re-
9 search in accordance with the plan provided under
10 subsection (a)(2)(D)(ii), with particular attention
11 provided to leveraging existing research to develop
12 and validate a test or tests, such as biomarkers or
13 imaging, to detect and accurately diagnose prostate
14 cancer in order to improve quality of life for millions
15 of individuals in the United States, and decrease
16 health care system costs.

17 (2) FUNDING.—Notwithstanding any other pro-
18 vision of law, the Secretary may make available
19 \$30,000,000, from any unobligated amounts appro-
20 priated to the National Institutes of Health, for each
21 of fiscal years 2027 through 2031 to carry out this
22 subsection.

23 **SEC. 7005. NATIONAL PROSTATE CANCER COUNCIL.**

24 (a) NATIONAL PROSTATE CANCER COUNCIL.—

1 (1) ESTABLISHMENT.—There is established in
2 the Office of the Secretary of Health and Human
3 Services (referred to in this section as the “Sec-
4 retary”) the National Prostate Cancer Council on
5 Screening, Early Detection, Assessment, and Moni-
6 toring of Prostate Cancer (referred to in this section
7 as the “Council”).

8 (2) PURPOSE OF THE COUNCIL.—The Council
9 shall—

10 (A) develop and implement a national stra-
11 tegic plan for the accelerated creation, advance-
12 ment, and testing of diagnostic tools to improve
13 screening, early detection, assessment, and
14 monitoring of prostate cancer, including—

15 (i) early detection of aggressive pros-
16 tate cancer to save lives;

17 (ii) monitoring of tumor response to
18 treatment, including recurrence and pro-
19 gression; and

20 (iii) accurate assessment and surveil-
21 lance of indolent disease to reduce unnec-
22 essary biopsies and treatment;

23 (B) provide information and coordination
24 of prostate cancer research and services across
25 all Federal agencies;

1 (C) review diagnostic tools and their over-
2 all effectiveness at screening, detecting, assess-
3 ing, and monitoring of prostate cancer;

4 (D) evaluate all programs in prostate can-
5 cer that are in existence on the date of enact-
6 ment of this Act, including Federal budget re-
7 quests and approvals and public-private part-
8 nerships;

9 (E) submit an annual report to the Sec-
10 retary and Congress on the creation and imple-
11 mentation of the national strategic plan under
12 subparagraph (A); and

13 (F) ensure the inclusion of men at high
14 risk for prostate cancer, including men from
15 minority ethnic and racial populations and men
16 who are least likely to receive care, in clinical,
17 research, and service efforts, with the purpose
18 of decreasing health disparities.

19 (3) MEMBERSHIP.—

20 (A) FEDERAL MEMBERS.—The Council
21 shall be led by the Secretary or the Secretary's
22 designee and composed of the following experts:

23 (i) Two representatives of the Na-
24 tional Institutes of Health, including 1 rep-
25 resentative of the National Institute of

1 Biomedical Imaging and Bioengineering
2 and 1 representative of the National Cancer
3 Institute.

4 (ii) A representative of the Centers
5 for Disease Control and Prevention.

6 (iii) A representative of the Centers
7 for Medicare & Medicaid Services.

8 (iv) A designee of the Director of the
9 Department of Defense Congressionally
10 Directed Medical Research Programs.

11 (v) A designee of the Director of the
12 Office of Minority Health.

13 (vi) A representative of the Food and
14 Drug Administration.

15 (vii) A representative of the Agency
16 for Healthcare Research and Quality.

17 (B) NON-FEDERAL MEMBERS.—In addition
18 to the members described in subparagraph
19 (A), the Council shall include 14 expert mem-
20 bers from outside the Federal Government,
21 which shall include—

22 (i) 6 prostate cancer patient advocates,
23 including—

24 (I) 2 patient-survivors;

1 (II) 2 caregivers of prostate can-
2 cer patients; and

3 (III) 2 representatives from na-
4 tional prostate cancer disease organi-
5 zations that fund research or have
6 demonstrated experience in providing
7 assistance to patients, families, and
8 medical professionals, including infor-
9 mation on health care options, edu-
10 cation, and referral; and

11 (ii) 8 health care stakeholders with
12 specific expertise in prostate cancer re-
13 search in the critical areas of clinical ex-
14 pertise, including medical oncology, radi-
15 ology, radiation oncology, urology, and pa-
16 thology.

17 (4) MEETINGS.—The Council shall meet quar-
18 terly and meetings shall be open to the public.

19 (5) ADVICE.—The Council shall advise the Sec-
20 retary, or the Secretary's designee.

21 (6) ANNUAL REPORT.—The Council shall sub-
22 mit annual reports, beginning not later than 1 year
23 after the date of enactment of this Act, to the Sec-
24 retary or the Secretary's designee and to Congress.

25 The annual report shall include—

1 (A) in the first year—

2 (i) an evaluation of all Federally fund-
3 ed efforts in prostate cancer research and
4 gaps relating to the development and vali-
5 dation of diagnostic tools for prostate can-
6 cer; and

7 (ii) recommendations for priority ac-
8 tions to expand, eliminate, coordinate, or
9 condense programs based on the perform-
10 ance, mission, and purpose of the pro-
11 grams; and

12 (B) annually thereafter for 5 years—

13 (i) an outline for the development and
14 implementation of a national research plan
15 for creation and validation of accurate di-
16 agnostic tools to improve prostate cancer
17 care in accordance with paragraph (1);

18 (ii) roles for the National Cancer In-
19 stitute, National Institute on Minority
20 Health and Health Disparities, and the Of-
21 fice of Minority Health of the Department
22 of Health and Human Services;

23 (iii) an analysis of the disparities in
24 the incidence and mortality rates of pros-
25 tate cancer in men at high risk of the dis-

ease, including individuals with family history, increasing age, or African-American heritage; and

(iv) a review of the progress towards the realization of the proposed strategic plan.

(7) TERMINATION.—The Council shall terminate on December 31, 2027.

**SEC. 7006. IMPROVED MEDICAID COVERAGE FOR CERTAIN
BREAST AND CERVICAL CANCER PATIENTS
IN THE TERRITORIES.**

(a) ELIMINATION OF FUNDING LIMITATIONS.—Section 1108(g)(4) of the Social Security Act (42 U.S.C. 1308(g)(4)) is amended—

(1) by striking “paragraphs (1), (2), (3), and (4) of”; and

(2) by adding at the end the following: “With respect to fiscal years beginning with fiscal year 2027, payment for medical assistance for individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII) shall not be taken into account in applying subsection (f) (as increased in accordance with this subsection) to Puerto Rico, the Virgin Islands, Guam, the Northern

1 Mariana Islands, or American Samoa for such fiscal
 2 year.”.

3 (b) APPLICATION OF ENHANCED FMAP FOR HIGH-
 4 EST STATE.—Section 1905(b) of such Act (42 U.S.C.
 5 1396d(b)) is amended by adding at the end the following:
 6 “Notwithstanding the first sentence of this subsection,
 7 with respect to medical assistance described in clause (4)
 8 of such sentence that is furnished in Puerto Rico, the Vir-
 9 gin Islands, Guam, the Northern Mariana Islands, or
 10 American Samoa in a fiscal year, the Federal medical as-
 11 sistance percentage is equal to the highest such percentage
 12 applied under such clause for such fiscal year for any of
 13 the 50 States or the District of Columbia that provides
 14 such medical assistance for any portion of such fiscal
 15 year.”.

16 (c) EFFECTIVE DATE.—The amendments made by
 17 this section shall apply to payment for medical assistance
 18 for items and services furnished on or after October 1,
 19 2026.

20 **SEC. 7007. CANCER PREVENTION AND TREATMENT DEM-**
 21 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
 22 **NORITIES.**

23 (a) DEMONSTRATION.—

24 (1) IN GENERAL.—The Secretary of Health and
 25 Human Services (in this section referred to as the

1 “Secretary”) shall, consistent with subsection (b),
2 conduct demonstration projects for the purpose of
3 developing models and evaluating methods that—

4 (A) improve the quality of items and serv-
5 ices provided to target individuals in order to
6 facilitate reduced disparities in early detection
7 and treatment of cancer;

8 (B) improve clinical outcomes, satisfaction,
9 quality of life, appropriate use of items and
10 services covered under the Medicare program
11 under title XVIII of the Social Security Act (42
12 U.S.C. 1395 et seq.), and referral patterns with
13 respect to target individuals with cancer;

14 (C) eliminate disparities in the rate of pre-
15 ventive cancer screening measures, such as Pap
16 smears, prostate cancer screenings, colon and
17 colorectal cancer screenings, breast cancer
18 screenings, and computed tomography scans,
19 for lung cancer among target individuals;

20 (D) promote collaboration with community-
21 based organizations to ensure cultural com-
22 petency of health care professionals and lin-
23 guistic access for target individuals with limited
24 English proficiency; and

1 (E) encourage the incorporation of commu-
 2 nity health workers to increase the efficiency
 3 and appropriateness of cancer screening pro-
 4 grams.

5 (2) COMMUNITY HEALTH WORKER DEFINED.—

6 In this section, the term “community health worker”
 7 includes a community health advocate, a lay health
 8 worker, a community health representative, a peer
 9 health promoter, a community health outreach work-
 10 er, and a promotore de salud, who promotes health
 11 or nutrition within the community in which the indi-
 12 vidual resides.

13 (3) TARGET INDIVIDUAL DEFINED.—In this
 14 section, the term “target individual” means an indi-
 15 vidual of a racial and ethnic minority group, as de-
 16 fined in section 1707(g)(1) of the Public Health
 17 Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-
 18 tled to benefits under part A, and enrolled under
 19 part B, of title XVIII of the Social Security Act.

20 (b) PROGRAM DESIGN.—

21 (1) INITIAL DESIGN.—Not later than 1 year
 22 after the date of the enactment of this Act, the Sec-
 23 retary shall evaluate best practices in the private
 24 sector, community programs, and academic research
 25 of methods that reduce disparities among individuals

1 of racial and ethnic minority groups in the preven-
2 tion and treatment of cancer and shall design the
3 demonstration projects based on such evaluation.

4 (2) NUMBER AND PROJECT AREAS.—Not later
5 than 2 years after the date of the enactment of this
6 Act, the Secretary shall implement at least 9 dem-
7 onstration projects, including the following:

8 (A) Two projects, each of which shall tar-
9 get different ethnic subpopulations, for each ra-
10 cial and ethnic minority group described in
11 clauses (i) through (vi) of section 1707(g)(1)(A)
12 of the Public Health Service Act (42 U.S.C.
13 300u–6(g)(1)(A)).

14 (B) One project within the Pacific Islands
15 or United States insular areas.

16 (C) At least 1 project in a rural area.

17 (D) At least 1 project in an inner-city
18 area.

19 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
20 TION OF DEMONSTRATION PROJECT RESULTS.—The
21 Secretary shall continue the demonstration projects
22 and may expand the number of demonstration
23 projects if the initial report under subsection (c)
24 contains an evaluation that the demonstration
25 projects—

1 (A) reduce expenditures under the Medi-
2 care program under title XVIII of the Social
3 Security Act (42 U.S.C. 1395 et seq.); or

4 (B) do not increase expenditures under
5 such Medicare program and reduce racial and
6 ethnic health disparities in the quality of health
7 care services provided to target individuals and
8 increase satisfaction of Medicare beneficiaries
9 and health care providers.

10 (c) REPORT TO CONGRESS.—

11 (1) IN GENERAL.—Not later than 2 years after
12 the date the Secretary implements the initial dem-
13 onstration projects under this section, and bian-
14 nually thereafter, the Secretary shall submit to Con-
15 gress a report regarding the demonstration projects.

16 (2) CONTENT OF REPORT.—Each report under
17 paragraph (1) shall include the following:

18 (A) A description of the demonstration
19 projects.

20 (B) An evaluation of—

21 (i) the cost-effectiveness of the dem-
22 onstration projects;

23 (ii) the quality of the health care serv-
24 ices provided to target individuals under
25 the demonstration projects; and

1 (iii) beneficiary and health care pro-
 2 vider satisfaction under the demonstration
 3 projects.

4 (C) Any other information regarding the
 5 demonstration projects that the Secretary de-
 6 termines to be appropriate.

7 (d) WAIVER AUTHORITY.—The Secretary shall waive
 8 compliance with the requirements of title XVIII of the So-
 9 cial Security Act (42 U.S.C. 1395 et seq.) to such extent
 10 and for such period as the Secretary determines is nec-
 11 essary to conduct the demonstration projects under this
 12 section.

13 **SEC. 7008. REDUCING CANCER DISPARITIES WITHIN THE**
 14 **MEDICARE PROGRAM.**

15 (a) DEVELOPMENT OF MEASURES OF DISPARITIES
 16 IN QUALITY OF CANCER CARE.—

17 (1) DEVELOPMENT OF MEASURES.—The Sec-
 18 retary of Health and Human Services (in this sec-
 19 tion referred to as the “Secretary”) shall enter into
 20 an agreement with an entity that specializes in de-
 21 veloping quality measures for cancer care under
 22 which the entity shall develop a uniform set of meas-
 23 ures to evaluate disparities in the quality of cancer
 24 care and annually update such set of measures.

1 (2) MEASURES TO BE INCLUDED.—Such set of
2 measures shall include, with respect to the treatment
3 of cancer, measures of patient outcomes, the process
4 for delivering medical care related to such treat-
5 ment, patient counseling and engagement in decision
6 making, patient experience of care, resource use, and
7 practice capabilities, such as care coordination.

8 (b) ESTABLISHMENT OF REPORTING PROCESS.—

9 (1) IN GENERAL.—The Secretary shall establish
10 a reporting process that requires, and provides for,
11 a method for health care providers specified under
12 paragraph (2) to submit to the Secretary and make
13 public data on the performance of such providers
14 during each reporting period through use of the
15 measures developed pursuant to subsection (a). Such
16 data shall be submitted in a form and manner and
17 at a time specified by the Secretary.

18 (2) SPECIFICATION OF PROVIDERS TO REPORT
19 ON MEASURES.—The Secretary shall specify the
20 classes of Medicare providers of services and sup-
21 pliers, including hospitals, cancer centers, physi-
22 cians, primary care providers, and specialty pro-
23 viders, that will be required under such process to
24 publicly report on the measures specified under sub-
25 section (a).

1 (3) ASSESSMENT OF CHANGES.—Under such
 2 reporting process, the Secretary shall establish a for-
 3 mat that assesses changes in both the absolute and
 4 relative disparities in cancer care over time. These
 5 measures shall be presented in an easily comprehen-
 6 sible format, such as those presented in the final
 7 publications relating to Healthy People 2010 or the
 8 National Healthcare Disparities Report.

9 (4) INITIAL IMPLEMENTATION.—The Secretary
 10 shall implement the reporting process under this
 11 subsection for reporting periods beginning not later
 12 than 6 months after the date that measures are first
 13 established under subsection (a).

14 **Subtitle B—Viral Hepatitis and**
 15 **Liver Cancer Control and Pre-**
 16 **vention**

17 **SEC. 7101. BIENNIAL ASSESSMENT OF HHS HEPATITIS B**
 18 **AND HEPATITIS C PREVENTION, EDUCATION,**
 19 **RESEARCH, AND MEDICAL MANAGEMENT**
 20 **PLAN.**

21 Title III of the Public Health Service Act (42 U.S.C.
 22 241 et seq.) is amended—

23 (1) by striking section 317N (42 U.S.C. 247b–
 24 15); and

25 (2) by adding after part W the following:

1 **“PART X—BIENNIAL ASSESSMENT OF HHS HEPA-**
 2 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
 3 **CATION, RESEARCH, AND MEDICAL MANAGE-**
 4 **MENT PLAN**

5 **“SEC. 399PP. BIENNIAL UPDATE OF THE PLAN.**

6 “(a) IN GENERAL.—The Secretary shall conduct a bi-
 7 ennial assessment of the Secretary’s plan for the preven-
 8 tion, control, and medical management of, and education
 9 and research relating to, hepatitis B and hepatitis C, for
 10 the purposes of—

11 “(1) incorporating into such plan new knowl-
 12 edge or observations relating to hepatitis B and hep-
 13 atitis C (such as knowledge and observations that
 14 may be derived from clinical, laboratory, and epide-
 15 miological research and disease detection, preven-
 16 tion, and surveillance outcomes);

17 “(2) addressing gaps in the coverage or effec-
 18 tiveness of the plan; and

19 “(3) evaluating and, if appropriate, updating
 20 recommendations, guidelines, or educational mate-
 21 rials of the Centers for Disease Control and Preven-
 22 tion or the National Institutes of Health for health
 23 care providers or the public on viral hepatitis in
 24 order to be consistent with the plan.

25 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
 26 Not later than October 1 of the first even-numbered year

1 beginning after the date of the enactment of this part,
2 and October 1 of each even-numbered year thereafter, the
3 Secretary shall publish in the Federal Register a notice
4 of the results of the assessments conducted under sub-
5 section (a). Such notice shall include—

6 “(1) a description of any revisions to the plan
7 referred to in subsection (a) as a result of the as-
8 sessment;

9 “(2) an explanation of the basis for any such
10 revisions, including the ways in which such revisions
11 can reasonably be expected to further promote the
12 original goals and objectives of the plan; and

13 “(3) in the case of a determination by the Sec-
14 retary that the plan does not need revision, an expla-
15 nation of the basis for such determination.

16 **“SEC. 399PP-1. ELEMENTS OF PROGRAM.**

17 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
18 Secretary, acting through the Director of the Centers for
19 Disease Control and Prevention, the Administrator of the
20 Health Resources and Services Administration, and the
21 Assistant Secretary for Mental Health and Substance Use,
22 and in accordance with the plan referred to in section
23 399PP(a), shall implement programs to increase aware-
24 ness and enhance knowledge and understanding of hepa-
25 titis B and hepatitis C. Such programs shall include—

1 “(1) the conduct of culturally and linguistically
2 appropriate health education in primary and sec-
3 ondary schools, college campuses, public awareness
4 campaigns, and community outreach activities (espe-
5 cially to the ethnic communities with high rates of
6 chronic hepatitis B and chronic hepatitis C and
7 other high-risk groups) to promote public awareness
8 and knowledge about—

9 “(A) the value of hepatitis A and hepatitis
10 B immunization, including the importance of
11 universal birth dose hepatitis B vaccination and
12 universal childhood and adult hepatitis B vac-
13 cination;

14 “(B) risk factors, transmission, and pre-
15 vention of hepatitis B and hepatitis C;

16 “(C) the value of screening for the early
17 detection of hepatitis B and hepatitis C; and

18 “(D) options available for the treatment of
19 chronic hepatitis B and chronic hepatitis C;

20 “(2) the promotion of immunization programs
21 that increase awareness and access to hepatitis A
22 and hepatitis B vaccines for susceptible adults and
23 children;

24 “(3) the training of health care professionals
25 regarding the importance of vaccinating individuals

1 regarding the importance of hepatitis B screening in
2 individuals infected with hepatitis C and the impor-
3 tance of vaccinating individuals who are at risk for
4 hepatitis C infection against hepatitis A and hepa-
5 titis B;

6 “(4) the training of health care professionals
7 regarding the importance of vaccinating individuals
8 chronically infected with hepatitis B and individuals
9 who are at risk for chronic hepatitis B infection
10 against the hepatitis A virus;

11 “(5) the training of health care professionals
12 and health educators to make them aware of the
13 high rates of chronic hepatitis B and chronic hepa-
14 titis C in certain adult ethnic populations, and the
15 importance of prevention, detection, and medical
16 management of hepatitis B and hepatitis C and of
17 liver cancer screening;

18 “(6) the development and distribution of health
19 education curricula (including information relating
20 to the special needs of individuals infected with or
21 at risk of hepatitis B and hepatitis C, such as the
22 importance of prevention and early intervention, reg-
23 ular monitoring, the recognition of psychosocial
24 needs, appropriate treatment, and liver cancer

1 screening) for individuals providing hepatitis B and
2 hepatitis C counseling; and

3 “(7) support for the implementation of the cur-
4 ricula described in paragraph (6) by State and local
5 public health agencies.

6 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
7 PROGRAMS.—

8 “(1) IN GENERAL.—The Secretary, acting
9 through the Director of the Centers for Disease
10 Control and Prevention, shall support the integra-
11 tion of activities described in paragraph (3) into ex-
12 isting clinical and public health programs at State,
13 local, territorial, and Tribal levels (including commu-
14 nity health clinics, programs for the prevention and
15 treatment of HIV/AIDS, sexually transmitted infec-
16 tions, and substance use disorder, and programs for
17 individuals in correctional settings).

18 “(2) COORDINATION OF DEVELOPMENT OF
19 FEDERAL SCREENING GUIDELINES.—

20 “(A) REFERENCES.—For purposes of this
21 subsection, the term ‘CDC Director’ means the
22 Director of the Centers for Disease Control and
23 Prevention, and the term ‘AHRQ Director’
24 means the Director of the Agency for
25 Healthcare Research and Quality.

1 “(B) AGENCY FOR HEALTHCARE RE-
2 SEARCH AND QUALITY.—Due to the rapidly
3 evolving standard of care associated with diag-
4 nosing and treating viral hepatitis infection, the
5 AHRQ Director shall convene the Preventive
6 Services Task Force under section 915(a) to re-
7 view its recommendation for screening for HBV
8 and HCV infection every 3 years.

9 “(3) ACTIVITIES.—

10 “(A) VOLUNTARY TESTING PROGRAMS.—

11 “(i) IN GENERAL.—The Secretary
12 shall establish a mechanism by which to
13 support and promote the development of
14 State, local, territorial, and Tribal vol-
15 untary hepatitis B and hepatitis C testing
16 programs to screen the high-prevalence
17 populations to aid in the early identifica-
18 tion of chronically infected individuals.

19 “(ii) CONFIDENTIALITY OF THE TEST
20 RESULTS.—The Secretary shall prohibit
21 the use of the results of a hepatitis B or
22 hepatitis C test conducted by a testing pro-
23 gram developed or supported under this
24 subparagraph for any of the following:

1 “(I) Issues relating to health in-
2 surance.

3 “(II) To screen or determine
4 suitability for employment.

5 “(III) To discharge a person
6 from employment with issues relating
7 to immigration status.

8 “(B) COUNSELING REGARDING VIRAL HEP-
9 ATITIS.—The Secretary shall support State,
10 local, territorial, and Tribal programs in a wide
11 variety of settings, including those providing
12 primary and specialty health care services in
13 nonprofit private and public sectors, to—

14 “(i) provide individuals with ongoing
15 risk factors for hepatitis B and hepatitis C
16 infection with client-centered education
17 and counseling which concentrates on—

18 “(I) promoting testing of individ-
19 uals that have been exposed to their
20 blood, family members, and their sex-
21 ual partners; and

22 “(II) changing behaviors that
23 place individuals at risk for infection;

24 “(ii) provide individuals chronically in-
25 fected with hepatitis B or hepatitis C with

1 education, health information, and coun-
2 seling to reduce their risk of—

3 “(I) dying from end-stage liver
4 disease and liver cancer; and

5 “(II) transmitting viral hepatitis
6 to others; and

7 “(iii) provide people chronically in-
8 fected with hepatitis B or hepatitis C who
9 are pregnant or of childbearing age with
10 culturally and linguistically appropriate
11 health information, such as how to prevent
12 hepatitis B perinatal infection, and to al-
13 leviate fears associated with pregnancy or
14 raising a family.

15 “(C) IMMUNIZATION.—The Secretary shall
16 support State, local, territorial, and Tribal ef-
17 forts to expand the current vaccination pro-
18 grams to protect every child in the Nation and
19 all susceptible adults, particularly those infected
20 with hepatitis C and high-prevalence ethnic
21 populations and other high-risk groups, from
22 the risks of acute and chronic hepatitis B infec-
23 tion by—

24 “(i) ensuring continued funding for
25 hepatitis B vaccination for all children 18

1 years of age or younger through the Vac-
2 cines for Children program;

3 “(ii) ensuring that the recommenda-
4 tions of the American Academy of Pediat-
5 rics and American College of Physicians
6 are followed regarding hepatitis B vaccina-
7 tion for infants, children, and adults;

8 “(iii) requiring proof of hepatitis B
9 vaccination for entry into public or private
10 daycare, preschool, elementary school, sec-
11 ondary school, and institutions of higher
12 education for those not infected with hepa-
13 titis B;

14 “(iv) expanding the availability of
15 hepatitis B vaccination for all adults to
16 protect them from becoming acutely or
17 chronically infected, including ethnic and
18 other populations with high prevalence
19 rates of chronic hepatitis B infection;

20 “(v) expanding the availability of hep-
21 atitis B vaccination for all adults, particu-
22 larly those of reproductive age, to protect
23 them from the risk of hepatitis B infection;

24 “(vi) ensuring the vaccination of indi-
25 viduals infected, or at risk for infection,

1 with hepatitis C against hepatitis A, hepa-
2 titis B, and other infectious diseases, as
3 appropriate, for which such individuals
4 may be at increased risk; and

5 “(vii) ensuring the vaccination of indi-
6 viduals infected, or at risk for infection,
7 with hepatitis B against hepatitis A virus
8 and other infectious diseases, as appro-
9 priate, for which such individuals may be
10 at increased risk.

11 “(D) MEDICAL REFERRAL.—The Secretary
12 shall support State, local, territorial, and Tribal
13 programs that support—

14 “(i) referral of persons chronically in-
15 fected with hepatitis B or hepatitis C—

16 “(I) for medical evaluation to de-
17 termine the appropriateness for
18 antiviral treatment to reduce the risk
19 of progression to cirrhosis and liver
20 cancer; and

21 “(II) for ongoing medical man-
22 agement including regular monitoring
23 of liver function and screening for
24 liver cancer; and

1 “(ii) referral of persons infected with
2 acute or chronic hepatitis B infection or
3 acute or chronic hepatitis C infection for
4 drug and alcohol abuse treatment where
5 appropriate.

6 “(4) INCREASED SUPPORT FOR ADULT VIRAL
7 HEPATITIS PREVENTION COORDINATORS.—The Sec-
8 retary, acting through the CDC Director, shall pro-
9 vide increased support to adult viral hepatitis pre-
10 vention coordinators in State, local, territorial, and
11 Tribal health departments in order to enhance the
12 additional management, networking, and technical
13 expertise needed to ensure successful integration of
14 hepatitis B and hepatitis C prevention and control
15 activities into existing public health programs.

16 “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Director of the Centers for Disease
19 Control and Prevention, shall support the establish-
20 ment and maintenance of a national chronic and
21 acute hepatitis B and hepatitis C surveillance pro-
22 gram, in order to identify—

23 “(A) trends in the incidence of acute and
24 chronic hepatitis B and acute and chronic hepa-
25 titis C;

1 “(B) trends in the prevalence of acute and
2 chronic hepatitis B and acute and chronic hepa-
3 titis C infection among groups that may be dis-
4 proportionately affected; and

5 “(C) trends in liver cancer and end-stage
6 liver disease incidence and deaths, caused by
7 chronic hepatitis B and chronic hepatitis C in
8 the high-risk ethnic populations.

9 “(2) SEROPREVALENCE AND LIVER CANCER
10 STUDIES.—The Secretary, acting through the Direc-
11 tor of the Centers for Disease Control and Preven-
12 tion, shall prepare a report outlining the population-
13 based seroprevalence studies currently underway, fu-
14 ture planned studies, the criteria involved in deter-
15 mining which seroprevalence studies to conduct,
16 defer, or suspend, and the scope of those studies, the
17 economic and clinical impact of hepatitis B and hep-
18 atitis C, and the impact of chronic hepatitis B and
19 chronic hepatitis C infections on the quality of life.
20 Not later than one year after the date of the enact-
21 ment of this part, the Secretary shall submit the re-
22 port to the Committee on Health, Education, Labor,
23 and Pensions of the Senate and the Committee on
24 Energy and Commerce of the House of Representa-
25 tives.

1 “(3) CONFIDENTIALITY.—The Secretary shall
2 not disclose any individually identifiable information
3 identified under paragraph (1) or derived through
4 studies under paragraph (2).

5 “(d) RESEARCH.—The Secretary, acting through the
6 Director of the Centers for Disease Control and Preven-
7 tion, the Director of the National Cancer Institute, and
8 the Director of the National Institutes of Health, shall—

9 “(1) conduct epidemiologic and community-
10 based research to develop, implement, and evaluate
11 best practices for hepatitis B and hepatitis C pre-
12 vention especially in the ethnic populations with high
13 rates of chronic hepatitis B and chronic hepatitis C
14 and other high-risk groups;

15 “(2) conduct research on hepatitis B and hepa-
16 titis C natural history, pathophysiology, improved
17 treatments and prevention (such as the hepatitis C
18 vaccine), and noninvasive tests that help to predict
19 the risk of progression to liver cirrhosis and liver
20 cancer;

21 “(3) conduct research that will lead to better
22 noninvasive or blood tests to screen for liver cancer,
23 and more effective treatments of liver cancer caused
24 by chronic hepatitis B and chronic hepatitis C; and

1 “(4) conduct research comparing the effective-
2 ness of screening, diagnostic, management, and
3 treatment approaches for chronic hepatitis B, chron-
4 ic hepatitis C, and liver cancer in the affected com-
5 munities.

6 “(e) UNDERSERVED AND DISPROPORTIONATELY AF-
7 FECTED POPULATIONS.—In carrying out this section, the
8 Secretary shall provide expanded support for individuals
9 with limited access to health education, testing, and health
10 care services and groups that may be disproportionately
11 affected by hepatitis B and hepatitis C.

12 “(f) EVALUATION OF PROGRAM.—The Secretary
13 shall develop benchmarks for evaluating the effectiveness
14 of the programs and activities conducted under this sec-
15 tion and make determinations as to whether such bench-
16 marks have been achieved.

17 **“SEC. 399PP-2. GRANTS.**

18 “(a) IN GENERAL.—The Secretary may award grants
19 to, or enter into contracts or cooperative agreements with,
20 States, political subdivisions of States, territories, Indian
21 Tribes, or nonprofit entities that have special expertise re-
22 lating to hepatitis B, hepatitis C, or both, to carry out
23 activities under this part.

24 “(b) APPLICATION.—To be eligible for a grant, con-
25 tract, or cooperative agreement under subsection (a), an

1 entity shall prepare and submit to the Secretary an appli-
 2 cation at such time, in such manner, and containing such
 3 information as the Secretary may require.

4 **“SEC. 399PP-3. AUTHORIZATION OF APPROPRIATIONS.**

5 “There are authorized to be appropriated to carry out
 6 this part \$90,000,000 for fiscal year 2027, \$110,000,000
 7 for fiscal year 2028, \$130,000,000 for fiscal year 2029,
 8 and \$150,000,000 for fiscal year 2030.”.

9 **SEC. 7102. LIVER CANCER AND DISEASE PREVENTION,**
 10 **AWARENESS, AND PATIENT TRACKING**
 11 **GRANTS.**

12 Subpart I of part D of title III of the Public Health
 13 Service Act (42 U.S.C. 254b et seq.) is amended by adding
 14 at the end the following:

15 **“SEC. 330Q. LIVER CANCER AND DISEASE PREVENTION,**
 16 **AWARENESS, AND PATIENT TRACKING**
 17 **GRANTS.**

18 “(a) PREVENTION INITIATIVE GRANT PROGRAM.—

19 “(1) IN GENERAL.—The Secretary, acting
 20 through the Director of the Centers for Disease
 21 Control and Prevention, may award grants and
 22 enter into cooperative agreements with entities for
 23 the purpose of expanding and supporting—

24 “(A) prevention activities (including pro-
 25 viding screenings, vaccinations, or other pre-

1 ventative interventions) for conditions known to
2 increase an individual's risk of developing a
3 major liver disease, such as liver cancer, hepa-
4 titis B, hepatitis C, nonalcoholic fatty liver dis-
5 ease, nonalcoholic steatohepatitis, and cirrhosis
6 of the liver;

7 “(B) activities relating to detection and
8 provision of guidance for individuals at high
9 risk for contracting liver cancer and other liver
10 diseases; and

11 “(C) viral hepatitis surveillance to provide
12 for timely and accurate information regarding
13 progress to eliminate viral hepatitis.

14 “(2) REPORT.—An entity that receives a grant
15 or cooperative agreement under paragraph (1) shall
16 submit to the Secretary, at a time specified by the
17 Secretary, a report describing each activity carried
18 out pursuant to such paragraph and evaluating the
19 effectiveness of such activity in promoting prevention
20 and treatment of liver cancer and other liver dis-
21 eases.

22 “(3) AUTHORIZATION OF APPROPRIATIONS.—
23 For purposes of carrying out this subsection, there
24 is authorized to be appropriated \$90,000,000 for
25 each of fiscal years 2027 through 2031.

1 “(b) AWARENESS INITIATIVE GRANT PROGRAM.—

2 “(1) IN GENERAL.—The Secretary, acting
3 through the Director of the Centers for Disease
4 Control and Prevention, may award grants to eligi-
5 ble entities for the purpose of raising awareness for
6 liver cancer and other liver diseases, which may in-
7 clude the production, dissemination, and distribution
8 of informational materials targeted towards commu-
9 nities and populations with a higher risk for devel-
10 oping liver cancer and other liver diseases.

11 “(2) ELIGIBLE ENTITIES.—To be eligible to re-
12 ceive a grant under paragraph (1), an entity shall
13 submit to the Secretary an application, at such time,
14 in such manner, and containing such information as
15 the Secretary may require, including a description of
16 how the entity, in disseminating information on liver
17 cancer and other liver diseases pursuant to para-
18 graph (1), will—

19 “(A) with respect to any community or
20 population, consult with members of such com-
21 munity or population and provide such informa-
22 tion in a manner that is culturally and linguis-
23 tically appropriate for such community or popu-
24 lation;

1 “(B) highlight the range of preventative
2 measures and treatments available for liver can-
3 cer and other liver diseases;

4 “(C) integrate information on available
5 hepatitis B and hepatitis C testing programs
6 into any liver cancer presentations carried out
7 by the entity; and

8 “(D) address communities and populations
9 with a higher risk for contracting liver cancer
10 and other liver diseases.

11 “(3) PREFERENCE.—In awarding grants under
12 paragraph (1), the Secretary shall give preference to
13 entities that—

14 “(A) work with a Federally qualified
15 health center;

16 “(B) are community-based organizations;
17 or

18 “(C) serve communities and populations
19 with a higher risk for contracting liver cancer
20 and other liver diseases.

21 “(4) REPORT.—An entity that receives a grant
22 under paragraph (1) shall submit to the Secretary,
23 at a time specified by the Secretary, a report de-
24 scribing each activity carried out pursuant to such
25 paragraph and evaluating the effectiveness of such

1 activity in raising awareness for liver cancer and
 2 other liver diseases.

3 “(5) AUTHORIZATION OF APPROPRIATIONS.—
 4 For purposes of carrying out this subsection, there
 5 is authorized to be appropriated \$10,000,000 for
 6 each of fiscal years 2027 through 2031.”.

7 **Subtitle C—Acquired Bone Marrow** 8 **Failure Diseases**

9 **SEC. 7201. ACQUIRED BONE MARROW FAILURE DISEASES.**

10 (a) NATIONAL ACQUIRED BONE MARROW FAILURE
 11 DISEASE REGISTRY.—Title III of the Public Health Serv-
 12 ice Act (42 U.S.C. 241 et seq.) is amended by inserting
 13 after section 317W, as added by section 1009, the fol-
 14 lowing:

15 **“SEC. 317X. NATIONAL ACQUIRED BONE MARROW FAILURE** 16 **DISEASE REGISTRY.**

17 “(a) ESTABLISHMENT OF REGISTRY.—

18 “(1) IN GENERAL.—Not later than 6 months
 19 after the date of the enactment of this section, the
 20 Secretary, acting through the Director of the Cen-
 21 ters for Disease Control and Prevention, shall—

22 “(A) develop a system to collect data on
 23 acquired bone marrow failure diseases; and

24 “(B) establish and maintain a national and
 25 publicly available registry, to be known as the

1 National Acquired Bone Marrow Failure Dis-
2 ease Registry, in accordance with paragraph
3 (3).

4 “(2) RECOMMENDATIONS OF ADVISORY COM-
5 MITTEE.—In carrying out this subsection, the Sec-
6 retary shall take into consideration the recommenda-
7 tions of the Advisory Committee on Acquired Bone
8 Marrow Failure Diseases established under sub-
9 section (b).

10 “(3) PURPOSES OF REGISTRY.—The National
11 Acquired Bone Marrow Failure Disease Registry
12 shall—

13 “(A) identify the incidence and prevalence
14 of acquired bone marrow failure diseases in the
15 United States;

16 “(B) be used to collect and store data on
17 acquired bone marrow failure diseases, includ-
18 ing data concerning—

19 “(i) the age, race or ethnicity, general
20 geographic location, sex, and family history
21 of individuals who are diagnosed with ac-
22 quired bone marrow failure diseases, and
23 any other characteristics of such individ-
24 uals determined appropriate by the Sec-
25 retary;

1 “(ii) the genetic and environmental
2 factors that may be associated with devel-
3 oping acquired bone marrow failure dis-
4 eases;

5 “(iii) treatment approaches for deal-
6 ing with acquired bone marrow failure dis-
7 eases;

8 “(iv) outcomes for individuals treated
9 for acquired bone marrow failure diseases,
10 including outcomes for recipients of stem
11 cell therapeutic products as contained in
12 the database established pursuant to sec-
13 tion 379A; and

14 “(v) any other factors pertaining to
15 acquired bone marrow failure diseases de-
16 termined appropriate by the Secretary; and
17 “(C) be made available—

18 “(i) to the general public; and

19 “(ii) to researchers to facilitate fur-
20 ther research into the causes of, and treat-
21 ments for, acquired bone marrow failure
22 diseases in accordance with standard prac-
23 tices of the Centers for Disease Control
24 and Prevention.

25 “(b) ADVISORY COMMITTEE.—

1 “(1) ESTABLISHMENT.—Not later than 6
2 months after the date of the enactment of this sec-
3 tion, the Secretary, acting through the Director of
4 the Centers for Disease Control and Prevention,
5 shall establish an advisory committee, to be known
6 as the Advisory Committee on Acquired Bone Mar-
7 row Failure Diseases.

8 “(2) MEMBERS.—The members of the Advisory
9 Committee on Acquired Bone Marrow Failure Dis-
10 eases shall be appointed by the Secretary, acting
11 through the Director of the Centers for Disease
12 Control and Prevention, and shall include at least
13 one representative from each of the following:

14 “(A) A national patient advocacy organiza-
15 tion with experience advocating on behalf of pa-
16 tients suffering from acquired bone marrow
17 failure diseases.

18 “(B) The National Institutes of Health, in-
19 cluding at least one representative from each
20 of—

21 “(i) the National Cancer Institute;

22 “(ii) the National Heart, Lung, and
23 Blood Institute; and

24 “(iii) the Office of Rare Diseases.

1 “(C) The Centers for Disease Control and
2 Prevention.

3 “(D) Clinicians with experience in—
4 “(i) diagnosing or treating acquired
5 bone marrow failure diseases; or
6 “(ii) medical data registries.

7 “(E) Epidemiologists who have experience
8 with data registries.

9 “(F) Publicly or privately funded research-
10 ers who have experience researching acquired
11 bone marrow failure diseases.

12 “(G) The entity operating the C.W. Bill
13 Young Cell Transplantation Program estab-
14 lished pursuant to section 379 and the entity
15 operating the C.W. Bill Young Cell Transplan-
16 tation Program Outcomes Database.

17 “(3) RESPONSIBILITIES.—The Advisory Com-
18 mittee on Acquired Bone Marrow Failure Diseases
19 shall provide recommendations to the Secretary on
20 the establishment and maintenance of the National
21 Acquired Bone Marrow Failure Disease Registry, in-
22 cluding recommendations on the collection, mainte-
23 nance, and dissemination of data.

24 “(4) PUBLIC AVAILABILITY.—The Secretary
25 shall make the recommendations of the Advisory

1 Committee on Acquired Bone Marrow Failure Dis-
2 ease publicly available.

3 “(c) GRANTS.—The Secretary, acting through the
4 Director of the Centers for Disease Control and Preven-
5 tion, may award grants to, and enter into contracts and
6 cooperative agreements with, public or private nonprofit
7 entities for the management of, as well as the collection,
8 analysis, and reporting of data to be included in, the Na-
9 tional Acquired Bone Marrow Failure Disease Registry.

10 “(d) DEFINITION.—In this section, the term ‘ac-
11 quired bone marrow failure disease’ means—

12 “(1) myelodysplastic syndromes;

13 “(2) aplastic anemia;

14 “(3) paroxysmal nocturnal hemoglobinuria;

15 “(4) pure red cell aplasia;

16 “(5) acute myeloid leukemia that has pro-
17 gressed from myelodysplastic syndromes; or

18 “(6) large granular lymphocytic leukemia.

19 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated to carry out this section
21 \$3,000,000 for each of fiscal years 2027 through 2031.”.

22 (b) PILOT STUDIES THROUGH THE AGENCY FOR
23 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

24 (1) PILOT STUDIES.—The Secretary of Health
25 and Human Services, acting through the Director of

1 the Agency for Toxic Substances and Disease Reg-
 2 istry, shall conduct pilot studies to determine which
 3 environmental factors, including exposure to toxins,
 4 may cause acquired bone marrow failure diseases.

5 (2) COLLABORATION WITH THE RADIATION IN-
 6 JURY TREATMENT NETWORK.—In carrying out the
 7 directives of this section, the Secretary of Health
 8 and Human Services may collaborate with the Radi-
 9 ation Injury Treatment Network of the C.W. Bill
 10 Young Cell Transplantation Program established
 11 pursuant to section 379 of the Public Health Service
 12 Act (42 U.S.C. 274k) to—

13 (A) augment data for the pilot studies au-
 14 thorized by this section;

15 (B) access technical assistance that may be
 16 provided by the Radiation Injury Treatment
 17 Network; or

18 (C) perform joint research projects.

19 (3) AUTHORIZATION OF APPROPRIATIONS.—
 20 There is authorized to be appropriated to carry out
 21 this subsection \$1,000,000 for each of fiscal years
 22 2027 through 2031.

23 (c) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
 24 BONE MARROW FAILURE DISEASES.—Title XVII of the

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

3 **“SEC. 1707B. MINORITY-FOCUSED PROGRAMS ON AC-**
4 **QUIRED BONE MARROW FAILURE DISEASE.**

5 “(a) INFORMATION AND REFERRAL SERVICES.—

6 “(1) IN GENERAL.—Not later than 6 months
7 after the date of the enactment of this section, the
8 Secretary, acting through the Deputy Assistant Sec-
9 retary for Minority Health, shall establish and co-
10 ordinate outreach and informational programs tar-
11 geted to minority populations affected by acquired
12 bone marrow failure diseases.

13 “(2) PROGRAM REQUIREMENTS.—Minority-fo-
14 cused outreach and informational programs author-
15 ized by this section at the National Minority Health
16 Resource Center supported under section 1707(b)(8)
17 (including by means of the Center’s website, through
18 appropriate locations such as the Center’s knowledge
19 center, and through appropriate programs such as
20 the Center’s resource persons network) and through
21 minority health consultants located at each Depart-
22 ment of Health and Human Services regional of-
23 fice—

24 “(A) shall make information about treat-
25 ment options and clinical trials for acquired

1 bone marrow failure diseases publicly available;
2 and

3 “(B) shall provide referral services for
4 treatment options and clinical trials.

5 “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
6 ISLANDER OUTREACH.—

7 “(1) IN GENERAL.—The Secretary, acting
8 through the Deputy Assistant Secretary for Minority
9 Health, shall undertake a coordinated outreach ef-
10 fort to connect Hispanic, Asian-American, and Pa-
11 cific Islander communities with comprehensive serv-
12 ices focused on treatment of, and information about,
13 acquired bone marrow failure diseases.

14 “(2) COLLABORATION.—In carrying out this
15 subsection, the Secretary may collaborate with public
16 health agencies, nonprofit organizations, community
17 groups, and online entities to disseminate informa-
18 tion about treatment options and clinical trials for
19 acquired bone marrow failure diseases.

20 “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

21 “(1) IN GENERAL.—Not later than 6 months
22 after the date of the enactment of this section, the
23 Secretary, acting through the Deputy Assistant Sec-
24 retary for Minority Health, shall award grants to, or
25 enter into cooperative agreements with, entities to

1 perform research on acquired bone marrow failure
2 diseases.

3 “(2) REQUIREMENT.—Grants and cooperative
4 agreements authorized by this subsection shall be
5 awarded or entered into on a competitive, peer-re-
6 viewed basis.

7 “(3) SCOPE OF RESEARCH.—Research funded
8 under this subsection shall examine factors affecting
9 the incidence of acquired bone marrow failure dis-
10 eases in minority populations.

11 “(d) DEFINITION.—In this section, the term ‘ac-
12 quired bone marrow failure disease’ has the meaning given
13 to such term in section 317X(d).

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section
16 \$2,000,000 for each of fiscal years 2027 through 2031.”.

17 (d) DIAGNOSIS AND QUALITY OF CARE FOR AC-
18 QUIRED BONE MARROW FAILURE DISEASES.—

19 (1) GRANTS.—The Secretary of Health and
20 Human Services, acting through the Director of the
21 Agency for Healthcare Research and Quality, shall
22 award grants to entities to improve diagnostic prac-
23 tices and quality of care with respect to patients
24 with acquired bone marrow failure diseases.

1 (2) AUTHORIZATION OF APPROPRIATIONS.—

2 There is authorized to be appropriated to carry out
 3 this subsection \$2,000,000 for each of fiscal years
 4 2027 through 2031.

5 (e) DEFINITION.—In this section, the term “acquired
 6 bone marrow failure disease” has the meaning given such
 7 term in section 317X(d) of the Public Health Service Act,
 8 as added by subsection (a).

9 **Subtitle D—Cardiovascular Dis-**
 10 **ease, Chronic Disease, Obesity,**
 11 **and Other Disease Issues**

12 **SEC. 7301. GUIDELINES FOR DISEASE SCREENING FOR MI-**
 13 **NORITY PATIENTS.**

14 (a) IN GENERAL.—The Secretary of Health and
 15 Human Services (in this section referred to as the “Sec-
 16 retary”), acting through the Director of the Agency for
 17 Healthcare Research and Quality, shall convene a series
 18 of meetings to develop guidelines for disease screening for
 19 minority patient populations that have a higher than aver-
 20 age risk for many chronic diseases and cancers.

21 (b) PARTICIPANTS.—In convening meetings under
 22 subsection (a), the Secretary shall ensure that meeting
 23 participants include representatives of—

24 (1) professional societies and associations;

25 (2) minority health organizations;

1 (3) health care researchers and providers, in-
2 cluding those with expertise in minority health;

3 (4) Federal health agencies, including the Of-
4 fice of Minority Health, the National Institute on
5 Minority Health and Health Disparities, and the
6 National Institutes of Health; and

7 (5) other experts as the Secretary determines
8 appropriate.

9 (c) DISEASES.—Screening guidelines for minority
10 populations shall be developed as appropriate under sub-
11 section (a) for—

12 (1) hypertension;

13 (2) hypercholesterolemia;

14 (3) diabetes;

15 (4) cardiovascular disease;

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

18 (6) other pulmonary problems including sleep
19 apnea;

20 (7) asthma;

21 (8) kidney diseases;

22 (9) eye diseases and disorders, including glau-
23 coma;

24 (10) HIV/AIDS and sexually transmitted infec-
25 tions;

- 1 (11) uterine fibroids;
- 2 (12) autoimmune diseases, including lupus;
- 3 (13) mental health conditions;
- 4 (14) dental health conditions and oral diseases,
- 5 including oral cancer;
- 6 (15) environmental and related health illnesses
- 7 and conditions;
- 8 (16) sickle cell disease and sickle cell trait;
- 9 (17) violence and injury prevention and control;
- 10 (18) genetic and related conditions;
- 11 (19) heart disease and stroke;
- 12 (20) tuberculosis;
- 13 (21) chronic obstructive pulmonary disease;
- 14 (22) musculoskeletal diseases, arthritis, and
- 15 obesity; and
- 16 (23) other diseases determined appropriate by
- 17 the Secretary.

18 (d) DISSEMINATION.—Not later than 2 years after
19 the date of enactment of this Act, the Secretary shall pub-
20 lish and disseminate to health care provider organizations
21 the guidelines developed under subsection (a).

22 (e) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2027 through 2031.

1 **SEC. 7302. CDC WISEWOMAN SCREENING PROGRAM.**

2 Section 1509 of the Public Health Service Act (42
3 U.S.C. 300n-4a) is amended—

4 (1) in subsection (a)—

5 (A) by striking the heading and inserting
6 “IN GENERAL”; and

7 (B) in the matter preceding paragraph (1),
8 by striking “may make grants” and all that fol-
9 lows through “purpose” and inserting the fol-
10 lowing: “may make grants to such States for
11 the purpose”; and

12 (2) in subsection (d)(1), by striking “there are
13 authorized” and all that follows through the period
14 and inserting “there are authorized to be appro-
15 priated \$23,000,000 for fiscal year 2027,
16 \$25,300,000 for fiscal year 2028, \$27,800,000 for
17 fiscal year 2029, \$30,800,000 for fiscal year 2030,
18 and \$34,000,000 for fiscal year 2031.”.

19 **SEC. 7303. REPORT ON CARDIOVASCULAR CARE FOR**
20 **WOMEN AND MINORITIES.**

21 Part P of title III of the Public Health Service Act
22 (42 U.S.C. 280g et seq.), as amended by section
23 5201(c)(3), is amended by adding at the end the following:

1 **“SEC. 399V-10. REPORT ON CARDIOVASCULAR CARE FOR**
2 **WOMEN AND MINORITIES.**

3 “Not later than September 30, 2027, and annually
4 thereafter, the Secretary shall prepare and submit to Con-
5 gress a report on the quality of and access to care for
6 women and minorities with heart disease, stroke, and
7 other cardiovascular diseases. The report shall contain rec-
8 ommendations for eliminating disparities in, and improv-
9 ing the treatment of, heart disease, stroke, and other car-
10 diovascular diseases in women, racial and ethnic minori-
11 ties, those for whom English is not their primary lan-
12 guage, and individuals with disabilities.”.

13 **SEC. 7304. GAO REPORT ON STRUCTURAL AND SYSTEMIC**
14 **FACTORS THAT PERPETUATE CARDIO-**
15 **VASCULAR DISPARITIES.**

16 (a) IN GENERAL.—Not later than September 30,
17 2027, the Comptroller General of the United States shall
18 prepare and submit a report to Congress that contains the
19 results of an investigation of—

20 (1) the structural and systemic factors that per-
21 petuate disparities in access to screenings, care, and
22 treatment of cardiovascular disease; and

23 (2) how care navigation, including community-
24 based health workers, can improve cardiovascular
25 disease management and improve health outcomes.

26 (b) CONTENTS.—The report shall—

1 (1) identify the challenges and barriers facing
2 health care providers and patients, which contribute
3 to postponed, delayed, or suboptimal treatments for
4 cardiovascular disease;

5 (2) examine efforts by Federal agencies and
6 Federal programs to improve screening and manage-
7 ment of patients with cardiovascular disease;

8 (3) identify and examine existing quality meas-
9 ures from the Centers for Medicare & Medicaid
10 Services related to cholesterol management and
11 whether these measures encourage providers and
12 health systems to—

13 (A) perform appropriate and timely low-
14 density-lipoprotein cholesterol (LDL-C) testing
15 on patients at risk of a cardiovascular event;
16 and

17 (B) better manage patients' elevated LDL-
18 C levels in concordance with clinical guidelines
19 prescribing directives to ensure patients are
20 progressing towards guideline-recommended
21 LDL-C levels;

22 (4) identify actions the Federal Government
23 could take to promote collaboration with community-
24 based organizations to ensure improvement in clin-
25 ical outcomes for patients with cardiovascular dis-

1 ease, including by building on recommendations
 2 from the National Academy of Medicine and the
 3 Centers for Disease Control to include community
 4 health workers to improve health care delivery for
 5 underserved and high-risk communities; and

6 (5) assess whether racial and ethnic minority
 7 groups, as defined in section 1707(g) of the Public
 8 Health Service Act (42 U.S.C. 300g–6(g)), have
 9 higher prior authorization rejection rates of prescrip-
 10 tion drugs to treat or prevent cardiovascular disease
 11 by health insurance providers and, if so, identify the
 12 resulting impacts on cardiovascular disease medica-
 13 tion adherence, morbidity, and mortality, as well as
 14 resulting postponed, delayed, or suboptimal treat-
 15 ment prescribing for cardiovascular disease among
 16 racial and ethnic minorities.

17 **SEC. 7305. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
 18 **SATION SERVICES IN MEDICAID, CHIP, AND**
 19 **PRIVATE HEALTH INSURANCE.**

20 (a) **REQUIRING MEDICAID COVERAGE OF COUN-**
 21 **SELING AND PHARMACOTHERAPY FOR CESSATION OF TO-**
 22 **BACCO USE AND TEMPORARY ENHANCED FMAP FOR**
 23 **COVERAGE OF TOBACCO CESSATION SERVICES.**—Section
 24 1905 of the Social Security Act (42 U.S.C. 1396d), as
 25 amended by section 5201(b)(2)(A)(i), is amended—

1 (1) in subsection (a)(4), by striking “(D)” and
 2 all that follows through “subsection (bb))” and in-
 3 serting the following: “(D) counseling and
 4 pharmacotherapy for cessation of tobacco use by in-
 5 dividuals who are eligible under the State plan (as
 6 defined in subsection (bb))”;

7 (2) in subsection (b), by inserting “(bb)(2),”
 8 after “(aa),”; and

9 (3) by striking subsection (bb) and inserting
 10 the following:

11 “(bb) COUNSELING AND PHARMACOTHERAPY FOR
 12 CESSATION OF TOBACCO USE.—

13 “(1) IN GENERAL.—For purposes of this title,
 14 the term ‘counseling and pharmacotherapy for ces-
 15 sation of tobacco use by individuals who are eligible
 16 under the State plan’ means diagnostic, therapy,
 17 and counseling services and pharmacotherapy (in-
 18 cluding the coverage of prescription and nonprescrip-
 19 tion tobacco cessation agents approved by the Food
 20 and Drug Administration) for the cessation of to-
 21 bacco use by individuals who use tobacco products or
 22 who are being treated for tobacco use that is fur-
 23 nished—

24 “(A) by or under the supervision of a phy-
 25 sician; or

1 “(B) by any other health care professional
2 who—

3 “(i) is legally authorized to furnish
4 such services under State law (or the State
5 regulatory mechanism provided by State
6 law) of the State in which the services are
7 furnished; and

8 “(ii) is authorized to receive payment
9 for other services under this title or is des-
10 ignated by the Secretary for this purpose,
11 which is recommended in the guideline en-
12 titled, ‘Treating Tobacco Use and Depend-
13 ence: 2008 Update: A Clinical Practice
14 Guideline’ published by the Public Health
15 Service in May 2008 (or any subsequent
16 modification of such guideline) or is rec-
17 ommended for the cessation of tobacco use
18 by the United States Preventive Services
19 Task Force or any additional intervention
20 approved by the Food and Drug Adminis-
21 tration as safe and effective in helping
22 smokers quit.

23 “(2) TEMPORARY ENHANCED FMAP FOR COV-
24 ERAGE OF TOBACCO CESSATION SERVICES.—Not-
25 withstanding subsection (b), for calendar quarters

1 occurring during the period beginning on the date of
 2 the enactment of this paragraph and ending 5 years
 3 after the date of enactment of this paragraph, the
 4 Federal medical assistance percentage with respect
 5 to amounts expended by a State for medical assist-
 6 ance for counseling and pharmacotherapy for ces-
 7 sation of tobacco use by individuals who are eligible
 8 under the State plan (as defined in paragraph (1))
 9 shall be equal to 90 percent.”.

10 (b) NO COST SHARING.—

11 (1) IN GENERAL.—Subsections (a)(2) and
 12 (b)(2) of section 1916 of the Social Security Act (42
 13 U.S.C. 1396o), as amended by section 2007(d)(4),
 14 are each amended—

15 (A) in subparagraph (B), by striking “,
 16 and counseling” and all that follows through
 17 “section 1905(bb)(2)(A)”;

18 (B) in subparagraph (J), by striking “or”
 19 after the comma;

20 (C) in subparagraph (K), by striking “;
 21 and” and inserting “, or”; and

22 (D) by adding at the end the following new
 23 subparagraph:

24 “(L) counseling and pharmacotherapy for
 25 cessation of tobacco use by individuals who are

1 eligible under the State plan (as defined in sec-
 2 tion 1905(bb)) and covered outpatient drugs (as
 3 defined in subsection (k)(2) of section 1927 and
 4 including nonprescription drugs described in
 5 subsection (d)(2) of such section) that are pre-
 6 scribed for purposes of promoting tobacco ces-
 7 sation in accordance with the guideline specified
 8 in section 1905(bb); and”.

9 (2) APPLICATION TO ALTERNATIVE COST SHAR-
 10 ING.—Section 1916A(b)(3)(B) of the Social Security
 11 Act (42 U.S.C. 1396o–1(b)(3)(B)) is amended—

12 (A) in clause (iii), by striking “, and coun-
 13 seling and pharmacotherapy for cessation of to-
 14 bacco use by pregnant women (as defined in
 15 section 1905(bb))”; and

16 (B) by adding at the end the following new
 17 clause:

18 “(xv) Counseling and
 19 pharmacotherapy for cessation of tobacco
 20 use by individuals who are eligible under
 21 the State plan (as defined in section
 22 1905(bb)) and covered outpatient drugs
 23 (as defined in subsection (k)(2) of section
 24 1927 and including nonprescription drugs
 25 described in subsection (d)(2) of such sec-

1 tion) that are prescribed for purposes of
 2 promoting tobacco cessation in accordance
 3 with the guideline specified in section
 4 1905(bb).”.

5 (c) EXCEPTION FROM OPTIONAL RESTRICTION
 6 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
 7 Section 1927(d)(2)(F) of the Social Security Act (42
 8 U.S.C. 1396r-8(d)(2)(F)) is amended to read as follows:

9 “(F) Nonprescription drugs, except, when
 10 recommended in accordance with the guideline
 11 referred to in section 1905(bb), agents ap-
 12 proved by the Food and Drug Administration
 13 under the over-the-counter monograph process
 14 for purposes of promoting tobacco cessation.”.

15 (d) STATE MONITORING AND PROMOTING OF COM-
 16 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
 17 MEDICAID.—Section 1902(a) of the Social Security Act
 18 (42 U.S.C. 1396a(a)), as amended by section
 19 5201(c)(2)(B), is amended—

20 (1) in paragraph (90)(C), by striking “and” at
 21 the end;

22 (2) in paragraph (91), by striking the period at
 23 the end and inserting “; and”; and

24 (3) by inserting after paragraph (91) the fol-
 25 lowing new paragraph:

1 “(92) provide that the State will monitor and
2 promote the use of comprehensive tobacco cessation
3 services under the State plan (including conducting
4 an outreach campaign to increase awareness of the
5 benefits of using such services) among—

6 “(A) individuals entitled to medical assist-
7 ance under the State plan who use tobacco
8 products; and

9 “(B) clinicians and others who provide
10 services to individuals entitled to medical assist-
11 ance under the State plan.”.

12 (e) FEDERAL REIMBURSEMENT FOR OUTREACH
13 CAMPAIGN.—Section 1903(a) of the Social Security Act
14 (42 U.S.C. 1396b(a)) is amended—

15 (1) in paragraph (6)(B), by striking “plus” at
16 the end;

17 (2) in paragraph (7), by striking the period at
18 the end and inserting “; plus”; and

19 (3) by inserting after paragraph (7) the fol-
20 lowing new paragraph:

21 “(8) with respect to the development, imple-
22 mentation, and evaluation of an outreach campaign
23 to—

1 “(A) increase awareness of comprehensive
2 tobacco cessation services covered in the State
3 plan among—

4 “(i) individuals who are likely to be el-
5 ible for medical assistance under the
6 State plan; and

7 “(ii) clinicians and others who provide
8 services to individuals who are likely to be
9 eligible for medical assistance under the
10 State plan; and

11 “(B) increase awareness of the benefits of
12 using comprehensive tobacco cessation services
13 covered in the State plan among—

14 “(i) individuals who are likely to be el-
15 ible for medical assistance under the
16 State plan; and

17 “(ii) clinicians and others who provide
18 services to individuals who are likely to be
19 eligible for medical assistance under the
20 State plan about the benefits of using com-
21 prehensive tobacco cessation services, for
22 calendar quarters occurring during the pe-
23 riod beginning on the date of the enact-
24 ment of this paragraph and ending on the
25 date that is 5 years after the date of enact-

1 ment of this paragraph, an amount equal
 2 to 90 percent of the sums expended during
 3 each quarter which are attributable to such
 4 development, implementation, and evalua-
 5 tion, and for calendar quarters succeeding
 6 such period, an amount equal to Federal
 7 medical assistance percentage determined
 8 under section 1905(b) of the sums ex-
 9 pended during each quarter which are so
 10 attributable.”.

11 (f) NO PRIOR AUTHORIZATION FOR TOBACCO CES-
 12 sation drugs under Medicaid.—Section 1927(d) of
 13 the Social Security Act (42 U.S.C. 1396r–8(d)) is amend-
 14 ed—

15 (1) in paragraph (1)(A), by striking “A State”
 16 and inserting “Subject to paragraph (8), a State”;
 17 and

18 (2) by adding at the end the following new
 19 paragraph:

20 “(8) NO PRIOR AUTHORIZATION PROGRAMS FOR
 21 TOBACCO CESSATION DRUGS.—A State plan may not
 22 require, as a condition of coverage or payment for
 23 a covered outpatient drug, the approval of an agent
 24 to promote smoking cessation (including agents ap-

1 proved by the Food and Drug Administration) or to-
 2 bacco cessation.”.

3 (g) EXCLUSION OF ENHANCED PAYMENTS FROM
 4 TERRITORIAL CAPS.—Notwithstanding any other provi-
 5 sion of law, for purposes of section 1108 of the Social Se-
 6 curity Act (42 U.S.C. 1308), with respect to any addi-
 7 tional amount paid to a territory as a result of the applica-
 8 tion of section 1905(bb)(2) of the Social Security Act (42
 9 U.S.C. 1396d(bb)(2))—

10 (1) the limitation on payments to territories
 11 under subsections (f) and (g) of such section 1108
 12 shall not apply to such additional amounts; and

13 (2) such additional amounts shall be dis-
 14 regarded in applying such subsections.

15 (h) REQUIRING CHIP COVERAGE OF COUNSELING
 16 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
 17 USE.—

18 (1) IN GENERAL.—Section 2103(c)(2) of the
 19 Social Security Act (42 U.S.C. 1397cc(c)(2)) is
 20 amended by adding at the end the following new
 21 subparagraph:

22 “(D) Counseling and pharmacotherapy for
 23 cessation of tobacco use by individuals who are
 24 eligible under the State child health plan.”.

1 (2) COUNSELING AND PHARMACOTHERAPY FOR
2 CESSATION OF TOBACCO USE DEFINED.—Section
3 2110(c) of the Social Security Act (42 U.S.C.
4 1397jj(c)) is amended by adding at the end the fol-
5 lowing new paragraph:

6 “(10) COUNSELING AND PHARMACOTHERAPY
7 FOR CESSATION OF TOBACCO USE.—The term ‘coun-
8 seling and pharmacotherapy for cessation of tobacco
9 use’ means diagnostic, therapy, and counseling serv-
10 ices and pharmacotherapy (including the coverage of
11 prescription and nonprescription tobacco cessation
12 agents approved by the Food and Drug Administra-
13 tion) for the cessation of tobacco use by individuals
14 who use tobacco products or who are being treated
15 for tobacco use that are furnished—

16 “(A) by or under the supervision of a phy-
17 sician; or

18 “(B) by any other health care professional
19 who—

20 “(i) is legally authorized to furnish
21 such services under State law (or the State
22 regulatory mechanism provided by State
23 law) of the State in which the services are
24 furnished; and

1 “(ii) is authorized to receive payment
 2 for other services under this title or is des-
 3 ignated by the Secretary for this purpose,
 4 which is recommended in the guideline en-
 5 titled, ‘Treating Tobacco Use and Depend-
 6 ence: 2008 Update: A Clinical Practice
 7 Guideline’ published by the Public Health
 8 Service in May 2008 (or any subsequent
 9 modification of such guideline) or is rec-
 10 ommended for the cessation of tobacco use
 11 by the United States Preventive Services
 12 Task Force or any additional intervention
 13 approved by the Food and Drug Adminis-
 14 tration as safe and effective in helping
 15 smokers quit.”.

16 (i) NO COST SHARING.—Section 2103(e) of the So-
 17 cial Security Act (42 U.S.C. 1397cc(e)) is amended by
 18 adding at the end the following new paragraph:

19 “(5) NO COST SHARING ON BENEFITS FOR
 20 COUNSELING AND PHARMACOTHERAPY FOR CES-
 21 SATION OF TOBACCO USE.—The State child health
 22 plan may not impose deductibles, coinsurance, or
 23 other cost sharing with respect to benefits for coun-
 24 seling and pharmacotherapy for cessation of tobacco
 25 use (as defined in section 2110(c)(10)) and prescrip-

1 tion drugs that are covered under a State child
 2 health plan that are prescribed for purposes of pro-
 3 moting tobacco cessation in accordance with the
 4 guideline specified in section 2110(c)(10)(B).”.

5 (j) EXCEPTION FROM OPTIONAL RESTRICTION
 6 UNDER CHIP PRESCRIPTION DRUG COVERAGE.—Section
 7 2103 of the Social Security Act (42 U.S.C. 1397cc) is
 8 amended by adding at the end the following new sub-
 9 section:

10 “(g) EXCEPTION FROM OPTIONAL RESTRICTION
 11 UNDER CHIP PRESCRIPTION DRUG COVERAGE.—The
 12 State child health plan may exclude or otherwise restrict
 13 nonprescription drugs, except, in the case of—

14 “(1) pregnant women when recommended in ac-
 15 cordance with the guideline specified in section
 16 2110(c)(10)(B), agents approved by the Food and
 17 Drug Administration under the over-the-counter
 18 monograph process for purposes of promoting to-
 19 bacco cessation; and

20 “(2) individuals who are eligible under the
 21 State child health plan when recommended in ac-
 22 cordance with the Guideline referred to in section
 23 2110(c)(10)(B), agents approved by the Food and
 24 Drug Administration under the over-the-counter

1 monograph process for purposes of promoting to-
 2 bacco cessation.”.

3 (k) STATE MONITORING AND PROMOTING OF COM-
 4 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
 5 CHIP.—Section 2102 of the Social Security Act (42
 6 U.S.C. 1397bb) is amended by adding at the end the fol-
 7 lowing new subsection:

8 “(e) STATE MONITORING AND PROMOTING OF COM-
 9 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
 10 CHIP.—A State child health plan shall include a descrip-
 11 tion of the procedures to be used by the State to monitor
 12 and promote the use of comprehensive tobacco cessation
 13 services under the State plan (including conducting an
 14 outreach campaign to increase awareness of the benefits
 15 of using such services) among—

16 “(1) individuals entitled to medical assistance
 17 under the State child health plan who use tobacco
 18 products; and

19 “(2) clinicians and others who provide services
 20 to individuals entitled to medical assistance under
 21 the State child health plan.”.

22 (l) FEDERAL REIMBURSEMENT FOR CHIP COV-
 23 ERAGE AND OUTREACH CAMPAIGN.—

1 (1) IN GENERAL.—Section 2105(a) of the So-
2 cial Security Act (42 U.S.C. 1397ee(a)) is amended
3 by adding at the end the following new paragraph:

4 “(5) FEDERAL REIMBURSEMENT FOR CHIP
5 COVERAGE OF COMPREHENSIVE TOBACCO CES-
6 SATION SERVICES AND OUTREACH CAMPAIGN.—In
7 addition to the payments made under paragraph (1)
8 for calendar quarters occurring during the period be-
9 ginning on the date of the enactment of this para-
10 graph and ending 5 years after such date, the Sec-
11 retary shall pay—

12 “(A) an amount equal to 90 percent of the
13 sums expended during each quarter which are
14 attributable to the cost of furnishing counseling
15 and pharmacotherapy for cessation of tobacco
16 use by individuals who are eligible under the
17 State child health plan (net of any payments
18 made to the State under paragraph (1) with re-
19 spect to such counseling and pharmacotherapy);
20 plus

21 “(B) an amount equal to 90 percent of the
22 sums expended during each quarter which are
23 attributable to the development, implementa-
24 tion, and evaluation of an outreach campaign
25 to—

1 “(i) increase awareness of comprehen-
2 sive tobacco cessation services covered in
3 the State child health plan among—

4 “(I) individuals who are likely to
5 be eligible for medical assistance
6 under the State child health plan; and

7 “(II) clinicians and others who
8 provide services to individuals who are
9 likely to be eligible for medical assist-
10 ance under the State child health
11 plan; and

12 “(ii) increase awareness of the bene-
13 fits of using comprehensive tobacco ces-
14 sation services covered in the State child
15 health plan among—

16 “(I) individuals who are likely to
17 be eligible for medical assistance
18 under the State child health plan; and

19 “(II) clinicians and others who
20 provide services to individuals who are
21 likely to be eligible for medical assist-
22 ance under the State child health plan
23 about the benefits of using com-
24 prehensive tobacco cessation serv-
25 ices.”.

1 (2) ADJUSTMENT OF CHIP ALLOTMENTS.—Sec-
 2 tion 2104(m) of the Social Security Act (42 U.S.C.
 3 1397dd(m)) is amended—

4 (A) in paragraph (2)(B), by striking “and
 5 (12)” and inserting “(12), and (13)”; and

6 (B) by adding at the end the following new
 7 paragraph:

8 “(13) ADJUSTING ALLOTMENTS TO ACCOUNT
 9 FOR FEDERAL PAYMENTS FOR CHIP COVERAGE OF
 10 COMPREHENSIVE TOBACCO CESSATION SERVICES
 11 AND OUTREACH CAMPAIGN.—If a State (including
 12 the District of Columbia and each commonwealth
 13 and territory) receives a payment for a fiscal year
 14 under section 2105(a)(5), the allotment determined
 15 for the State for such fiscal year shall be increased
 16 by the amount of such payment.”.

17 (m) NO PRIOR AUTHORIZATION FOR TOBACCO CES-
 18 SATION DRUGS UNDER CHIP.—Section 2103 of the So-
 19 cial Security Act (42 U.S.C. 1397cc), as amended by sub-
 20 section (h), is further amended—

21 (1) in subsection (c)(2)(A), by inserting “(in ac-
 22 cordance with subsection (h))” after “Coverage of
 23 prescription drugs”; and

24 (2) by adding at the end the following new sub-
 25 section:

1 “(h) NO PRIOR AUTHORIZATION PROGRAMS FOR TO-
 2 BACCO CESSATION DRUGS.—A State child health plan
 3 may not require, as a condition of coverage or payment
 4 for prescription drugs, the approval of an agent to pro-
 5 mote smoking cessation (including agents approved by the
 6 Food and Drug Administration) or tobacco cessation.”.

7 (n) COMPREHENSIVE COVERAGE OF TOBACCO CES-
 8 SATION COVERAGE IN PRIVATE HEALTH INSURANCE.—
 9 Section 2713 of the Public Health Service Act (42 U.S.C.
 10 300gg–13) is amended by adding at the end the following:

11 “(d) NO PRIOR AUTHORIZATION.—A group health
 12 plan and a health insurance issuer offering group or indi-
 13 vidual health insurance coverage shall not impose any
 14 prior authorization requirement for tobacco cessation
 15 counseling and pharmacotherapy that has in effect a rat-
 16 ing of ‘A’ or ‘B’ in the current recommendations of the
 17 United States Preventive Services Task Force.”.

18 (o) RULE OF CONSTRUCTION.—None of the amend-
 19 ments made by this section shall be construed to limit cov-
 20 erage of any counseling or pharmacotherapy for individ-
 21 uals under 18 years of age.

22 (p) EFFECTIVE DATE.—The amendments made by
 23 this section shall take effect on the first day of the first
 24 fiscal year that begins on or after the date of enactment
 25 of this Act.

1 **SEC. 7306. CLINICAL RESEARCH FUNDING FOR ORAL**
2 **HEALTH.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services shall expand and intensify the conduct
5 and support of the research activities of the National In-
6 stitutes of Health and the National Institute of Dental
7 and Craniofacial Research to improve the oral health of
8 the population through the prevention and management
9 of oral diseases and conditions.

10 (b) INCLUDED RESEARCH ACTIVITIES.—Research
11 activities under subsection (a) shall include—

12 (1) comparative effectiveness research and clin-
13 ical disease management research addressing early
14 childhood cancer and oral cancer; and

15 (2) awarding of grants and contracts to support
16 the training and development of health services re-
17 searchers, comparative effectiveness researchers, and
18 clinical researchers whose research improves the oral
19 health of the population.

20 **SEC. 7307. GUIDE ON EVIDENCE-BASED STRATEGIES FOR**
21 **PUBLIC HEALTH DEPARTMENT OBESITY PRE-**
22 **VENTION PROGRAMS.**

23 (a) DEVELOPMENT AND DISSEMINATION OF AN EVI-
24 DENCE-BASED STRATEGIES GUIDE.—The Secretary of
25 Health and Human Services (referred to in this section
26 as the “Secretary”), acting through the Director of the

1 Centers for Disease Control and Prevention, not later than
2 2 years after the date of enactment of this Act, shall—

3 (1) develop a guide on evidence-based strategies
4 for State, territorial, and local health departments to
5 use to build and maintain effective obesity preven-
6 tion and reduction programs, and, in consultation
7 with stakeholders that have expertise in Tribal
8 health, a guide on such evidence-based strategies
9 with respect to Indian Tribes and Tribal organiza-
10 tions for such Indian Tribes and Tribal organiza-
11 tions to use for such purpose, both of which guides
12 shall—

13 (A) describe an integrated program struc-
14 ture for implementing interventions proven to
15 be effective in preventing and reducing the inci-
16 dence of obesity; and

17 (B) recommend—

18 (i) optimal resources, including staff-
19 ing and infrastructure, for promoting nu-
20 trition and obesity prevention and reduc-
21 tion; and

22 (ii) strategies for effective obesity pre-
23 vention programs for State and local
24 health departments, Indian Tribes, and

1 Tribal organizations, including strategies
2 related to—

3 (I) the application of evidence-
4 based and evidence-informed practices
5 to prevent and reduce obesity rates;

6 (II) the development, implemen-
7 tation, and evaluation of obesity pre-
8 vention and reduction strategies for
9 specific communities and populations;

10 (III) demonstrated knowledge of
11 obesity prevention practices that re-
12 duce associated preventable diseases,
13 health conditions, death, and health
14 care costs;

15 (IV) best practices for the coordi-
16 nation of efforts to prevent and re-
17 duce obesity and related chronic dis-
18 eases;

19 (V) addressing the underlying
20 risk factors and social determinants of
21 health that impact obesity rates; and

22 (VI) interdisciplinary coordina-
23 tion between relevant public health of-
24 ficials specializing in fields such as
25 nutrition, physical activity, epidemi-

1 ology, communications, and policy im-
 2 plementation, and collaboration be-
 3 tween public health officials and com-
 4 munity-based organizations; and

5 (2) disseminate the guides and current re-
 6 search, evidence-based practices, tools, and edu-
 7 cational materials related to obesity prevention, con-
 8 sistent with the guides, to State and local health de-
 9 partments, Indian Tribes, and Tribal organizations.

10 (b) TECHNICAL ASSISTANCE.—The Secretary, acting
 11 through the Director of the Centers for Disease Control
 12 and Prevention, shall provide technical assistance to State
 13 and local health departments, Indian Tribes, and Tribal
 14 organizations to support such health departments in im-
 15 plementing the guides developed under subsection (a)(1).

16 (c) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—In
 17 this section, the terms “Indian Tribe” and “Tribal organi-
 18 zation” have the meanings given the terms in section 4
 19 of the Indian Self-Determination and Education Assist-
 20 ance Act (25 U.S.C. 5304).

21 **SEC. 7308. STEPHANIE TUBBS JONES UTERINE FIBROID RE-**
 22 **SEARCH AND EDUCATION ACT.**

23 (a) RESEARCH WITH RESPECT TO UTERINE
 24 FIBROIDS.—

1 (1) RESEARCH.—The Secretary of Health and
2 Human Services (referred to in this section as the
3 “Secretary”) shall expand, intensify, and coordinate
4 programs for the conduct and support of research
5 with respect to uterine fibroids.

6 (2) ADMINISTRATION AND COORDINATION.—
7 The Secretary shall carry out the conduct and sup-
8 port of research pursuant to paragraph (1), in co-
9 ordination with the appropriate institutes, offices,
10 and centers of the National Institutes of Health and
11 any other relevant Federal agency, as determined by
12 the Director of the National Institutes of Health.

13 (3) AUTHORIZATION OF APPROPRIATIONS.—For
14 the purpose of carrying out this subsection, there
15 are authorized to be appropriated \$30,000,000 for
16 each of fiscal years 2027 through 2031.

17 (b) RESEARCH WITH RESPECT TO MEDICAID COV-
18 ERAGE OF UTERINE FIBROIDS TREATMENT.—

19 (1) RESEARCH.—The Secretary (or the Sec-
20 retary’s designee) shall establish a research data-
21 base, or expand an existing research database, to
22 collect data on services furnished to individuals diag-
23 nosed with uterine fibroids under a State plan (or a
24 waiver of such a plan) under the Medicaid program
25 under title XIX of the Social Security Act (42

1 U.S.C. 1396 et seq.) or under a State child health
2 plan (or a waiver of such a plan) under the Chil-
3 dren's Health Insurance Program under title XXI of
4 such Act (42 U.S.C. 1397aa et seq.) for the treat-
5 ment of such fibroids for purposes of assessing the
6 frequency at which such individuals are furnished
7 such services.

8 (2) REPORT.—

9 (A) IN GENERAL.—Not later than 2 years
10 after the date of enactment of this Act, the Sec-
11 retary shall submit to Congress a report on the
12 amount of Federal and State expenditures with
13 respect to services furnished for the treatment
14 of uterine fibroids under State plans (or waivers
15 of such plans) under the Medicaid program
16 under such title XIX and State child health
17 plans (or waivers of such plans) under the Chil-
18 dren's Health Insurance Program under such
19 title XXI.

20 (B) COORDINATION.—The Secretary shall
21 coordinate the development and submission of
22 the report required under paragraph (1) with
23 any other relevant Federal agency, as deter-
24 mined by the Secretary.

1 (c) EDUCATION AND DISSEMINATION OF INFORMA-
2 TION WITH RESPECT TO UTERINE FIBROIDS.—

3 (1) UTERINE FIBROIDS PUBLIC EDUCATION
4 PROGRAM.—The Secretary shall develop and dis-
5 seminate to the public information regarding uterine
6 fibroids, including information on—

7 (A) the awareness, incidence, and preva-
8 lence of uterine fibroids among individuals, in-
9 cluding all minority individuals;

10 (B) the elevated risk for minority individ-
11 uals to develop uterine fibroids; and

12 (C) the availability, as medically appro-
13 priate, of the range of treatment options for
14 symptomatic uterine fibroids, including non-
15 hysterectomy treatments and procedures.

16 (2) DISSEMINATION OF INFORMATION.—The
17 Secretary may disseminate information under para-
18 graph (1) directly or through arrangements with
19 intra-agency initiatives, nonprofit organizations, con-
20 sumer groups, institutions of higher education (as
21 defined in section 101 of the Higher Education Act
22 of 1965 (20 U.S.C. 1001)), or Federal, State, or
23 local public private partnerships.

24 (3) AUTHORIZATION OF APPROPRIATIONS.—For
25 the purpose of carrying out this subsection, there

1 are authorized to be appropriated such sums as may
2 be necessary for each of fiscal years 2027 through
3 2031.

4 (d) INFORMATION TO HEALTH CARE PROVIDERS
5 WITH RESPECT TO UTERINE FIBROIDS.—

6 (1) DISSEMINATION OF INFORMATION.—The
7 Secretary shall, in consultation and in accordance
8 with guidelines from relevant medical societies, work
9 with health care-related specialty societies and
10 health systems to promote evidence-based care for
11 individuals with fibroids. Such efforts shall include
12 minority individuals who have an elevated risk to de-
13 velop uterine fibroids and the range of available op-
14 tions for the treatment of symptomatic uterine
15 fibroids, including non-hysterectomy drugs and de-
16 vices approved under the Federal Food, Drug, and
17 Cosmetic Act (21 U.S.C. 301 et seq.).

18 (2) AUTHORIZATION OF APPROPRIATIONS.—For
19 the purpose of carrying out this subsection, there
20 are authorized to be appropriated such sums as may
21 be necessary for each of fiscal years 2027 through
22 2031.

23 (e) DEFINITION.—In this section, the term “minority
24 individuals” means individuals who are members of a ra-
25 cial and ethnic minority group, as defined in section

1 1707(g) of the Public Health Service Act (42 U.S.C.
2 300u-6(g)).

3 **Subtitle E—HIV/AIDS**

4 **SEC. 7401. STATEMENT OF POLICY.**

5 It is the policy of the United States to achieve an
6 AIDS-free generation, and to—

7 (1) expand access to lifesaving antiretroviral
8 therapy for people living with HIV and immediately
9 link people to continuous and coordinated high-quality
10 care when they learn they are living with HIV;

11 (2) expand targeted efforts to prevent HIV in-
12 fection using a combination of effective, evidence-
13 based approaches, including routine HIV screening,
14 and universal access to HIV prevention tools, includ-
15 ing preexposure prophylaxis, in communities dis-
16 proportionately impacted by HIV, particularly com-
17 munities of color;

18 (3) ensure laws, policies, and regulations do not
19 impede access to prevention, treatment, and care for
20 people living with HIV or disproportionately im-
21 pacted by HIV;

22 (4) accelerate research for more efficacious HIV
23 prevention and treatments, tools, a cure, and a vac-
24 cine; and

1 (5) respect the human rights and dignity of
2 persons living with HIV.

3 **SEC. 7402. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
4 **ANCE PROGRAM TREATMENTS.**

5 Section 2623 of the Public Health Service Act (42
6 U.S.C. 300ff–31b) is amended by adding at the end the
7 following:

8 “(c) ADDITIONAL FUNDING FOR AIDS DRUG AS-
9 SISTANCE PROGRAM TREATMENTS.—In addition to
10 amounts otherwise authorized to be appropriated for car-
11 rying out this subpart, there are authorized to be appro-
12 priated such sums as may be necessary to carry out sec-
13 tions 2612(b)(3)(B) and 2616 for each of fiscal years
14 2027 through 2030.”.

15 **SEC. 7403. ENHANCING THE NATIONAL HIV SURVEILLANCE**
16 **SYSTEM.**

17 (a) GRANTS.—The Secretary of Health and Human
18 Services, acting through the Director of the Centers for
19 Disease Control and Prevention, shall make grants to
20 States to support integration of public health surveillance
21 systems into all electronic health records in order to allow
22 rapid communications between the clinical setting and
23 health departments, by means that include—

24 (1) providing technical assistance and policy
25 guidance to State and local health departments, clin-

1 ical providers, and other agencies serving individuals
2 with HIV to improve the interoperability of data sys-
3 tems relevant to monitoring HIV care and sup-
4 portive services;

5 (2) capturing longitudinal data pertaining to
6 the initiation and ongoing prescription or dispensing
7 of antiretroviral therapy for individuals diagnosed
8 with HIV (such as through pharmacy-based report-
9 ing);

10 (3) obtaining information—

11 (A) on a voluntary basis, on sexual orienta-
12 tion and gender identity; and

13 (B) on sources of coverage (or the lack of
14 coverage) for medical treatment (including cov-
15 erage through the Medicaid program under title
16 XIX of the Social Security Act (42 U.S.C. 1396
17 et seq.), the Medicare program under title
18 XVIII of such Act (42 U.S.C. 1395 et seq.), the
19 program under title XXVI of the Public Health
20 Service Act (42 U.S.C. 300ff–11 et seq.; com-
21 monly referred to as the “Ryan White HIV/
22 AIDS Program”), other public funding, private
23 insurance, and health maintenance organiza-
24 tions); and

1 (4) obtaining and using current geographic
2 markers of residence (such as current address, ZIP
3 Code, partial ZIP Code, and census block).

4 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
5 rying out this section, the Secretary of Health and Human
6 Services shall ensure that appropriate privacy and security
7 safeguards are met to prevent unauthorized disclosure of
8 protected health information and compliance with the
9 HIPAA privacy and security law (as defined in section
10 3009 of the Public Health Service Act (42 U.S.C. 300jj–
11 19)) and other relevant laws and regulations.

12 (c) PROHIBITION AGAINST IMPROPER USE OF
13 DATA.—No grant under this section may be used to allow
14 or facilitate the collection or use of surveillance or clinical
15 data or records—

16 (1) for punitive measures of any kind, civil or
17 criminal, against the subject of such data or records;
18 or

19 (2) for imposing any requirement or restriction
20 with respect to an individual without the individual’s
21 written consent.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
23 out this section, there are authorized to be appropriated
24 such sums as may be necessary for each of fiscal years
25 2027 through 2030.

1 **SEC. 7404. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
2 **LINKAGE TO, AND RETENTION IN, APPRO-**
3 **PRIATE CARE.**

4 (a) STRATEGIES.—The Secretary of Health and
5 Human Services, in collaboration with the Director of the
6 Centers for Disease Control and Prevention, the Assistant
7 Secretary for Mental Health and Substance Use, the Di-
8 rector of the Office of AIDS Research, the Administrator
9 of the Health Resources and Services Administration, and
10 the Administrator of the Centers for Medicare & Medicaid
11 Services, shall—

12 (1) identify evidence-based strategies most ef-
13 fective at addressing the multifaceted issues that im-
14 pede disease status awareness with respect to HIV/
15 AIDS and linkage to, and retention in, appropriate
16 care, taking into consideration health care systems
17 issues, clinic and provider issues, and individual psy-
18 chosocial, environmental, and other contextual fac-
19 tors;

20 (2) support the wide-scale implementation of
21 the evidence-based strategies identified pursuant to
22 paragraph (1), including through incorporating such
23 strategies into health care coverage supported by the
24 Medicaid program under title XIX of the Social Se-
25 curity Act (42 U.S.C. 1396 et seq.), the program
26 under title XXVI of the Public Health Service Act

1 (42 U.S.C. 300ff–11 et seq.; commonly referred to
 2 as the “Ryan White HIV/AIDS Program”), and
 3 health plans purchased through an Exchange estab-
 4 lished under title I of the Patient Protection and Af-
 5 fordable Care Act (Public Law 111–148); and

6 (3) not later than 1 year after the date of the
 7 enactment of this Act, submit a report to the Con-
 8 gress on the status of activities under paragraphs
 9 (1) and (2).

10 (b) **AUTHORIZATION OF APPROPRIATIONS.**—To carry
 11 out this section, there are authorized to be appropriated
 12 such sums as may be necessary for fiscal years 2027
 13 through 2030.

14 **SEC. 7405. IMPROVING ENTRY INTO, AND RETENTION IN,**
 15 **CARE AND ANTIRETROVIRAL ADHERENCE**
 16 **FOR PERSONS WITH HIV.**

17 (a) **SENSE OF CONGRESS.**—It is the sense of Con-
 18 gress that AIDS research has led to scientific advance-
 19 ments that have—

20 (1) saved the lives of millions of people living
 21 with HIV;

22 (2) prevented millions of individuals from re-
 23 ceiving new diagnoses of HIV; and

24 (3) had broad benefits that extend far beyond
 25 helping people at risk for, or living with, HIV.

1 (b) IN GENERAL.—The Secretary of Health and
2 Human Services, acting through the Director of the Na-
3 tional Institutes of Health, shall expand, intensify, and co-
4 ordinate operational and translational research and other
5 activities of the National Institutes of Health regarding
6 methods—

7 (1) to increase adoption of evidence-based ad-
8 herence strategies within HIV care and treatment
9 programs;

10 (2) to increase HIV testing and case detection
11 rates;

12 (3) to reduce HIV-related health disparities;

13 (4) to ensure that research to improve adher-
14 ence to HIV care and treatment programs address
15 the unique concerns of women;

16 (5) to integrate HIV prevention and care serv-
17 ices with mental health and substance use preven-
18 tion and treatment delivery systems;

19 (6) to increase knowledge on the implementa-
20 tion of preexposure prophylaxis (referred to in this
21 section as “PrEP”), including with respect to—

22 (A) who can benefit most from PrEP;

23 (B) how to provide PrEP safely and effi-
24 ciently;

1 (C) how to integrate PrEP with other es-
2 sential prevention methods such as condoms;
3 and

4 (D) how to ensure high levels of adherence;
5 and

6 (7) to increase knowledge of “undetectable and
7 untransmittable”, when a person living with HIV
8 who is on antiretroviral therapy and is durably
9 virally suppressed (defined as having a consistent
10 viral load of less than 200 copies/ml) cannot sexually
11 transmit HIV.

12 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there are authorized to be appropriated
14 such sums as may be necessary for fiscal years 2027
15 through 2030.

16 **SEC. 7406. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
17 **ETHNIC MINORITY COMMUNITIES.**

18 (a) IN GENERAL.—For the purpose of reducing new
19 HIV diagnoses in racial and ethnic minority communities,
20 the Secretary of Health and Human Services, acting
21 through the Deputy Assistant Secretary for Minority
22 Health, may make grants to public health agencies and
23 faith-based organizations to conduct—

24 (1) outreach activities related to HIV preven-
25 tion and testing activities;

- 1 (2) HIV prevention activities;
- 2 (3) HIV testing activities; and
- 3 (4) public health education campaigns on ac-
- 4 cessing HIV prevention medication.

5 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
6 out this section, there are authorized to be appropriated
7 such sums as may be necessary for fiscal years 2027
8 through 2030.

9 **SEC. 7407. MINORITY AIDS INITIATIVE.**

10 (a) EXPANDED FUNDING.—The Secretary of Health
11 and Human Services, in collaboration with the Deputy As-
12 sistant Secretary for Minority Health, the Director of the
13 Centers for Disease Control and Prevention, the Adminis-
14 trator of the Health Resources and Services Administra-
15 tion, and the Assistant Secretary for Mental Health and
16 Substance Use, shall provide funds and carry out activities
17 to expand the Minority AIDS Initiative.

18 (b) USE OF FUNDS.—The additional funds made
19 available under this section may be used, through the Mi-
20 nority AIDS Initiative, to support the following activities:

- 21 (1) Providing technical assistance and infra-
22 structure support to reduce HIV/AIDS in minority
23 populations.
- 24 (2) Increasing minority populations' access to
25 HIV prevention and care services.

1 (3) Building strong community programs and
2 partnerships to address HIV prevention and the
3 health care needs of specific racial and ethnic minor-
4 ity populations.

5 (c) PRIORITY INTERVENTIONS.—Within the racial
6 and ethnic minority populations referred to in subsection
7 (b), priority in conducting intervention services shall be
8 given to—

9 (1) men who have sex with men;

10 (2) youth;

11 (3) persons who engage in intravenous drug
12 abuse;

13 (4) women;

14 (5) homeless individuals;

15 (6) individuals incarcerated or in the penal sys-
16 tem;

17 (7) transgender individuals; and

18 (8) nonbinary individuals.

19 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
20 rying out this section, there are authorized to be appro-
21 priated \$610,000,000 for fiscal year 2027 and such sums
22 as may be necessary for each of fiscal years 2028 through
23 2031.

1 **SEC. 7408. HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV.**
2

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services, acting through the Administrator of the
5 Health Resources and Services Administration, shall ex-
6 pand, intensify, and coordinate workforce initiatives of the
7 Health Resources and Services Administration to increase
8 the capacity of the health workforce focusing primarily on
9 HIV to meet the demand for culturally competent care,
10 and may award grants for any of the following:

11 (1) Development of curricula for training pri-
12 mary care providers in HIV/AIDS prevention and
13 care, including routine HIV testing.

14 (2) Support to expand access to culturally and
15 linguistically accessible benefits counselors, trained
16 peer navigators, and mental and behavioral health
17 professionals with expertise in HIV.

18 (3) Training health care professionals to pro-
19 vide care to individuals living with HIV.

20 (4) Development by grant recipients under title
21 XXVI of the Public Health Service Act (42 U.S.C.
22 300ff–11 et seq.; commonly referred to as the “Ryan
23 White HIV/AIDS Program”) and other persons, of
24 policies for providing culturally relevant and sen-
25 sitive treatment to individuals living with HIV, with
26 particular emphasis on treatment to racial and eth-

1 nic minorities, men who have sex with men, and
2 women, young people, and children living with HIV.

3 (5) Development and implementation of pro-
4 grams to increase the use of telehealth to respond to
5 HIV-specific health care needs in rural and minority
6 communities, with particular emphasis given to
7 medically underserved communities and insular
8 areas.

9 (6) Evaluating interdisciplinary medical pro-
10 vider care team models that promote high-quality
11 care, with particular emphasis on care to racial and
12 ethnic minorities.

13 (7) Training health care professionals to make
14 them aware of the high rates of chronic hepatitis B
15 and chronic hepatitis C in adult racial and ethnic
16 minority populations, and the importance of preven-
17 tion, detection, and medical management of hepatitis
18 B and hepatitis C and of liver cancer screening.

19 (8) Development of curricula for training pri-
20 mary care providers that HIV and tuberculosis are
21 significant mutual comorbidities, and that a patient
22 who tests positive for one disease should be offered
23 and encouraged to receive testing for the other.

24 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
25 out this section, there are authorized to be appropriated

1 such sums as may be necessary for fiscal years 2027
2 through 2030.

3 **SEC. 7409. HIV/AIDS PROVIDER LOAN REPAYMENT PRO-**
4 **GRAM.**

5 (a) IN GENERAL.—The Secretary may enter into an
6 agreement with any physician, nurse practitioner, or phy-
7 sician assistant under which—

8 (1) the physician, nurse practitioner, or physi-
9 cian assistant agrees to serve as a medical provider
10 for a period of not less than 2 years—

11 (A) at a Ryan White-funded or title X-
12 funded facility with a critical shortage of doc-
13 tors (as determined by the Secretary); or

14 (B) in an area with a high incidence of
15 HIV/AIDS; and

16 (2) the Secretary agrees to make payments in
17 accordance with subsection (b) on the professional
18 education loans of the physician, nurse practitioner,
19 or physician assistant.

20 (b) MANNER OF PAYMENTS.—The payments de-
21 scribed in subsection (a) shall be made by the Secretary
22 as follows:

23 (1) Upon completion by the physician, nurse
24 practitioner, or physician assistant for whom the
25 payments are to be made of the first year of the

1 service specified in the agreement entered into with
2 the Secretary under subsection (a), the Secretary
3 shall pay 30 percent of the principal of and the in-
4 terest on the individual's professional education
5 loans.

6 (2) Upon completion by the physician, nurse
7 practitioner, or physician assistant of the second
8 year of such service, the Secretary shall pay another
9 30 percent of the principal of and the interest on
10 such loans.

11 (3) Upon completion by that individual of a
12 third year of such service, the Secretary shall pay
13 another 25 percent of the principal of and the inter-
14 est on such loans.

15 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
16 part III of part D of title III of the Public Health Service
17 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent
18 with this section, apply to the program carried out under
19 this section in the same manner and to the same extent
20 as such provisions apply to the National Health Service
21 Corps loan repayment program.

22 (d) REPORTS.—Not later than 18 months after the
23 date of the enactment of this Act, and annually thereafter,
24 the Secretary shall prepare and submit to Congress a re-

1 port describing the program carried out under this section,
2 including statements regarding the following:

3 (1) The number of physicians, nurse practi-
4 tioners, and physician assistants enrolled in the pro-
5 gram.

6 (2) The number and amount of loan repay-
7 ments provided through the program.

8 (3) The placement location of loan repayment
9 recipients at facilities described in subsection (a)(1).

10 (4) The default rate on such loans and actions
11 required.

12 (5) The amount of outstanding default funds
13 with respect to such loans.

14 (6) To the extent that it can be determined, the
15 reason for the default on such a loan.

16 (7) The demographics of individuals partici-
17 pating in the program.

18 (8) An evaluation of the overall costs and bene-
19 fits of the program.

20 (e) DEFINITIONS.—In this section:

21 (1) HIV/AIDS.—The term “HIV/AIDS” means
22 human immunodeficiency virus and acquired im-
23 mune deficiency syndrome.

24 (2) NURSE PRACTITIONER.—The term “nurse
25 practitioner” means a registered nurse who has com-

1 pleted an accredited graduate degree program in ad-
2 vanced nurse practice and has successfully passed a
3 national certification exam.

4 (3) PHYSICIAN.—The term “physician” means
5 a graduate of a school of medicine who has com-
6 pleted postgraduate training in general or pediatric
7 medicine.

8 (4) PHYSICIAN ASSISTANT.—The term “physi-
9 cian assistant” means a medical provider who com-
10 pleted an accredited physician assistant training pro-
11 gram and successfully passed the Physician Assist-
12 ant National Certifying Examination.

13 (5) PROFESSIONAL EDUCATION LOAN.—The
14 term “professional education loan”—

15 (A) means a loan that is incurred for the
16 cost of attendance (including tuition, other rea-
17 sonable educational expenses, and reasonable
18 living costs) at a school of medicine, school of
19 nursing, or physician assistant training pro-
20 gram; and

21 (B) includes only the portion of the loan
22 that is outstanding on the date the physician,
23 nurse practitioner, or physician assistant in-
24 volved begins the service specified in the agree-
25 ment under subsection (a).

1 (6) RYAN WHITE-FUNDED.—The term “Ryan
2 White-funded” means, with respect to a facility, re-
3 ceiving funds under title XXVI of the Public Health
4 Service Act (42 U.S.C. 300ff–11 et seq.).

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

7 (8) SCHOOL OF MEDICINE.—The term “school
8 of medicine” has the meaning given to that term in
9 section 799B of the Public Health Service Act (42
10 U.S.C. 295p).

11 (9) TITLE X-FUNDED.—The term “title X-fund-
12 ed” means, with respect to a facility, receiving funds
13 under title X of the Public Health Service Act (42
14 U.S.C. 300 et seq.).

15 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
16 out this section, there are authorized to be appropriated
17 such sums as may be necessary for fiscal years 2027
18 through 2030.

19 **SEC. 7410. DENTAL EDUCATION LOAN REPAYMENT PRO-**
20 **GRAM.**

21 (a) IN GENERAL.—The Secretary may enter into an
22 agreement with any dentist under which—

23 (1) the dentist agrees to serve as a dentist for
24 a period of not less than 2 years at a facility with
25 a critical shortage of dentists (as determined by the

1 Secretary) in an area with a high incidence of HIV/
2 AIDS; and

3 (2) the Secretary agrees to make payments in
4 accordance with subsection (b) on the dental edu-
5 cation loans of the dentist.

6 (b) MANNER OF PAYMENTS.—The payments de-
7 scribed in subsection (a) shall be made by the Secretary
8 as follows:

9 (1) Upon completion by the dentist for whom
10 the payments are to be made of the first year of the
11 service specified in the agreement entered into with
12 the Secretary under subsection (a), the Secretary
13 shall pay 30 percent of the principal of and the in-
14 terest on the dental education loans of the dentist.

15 (2) Upon completion by the dentist of the sec-
16 ond year of such service, the Secretary shall pay an-
17 other 30 percent of the principal of and the interest
18 on such loans.

19 (3) Upon completion by that individual of a
20 third year of such service, the Secretary shall pay
21 another 25 percent of the principal of and the inter-
22 est on such loans.

23 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
24 part III of part D of title III of the Public Health Service
25 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent

1 with this section, apply to the program carried out under
2 this section in the same manner and to the same extent
3 as such provisions apply to the National Health Service
4 Corps Loan Repayment Program.

5 (d) REPORTS.—Not later than 18 months after the
6 date of the enactment of this Act, and annually thereafter,
7 the Secretary shall prepare and submit to the Congress
8 a report describing the program carried out under this sec-
9 tion, including statements regarding the following:

10 (1) The number of dentists enrolled in the pro-
11 gram.

12 (2) The number and amount of loan repay-
13 ments provided through the program.

14 (3) The placement location of loan repayment
15 recipients at facilities described in subsection (a)(1).

16 (4) The default rate on such loans and actions
17 required.

18 (5) The amount of outstanding default funds
19 with respect to such loans.

20 (6) To the extent that it can be determined, the
21 reason for the default on such a loan.

22 (7) The demographics of individuals partici-
23 pating in the program.

24 (8) An evaluation of the overall costs and bene-
25 fits of the program.

1 (e) DEFINITIONS.—In this section:

2 (1) DENTAL EDUCATION LOAN.—The term
3 “dental education loan”—

4 (A) means a loan that is incurred for the
5 cost of attendance (including tuition, other rea-
6 sonable educational expenses, and reasonable
7 living costs) at a school of dentistry; and

8 (B) includes only the portion of the loan
9 that is outstanding on the date the dentist in-
10 volved begins the service specified in the agree-
11 ment under subsection (a).

12 (2) DENTIST.—The term “dentist” means a
13 graduate of a school of dentistry who has completed
14 postgraduate training in general or pediatric den-
15 tistry.

16 (3) HIV/AIDS.—The term “HIV/AIDS” means
17 human immunodeficiency virus and acquired im-
18 mune deficiency syndrome.

19 (4) SCHOOL OF DENTISTRY.—The term “school
20 of dentistry” has the meaning given to that term in
21 section 799B of the Public Health Service Act (42
22 U.S.C. 295p).

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

1 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 such sums as may be necessary for each of fiscal years
4 2027 through 2030.

5 **SEC. 7411. REDUCING NEW HIV INFECTIONS AMONG IN-**
6 **JECTING DRUG USERS.**

7 (a) SENSE OF CONGRESS.—It is the sense of Con-
8 gress that providing sterile syringes and sterilized equip-
9 ment to injecting drug users substantially reduces risk of
10 HIV infection, increases the probability that they will ini-
11 tiate drug treatment, and does not increase drug use.

12 (b) IN GENERAL.—The Secretary of Health and
13 Human Services may provide grants and technical assist-
14 ance for the purpose of reducing the rate of HIV infections
15 among injecting drug users through a comprehensive
16 package of services for such users, including the provision
17 of sterile syringes, education and outreach, access to infec-
18 tious disease testing, overdose prevention, and treatment
19 for drug dependence.

20 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
21 out this section, there are authorized to be appropriated
22 such sums as may be necessary for fiscal years 2027
23 through 2030.

1 **SEC. 7412. REPORT ON IMPACT OF HIV/AIDS IN VULNER-**
2 **ABLE POPULATIONS.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services shall submit to Congress and the Presi-
5 dent an annual report on the impact of HIV/AIDS for
6 racial and ethnic minority communities, women, and youth
7 aged 24 and younger.

8 (b) CONTENTS.—The report under subsection (a)
9 shall include information on the—

10 (1) progress that has been made in reducing
11 the impact of HIV/AIDS in such communities;

12 (2) opportunities that exist to make additional
13 progress in reducing the impact of HIV/AIDS in
14 such communities;

15 (3) challenges that may impede such additional
16 progress; and

17 (4) Federal funding necessary to achieve sub-
18 stantial reductions in HIV/AIDS in racial and ethnic
19 minority communities.

20 **SEC. 7413. NATIONAL HIV/AIDS OBSERVANCE DAYS.**

21 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
22 of Congress that national observance days highlighting the
23 impact of HIV on communities of color include the fol-
24 lowing:

25 (1) National Black HIV/AIDS Awareness Day.

26 (2) National Latino AIDS Awareness Day.

1 (3) National Asian and Pacific Islander HIV/
2 AIDS Awareness Day.

3 (4) National Native American HIV/AIDS
4 Awareness Day.

5 (5) National Youth HIV/AIDS Awareness Day.

6 (b) CALL TO ACTION.—It is the sense of Congress
7 that the President should call on members of communities
8 of color—

9 (1) to become involved at the local community
10 level in HIV testing, policy, and advocacy;

11 (2) to become aware, engaged, and empowered
12 on the HIV epidemic within their communities; and

13 (3) to urge members of their communities to re-
14 duce risk factors, practice safe sex and other preven-
15 tive measures, be tested for HIV, and seek care
16 when appropriate.

17 **SEC. 7414. REVIEW OF ALL FEDERAL AND STATE LAWS,**
18 **POLICIES, AND REGULATIONS REGARDING**
19 **THE CRIMINAL PROSECUTION OF INDIVID-**
20 **UALS FOR HIV-RELATED OFFENSES.**

21 (a) SENSE OF CONGRESS REGARDING LAWS OR REG-
22 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV.—
23 It is the sense of Congress that Federal and State laws,
24 policies, and regulations regarding people living with
25 HIV—

1 (1) should not place unique or additional bur-
 2 dens on such individuals solely as a result of their
 3 HIV status; and

4 (2) should instead demonstrate a public health-
 5 oriented, evidence-based, medically accurate, and
 6 contemporary understanding of—

7 (A) the multiple factors that lead to HIV
 8 transmission;

9 (B) the relative risk of demonstrated HIV
 10 transmission routes;

11 (C) the current health implications of liv-
 12 ing with HIV;

13 (D) the associated benefits of treatment
 14 and support services for people living with HIV;
 15 and

16 (E) the impact of punitive HIV-specific
 17 laws, policies, regulations, and judicial prece-
 18 dents and decisions on public health, on people
 19 living with or affected by HIV, and on their
 20 families and communities.

21 (b) REVIEW OF FEDERAL AND STATE LAWS.—

22 (1) REVIEW OF FEDERAL AND STATE LAWS.—

23 (A) IN GENERAL.—Not later than 90 days
 24 after the date of the enactment of this Act, the
 25 Attorney General, the Secretary of Health and

1 Human Services, and the Secretary of Defense
2 acting jointly (in this section referred to as the
3 “designated officials”) shall initiate a national
4 review of Federal and State laws, including the
5 Uniform Code of Military Justice (referred to in
6 this section as the “UCMJ”), policies, regula-
7 tions, and judicial precedents and decisions re-
8 garding criminal and related civil commitment
9 cases involving people living with HIV/AIDS.

10 (B) CONSULTATION.—In carrying out the
11 review under subparagraph (A), the designated
12 officials shall seek to include diverse participa-
13 tion from, and consultation with, each of the
14 following:

15 (i) Each State.

16 (ii) State attorneys general (or their
17 representatives).

18 (iii) State public health officials (or
19 their representatives).

20 (iv) State judicial and court system
21 officers, including judges, district attor-
22 neys, prosecutors, defense attorneys, law
23 enforcement, and correctional officers.

1 (v) Members of the United States
2 Armed Forces, including members of other
3 Federal services subject to the UCMJ.

4 (vi) People living with HIV/AIDS,
5 particularly those who have been subject to
6 HIV-related prosecution or who are from
7 minority communities whose members have
8 been disproportionately subject to HIV-
9 specific arrests and prosecution.

10 (vii) Legal advocacy and HIV/AIDS
11 service organizations that work with people
12 living with HIV/AIDS.

13 (viii) Nongovernmental health organi-
14 zations that work on behalf of people living
15 with HIV/AIDS, including syringe services
16 programs, LGBTQ-focused health organi-
17 zations, and organizations who serve peo-
18 ple who engage in sex work.

19 (ix) Trade organizations or associa-
20 tions representing persons or entities de-
21 scribed in clauses (i) through (vii).

22 (C) RELATION TO OTHER REVIEWS.—In
23 carrying out the review under subparagraph
24 (A), the designated officials may utilize other
25 existing reviews of criminal and related civil

1 commitment cases involving people living with
2 HIV, including any such review conducted by
3 any Federal or State agency or any public
4 health, legal advocacy, or trade organization or
5 association if the designated officials determines
6 that such reviews were conducted in accordance
7 with the principles set forth in subsection (a).

8 (2) REPORT.—Not later than 180 days after
9 initiating the review required under paragraph (1),
10 the Attorney General shall transmit to the Congress
11 and make publicly available a report containing the
12 results of the review, which includes the following:

13 (A) For each State and for the UCMJ, a
14 summary of the relevant laws, policies, regula-
15 tions, and judicial precedents and decisions re-
16 garding criminal cases involving people living
17 with HIV, including the following:

18 (i) A determination of whether such
19 laws, policies, regulations, and judicial
20 precedents and decisions place any unique
21 or additional burdens upon people living
22 with HIV.

23 (ii) A determination of whether such
24 laws, policies, regulations, and judicial
25 precedents and decisions demonstrate a

1 public health-oriented, evidence-based,
2 medically accurate, and contemporary un-
3 derstanding of—

4 (I) the multiple factors that lead
5 to HIV transmission;

6 (II) the relative risk of HIV
7 transmission routes, including that a
8 person that has an undetectable viral
9 load cannot transmit HIV;

10 (III) the current health implica-
11 tions of living with HIV, including
12 data disaggregated by race and eth-
13 nicity;

14 (IV) the current status of pro-
15 viding protection to people who en-
16 gage in survival sex work against
17 whom condom possession has been
18 used as evidence of intent to commit
19 a crime;

20 (V) States that have the classi-
21 fication of mandatory sex offenders;

22 (VI) the associated benefits of
23 treatment and support services for
24 people living with HIV; and

1 (VII) the impact of punitive
 2 HIV-specific laws and policies on pub-
 3 lic health, on people living with or af-
 4 fected by HIV, and on their families
 5 and communities, including people
 6 who are in abusive, dependent, violent,
 7 or nonconsensual relationships and
 8 are unable to both negotiate the use
 9 of condoms and status disclosure.

10 (iii) An analysis of the public health
 11 and legal implications of such laws, poli-
 12 cies, regulations, and judicial precedents
 13 and decisions, including an analysis of the
 14 consequences of having a similar penal
 15 scheme applied to comparable situations
 16 involving other communicable diseases.

17 (iv) An analysis of the proportionality
 18 of punishments imposed under HIV-spe-
 19 cific laws, policies, regulations, and judicial
 20 precedents, taking into consideration pen-
 21 alties attached to violation of State laws
 22 against similar degrees of endangerment or
 23 harm, such as driving while intoxicated or
 24 transmission of other communicable dis-

1 eases, or more serious harms, such as ve-
2 hicular manslaughter offenses.

3 (B) An analysis of common elements
4 shared between State laws, policies, regulations,
5 and judicial precedents.

6 (C) A set of best practice recommendations
7 directed to State governments, including State
8 attorneys general, public health officials, and
9 judicial officers, in order to ensure that laws,
10 policies, regulations, and judicial precedents re-
11 garding people living with HIV are in accord-
12 ance with the principles set forth in subsection
13 (a).

14 (D) Recommendations for adjustments to
15 the UCMJ, including discontinuing the use of a
16 service member's HIV diagnosis as the basis for
17 prosecution, enhanced penalties, or discharge
18 from military service, in order to ensure that
19 laws, policies, regulations, and judicial prece-
20 dents regarding people living with HIV are in
21 accordance with the principles set forth in sub-
22 section (a). Such recommendations should in-
23 clude any necessary and appropriate changes to
24 "Orders to Follow Preventative Medicine Re-
25 quirements".

1 (3) GUIDANCE.—Not later than 90 days after
2 the date of the release of the report required by
3 paragraph (2), the Attorney General and the Sec-
4 retary of Health and Human Services shall jointly
5 develop and publicly release updated guidance for
6 States based on the set of best practice rec-
7 ommendations required under paragraph (2)(C) in
8 order to assist States dealing with criminal and re-
9 lated civil commitment cases regarding people living
10 with HIV.

11 (4) MONITORING AND EVALUATION SYSTEM.—
12 Not later than 60 days after the date of the release
13 of the guidance required under paragraph (3), the
14 Attorney General and the Secretary of Health and
15 Human Services shall jointly establish an integrated
16 monitoring and evaluation system that includes,
17 where appropriate, objective and quantifiable per-
18 formance goals and indicators to measure progress
19 toward statewide implementation in each State of
20 the best practice recommendations required under
21 paragraph (2)(C).

22 (5) MODERNIZATION OF FEDERAL LAWS, POLI-
23 CIES, AND REGULATIONS.—Not later than 90 days
24 after the date of the release of the report required
25 under paragraph (2), the designated officials shall

(d) NO ADDITIONAL APPROPRIATIONS AUTHORIZED.—This section shall not be construed to increase the amount of appropriations that are authorized to be appropriated for any fiscal year.

(a) SENSE OF CONGRESS REGARDING DISTRIBUTION OF SEXUAL BARRIER PROTECTION DEVICES IN STATE PRISON SYSTEMS.—It is the sense of Congress that States shall allow for the legal distribution of sexual barrier protection devices in State correctional facilities to reduce the prevalence and spread of STIs in those facilities.

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1 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-
2 VICES IN FEDERAL CORRECTIONAL FACILITIES.—

3 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not
4 later than 30 days after the date of enactment of
5 this Act, the Attorney General shall direct the Direc-
6 tor of the Bureau of Prisons to allow community or-
7 ganizations to, in accordance with all relevant Fed-
8 eral laws and regulations that govern visitation in
9 Federal correctional facilities—

10 (A) distribute sexual barrier protection de-
11 vices in Federal correctional facilities; and

12 (B) engage in STI counseling and STI pre-
13 vention education in Federal correctional facili-
14 ties.

15 (2) INFORMATION REQUIREMENT.—Any com-
16 munity organization permitted to distribute sexual
17 barrier protection devices under paragraph (1) shall
18 ensure that the individuals to whom the devices are
19 distributed are informed about the proper use and
20 disposal of sexual barrier protection devices in ac-
21 cordance with established public health practices.
22 Any community organization conducting STI coun-
23 seling or STI prevention education under paragraph
24 (1) shall offer comprehensive sexuality education.

1 (3) POSSESSION OF DEVICE PROTECTED.—A
2 Federal correctional facility may not, because of the
3 possession or use of a sexual barrier protection de-
4 vice—

5 (A) take adverse action against an incar-
6 cerated individual; or

7 (B) consider possession or use as evidence
8 of prohibited activity for the purpose of any
9 Federal correctional facility administrative pro-
10 ceeding.

11 (4) IMPLEMENTATION.—The Attorney General
12 and the Director of the Bureau of Prisons shall im-
13 plement this section according to established public
14 health practices in a manner that protects the
15 health, safety, and privacy of incarcerated individ-
16 uals and of correctional facility staff.

17 (c) SURVEY OF AND REPORT ON CORRECTIONAL FA-
18 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
19 STIs.—

20 (1) SURVEY.—Not later than 180 days after
21 the date of enactment of this Act, and annually
22 thereafter for 5 years, the Attorney General, after
23 consulting with the Secretary of Health and Human
24 Services, State officials, and community organiza-
25 tions, shall, to the maximum extent practicable, con-

duct a survey of all Federal and State correctional facilities, to determine the following:

(A) COUNSELING, TREATMENT, AND SUPPORTIVE SERVICES.—Whether the correctional facility—

(i) requires incarcerated individuals to participate in counseling, treatment, and supportive services relating to STIs; or

(ii) offers such programs to incarcerated individuals.

(B) ACCESS TO SEXUAL BARRIER PROTECTION DEVICES.—Whether incarcerated individuals can—

(i) possess sexual barrier protection devices;

(ii) purchase sexual barrier protection devices;

(iii) purchase sexual barrier protection devices at a reduced cost; or

(iv) obtain sexual barrier protection devices without cost.

(C) INCIDENCE OF SEXUAL VIOLENCE.—The incidence of sexual violence and assault committed by incarcerated individuals and by correctional facility staff.

1 (D) PREVENTION EDUCATION OFFERED.—

2 The type of prevention education, information,
3 or training offered to incarcerated individuals
4 and correctional facility staff regarding sexual
5 violence and the spread of STIs, including
6 whether such education, information, or train-
7 ing—

8 (i) constitutes comprehensive sexuality
9 education;

10 (ii) is compulsory for new incarcerated
11 individuals and for new correctional facility
12 staff; and

13 (iii) is offered on an ongoing basis.

14 (E) STI TESTING.—Whether the correc-
15 tional facility tests incarcerated individuals for
16 STIs or gives them the option to undergo such
17 testing—

18 (i) at intake;

19 (ii) on a regular basis; and

20 (iii) prior to release.

21 (F) STI TEST RESULTS.—The number of
22 incarcerated individuals who are tested for STIs
23 and the outcome of such tests at each correc-
24 tional facility, disaggregated to include results
25 for—

- 1 (i) the type of STI tested for;
- 2 (ii) the race and ethnicity of an indi-
- 3 vidual tested;
- 4 (iii) the age of an individual tested;
- 5 and
- 6 (iv) the gender of the individual test-
- 7 ed.

8 (G) PRERELEASE REFERRAL POLICY.—

9 Whether incarcerated individuals are informed
10 prior to release about STI-related services or
11 other health services in their communities, in-
12 cluding free and low-cost counseling and treat-
13 ment options.

14 (H) PRERELEASE REFERRALS MADE.—

15 The number of referrals to community-based
16 organizations or public health facilities offering
17 STI-related or other health services provided to
18 incarcerated individuals prior to release, and
19 the type of counseling or treatment for which
20 the referral was made.

21 (I) REINSTATEMENT OF MEDICAID BENE-
22 FITS.—Whether—

- 23 (i) the correctional facility assists in-
- 24 carcerated individuals that were enrolled in
- 25 the State Medicaid program prior to their

incarceration in reinstating their enrollment upon release; and

(ii) such individuals receive referrals as described in subparagraph (G) to entities that accept the State Medicaid program, including, if applicable—

(I) the number of such individuals, including those diagnosed with HIV, that have been reinstated;

(II) a list of obstacles to reinstating enrollment or to making determinations of eligibility for reinstatement, if any; and

(III) the number of individuals denied enrollment.

(J) OTHER ACTIONS TAKEN.—Whether the correctional facility has taken any other action, in conjunction with community organizations or otherwise, to reduce the prevalence and spread of STIs in that facility.

(2) PRIVACY.—In conducting the survey under paragraph (1), the Attorney General shall not request or retain the identity of any individual who has sought or been offered counseling, treatment, testing, or prevention education information regard-

1 ing an STI (including information about sexual bar-
2 rier protection devices), or who has tested positive
3 for an STI.

4 (3) REPORT.—

5 (A) IN GENERAL.—The Attorney General
6 shall transmit to Congress and make publicly
7 available the results of the survey required
8 under paragraph (1), both for the United
9 States as a whole and disaggregated as to each
10 State and each correctional facility.

11 (B) DEADLINES.—To the maximum extent
12 possible, the Attorney General shall—

13 (i) issue the first report under sub-
14 paragraph (A) not later than 1 year after
15 the date of enactment of this Act; and

16 (ii) issue reports under subparagraph
17 (A) annually thereafter for 5 years.

18 (d) STRATEGY.—

19 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
20 Attorney General, in consultation with the Secretary
21 of Health and Human Services, State officials, and
22 community organizations, shall develop and imple-
23 ment a 5-year strategy to reduce the prevalence and
24 spread of STIs in Federal and State correctional fa-
25 cilities. To the maximum extent possible, the strat-

1 egy shall be developed, transmitted to Congress, and
2 made publicly available not later than 180 days after
3 the transmission of the first report required under
4 subsection (c)(3).

5 (2) CONTENTS OF STRATEGY.—The strategy
6 developed under paragraph (1) shall include the fol-
7 lowing:

8 (A) PREVENTION EDUCATION.—A plan for
9 improving prevention education, information,
10 and training offered to incarcerated individuals
11 and correctional facility staff, including infor-
12 mation and training on sexual violence and the
13 spread of STIs, and comprehensive sexuality
14 education.

15 (B) SEXUAL BARRIER PROTECTION DEVICE
16 ACCESS.—A plan for expanding access to sexual
17 barrier protection devices in correctional facili-
18 ties.

19 (C) SEXUAL VIOLENCE REDUCTION.—A
20 plan for reducing the incidence of sexual vio-
21 lence among incarcerated individuals and cor-
22 rectional facility staff.

23 (D) COUNSELING AND SUPPORTIVE SERV-
24 ICES.—A plan for expanding access to coun-

1 selling and supportive services related to STIs in
2 correctional facilities.

3 (E) TESTING.—A plan for testing incarcerated
4 individuals for STIs during intake, during
5 regular health exams, and prior to release
6 that—

7 (i) is conducted in accordance with
8 guidelines established by the Centers for
9 Disease Control and Prevention;

10 (ii) includes pretest counseling;

11 (iii) requires that incarcerated individ-
12 uals are notified of their option to decline
13 testing at any time;

14 (iv) requires that incarcerated individ-
15 uals are confidentially notified of their test
16 results in a timely manner; and

17 (v) ensures that incarcerated individ-
18 uals testing positive for STIs receive post-
19 test counseling, care, treatment, and sup-
20 portive services.

21 (F) TREATMENT.—A plan for ensuring
22 that correctional facilities have the necessary
23 medicine and equipment to treat and monitor
24 STIs and for ensuring that incarcerated indi-
25 viduals living with or testing positive for STIs

1 receive and have access to care and treatment
2 services.

3 (G) STRATEGIES FOR DEMOGRAPHIC
4 GROUPS.—A plan for developing and imple-
5 menting culturally appropriate, sensitive, and
6 specific strategies to reduce the spread of STIs
7 among demographic groups heavily impacted by
8 STIs.

9 (H) LINKAGES WITH COMMUNITIES AND
10 FACILITIES.—A plan for establishing and
11 strengthening linkages to local community and
12 health facilities that—

13 (i) provide counseling, testing, care,
14 and treatment services;

15 (ii) may receive individuals recently
16 released from incarceration who are living
17 with STIs; and

18 (iii) accept payment through the State
19 Medicaid program.

20 (I) ENROLLMENT IN STATE MEDICAID
21 PROGRAMS.—Plans to ensure that—

22 (i) incarcerated individuals who were
23 enrolled in their State Medicaid program
24 prior to incarceration in a correctional fa-

1 cility are automatically reenrolled in such
2 program upon their release; and

3 (ii) incarcerated individuals who were
4 not enrolled in their State Medicaid pro-
5 gram prior to incarceration, and who are
6 diagnosed with HIV while incarcerated in
7 a correctional facility, are automatically
8 enrolled in such program upon their re-
9 lease.

10 (J) OTHER PLANS.—Any other plans de-
11 veloped by the Attorney General for reducing
12 the spread of STIs or improving the quality of
13 health care in correctional facilities.

14 (K) MONITORING SYSTEM.—A monitoring
15 system that establishes performance goals re-
16 lated to reducing the prevalence and spread of
17 STIs in correctional facilities and which, where
18 feasible, expresses such goals in quantifiable
19 form.

20 (L) MONITORING SYSTEM PERFORMANCE
21 INDICATORS.—Performance indicators that
22 measure or assess the achievement of the per-
23 formance goals described in subparagraph (K).

24 (M) COST ESTIMATE.—A detailed estimate
25 of the funding necessary to implement the

1 strategy at the Federal and State levels for all
2 5 years, including the amount of funds required
3 by community organizations to implement the
4 parts of the strategy in which they take part.

5 (3) REPORT.—Not later than 1 year after the
6 date of the enactment of this Act, and annually
7 thereafter, the Attorney General shall transmit to
8 Congress and make publicly available an annual
9 progress report regarding the implementation and
10 effectiveness of the strategy described in paragraph
11 (1). The progress report shall include an evaluation
12 of the implementation of the strategy using the mon-
13 itoring system and performance indicators provided
14 for in subparagraphs (K) and (L) of paragraph (2).

15 (e) AUTHORIZATION OF APPROPRIATIONS.—

16 (1) IN GENERAL.—There are authorized to be
17 appropriated such sums as may be necessary to
18 carry out this section for each of fiscal years 2027
19 through 2031.

20 (2) AVAILABILITY OF FUNDS.—Amounts made
21 available under paragraph (1) are authorized to re-
22 main available until expended.

23 (f) DEFINITIONS.—In this section:

24 (1) COMMUNITY ORGANIZATION.—The term
25 “community organization” means a public health

1 care facility or a nonprofit organization that pro-
2 vides health- or STI-related services according to es-
3 tablished public health standards.

4 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
5 The term “comprehensive sexuality education”
6 means sexuality education—

7 (A) that includes information about absti-
8 nence and about the proper use and disposal of
9 sexual barrier protection devices; and

10 (B) that is—

11 (i) evidence based;

12 (ii) medically accurate;

13 (iii) age and developmentally appro-
14 priate;

15 (iv) gender and identity sensitive;

16 (v) culturally and linguistically appro-
17 priate; and

18 (vi) structured to promote critical
19 thinking, self-esteem, respect for others,
20 and the development of healthy attitudes
21 and relationships.

22 (3) CORRECTIONAL FACILITY.—The term “cor-
23 rectional facility” means any prison, penitentiary,
24 adult detention facility, juvenile detention facility,
25 jail, or other facility to which individuals may be

1 sent after conviction of a crime or act of juvenile de-
2 linquency within the United States.

3 (4) INCARCERATED INDIVIDUAL.—The term
4 “incarcerated individual” means any individual who
5 is serving a sentence in a correctional facility after
6 conviction of a crime.

7 (5) SEXUAL BARRIER PROTECTION DEVICE.—
8 The term “sexual barrier protection device” means
9 any physical device approved, cleared, or otherwise
10 authorized by the Food and Drug Administration
11 that has not been tampered with and which reduces
12 the probability of STI transmission or infection be-
13 tween sexual partners, including female condoms,
14 male condoms, and dental dams.

15 (6) SEXUALLY TRANSMITTED INFECTION.—The
16 term “sexually transmitted infection” or “STI”
17 means any disease or infection that is commonly
18 transmitted through sexual activity, including HIV,
19 gonorrhea, chlamydia, syphilis, genital herpes, viral
20 hepatitis, and human papillomavirus.

21 (7) STATE.—The term “State” includes the
22 District of Columbia, American Samoa, the Com-
23 monwealth of the Northern Mariana Islands, Guam,
24 Puerto Rico, and the United States Virgin Islands.

1 (8) STATE MEDICAID PROGRAM.—The term
 2 “State Medicaid program” means the State plan (or
 3 a waiver of such plan) under title XIX of the Social
 4 Security Act (42 U.S.C. 1396 et seq.).

5 **SEC. 7416. AUTOMATIC REINSTATEMENT OR ENROLLMENT**
 6 **IN MEDICAID FOR PEOPLE WHO TEST POSI-**
 7 **TIVE FOR HIV BEFORE REENTERING COMMU-**
 8 **NITIES.**

9 (a) IN GENERAL.—Section 1902(e) of the Social Se-
 10 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
 11 the end the following:

12 “(17) ENROLLMENT OF EX-OFFENDERS.—

13 “(A) AUTOMATIC ENROLLMENT OR REIN-
 14 STATEMENT.—

15 “(i) IN GENERAL.—The State plan
 16 shall provide for the automatic enrollment
 17 or reinstatement of enrollment of an eligi-
 18 ble individual—

19 “(I) if such individual is sched-
 20 uled to be released from a public insti-
 21 tution due to the completion of sen-
 22 tence, not less than 30 days prior to
 23 the scheduled date of the release; and

24 “(II) if such individual is to be
 25 released from a public institution on

1 parole or on probation, as soon as
 2 possible after the date on which the
 3 determination to release such indi-
 4 vidual was made, and before the date
 5 such individual is released.

6 “(ii) EXCEPTION.—If a State makes a
 7 determination that an individual is not eli-
 8 gible to be enrolled under the State plan—

9 “(I) on or before the date by
 10 which the individual would be enrolled
 11 under clause (i), such clause shall not
 12 apply to such individual; or

13 “(II) after such date, the State
 14 may terminate the enrollment of such
 15 individual.

16 “(B) RELATIONSHIP OF ENROLLMENT TO
 17 PAYMENT FOR SERVICES.—

18 “(i) IN GENERAL.—Subject to sub-
 19 paragraph (A)(ii), an eligible individual
 20 who is enrolled, or whose enrollment is re-
 21 instated, under subparagraph (A) shall be
 22 eligible for all services for which medical
 23 assistance is provided under the State plan
 24 after the date that the eligible individual is
 25 released from the public institution.

1 “(ii) RELATIONSHIP TO PAYMENT
 2 PROHIBITION FOR INMATES.—No provision
 3 of this paragraph may be construed to per-
 4 mit payment for care or services for which
 5 payment is excluded under subparagraph
 6 (A) following the last numbered paragraph
 7 of section 1905(a).

8 “(C) TREATMENT OF CONTINUOUS ELIGI-
 9 BILITY.—

10 “(i) SUSPENSION FOR INMATES.—Any
 11 period of continuous eligibility under this
 12 title shall be suspended on the date an in-
 13 dividual enrolled under this title becomes
 14 an inmate of a public institution (except as
 15 a patient of a medical institution).

16 “(ii) DETERMINATION OF REMAINING
 17 PERIOD.—Notwithstanding any changes to
 18 State law related to continuous eligibility
 19 during the time that an individual is an in-
 20 mate of a public institution (except as a
 21 patient of a medical institution), subject to
 22 clause (iii), with respect to an eligible indi-
 23 vidual who was subject to a suspension
 24 under clause (i), on the date that such in-
 25 dividual is released from a public institu-

1 tion the suspension of continuous eligibility
2 under such clause shall be lifted for a pe-
3 riod that is equal to the time remaining in
4 the period of continuous eligibility for such
5 individual on the date that such period was
6 suspended under such clause.

7 “(iii) EXCEPTION.—If a State makes
8 a determination that an individual is not
9 eligible to be enrolled under the State
10 plan—

11 “(I) on or before the date that
12 the suspension of continuous eligibility
13 is lifted under clause (ii), such clause
14 shall not apply to such individual; or

15 “(II) after such date, the State
16 may terminate the enrollment of such
17 individual.

18 “(D) AUTOMATIC ENROLLMENT OR REIN-
19 STATEMENT OF ENROLLMENT DEFINED.—For
20 purposes of this paragraph, the term ‘automatic
21 enrollment or reinstatement of enrollment’
22 means that the State determines eligibility for
23 medical assistance under the State plan without
24 a program application from, or on behalf of, the
25 eligible individual, but an individual can only be

1 automatically enrolled in the State Medicaid
 2 plan if the individual affirmatively consents to
 3 being enrolled through affirmation in writing,
 4 by telephone, orally, through electronic signa-
 5 ture, or through any other means specified by
 6 the Secretary.

7 “(E) ELIGIBLE INDIVIDUAL DEFINED.—

8 For purposes of this paragraph, the term ‘eligi-
 9 ble individual’ means an individual who is an
 10 inmate of a public institution (except as a pa-
 11 tient in a medical institution)—

12 “(i) who was enrolled under the State
 13 plan for medical assistance immediately be-
 14 fore becoming an inmate of such an insti-
 15 tution; or

16 “(ii) who is diagnosed with human im-
 17 munodeficiency virus.”.

18 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
 19 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
 20 ICAID BENEFITS.—

21 (1) IN GENERAL.—Subject to paragraph (3),
 22 with respect to a State, for each of the first 4 cal-
 23 endar quarters in which the State plan meets the re-
 24 quirements of paragraph (17) of section 1902(e) of
 25 the Social Security Act (42 U.S.C. 1396a(e)) (as

1 added by subsection (a)), the Federal matching pay-
 2 ments (including payments based on the Federal
 3 medical assistance percentage) made to such State
 4 under section 1903 of the Social Security Act (42
 5 U.S.C. 1396b) for the State expenditures described
 6 in paragraph (2) shall be increased by 5 percentage
 7 points.

8 (2) EXPENDITURES.—The expenditures de-
 9 scribed in this paragraph are the following:

10 (A) Expenditures for which payment is
 11 available under section 1903 of the Social Secu-
 12 rity Act (42 U.S.C. 1396b) and which are at-
 13 tributable to strengthening the State's enroll-
 14 ment and administrative resources for the pur-
 15 pose of improving processes for enrolling (or re-
 16 instating the enrollment of) eligible individuals
 17 (as such term is defined in subparagraph (E) of
 18 paragraph (17) of section 1902(e) of the Social
 19 Security Act (42 U.S.C. 1396a(e)) (as amended
 20 by subsection (a))).

21 (B) Expenditures for medical assistance
 22 (as such term is defined in section 1905(a) of
 23 the Social Security Act (42 U.S.C. 1396d(a)))
 24 provided to such eligible individuals.

25 (3) REQUIREMENTS; LIMITATION.—

1 (A) REPORT.—A State is not eligible for
2 an increase in its Federal matching payments
3 under paragraph (1) unless the State agrees to
4 submit to the Secretary of Health and Human
5 Services, and make publicly available, a report
6 that contains the information required under
7 paragraph (4) by the end of the 1-year period
8 during which the State receives increased Fed-
9 eral matching payments in accordance with that
10 paragraph.

11 (B) MAINTENANCE OF ELIGIBILITY.—

12 (i) IN GENERAL.—Subject to clause
13 (ii), a State is not eligible for an increase
14 in its Federal matching payments under
15 paragraph (1) if eligibility standards,
16 methodologies, or procedures under its
17 State plan under title XIX of the Social
18 Security Act (42 U.S.C. 1396 et seq.), or
19 waiver of such a plan, are more restrictive
20 than the eligibility standards, methodolo-
21 gies, or procedures, respectively, under
22 such plan or waiver as in effect on the date
23 of enactment of this Act.

24 (ii) STATE REINSTATEMENT OF ELIGI-
25 BILITY PERMITTED.—A State that has re-

1 stricted eligibility standards, methodolo-
 2 gies, or procedures under its State plan
 3 under title XIX of the Social Security Act
 4 (42 U.S.C. 1396 et seq.), or a waiver of
 5 such plan, after the date of enactment of
 6 this Act, is no longer ineligible under
 7 clause (i) beginning with the first calendar
 8 quarter in which the State has reinstated
 9 eligibility standards, methodologies, or pro-
 10 cedures that are no more restrictive than
 11 the eligibility standards, methodologies, or
 12 procedures, respectively, under such plan
 13 (or waiver) as in effect on such date.

14 (C) LIMITATION OF MATCHING PAYMENTS

15 TO 100 PERCENT.—In no case shall an increase
 16 in Federal matching payments under paragraph
 17 (1) result in Federal matching payments that
 18 exceed 100 percent of State expenditures.

19 (4) REQUIRED REPORT INFORMATION.—The in-
 20 formation that is required in the report under para-
 21 graph (3)(A) shall include—

22 (A) the results of an evaluation of the im-
 23 pact of the implementation of the requirements
 24 of paragraph (17) of section 1902(e) of the So-
 25 cial Security Act (42 U.S.C. 1396a(e)) on im-

1 proving the State's processes for enrolling indi-
2 viduals who are released from public institu-
3 tions under the State Medicaid plan;

4 (B) the number of individuals who were
5 automatically enrolled (or whose enrollment was
6 reinstated) under such paragraph during the 1-
7 year period during which the State received in-
8 creased payments under this subsection; and

9 (C) any other information that is required
10 by the Secretary of Health and Human Serv-
11 ices.

12 (c) EFFECTIVE DATE.—

13 (1) IN GENERAL.—Except as provided in para-
14 graph (2), the amendments made by subsection (a)
15 shall take effect 180 days after the date of the en-
16 actment of this Act.

17 (2) RULE FOR CHANGES REQUIRING STATE
18 LEGISLATION.—In the case of a State plan for med-
19 ical assistance under title XIX of the Social Security
20 Act (42 U.S.C. 1396 et seq.) which the Secretary of
21 Health and Human Services determines requires
22 State legislation (other than legislation appro-
23 priating funds) in order for the plan to meet the ad-
24 ditional requirement imposed by the amendments
25 made by subsection (a), the State plan shall not be

1 regarded as failing to comply with the requirements
2 of such title solely on the basis of its failure to meet
3 this additional requirement before the first day of
4 the first calendar quarter beginning after the close
5 of the first regular session of the State legislature
6 that begins after the date of the enactment of this
7 Act. For purposes of the previous sentence, in the
8 case of a State that has a 2-year legislative session,
9 each year of such session shall be deemed to be a
10 separate regular session of the State legislature.

11 **SEC. 7417. STOP HIV IN PRISON.**

12 (a) HIV POLICY.—The Director of the Bureau of
13 Prisons (referred to in this section as the “Director”) shall
14 develop a comprehensive policy to provide HIV testing,
15 treatment, and prevention for inmates within the correc-
16 tional setting and upon reentry.

17 (b) PURPOSE.—The purposes of the policy required
18 to be developed under subsection (a) shall be as follows:

19 (1) To stop the spread of HIV among inmates.

20 (2) To protect guards and other personnel at
21 correctional facilities from HIV infection.

22 (3) To provide comprehensive medical treat-
23 ment to inmates who are living with HIV.

24 (4) To promote HIV awareness and prevention
25 among inmates.

1 (5) To encourage inmates to take personal re-
2 sponsibility for their health.

3 (6) To reduce the risk that inmates will trans-
4 mit HIV to other persons in the community fol-
5 lowing their release from a correctional facility.

6 (c) CONSULTATION.—The Director shall consult with
7 appropriate officials of the Department of Health and
8 Human Services, the Office of National Drug Control Pol-
9 icy, the Office of National AIDS Policy, and the Centers
10 for Disease Control and Prevention regarding the develop-
11 ment of the policy required under subsection (a).

12 (d) TIME LIMIT.—Not later than 1 year after the
13 date of enactment of this Act, the Director shall draft ap-
14 propriate regulations to implement the policy required to
15 be developed under subsection (a).

16 (e) REQUIREMENTS FOR POLICY.—The policy re-
17 quired to be developed under subsection (a) shall provide
18 for the following:

19 (1) TESTING AND COUNSELING UPON IN-
20 TAKE.—

21 (A) Health care personnel shall provide
22 routine HIV testing to all inmates as a part of
23 a comprehensive medical examination imme-
24 diately following admission to a facility. Health
25 care personnel need not provide routine HIV

1 testing to an inmate who is transferred to a fa-
2 cility from another facility if the inmate's med-
3 ical records are transferred with the inmate and
4 indicate that the inmate has been tested pre-
5 viously.

6 (B) With respect to all inmates admitted
7 to a facility prior to the effective date of the
8 policy—

9 (i) health care personnel shall provide
10 routine HIV testing by not later than 180
11 days after such effective date; and

12 (ii) HIV testing described in clause (i)
13 may be performed in conjunction with
14 other health services provided to these in-
15 mates by health care personnel.

16 (C) All HIV tests under this paragraph
17 shall comply with the opt-out provision under
18 paragraph (9).

19 (2) PRE-TEST AND POST-TEST COUNSELING.—

20 Health care personnel shall provide confidential pre-
21 test and post-test counseling to all inmates who are
22 tested for HIV. Counseling may be included with
23 other general health counseling provided to inmates
24 by health care personnel.

25 (3) HIV PREVENTION EDUCATION.—

1 (A) Health care personnel shall improve
2 HIV awareness through frequent educational
3 programs for all inmates. HIV educational pro-
4 grams may be provided by community-based or-
5 ganizations, local health departments, and in-
6 mate peer educators.

7 (B) HIV educational materials shall be
8 made available to all inmates at orientation, at
9 health care clinics, at regular educational pro-
10 grams, and prior to release. Both written and
11 audiovisual materials shall be made available to
12 all inmates.

13 (C)(i) The HIV educational programs and
14 materials under this paragraph shall include in-
15 formation on—

16 (I) modes of transmission, including
17 transmission through tattooing, sexual con-
18 tact, and intravenous drug use;

19 (II) prevention methods;

20 (III) treatment; and

21 (IV) disease progression.

22 (ii) The programs and materials shall
23 be culturally sensitive, written or designed
24 for low-literacy levels, available in a variety
25 of languages, and present scientifically ac-

1 curate information in a clear and under-
2 standable manner.

3 (4) HIV TESTING UPON REQUEST.—

4 (A) Health care personnel shall allow in-
5 mates to obtain HIV tests upon request once
6 per year or whenever an inmate has a reason to
7 believe the inmate may have been exposed to
8 HIV. Health care personnel shall, both orally
9 and in writing, inform inmates, during orienta-
10 tion and periodically throughout incarceration,
11 of their right to obtain HIV tests.

12 (B) Health care personnel shall encourage
13 inmates to request HIV tests if the inmate is
14 sexually active, has been raped, uses intra-
15 venous drugs, receives a tattoo, or if the inmate
16 is concerned that the inmate may have been ex-
17 posed to HIV.

18 (C) An inmate's request for an HIV test
19 shall not be considered an indication that the
20 inmate has put themselves at risk of infection
21 or committed a violation of the rules of the cor-
22 rectional facility.

23 (5) HIV TESTING OF PREGNANT WOMAN.—

1 (A) Health care personnel shall provide
2 routine HIV testing to all inmates who become
3 pregnant.

4 (B) All HIV tests under this paragraph
5 shall comply with the opt-out provision under
6 paragraph (9).

7 (6) COMPREHENSIVE TREATMENT.—

8 (A) Health care personnel shall provide all
9 inmates who test positive for HIV—

10 (i) timely, comprehensive medical
11 treatment;

12 (ii) confidential counseling on man-
13 aging their medical condition and pre-
14 venting its transmission to other persons;
15 and

16 (iii) voluntary partner notification
17 services.

18 (B) Health care provided under this para-
19 graph shall be consistent with Department of
20 Health and Human Services guidelines and
21 standard medical practice. Health care per-
22 sonnel shall discuss treatment options, the im-
23 portance of adherence to antiretroviral therapy,
24 and the side effects of medications with inmates
25 receiving treatment.

1 (C) Health care personnel and pharmacy
2 personnel shall ensure that the facility for-
3 mulary contains all Food and Drug Administra-
4 tion-approved medications necessary to provide
5 comprehensive treatment for inmates living with
6 HIV, and that the facility maintains adequate
7 supplies of such medications to meet inmates'
8 medical needs. Health care personnel and phar-
9 macy personnel shall also develop and imple-
10 ment automatic renewal systems for these medi-
11 cations to prevent interruptions in care.

12 (D) Correctional staff, health care per-
13 sonnel, and pharmacy personnel shall develop
14 and implement distribution procedures to en-
15 sure timely and confidential access to medica-
16 tions.

17 (7) PROTECTION OF CONFIDENTIALITY.—

18 (A) Health care personnel shall develop
19 and implement procedures to ensure the con-
20 fidentiality of inmate tests, diagnoses, and
21 treatment. Health care personnel and correc-
22 tional staff shall receive regular training on the
23 implementation of these procedures. Penalties
24 for violations of inmate confidentiality by health

1 care personnel or correctional staff shall be
2 specified and strictly enforced.

3 (B) HIV testing, counseling, and treat-
4 ment shall be provided in a confidential setting
5 where other routine health services are provided
6 and in a manner that allows the inmate to re-
7 quest and obtain these services as routine med-
8 ical services.

9 (8) TESTING, COUNSELING, AND REFERRAL
10 PRIOR TO REENTRY.—

11 (A) Health care personnel shall provide
12 routine HIV testing to all inmates not earlier
13 than 90 days prior to their release and reentry
14 into the community. Inmates who are already
15 known to be infected need not be tested again.
16 This requirement may be waived if an inmate's
17 release occurs without sufficient notice to the
18 Director to allow health care personnel to per-
19 form a routine HIV test and notify the inmate
20 of the results.

21 (B) All HIV tests under this paragraph
22 shall comply with the opt-out provision under
23 paragraph (9).

24 (C) With respect to all inmates who test
25 positive for HIV and all inmates who already

1 are known to have HIV, health care personnel
2 shall provide—

3 (i) confidential prerelease counseling
4 on managing their medical condition in the
5 community, accessing appropriate treat-
6 ment and services in the community, and
7 preventing the transmission of their condi-
8 tion to family members and other persons
9 in the community;

10 (ii) referrals to appropriate health
11 care providers and social service agencies
12 in the community that meet the inmate's
13 individual needs, including voluntary part-
14 ner notification services and prevention
15 counseling services for people living with
16 HIV; and

17 (iii) a 30-day supply of any medically
18 necessary medications the inmate is cur-
19 rently receiving.

20 (9) OPT-OUT PROVISION.—Inmates shall have
21 the right to refuse routine HIV testing. Inmates
22 shall be informed both orally and in writing of this
23 right. Oral and written disclosure of this right may
24 be included with other general health information
25 and counseling provided to inmates by health care

1 personnel. If an inmate refuses a routine test for
2 HIV, health care personnel shall make a note of the
3 inmate's refusal in the inmate's confidential medical
4 records. However, the inmate's refusal shall not be
5 considered a violation of the rules of the correctional
6 facility or result in disciplinary action.

7 (10) EXCLUSION OF TESTS PERFORMED UNDER
8 SECTION 4014(B) FROM THE DEFINITION OF ROU-
9 TINE HIV TESTING.—HIV testing of an inmate
10 under section 4014(b) of title 18, United States
11 Code, is not routine HIV testing for the purposes of
12 the opt-out provision under paragraph (9). Health
13 care personnel shall document the reason for testing
14 under section 4014(b) of title 18, United States
15 Code, in the inmate's confidential medical records.

16 (11) TIMELY NOTIFICATION OF TEST RE-
17 SULTS.—Health care personnel shall provide timely
18 notification to inmates of the results of HIV tests.

19 (f) CHANGES IN EXISTING LAW.—

20 (1) SCREENING IN GENERAL.—Section 4014(a)
21 of title 18, United States Code, is amended—

22 (A) by striking “for a period of 6 months
23 or more”;

24 (B) by striking “, as appropriate,”; and

1 (C) by striking “if such individual is deter-
2 mined to be at risk for infection with such virus
3 in accordance with the guidelines issued by the
4 Bureau of Prisons relating to infectious disease
5 management.” and inserting “unless the indi-
6 vidual declines. The Attorney General shall also
7 cause such individual to be so tested before re-
8 lease from that incarceration unless the indi-
9 vidual declines.”.

10 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
11 CIVIL AND CRIMINAL PROCEEDINGS.—Section
12 4014(d) of title 18, United States Code, is amended
13 by inserting “or under section 7417 of the Health
14 Equity and Accountability Act of 2026” after
15 “under this section”.

16 (3) SCREENING AS PART OF ROUTINE SCREEN-
17 ING.—Section 4014(e) of title 18, United States
18 Code, is amended by adding at the end the fol-
19 lowing: “Such rules shall also provide that the initial
20 test under this section be performed as part of the
21 routine health screening conducted at intake.”.

22 (g) REPORTING REQUIREMENTS.—

23 (1) REPORT ON HEPATITIS, LIVER, AND OTHER
24 DISEASES.—Not later than 1 year after the date of
25 enactment of this Act, the Director shall submit to

1 Congress a report on the policies and procedures of
2 the Bureau of Prisons to provide testing, treatment,
3 and prevention education programs for hepatitis,
4 liver failure, and other liver-related diseases trans-
5 mitted through sexual activity, intravenous drug use,
6 or other means. The Director shall consult with ap-
7 propriate officials of the Department of Health and
8 Human Services, the Office of National Drug Con-
9 trol Policy, the Office of National AIDS Policy, and
10 the Centers for Disease Control and Prevention re-
11 garding the development of this report.

12 (2) ANNUAL REPORTS.—

13 (A) GENERALLY.—Not later than 2 years
14 after the date of enactment of this Act, and an-
15 nually thereafter, the Director submit to Con-
16 gress a report on the incidence among inmates
17 of diseases transmitted through sexual activity
18 and intravenous drug use.

19 (B) MATTERS PERTAINING TO VARIOUS
20 DISEASES.—Each report under subparagraph
21 (A) shall discuss—

22 (i) the incidence among inmates of
23 HIV, hepatitis, and other diseases trans-
24 mitted through sexual activity and intra-
25 venous drug use; and

1 (ii) updates on the testing, treatment,
2 and prevention education programs for
3 these diseases conducted by the Bureau of
4 Prisons.

5 (C) MATTERS PERTAINING TO HIV
6 ONLY.—Each report under subparagraph (A)
7 shall also include—

8 (i) the number of inmates who tested
9 positive for HIV upon intake;

10 (ii) the number of inmates who tested
11 positive for HIV prior to reentry;

12 (iii) the number of inmates who were
13 not tested for HIV prior to reentry because
14 they were released without sufficient no-
15 tice;

16 (iv) the number of inmates who opted
17 out of taking an HIV test;

18 (v) the number of inmates who were
19 tested under section 4014(b) of title 18,
20 United States Code; and

21 (vi) the number of inmates under
22 treatment for HIV.

23 (D) CONSULTATION.—The Director shall
24 consult with appropriate officials of the Depart-
25 ment of Health and Human Services, the Office

1 of National Drug Control Policy, the Office of
2 National AIDS Policy, and the Centers for Dis-
3 ease Control and Prevention regarding the de-
4 velopment of each report under subparagraph
5 (A).

6 **SEC. 7418. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**
7 **ENDING THE HIV EPIDEMIC: A PLAN FOR**
8 **AMERICA.**

9 Title II of the Public Health Service Act (42 U.S.C.
10 202 et seq.) is amended by inserting after section 241 (42
11 U.S.C. 238j) the following:

12 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
13 **OF NATIONAL HIV/AIDS STRATEGY.**

14 “(a) **TRANSFER AUTHORIZATION.**—Of the discre-
15 tionary appropriations made available to the Department
16 of Health and Human Services for any fiscal year for pro-
17 grams and activities that, as determined by the Secretary,
18 pertain to HIV, the Secretary may transfer up to 1 per-
19 cent of such appropriations to the Office of the Assistant
20 Secretary for Health for implementation of the Ending the
21 HIV Epidemic: A Plan for America.

22 “(b) **CONGRESSIONAL NOTIFICATION.**—Not less than
23 30 days before making any transfer under this section,
24 the Secretary shall give notice of the transfer to the Con-
25 gress.

1 “(c) DEFINITIONS.—In this section, the term ‘End-
 2 ing the HIV Epidemic: A Plan for America’ means the
 3 initiative of the Department of Health and Human Serv-
 4 ices that seeks to reduce the number of new HIV infec-
 5 tions in the United States by 75 percent by 2027, and
 6 then by at least 90 percent by 2032, for an estimated
 7 250,000 total HIV infections averted.”.

8 **SEC. 7419. PREP ACCESS AND COVERAGE.**

9 (a) COVERAGE OF HIV TESTING AND PREVENTION
 10 SERVICES.—

11 (1) PRIVATE INSURANCE.—

12 (A) IN GENERAL.—Section 2713(a) of the
 13 Public Health Service Act (42 U.S.C. 300gg–
 14 13(a)) is amended to read as follows:

15 “(a) COVERAGE OF PREVENTIVE HEALTH SERV-
 16 ICES.—

17 “(1) IN GENERAL.—A group health plan and a
 18 health insurance issuer offering group or individual
 19 health insurance coverage shall, at a minimum, pro-
 20 vide coverage for and shall not impose any cost shar-
 21 ing requirements for—

22 “(A) evidence-based items or services that
 23 have in effect a rating of ‘A’ or ‘B’ in the cur-
 24 rent recommendations of the United States Pre-
 25 ventive Services Task Force;

1 “(B) immunizations that have in effect a
2 recommendation from the Advisory Committee
3 on Immunization Practices of the Centers for
4 Disease Control and Prevention with respect to
5 the individual involved;

6 “(C) with respect to infants, children, and
7 adolescents, evidence-informed preventive care
8 and screenings provided for in the comprehen-
9 sive guidelines supported by the Health Re-
10 sources and Services Administration;

11 “(D) with respect to women, such addi-
12 tional preventive care and screenings not de-
13 scribed in subparagraph (A) as provided for in
14 comprehensive guidelines supported by the
15 Health Resources and Services Administration
16 for purposes of this subparagraph;

17 “(E) any prescription drug approved by
18 the Food and Drug Administration for the pre-
19 vention of HIV (other than a drug subject to
20 preauthorization requirements consistent with
21 section 2729A), administrative fees for such
22 drugs, laboratory and other diagnostic proce-
23 dures associated with the use of such drugs,
24 and clinical follow-up and monitoring, including
25 any related services recommended in current

1 United States Public Health Service clinical
 2 practice guidelines, without limitation; and”.

3 (B) PROHIBITION ON PREAUTHORIZATION
 4 REQUIREMENTS.—

5 (i) PHSA.—Part D of title XXVII of
 6 the Public Health Service Act (42 U.S.C.
 7 300gg–111 et seq.) is amended by adding
 8 at the end the following:

9 **“SEC. 2799A–12. PROHIBITION ON PREAUTHORIZATION RE-**
 10 **QUIREMENTS WITH RESPECT TO CERTAIN**
 11 **SERVICES.**

12 “A group health plan or a health insurance issuer of-
 13 fering group or individual health insurance coverage shall
 14 not impose any preauthorization requirements with re-
 15 spect to coverage of the services described in section
 16 2713(a)(1)(E), except that a plan or issuer may impose
 17 preauthorization requirements with respect to coverage of
 18 a particular drug approved under section 505(c) of the
 19 Federal Food, Drug, and Cosmetic Act or section 351(a)
 20 of this Act if such plan or issuer provides coverage without
 21 any preauthorization requirements for a drug that is ther-
 22 apeutically equivalent.”.

23 (ii) ERISA.—

24 (I) IN GENERAL.—Subpart B of
 25 part 7 of subtitle B of title I of the

1 Employee Retirement Income Security
 2 Act of 1974 (29 U.S.C. 1185 et seq.)
 3 is amended by adding at the end the
 4 following:

5 **“SEC. 727. PROHIBITION ON PREAUTHORIZATION REQUIRE-**
 6 **MENTS WITH RESPECT TO CERTAIN SERV-**
 7 **ICES.**

8 “A group health plan or a health insurance issuer of-
 9 fering group health insurance coverage shall not impose
 10 any preauthorization requirements with respect to cov-
 11 erage of the services described in section 2713(a)(1)(E),
 12 except that a plan or issuer may impose preauthorization
 13 requirements with respect to coverage of a particular drug
 14 approved under section 505(c) of the Federal Food, Drug,
 15 and Cosmetic Act or section 351(a) of this Act if such
 16 plan or issuer provides coverage without any
 17 preauthorization requirements for a drug that is thera-
 18apeutically equivalent.”.

19 (II) CLERICAL AMENDMENT.—
 20 The table of contents in section 1 of
 21 such Act is amended by inserting
 22 after the item relating to section 726
 23 the following new item:

“Sec. 727. Prohibition on preauthorization requirements with respect to certain
 services.”.

24 (iii) IRC.—

1 (I) IN GENERAL.—Subchapter B
 2 of chapter 100 of the Internal Rev-
 3 enue Code of 1986 is amended by
 4 adding at the end the following:

5 **“SEC. 9827. PROHIBITION ON PREAUTHORIZATION RE-**
 6 **QUIREMENTS WITH RESPECT TO CERTAIN**
 7 **SERVICES.**

8 “A group health plan shall not impose any
 9 preauthorization requirements with respect to coverage of
 10 the services described in section 2713(a)(1)(E), except
 11 that a plan may impose preauthorization requirements
 12 with respect to coverage of a particular drug approved
 13 under section 505(c) of the Federal Food, Drug, and Cos-
 14 metic Act or section 351(a) of this Act if such plan pro-
 15 vides coverage without any preauthorization requirements
 16 for a drug that is therapeutically equivalent.”.

17 (C) CLERICAL AMENDMENT.—The table of
 18 sections for subchapter B of chapter 100 of the
 19 Internal Revenue Code of 1986 is amended by
 20 adding at the end the following new item:

“Sec. 9827. Prohibition on preauthorization requirements with respect to cer-
 tain services.”.

21 (2) COVERAGE UNDER FEDERAL EMPLOYEES
 22 HEALTH BENEFITS PROGRAM.—Section 8904 of title
 23 5, United States Code, is amended by adding at the
 24 end the following:

1 “(c) Any health benefits plan offered under this chap-
 2 ter shall include benefits for, and may not impose any cost
 3 sharing requirements for, any prescription drug approved
 4 by the Food and Drug Administration for the prevention
 5 of HIV, administrative fees for such drugs, laboratory and
 6 other diagnostic procedures associated with the use of
 7 such drugs, and clinical follow-up and monitoring, includ-
 8 ing any related services recommended in current United
 9 States Public Health Service clinical practice guidelines,
 10 without limitation.”.

11 (3) MEDICAID.—

12 (A) IN GENERAL.—Section 1905 of the So-
 13 cial Security Act (42 U.S.C. 1396d), as amend-
 14 ed by section 5201(b)(2)(A)(i) and 5406(f), is
 15 amended—

16 (i) in subsection (a)(4)—

17 (I) by striking “; and (G)” and
 18 inserting “; (G)”; and

19 (II) by striking the semicolon at
 20 the end and inserting “; and (H) HIV
 21 prevention services;”; and

22 (ii) by adding at the end the following
 23 new subsection:

24 “(rr) HIV PREVENTION SERVICES.—For purposes of
 25 subsection (a)(4)(H), the term ‘HIV prevention services’

1 means prescription drugs for the prevention of HIV acqui-
2 sition, administrative fees for such drugs, laboratory and
3 other diagnostic procedures associated with the use of
4 such drugs, and clinical follow-up and monitoring, includ-
5 ing any related services recommended in current United
6 States Public Health Service clinical practice guidelines,
7 without limitation.”.

8 (B) NO COST-SHARING.—Title XIX of the
9 Social Security Act (42 U.S.C. 1396 et seq.) is
10 amended—

11 (i) in section 1916, by inserting “HIV
12 prevention services described in section
13 1905(a)(4)(H),” after “section
14 1905(a)(4)(C),” each place it appears; and

15 (ii) in section 1916A(b)(3)(B), as
16 amended by section 7305, by adding at the
17 end the following new clause:

18 “(xvi) HIV prevention services de-
19 scribed in section 1905(a)(4)(H).”.

20 (C) INCLUSION IN BENCHMARK COV-
21 ERAGE.—Section 1937(b)(7) of the Social Secu-
22 rity Act (42 U.S.C. 1396u–7(b)(7)) is amend-
23 ed—

(i) in the paragraph header, by inserting “AND HIV PREVENTION SERVICES” after “SUPPLIES”; and

(ii) by striking “includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section” and inserting “includes medical assistance for HIV prevention services described in section 1905(a)(4)(H), and includes, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section”.

(4) CHIP.—

(A) IN GENERAL.—Section 2103 of the Social Security Act (42 U.S.C. 1397cc), as amended by section 2007(d)(5), is amended—

(i) in subsection (a), by striking “through (13)” and inserting “through (14)”; and

(ii) in subsection (c), by adding at the end the following new paragraph:

“(14) HIV PREVENTION SERVICES.—Regardless of the type of coverage elected by a State under

1 subsection (a), the child health assistance provided
 2 for a targeted low-income child, and, in the case of
 3 a State that elects to provide pregnancy-related as-
 4 sistance pursuant to section 2112, the pregnancy-re-
 5 lated assistance provided for a targeted low-income
 6 pregnant woman (as such terms are defined for pur-
 7 poses of such section), shall include coverage of HIV
 8 prevention services (as defined in section
 9 1905(rr)).”.

10 (B) NO COST-SHARING.—Section
 11 2103(e)(2) of the Social Security Act (42
 12 U.S.C. 1397cc(e)(2)) is amended by inserting
 13 “HIV prevention services described in sub-
 14 section (c)(14),” before “or for pregnancy-re-
 15 lated assistance”.

16 (C) EFFECTIVE DATE.—

17 (i) IN GENERAL.—Subject to clause
 18 (ii), the amendments made by paragraph
 19 (3) and this paragraph shall take effect on
 20 January 1, 2027.

21 (ii) DELAY PERMITTED IF STATE LEG-
 22 ISLATION REQUIRED.—In the case of a
 23 State plan approved under title XIX or
 24 XXI of the Social Security Act which the
 25 Secretary of Health and Human Services

determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of the failure of the plan to meet such additional requirements before the 1st day of the 1st calendar quarter beginning after the close of the 1st regular session of the State legislature that ends after the 1-year period beginning with the date of the enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature.

(5) COVERAGE AND ELIMINATION OF COST-SHARING UNDER MEDICARE.—

(A) COVERAGE OF HIV PREVENTION SERVICES UNDER PART B.—

(i) COVERAGE.—

(I) IN GENERAL.—Section 1861(s)(2) of the Social Security Act

1 (42 U.S.C. 1395x(s)(2)), as amended
 2 by section 4251(c)(1) and 6101(a)(1),
 3 is amended—

4 (aa) by striking “and” at
 5 the end of subparagraph (LL);

6 (bb) by inserting “and” at
 7 the end of subparagraph (MM);
 8 and

9 (cc) by adding at the end
 10 the following new subparagraph:

11 “(NN) HIV prevention services (as defined
 12 in subsection (sss));”.

13 (II) DEFINITION.—Section 1861
 14 of the Social Security Act (42 U.S.C.
 15 1395x), as amended by sections
 16 2007(b), 4221(a), 4251(c)(2), and
 17 6101(a)(2), is amended by adding at
 18 the end the following new subsection:

19 “(sss) HIV PREVENTION SERVICES.—The term ‘HIV
 20 prevention services’ means—

21 “(1) drugs or biologicals approved by the Food
 22 and Drug Administration for the prevention of HIV;

23 “(2) administrative fees for such drugs;

24 “(3) laboratory and other diagnostic procedures
 25 associated with the use of such drugs; and

1 “(4) clinical follow-up and monitoring, including
 2 any related services recommended in current United
 3 States Public Health Service clinical practice guide-
 4 lines, without limitation.”.

5 (ii) ELIMINATION OF COINSURANCE.—

6 Section 1833(a)(1) of the Social Security
 7 Act (42 U.S.C. 1395l(a)(1)), as amended
 8 by sections 4251(c)(3) and 6101(a)(4), is
 9 amended—

10 (I) by striking “and” before
 11 “(JJ)”; and

12 (II) by inserting before the semi-
 13 colon at the end the following: “and
 14 (KK) with respect to HIV prevention
 15 services (as defined in section
 16 1861(sss)), the amount paid shall be
 17 100 percent of (i) except as provided
 18 in clause (ii), the lesser of the actual
 19 charge for the service or the amount
 20 determined under the fee schedule
 21 that applies to such services under
 22 this part, and (ii) in the case of such
 23 services that are covered OPD serv-
 24 ices (as defined in subsection

1 (t)(1)(B)), the amount determined
 2 under subsection (t)”.

3 (iii) EXEMPTION FROM PART B DE-
 4 DUCTIBLE.—Section 1833(b) of the Social
 5 Security Act (42 U.S.C. 1395l(b)) is
 6 amended—

7 (I) in paragraph (12), by striking
 8 “section 1861(s)(10)(A),, and” and
 9 inserting “section 1861(s)(10)(A),”;

10 (II) in paragraph (13), by strik-
 11 ing “section 1861(n)..” and inserting
 12 “section 1861(n), and (14) such de-
 13 ductible shall not apply with respect
 14 to HIV prevention services (as defined
 15 in section 1861(sss)).”.

16 (iv) EFFECTIVE DATE.—The amend-
 17 ments made by this subparagraph shall
 18 apply to items and services furnished on or
 19 after January 1, 2027.

20 (B) ELIMINATION OF COST-SHARING FOR
 21 DRUGS FOR THE PREVENTION OF HIV UNDER
 22 PART D.—

23 (i) IN GENERAL.—Section 1860D–2
 24 of the Social Security Act (42 U.S.C.
 25 1395w–102) is amended—

1 (I) in subsection (b)—

2 (aa) in paragraph (1)(A), in
3 the matter preceding clause (i),
4 by striking “(8) and (9)” and in-
5 serting “(8), (9), and (10)”;

6 (bb) in paragraph (2)(A), in
7 subparagraph (A), in the matter
8 preceding clause (i), by striking
9 “(8) and (9)” and inserting “(8),
10 (9), and (10)”;

11 (cc) by adding at the end
12 the following new paragraph:

13 “(10) ELIMINATION OF COST-SHARING FOR
14 DRUGS FOR THE PREVENTION OF HIV.—For plan
15 years beginning on or after January 1, 2027, with
16 respect to a covered part D drug that is for the pre-
17 vention of HIV—

18 “(A) the deductible under paragraph (1)
19 shall not apply; and

20 “(B) there shall be no coinsurance or other
21 cost-sharing under this part with respect to
22 such drug.”; and

23 (II) in subsection (c), by adding
24 at the end the following new para-
25 graph:

1 “(7) TREATMENT OF COST-SHARING FOR
2 DRUGS FOR THE PREVENTION OF HIV.—The cov-
3 erage is in accordance with subsection (b)(10).”.

4 (ii) CONFORMING AMENDMENTS TO
5 COST-SHARING FOR LOW-INCOME INDIVID-
6 UALS.—Section 1860D–14(a)(1)(D) of the
7 Social Security Act (42 U.S.C. 1395w–
8 114(a)(1)(D)) is amended in each of
9 clauses (ii) and (iii), by striking “para-
10 graph (6)” and inserting “paragraph (6)
11 and section 1860D–2(b)(10)”.

12 (6) COVERAGE OF HIV PREVENTION TREAT-
13 MENT BY DEPARTMENT OF VETERANS AFFAIRS.—

14 (A) ELIMINATION OF MEDICATION COPAY-
15 MENTS.—Section 1722A(a) of title 38, United
16 States Code, is amended by adding at the end
17 the following new paragraph:

18 “(5) Paragraph (1) does not apply to a medication
19 for the prevention of HIV.”.

20 (B) ELIMINATION OF HOSPITAL CARE AND
21 MEDICAL SERVICES COPAYMENTS.—Section
22 1710 of such title is amended—

23 (i) in subsection (f)—

24 (I) by redesignating paragraph
25 (5) as paragraph (6); and

1 (II) by inserting after paragraph
2 (4) the following new paragraph (5):

3 “(5) A veteran shall not be liable to the United States
4 under this subsection for any amounts for laboratory and
5 other diagnostic procedures associated with the use of any
6 prescription drug approved by the Food and Drug Admin-
7 istration for the prevention of HIV, administrative fees for
8 such drugs, or for laboratory or other diagnostic proce-
9 dures associated with the use of such drugs, or clinical
10 follow-up and monitoring, including any related services
11 recommended in current United States Public Health
12 Service clinical practice guidelines, without limitation.”;
13 and

14 (ii) in subsection (g)(3), by adding at
15 the end the following new subparagraph:

16 “(C) Any prescription drug approved by the
17 Food and Drug Administration for the prevention of
18 HIV, administrative fees for such drugs, laboratory
19 and other diagnostic procedures associated with the
20 use of such drugs, and clinical follow-up and moni-
21 toring, including any related services recommended
22 in current United States Public Health Service clin-
23 ical practice guidelines, without limitation.”.

(C) INCLUSION AS PREVENTIVE HEALTH SERVICE.—Section 1701(9) of such title is amended—

(i) in subparagraph (K), by striking “; and” and inserting a semicolon;

(ii) by redesignating subparagraph (L) as subparagraph (M); and

(iii) by inserting after subparagraph (K) the following new subparagraph (L):

“(L) any prescription drug approved by the Food and Drug Administration for the prevention of HIV, administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow-up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation; and”.

(7) COVERAGE OF HIV PREVENTION TREATMENT BY DEPARTMENT OF DEFENSE.—

(A) IN GENERAL.—Chapter 55 of title 10, United States Code, is amended by inserting after section 1079c the following new section:

1 **“§ 1079d. Coverage of HIV prevention treatment**

2 “(a) IN GENERAL.—The Secretary of Defense shall
3 ensure coverage under the TRICARE program of HIV
4 prevention treatment described in subsection (b) for any
5 beneficiary under section 1074(a) of this title.

6 “(b) HIV PREVENTION TREATMENT DESCRIBED.—
7 HIV prevention treatment described in this subsection in-
8 cludes any prescription drug approved by the Food and
9 Drug Administration for the prevention of HIV, adminis-
10 trative fees for such drugs, laboratory and other diagnostic
11 procedures associated with the use of such drugs, and clin-
12 ical follow-up and monitoring, including any related serv-
13 ices recommended in current United States Public Health
14 Service clinical practice guidelines, without limitation.

15 “(c) NO COST-SHARING.—Notwithstanding section
16 1075, 1075a, or 1074g(a)(6) of this title or any other pro-
17 vision of law, there is no cost-sharing requirement for HIV
18 prevention treatment covered under this section.”.

19 (B) CLERICAL AMENDMENT.—The table of
20 sections at the beginning of such chapter is
21 amended by inserting after the item relating to
22 section 1079c the following new item:

23

“1079d. Coverage of HIV prevention treatment.”.

24 (8) INDIAN HEALTH SERVICE TESTING, MONI-
25 TORING, AND PRESCRIPTION DRUGS FOR THE PRE-

1 VENTION OF HIV.—Title II of the Indian Health
 2 Care Improvement Act is amended by inserting after
 3 section 223 (25 U.S.C. 1621v) the following:

4 **“SEC. 224. TESTING, MONITORING, AND PRESCRIPTION**
 5 **DRUGS FOR THE PREVENTION OF HIV.**

6 “(a) IN GENERAL.—The Secretary, acting through
 7 the Service, Indian tribes, and tribal organizations, shall
 8 provide, without limitation, funding for any prescription
 9 drug approved by the Food and Drug Administration for
 10 the prevention of human immunodeficiency virus (com-
 11 monly known as ‘HIV’), administrative fees for that drug,
 12 laboratory and other diagnostic procedures associated with
 13 the use of that drug, and clinical follow-up and moni-
 14 toring, including any related services recommended in cur-
 15 rent Public Health Service clinical practice guidelines.

16 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
 17 are authorized to be appropriated such sums as are nec-
 18 essary to carry out this section.”.

19 (b) PROHIBITION ON DENIAL OF COVERAGE OR IN-
 20 CREASE IN PREMIUMS OF LIFE, DISABILITY, OR LONG-
 21 TERM CARE INSURANCE FOR INDIVIDUALS TAKING
 22 MEDICATION FOR THE PREVENTION OF HIV ACQUI-
 23 TION.—

24 (1) PROHIBITION.—Notwithstanding any other
 25 provision of law, it shall be unlawful to—

1 (A) decline or limit coverage of a person
2 under any life insurance policy, disability insur-
3 ance policy, or long-term care insurance policy,
4 on account of the individual taking medication
5 for the purpose of preventing the acquisition of
6 HIV;

7 (B) preclude an individual from taking
8 medication for the purpose of preventing the ac-
9 quisition of HIV as a condition of receiving a
10 life insurance policy, disability insurance policy,
11 or long-term care insurance policy;

12 (C) consider whether an individual is tak-
13 ing medication for the purpose of preventing
14 the acquisition of HIV in determining the pre-
15 mium rate for coverage of such individual under
16 a life insurance policy, disability insurance pol-
17 icy, or long-term care insurance policy; or

18 (D) otherwise discriminate in the offering,
19 issuance, cancellation, amount of such coverage,
20 price, or any other condition of a life insurance
21 policy, disability insurance policy, or long-term
22 care insurance policy for an individual, based
23 solely and without any additional actuarial risks
24 upon whether the individual is taking medica-

1 tion for the purpose of preventing the acquisi-
2 tion of HIV.

3 (2) ENFORCEMENT.—A State insurance regu-
4 lator may take such actions to enforce paragraph (1)
5 as are specifically authorized under the laws of such
6 State.

7 (3) DEFINITIONS.—In this subsection:

8 (A) DISABILITY INSURANCE POLICY.—The
9 term “disability insurance policy” means a con-
10 tract under which an entity promises to pay a
11 person a sum of money in the event that an ill-
12 ness or injury resulting in a disability prevents
13 such person from working.

14 (B) LIFE INSURANCE POLICY.—The term
15 “life insurance policy” means a contract under
16 which an entity promises to pay a designated
17 beneficiary a sum of money upon the death of
18 the insured.

19 (C) LONG-TERM CARE INSURANCE POL-
20 ICY.—The term “long-term care insurance pol-
21 icy” means a contract for which the only insur-
22 ance protection provided under the contract is
23 coverage of qualified long-term care services (as
24 defined in section 7702B(c) of the Internal
25 Revenue Code of 1986).

1 (c) PATIENT CONFIDENTIALITY.—The Secretary of
 2 Health and Human Services shall amend the regulations
 3 promulgated under section 264(c) of the Health Insurance
 4 Portability and Accountability Act of 1996 (42 U.S.C.
 5 1320d–2 note), as necessary, to ensure that individuals
 6 are able to access the benefits described in section
 7 2713(a)(1)(E) of the Public Health Service Act under a
 8 family plan without any other individual enrolled in such
 9 family plan, including a primary subscriber or policyholder
 10 of such plan, being informed of such use of such benefits.

11 (d) PRE-EXPOSURE PROPHYLAXIS AND POST-EXPO-
 12 SURE PROPHYLAXIS FUNDING.—Part P of title III of the
 13 Public Health Service Act (42 U.S.C. 280g et seq.), as
 14 amended by section 7303, is amended by adding at the
 15 end the following:

16 **“SEC. 399V–11. PRE-EXPOSURE PROPHYLAXIS AND POST-EX-**
 17 **POSURE PROPHYLAXIS FUNDING.**

18 “(a) IN GENERAL.—Not later than 1 year after the
 19 date of enactment of this section, the Secretary shall es-
 20 tablish a program that awards grants to States, terri-
 21 tories, Indian Tribes, and directly eligible entities for the
 22 establishment and support of pre-exposure prophylaxis
 23 (referred to in this section as ‘PrEP’) and post-exposure
 24 prophylaxis (referred to in this section as ‘PEP’) HIV pro-
 25 grams.

1 “(b) APPLICATIONS.—To be eligible to receive a
2 grant under subsection (a), a State, territory, Indian
3 Tribe, or directly eligible entity shall—

4 “(1) submit an application to the Secretary at
5 such time, in such manner, and containing such in-
6 formation as the Secretary may require, including a
7 plan describing how any funds awarded will be used
8 to increase access to PrEP for uninsured and under-
9 insured individuals and reduce disparities in access
10 to PrEP and PEP for uninsured and underinsured
11 individuals and reduce disparities in access to PrEP
12 and PEP; and

13 “(2) appoint a PrEP and PEP grant adminis-
14 trator to manage the program.

15 “(c) DIRECTLY ELIGIBLE ENTITY.—For purposes of
16 this section, the term ‘directly eligible entity’—

17 “(1) means a Federally qualified health center
18 or other nonprofit entity engaged in providing PrEP
19 and PEP information and services; and

20 “(2) may include—

21 “(A) a Federally qualified health center
22 (as defined in section 1861(aa)(4) of the Social
23 Security Act);

24 “(B) a family planning grantee (other than
25 States) funded under section 1001;

1 “(C) a rural health clinic (as defined in
2 section 1861(aa)(2) of the Social Security Act);

3 “(D) a health facility operated by or pur-
4 suant to a contract with the Indian Health
5 Service;

6 “(E) a community-based organization, clin-
7 ic, hospital, or other health facility that pro-
8 vides services to individuals at risk for or living
9 with HIV; and

10 “(F) a nonprofit private entity providing
11 comprehensive primary care to populations at
12 risk of HIV, including faith-based and commu-
13 nity-based organizations.

14 “(d) AWARDS.—In determining whether to award a
15 grant, and the grant amount for each grant awarded, the
16 Secretary shall consider the grant application and the
17 need for PrEP and PEP services in the area, the number
18 of uninsured and underinsured individuals in the area, and
19 how the State, territory, or Indian Tribe coordinates
20 PrEP and PEP activities with the directly funded entity,
21 if the State, territory, or Indian Tribe applies for the
22 funds.

23 “(e) USE OF FUNDS.—

24 “(1) IN GENERAL.—Any State, territory, Indian
25 Tribe, or directly eligible entity that is awarded

1 funds under subsection (a) shall use such funds for
2 eligible PrEP and PEP expenses.

3 “(2) ELIGIBLE PREP EXPENSES.—The Sec-
4 retary shall publish a list of expenses that qualify as
5 eligible PrEP and PEP expenses for purposes of this
6 section, which shall include—

7 “(A) any prescription drug approved by
8 the Food and Drug Administration for the pre-
9 vention of HIV, administrative fees for such
10 drugs, laboratory and other diagnostic proce-
11 dures associated with the use of such drugs,
12 and clinical follow-up and monitoring, including
13 any related services recommended in current
14 United States Public Health Service clinical
15 practice guidelines, without limitation;

16 “(B) outreach and public education activi-
17 ties directed toward populations overrepresented
18 in the domestic HIV epidemic that increase
19 awareness about the existence of PrEP and
20 PEP, provide education about access to and
21 health care coverage of PrEP and PEP, PrEP
22 and PEP adherence programs, and counter
23 stigma associated with the use of PrEP and
24 PEP; and

1 “(C) outreach activities directed toward
2 physicians and other providers that provide
3 education about PrEP and PEP.

4 “(f) REPORT TO CONGRESS.—The Secretary shall, in
5 each of the first 5 years beginning one year after the date
6 of the enactment of this section, submit to Congress, and
7 make public on the internet website of the Department
8 of Health and Human Services, a report on the impact
9 of any grants provided to States, territories, and Indian
10 Tribes and directly eligible entities for the establishment
11 and support of pre-exposure prophylaxis programs under
12 this section.

13 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
14 carry out this section, there are authorized to be appro-
15 priated such sums as may be necessary for each of fiscal
16 years 2027 through 2032.”.

17 (e) CLARIFICATION.—This section, including the
18 amendments made by this section, shall apply notwith-
19 standing any other provision of law, including Public Law
20 103–141.

21 (f) PRIVATE RIGHT OF ACTION.—Any person ag-
22 grieved by a violation of this section, including the amend-
23 ments made by this section, may commence a civil action
24 in an appropriate United States District Court or other
25 court of competent jurisdiction to obtain relief as allowed

1 by law as either an individual or member of a class. If
 2 the plaintiff is the prevailing party in such an action, the
 3 court shall order the defendant to pay the costs and rea-
 4 sonable attorney fees of the plaintiff.

5 **Subtitle F—Diabetes**

6 **SEC. 7501. RESEARCH, TREATMENT, AND EDUCATION.**

7 Subpart 3 of part C of title IV of the Public Health
 8 Service Act (42 U.S.C. 285c et seq.) is amended by adding
 9 at the end the following:

10 **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

11 “(a) IN GENERAL.—The Director of NIH shall ex-
 12 pand, intensify, and support ongoing research and other
 13 activities with respect to prediabetes and diabetes, particu-
 14 larly type 2, in minority populations.

15 “(b) RESEARCH.—

16 “(1) DESCRIPTION.—Research under subsection
 17 (a) shall include investigation into—

18 “(A) the causes of diabetes, including so-
 19 cioeconomic, geographic, clinical, environmental,
 20 genetic, and other factors that may contribute
 21 to increased rates of diabetes in minority popu-
 22 lations; and

23 “(B) the causes of increased incidence of
 24 diabetes complications in minority populations,

1 and possible interventions to decrease such inci-
2 dence.

3 “(2) INCLUSION OF MINORITY PARTICIPANTS.—

4 In conducting and supporting research described in
5 subsection (a), the Director of NIH shall seek to in-
6 clude minority participants as study subjects in clin-
7 ical trials.

8 “(c) REPORT; COMPREHENSIVE PLAN.—

9 “(1) IN GENERAL.—The Diabetes Mellitus
10 Interagency Coordinating Committee shall—

11 “(A) prepare and submit to Congress, not
12 later than 6 months after the date of enactment
13 of this section, a report on Federal research
14 and public health activities with respect to
15 prediabetes and diabetes in minority popu-
16 lations; and

17 “(B) develop and submit to Congress, not
18 later than 1 year after the date of enactment of
19 this section, an effective and comprehensive
20 Federal plan (including all appropriate Federal
21 health programs) to address prediabetes and di-
22 abetes in minority populations.

23 “(2) CONTENTS.—The report under paragraph
24 (1)(A) shall at minimum address each of the fol-
25 lowing:

1 “(A) Research on diabetes and prediabetes
2 in minority populations, including such research
3 on—

4 “(i) genetic, behavioral, socio-
5 economic, and environmental factors;

6 “(ii) prevention of diabetes within
7 these populations and which of the popu-
8 lations have individuals at increased risk of
9 developing diabetes;

10 “(iii) prevention of complications
11 among individuals in these populations who
12 have already developed diabetes; and

13 “(iv) barriers to health care access
14 and diabetes treatment within populations
15 at increased risk of developing diabetes.

16 “(B) Surveillance and data collection on
17 diabetes and prediabetes in minority popu-
18 lations, including with respect to—

19 “(i) efforts to better determine the
20 prevalence of diabetes among Asian-Amer-
21 ican, Native Hawaiian, and Pacific Is-
22 lander subgroups; and

23 “(ii) efforts to coordinate data collec-
24 tion on the American Indian population.

1 “(C) Community-based interventions to ad-
2 dress diabetes and prediabetes targeting minor-
3 ity populations, including—

4 “(i) the evidence base for such inter-
5 ventions;

6 “(ii) the cultural appropriateness of
7 such interventions; and

8 “(iii) efforts to educate the public on
9 the causes and consequences of diabetes.

10 “(D) Education and training programs for
11 health professionals (including community
12 health workers) on the prevention and manage-
13 ment of diabetes and its related complications
14 that is supported by the Health Resources and
15 Services Administration, including such pro-
16 grams supported by—

17 “(i) the National Health Service
18 Corps; or

19 “(ii) the community health centers
20 program under section 330.

21 “(d) EDUCATION.—The Director of NIH shall—

22 “(1) through the National Institute on Minority
23 Health and Health Disparities and the National Di-
24 abetes Education Program—

1 “(A) make grants to programs funded
 2 under section 464z–4 for the purpose of estab-
 3 lishing a medical education program for health
 4 care professionals to be more involved in weight
 5 counseling, obesity research, nutrition, and
 6 shared decision making; and

7 “(B) provide for the participation of mi-
 8 nority health professionals in diabetes-focused
 9 research programs; and

10 “(2) make grants to programs that establish a
 11 professional pipeline that will increase the participa-
 12 tion of minority individuals in diabetes-focused
 13 health fields by expanding Minority Access to Re-
 14 search Careers program internships and mentoring
 15 opportunities for the purposes of recruitment.

16 “(e) DEFINITIONS.—For purposes of this section:

17 “(1) DIABETES MELLITUS INTERAGENCY CO-
 18 ORDINATING COMMITTEE.—The ‘Diabetes Mellitus
 19 Interagency Coordinating Committee’ means the Di-
 20 abetes Mellitus Interagency Coordinating Committee
 21 established under section 429.

22 “(2) MINORITY POPULATION.—The term ‘mi-
 23 nority population’ means a racial and ethnic minor-
 24 ity group, as defined in section 1707.”.

1 **SEC. 7502. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
2 **TIES.**

3 Part B of title III of the Public Health Service Act
4 (42 U.S.C. 243 et seq.), as amended by section 7201, is
5 amended by inserting after section 317X the following:

6 **“SEC. 317Y. DIABETES IN MINORITY POPULATIONS.**

7 **“(a) RESEARCH AND OTHER ACTIVITIES.—**

8 **“(1) IN GENERAL.—**The Secretary, acting
9 through the Director of the Centers for Disease
10 Control and Prevention, shall conduct and support
11 research and public health activities with respect to
12 diabetes in minority populations.

13 **“(2) CERTAIN ACTIVITIES.—**Activities under
14 paragraph (1) regarding diabetes in minority popu-
15 lations shall include the following:

16 **“(A) Further enhancing the National**
17 **Health and Nutrition Examination Survey by**
18 **oversampling Asian Americans, Native Hawai-**
19 **ians, and Pacific Islanders in appropriate geo-**
20 **graphic areas to better determine the preva-**
21 **lence of diabetes in such populations as well as**
22 **to improve the data collection of diabetes pene-**
23 **tration disaggregated into major ethnic groups**
24 **within such populations. The Secretary shall en-**
25 **sure that any such oversampling does not re-**
26 **duce the oversampling of other minority popu-**

1 lations including African-American and Latino
2 populations.

3 “(B) Through the Division of Diabetes
4 Translation—

5 “(i) providing for prevention research
6 to better understand how to influence
7 health care systems changes to improve
8 quality of care being delivered to such pop-
9 ulations;

10 “(ii) carrying out model demonstra-
11 tion projects to design, implement, and
12 evaluate effective diabetes prevention and
13 control interventions for minority popu-
14 lations, including culturally appropriate
15 community-based interventions;

16 “(iii) developing and implementing a
17 strategic plan to reduce diabetes in minor-
18 ity populations through applied research to
19 reduce disparities and culturally and lin-
20 guistically appropriate community-based
21 interventions;

22 “(iv) supporting, through the national
23 diabetes prevention program under section
24 399V–3, diabetes prevention program sites

1 in underserved regions highly impacted by
2 diabetes; and

3 “(v) implementing, through the na-
4 tional diabetes prevention program under
5 section 399V–3, a demonstration program
6 developing new metrics measuring health
7 outcomes related to diabetes that can be
8 stratified by specific minority populations.

9 “(b) EDUCATION.—The Secretary, acting through
10 the Director of the Centers for Disease Control and Pre-
11 vention, shall direct the Division of Diabetes Translation
12 to conduct and support both programs to educate the pub-
13 lic on diabetes in minority populations and programs to
14 educate minority populations about the causes and effects
15 of diabetes.

16 “(c) DIABETES; HEALTH PROMOTION, PREVENTION
17 INITIATIVES, AND ACCESS.—The Secretary, acting
18 through the Director of the Centers for Disease Control
19 and Prevention and the National Diabetes Education Pro-
20 gram, shall conduct and support programs to educate spe-
21 cific minority populations through culturally appropriate
22 and linguistically appropriate information campaigns and
23 initiatives about prevention of, and managing, diabetes.

1 “(d) DEFINITION.—For purposes of this section, the
 2 term ‘minority population’ means a racial and ethnic mi-
 3 nority group, as defined in section 1707.”.

4 **SEC. 7503. PROGRAMS TO EDUCATE HEALTH PROVIDERS**
 5 **ON THE CAUSES AND EFFECTS OF DIABETES**
 6 **IN MINORITY POPULATIONS.**

7 Part P of title III of the Public Health Service Act
 8 (42 U.S.C. 280g et seq.), as amended by section 7419(d),
 9 is amended by adding at the end the following:

10 **“SEC. 399V-12. PROGRAMS TO EDUCATE HEALTH PRO-**
 11 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
 12 **ABETES IN MINORITY POPULATIONS.**

13 “(a) IN GENERAL.—The Secretary, acting through
 14 the Administrator of the Health Resources and Services
 15 Administration, shall conduct and support programs de-
 16 scribed in subsection (b) to educate health professionals
 17 on the causes and effects of diabetes in minority popu-
 18 lations.

19 “(b) PROGRAMS.—Programs described in this sub-
 20 section, with respect to education on diabetes in minority
 21 populations, shall include the following:

22 “(1) Giving priority, under the primary care
 23 training and enhancement program under section
 24 747—

1 “(A) to awarding grants to focus on or ad-
2 dress diabetes; and

3 “(B) to adding minority populations to the
4 list of vulnerable populations that should be
5 served by such grants.

6 “(2) Providing additional funds for the Health
7 Careers Opportunity Program and the Centers of
8 Excellence to partner with the Office of Minority
9 Health under section 1707 and the National Insti-
10 tutes of Health to strengthen programs for career
11 opportunities focused on diabetes treatment and care
12 within underserved regions highly impacted by dia-
13 betes.

14 “(3) Developing a diabetes focus within, and
15 providing additional funds for, the National Health
16 Service Corps scholarship program—

17 “(A) to place individuals in areas that are
18 disproportionately affected by diabetes and to
19 provide diabetes treatment and care in such
20 areas; and

21 “(B) to provide such individuals continuing
22 medical education specific to diabetes care.”.

1 **SEC. 7504. RESEARCH, EDUCATION, AND OTHER ACTIVITIES**
2 **REGARDING DIABETES IN AMERICAN INDIAN**
3 **POPULATIONS.**

4 Part P of title III of the Public Health Service Act
5 (42 U.S.C. 280g et seq.), as amended by section 7503,
6 is amended by adding at the end the following:

7 **“SEC. 399V-13. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
8 **TIES REGARDING DIABETES IN AMERICAN IN-**
9 **DIAN POPULATIONS.**

10 “In addition to activities under sections 317X, 399V-
11 12, and 434B, the Secretary, acting through the Indian
12 Health Service and in collaboration with other appropriate
13 Federal agencies, shall—

14 “(1) conduct and support research and other
15 activities with respect to diabetes; and

16 “(2) coordinate the collection of data on clini-
17 cally and culturally appropriate diabetes treatment,
18 care, prevention, and services by health care profes-
19 sionals to the American Indian population.”.

20 **SEC. 7505. UPDATED REPORT ON HEALTH DISPARITIES.**

21 The Secretary of Health and Human Services shall
22 seek to enter into an arrangement with the National Acad-
23 emy of Medicine under which the National Academy will—

24 (1) not later than 1 year after the date of en-
25 actment of this Act, submit to Congress an updated
26 version of the 2003 report entitled “Unequal Treat-

1 ment: Confronting Racial and Ethnic Disparities in
 2 Health Care”; and

3 (2) in such updated version, address how racial
 4 and ethnic health disparities have changed since the
 5 publication of the original report.

6 **Subtitle G—Lung Disease**

7 **SEC. 7601. ASTHMA-RELATED ACTIVITIES OF THE CENTERS** 8 **FOR DISEASE CONTROL AND PREVENTION.**

9 Section 317I of the Public Health Service Act (42
 10 U.S.C. 247b–10) is amended to read as follows:

11 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS** 12 **FOR DISEASE CONTROL AND PREVENTION.**

13 “(a) PROGRAM FOR PROVIDING INFORMATION AND
 14 EDUCATION TO THE PUBLIC.—The Secretary, acting
 15 through the Director of the Centers for Disease Control
 16 and Prevention, shall collaborate with State and local
 17 health departments to conduct activities, including the
 18 provision of information and education to the public, re-
 19 garding asthma including—

20 “(1) deterring the harmful consequences of un-
 21 controlled asthma; and

22 “(2) disseminating health education and infor-
 23 mation regarding prevention of asthma episodes and
 24 strategies for managing asthma.

1 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—

2 The Secretary, acting through the Director of the Centers
3 for Disease Control and Prevention, shall collaborate with
4 State and local health departments to develop State plans
5 incorporating public health responses to reduce the burden
6 of asthma, particularly regarding disproportionately af-
7 fected populations.

8 “(c) COMPILATION OF DATA.—The Secretary, acting
9 through the Director of the Centers for Disease Control
10 and Prevention, shall, in cooperation with State and local
11 public health officials—

12 “(1) conduct asthma surveillance activities to
13 collect data on the prevalence and severity of asth-
14 ma, the effectiveness of public health asthma inter-
15 ventions, and the quality of asthma management, in-
16 cluding—

17 “(A) collection of data among people with
18 asthma to monitor the impact on health and
19 quality of life;

20 “(B) surveillance of health care facilities;
21 and

22 “(C) collection of data not containing indi-
23 vidually identifiable information from electronic
24 health records or other electronic communica-
25 tions;

1 “(2) compile and annually publish data regard-
2 ing the prevalence and incidence of childhood asth-
3 ma, the child mortality rate, and the number of hos-
4 pital admissions and emergency department visits by
5 children associated with asthma nationally and in
6 each State and at the county level by age, sex, race,
7 and ethnicity, as well as lifetime and current preva-
8 lence; and

9 “(3) compile and annually publish data regard-
10 ing the prevalence and incidence of adult asthma,
11 the adult mortality rate, and the number of hospital
12 admissions and emergency department visits by
13 adults associated with asthma nationally and in each
14 State and at the county level by age, sex, race, eth-
15 nicity, industry, and occupation, as well as lifetime
16 and current prevalence.

17 “(d) COORDINATION OF DATA COLLECTION.—The
18 Director of the Centers for Disease Control and Preven-
19 tion, in conjunction with State and local health depart-
20 ments, shall coordinate data collection activities under
21 paragraphs (2) and (3) of subsection (c) so as to maximize
22 comparability of results.

23 “(e) COLLABORATION.—

24 “(1) IN GENERAL.—The Centers for Disease
25 Control and Prevention may collaborate with na-

1 tional, State, and local nonprofit organizations to
 2 provide information and education about asthma,
 3 and to strengthen such collaborations when possible.

4 “(2) SPECIFIC ACTIVITIES.—The Director of
 5 the Centers for Disease Control and Prevention, act-
 6 ing through the Division of Population Health of the
 7 Centers, may expand activities relating to asthma
 8 with non-Federal partners, especially State-level en-
 9 tities.

10 “(f) REPORTS TO CONGRESS.—

11 “(1) IN GENERAL.—Not later than 3 years
 12 after the date of the enactment of the Health Equity
 13 and Accountability Act of 2026, and once 2 years
 14 thereafter, the Secretary shall, in consultation with
 15 patient groups, nonprofit organizations, medical so-
 16 cieties, and other relevant governmental and non-
 17 governmental entities, submit to Congress a report
 18 that—

19 “(A) catalogs, with respect to asthma pre-
 20 vention, management, and surveillance—

21 “(i) the activities of the Federal Gov-
 22 ernment, including an assessment of the
 23 progress of the Federal Government and
 24 States, with respect to achieving the goals
 25 of the Healthy People 2030 initiative; and

1 “(ii) the activities of other entities
2 that participate in the program under this
3 section, including nonprofit organizations,
4 patient advocacy groups, and medical soci-
5 eties; and

6 “(B) makes recommendations for the fu-
7 ture direction of asthma activities, in consulta-
8 tion with researchers from the National Insti-
9 tutes of Health and other member bodies of the
10 Asthma Disparities Subcommittee, including—

11 “(i) a description of how the Federal
12 Government may improve its response to
13 asthma, including identifying any barriers
14 that may exist;

15 “(ii) a description of how the Federal
16 Government may continue, expand, and
17 improve its private-public partnerships
18 with respect to asthma, including identi-
19 fying any barriers that may exist;

20 “(iii) identification of steps that may
21 be taken to reduce the—

22 “(I) morbidity, mortality, and
23 overall prevalence of asthma;

24 “(II) financial burden of asthma
25 on society;

1 “(III) burden of asthma on dis-
2 proportionately affected areas, par-
3 ticularly those in medically under-
4 served populations (as defined in sec-
5 tion 330(b)(3)); and

6 “(IV) burden of asthma as a
7 chronic disease that can be worsened
8 by environmental exposures;

9 “(iv) the identification of programs
10 and policies that have achieved the steps
11 described under clause (iii), and steps that
12 may be taken to expand such programs
13 and policies to benefit larger populations;
14 and

15 “(v) recommendations for future re-
16 search and interventions.

17 “(2) SUBSEQUENT REPORTS.—

18 “(A) CONGRESSIONAL REQUEST.—During
19 the 5-year period following the submission of
20 the second report under paragraph (1), the Sec-
21 retary shall submit updates and revisions of the
22 report upon the request of the Congress.

23 “(B) FIVE-YEAR REEVALUATION.—At the
24 end of the 5-year period referred to in subpara-
25 graph (A), the Secretary shall—

1 “(i) evaluate the analyses and rec-
2 ommendations made in previous reports;
3 and

4 “(ii) determine whether an additional
5 report is needed and if so submit such an
6 updated report to the Congress, including
7 appropriate recommendations.

8 “(g) AUTHORIZATION OF APPROPRIATIONS FUND-
9 ING.—In addition to any other authorization of appropria-
10 tions that is available to the Centers for Disease Control
11 and Prevention for the purpose of carrying out this sec-
12 tion, there is authorized to be appropriated to such Cen-
13 ters \$65,000,000 for the period of fiscal years 2027
14 through 2031 for the purpose of carrying out this sec-
15 tion.”.

16 **SEC. 7602. INFLUENZA AND PNEUMONIA VACCINATION**
17 **CAMPAIGN.**

18 (a) IN GENERAL.—The Secretary of Health and
19 Human Services shall—

20 (1) enhance the annual campaign by the De-
21 partment of Health and Human Services to increase
22 the number of people vaccinated each year for influ-
23 enza and pneumonia; and

24 (2) include in such campaign the use of written
25 educational materials, public service announcements,

1 physician education, and any other means which the
2 Secretary determines effective.

3 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
4 out the annual campaign described in subsection (a), the
5 Secretary of Health and Human Services shall ensure
6 that—

7 (1) educational materials and public service an-
8 nouncements are readily and widely available in
9 communities experiencing disparities in the incidence
10 and mortality rates of influenza and pneumonia; and

11 (2) the campaign uses targeted, culturally ap-
12 propriate messages and messengers to reach under-
13 served communities.

14 (c) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section
16 such sums as may be necessary for each of fiscal years
17 2027 through 2031.

18 **SEC. 7603. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.**

19 (a) IN GENERAL.—The Director of the Centers for
20 Disease Control and Prevention shall conduct, support,
21 and expand public health strategies and prevention, diag-
22 nosis, surveillance, and public and professional awareness
23 activities regarding chronic obstructive pulmonary disease.

1 (b) CHRONIC DISEASE PREVENTION PROGRAMS.—

2 The Director of the National Heart, Lung, and Blood In-
3 stitute shall carry out the following:

4 (1) Conduct public education and awareness ac-
5 tivities with patient and professional organizations
6 to stimulate earlier diagnosis and improve patient
7 outcomes from treatment of chronic obstructive pul-
8 monary disease. To the extent known and relevant,
9 such public education and awareness activities shall
10 reflect differences in chronic obstructive pulmonary
11 disease by cause (tobacco, environmental, occupa-
12 tional, biological, and genetic) and include a focus
13 on outreach to undiagnosed and, as appropriate, mi-
14 nority populations.

15 (2) Supplement and expand upon the activities
16 of the National Heart, Lung, and Blood Institute by
17 making grants to nonprofit organizations, State and
18 local jurisdictions, and Indian Tribes for the purpose
19 of reducing the burden of chronic obstructive pul-
20 monary disease, especially in disproportionately im-
21 pacted communities, through public health interven-
22 tions and related activities.

23 (3) Coordinate with the Centers for Disease
24 Control and Prevention, the Indian Health Service,
25 the Health Resources and Services Administration,

1 and the Department of Veterans Affairs to develop
2 pilot programs to demonstrate best practices for the
3 diagnosis and management of chronic obstructive
4 pulmonary disease.

5 (4) Develop improved techniques and identify
6 best practices, in coordination with the Secretary of
7 Veterans Affairs, for assisting chronic obstructive
8 pulmonary disease patients to successfully stop
9 smoking, including identification of subpopulations
10 with different needs. Initiatives under this para-
11 graph may include research to determine whether
12 successful smoking cessation strategies are different
13 for chronic obstructive pulmonary disease patients
14 compared to such strategies for patients with other
15 chronic diseases.

16 (c) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
17 PROGRAMS.—The Director of the Centers for Disease
18 Control and Prevention shall—

19 (1) support research into the environmental and
20 occupational causes and biological mechanisms that
21 contribute to chronic obstructive pulmonary disease;
22 and

23 (2) develop and disseminate public health inter-
24 ventions that will lessen the impact of environmental

1 and occupational causes of chronic obstructive pul-
2 monary disease.

3 (d) DATA COLLECTION.—Not later than 180 days
4 after the date of enactment of this Act, the Director of
5 the National Heart, Lung, and Blood Institute and the
6 Director of the Centers for Disease Control and Preven-
7 tion, acting jointly, shall assess the depth and quality of
8 information on chronic obstructive pulmonary disease that
9 is collected in surveys and population studies conducted
10 by the Centers for Disease Control and Prevention, includ-
11 ing whether there are additional opportunities for informa-
12 tion to be collected in the National Health and Nutrition
13 Examination Survey, the National Health Interview Sur-
14 vey, and the Behavioral Risk Factors Surveillance System
15 surveys.

16 (e) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2027 through 2031.

20 **Subtitle H—Tuberculosis**

21 **SEC. 7701. UNITED STATES GOVERNMENT ASSISTANCE TO** 22 **COMBAT TUBERCULOSIS.**

23 Section 104B of the Foreign Assistance Act of 1961
24 (22 U.S.C. 2151b–3) is amended to read as follows:

1 **“SEC. 104B. ASSISTANCE TO COMBAT TUBERCULOSIS.**

2 “(a) POLICY.—

3 “(1) IN GENERAL.—It is a major objective of
4 the foreign assistance program of the United States
5 to help end the TB public health emergency through
6 accelerated actions—

7 “(A) to support the diagnosis and treat-
8 ment of all adults and children with all forms
9 of TB; and

10 “(B) to prevent new TB infections from
11 occurring.

12 “(2) SUPPORT FOR GLOBAL PLANS AND OBJEC-
13 TIVES.—In countries in which the United States
14 Government has established foreign assistance pro-
15 grams under this Act, particularly in countries with
16 the highest burden of TB and other countries with
17 high rates of infection and transmission of TB, it is
18 the policy of the United States—

19 “(A) to support the objectives of the World
20 Health Organization End TB Strategy, includ-
21 ing its goals—

22 “(i) to reduce TB deaths by 95 per-
23 cent by 2035;

24 “(ii) to reduce the TB incidence rate
25 by 90 percent by 2035; and

1 “(iii) to reduce the number of families
 2 facing catastrophic health costs due to TB
 3 by 100 percent by 2035;

4 “(B) to support the Stop TB Partnership’s
 5 Global Plan to End TB 2023–2030, including
 6 by providing support for—

7 “(i) developing and using innovative
 8 new technologies and therapies to increase
 9 active case finding and rapidly diagnose
 10 and treat children and adults with all
 11 forms of TB, alleviate suffering, and en-
 12 sure TB treatment completion;

13 “(ii) expanding diagnosis and treat-
 14 ment in line with the goals established by
 15 the Political Declaration of the High-Level
 16 Meeting of the General Assembly on the
 17 Fight Against Tuberculosis, including—

18 “(I) successfully treating
 19 40,000,000 people with active TB by
 20 2023, including 3,500,000 children,
 21 and 1,500,000 people with drug-re-
 22 sistant TB; and

23 “(II) diagnosing and treating la-
 24 tent tuberculosis infection, in support
 25 of the global goal of providing preven-

1 tive therapy to at least 30,000,000
2 people by 2023, including 4,000,000
3 children younger than 5 years of age,
4 20,000,000 household contacts of peo-
5 ple affected by TB, and 6,000,000
6 people living with HIV;

7 “(iii) ensuring high-quality TB care
8 by closing gaps in care cascades, imple-
9 menting continuous quality improvement
10 at all levels of care, and providing related
11 patient support; and

12 “(iv) sustainable procurements of TB
13 commodities to avoid interruptions in sup-
14 ply, the procurement of commodities of un-
15 known quality, or payment of excessive
16 commodity costs in countries impacted by
17 TB; and

18 “(C) to ensure, to the greatest extent prac-
19 ticable, that United States funding supports ac-
20 tivities that simultaneously emphasize—

21 “(i) the development of comprehensive
22 person-centered programs, including diag-
23 nosis, treatment, and prevention strategies
24 to ensure that—

1 “(I) all people sick with TB re-
2 ceive quality diagnosis and treatment
3 through active case finding; and

4 “(II) people at high risk for TB
5 infection are found and treated with
6 preventive therapies in a timely man-
7 ner;

8 “(ii) robust TB infection control prac-
9 tices are implemented in all congregate set-
10 tings, including hospitals and prisons;

11 “(iii) the deployment of diagnostic
12 and treatment capacity—

13 “(I) in areas with the highest TB
14 burdens; and

15 “(II) for highly at-risk and im-
16 poverished populations, including pa-
17 tient support services;

18 “(iv) program monitoring and evalua-
19 tion based on critical TB indicators, in-
20 cluding indicators relating to infection con-
21 trol, the numbers of patients accessing TB
22 treatment and patient support services,
23 and preventative therapy for those at risk,
24 including all close contacts, and treatment
25 outcomes for all forms of TB;

1 “(v) training and engagement of
 2 health care workers on the use of new di-
 3 agnostic tools and therapies as they be-
 4 come available, and increased support for
 5 training frontline health care workers to
 6 support expanded TB active case finding,
 7 contact tracing, and patient support serv-
 8 ices;

9 “(vi) coordination with domestic agen-
 10 cies and organizations to support an ag-
 11 gressive research agenda to develop vac-
 12 cines as well as new tools to diagnose,
 13 treat, and prevent TB globally;

14 “(vii) linkages with the private sector
 15 on—

16 “(I) research and development of
 17 a vaccine, and on new tools for diag-
 18 nosis and treatment of TB;

19 “(II) improving current tools for
 20 diagnosis and treatment of TB, in-
 21 cluding telehealth solutions for pre-
 22 vention and treatment; and

23 “(III) training healthcare profes-
 24 sionals on use of the newest and most

1 effective diagnostic and therapeutic
2 tools;

3 “(viii) the reduction of barriers to
4 care, including stigma and treatment and
5 diagnosis costs, including through—

6 “(I) training health workers;

7 “(II) sensitizing policy makers;

8 “(III) requiring that all relevant
9 grants and funding agreements in-
10 clude access and affordability provi-
11 sions;

12 “(IV) supporting education and
13 empowerment campaigns for TB pa-
14 tients regarding local TB services;

15 “(V) monitoring barriers to ac-
16 cessing TB services; and

17 “(VI) increasing support for pa-
18 tient-led and community-led TB out-
19 reach efforts;

20 “(ix) support for country-level, sus-
21 tainable accountability mechanisms and ca-
22 pacity to measure progress and ensure that
23 commitments made by governments and
24 relevant stakeholders are met; and

1 “(x) support for the integration of TB
2 diagnosis, treatment, and prevention activi-
3 ties into primary health care, as appro-
4 priate.

5 “(b) DEFINITIONS.—In this section:

6 “(1) APPROPRIATE CONGRESSIONAL COMMIT-
7 TEES.—The term ‘appropriate congressional com-
8 mittees’ means the Committee on Foreign Relations
9 of the Senate and the Committee on Foreign Affairs
10 of the House of Representatives.

11 “(2) END TB STRATEGY.—The term ‘End TB
12 Strategy’ means the strategy to eliminate TB that
13 was approved by the World Health Assembly in May
14 2014, and is described in ‘The End TB Strategy:
15 Global Strategy and Targets for Tuberculosis Pre-
16 vention, Care and Control After 2015’.

17 “(3) GLOBAL ALLIANCE FOR TUBERCULOSIS
18 DRUG DEVELOPMENT.—The term ‘Global Alliance
19 for Tuberculosis Drug Development’ means the pub-
20 lic-private partnership that bring together leaders in
21 health, science, philanthropy, and private industry to
22 devise new approaches to TB.

23 “(4) GLOBAL TUBERCULOSIS DRUG FACIL-
24 ITY.—The term ‘Global Tuberculosis Drug Facility’
25 means the initiative of the Stop Tuberculosis Part-

1 nership to increase access to the most advanced, af-
2 fordable, quality-assured TB drugs and diagnostics.

3 “(5) MDR–TB.—The term ‘MDR–TB’ means
4 multi-drug-resistant TB.

5 “(6) STOP TUBERCULOSIS PARTNERSHIP.—The
6 term ‘Stop Tuberculosis Partnership’ means the
7 partnership of 1,600 organizations (including inter-
8 national and technical organizations, government
9 programs, research and funding agencies, founda-
10 tions, nongovernmental organizations, civil society
11 and community groups, and the private sector), do-
12 nors, including the United States, high TB burden
13 countries, multilateral agencies, and nongovern-
14 mental and technical agencies, which is governed by
15 the Stop TB Partnership Coordinating Board and
16 hosted by a United Nations entity, committed to
17 short- and long-term measures required to control
18 and eventually eliminate TB as a public health prob-
19 lem in the world.

20 “(7) XDR–TB.—The term ‘XDR–TB’ means
21 extensively drug-resistant TB.

22 “(c) AUTHORIZATION.—To carry out this section, the
23 President is authorized, consistent with section 104(c), to
24 furnish assistance, on such terms and conditions as the

1 President may determine, for the prevention, treatment,
2 control, and elimination of TB.

3 “(d) GOALS.—In consultation with the appropriate
4 congressional committees, the President shall establish
5 goals, based on the policy and indicators described in sub-
6 section (a), for—

7 “(1) United States TB programs to detect,
8 cure, and prevent all forms of TB globally for the
9 period between 2023 and 2030 that are aligned with
10 the End TB Strategy’s 2030 targets and the
11 USAID’s Global Tuberculosis (TB) Strategy 2023–
12 2030; and

13 “(2) updating the National Action Plan for
14 Combating Multidrug-Resistant Tuberculosis.

15 “(e) COORDINATION.—

16 “(1) IN GENERAL.—In carrying out this sec-
17 tion, the President shall coordinate with the World
18 Health Organization, the Stop TB Partnership, the
19 Global Fund to Fight AIDS, Tuberculosis, and Ma-
20 laria, and other organizations with respect to the de-
21 velopment and implementation of a comprehensive
22 global TB response program.

23 “(2) BILATERAL ASSISTANCE.—In providing bi-
24 lateral assistance under this section, the President
25 shall—

1 “(A) catalyze support for research and de-
2 velopment of new tools to prevent, diagnose,
3 treat, and control TB worldwide, particularly to
4 reduce the incidence of, and mortality from, all
5 forms of drug-resistant TB;

6 “(B) ensure United States programs and
7 activities focus on finding individuals with ac-
8 tive TB disease and provide quality diagnosis
9 and treatment, including through digital health
10 solutions, and reaching those at high risk with
11 preventive therapy; and

12 “(C) ensure coordination among relevant
13 United States Government agencies, including
14 the Department of State, the Centers for Dis-
15 ease Control and Prevention, the National In-
16 stitutes of Health, the Biomedical Advanced
17 Research and Development Authority, the Food
18 and Drug Administration, the National Science
19 Foundation, the Department of Defense
20 (through its Congressionally Directed Medical
21 Research Programs), and other relevant Fed-
22 eral departments and agencies that engage in
23 international TB activities—

24 “(i) to ensure accountability and
25 transparency;

1 “(ii) to reduce duplication of efforts;
2 and
3 “(iii) to ensure appropriate integra-
4 tion and coordination of TB services into
5 other United States-supported health pro-
6 grams.

7 “(f) PRIORITY TO END TB STRATEGY.—In fur-
8 nishing assistance under subsection (c), the President
9 shall prioritize—

10 “(1) building and strengthening TB pro-
11 grams—

12 “(A) to increase the diagnosis and treat-
13 ment of everyone who is sick with TB; and

14 “(B) to ensure that such individuals have
15 access to quality diagnosis and treatment;

16 “(2) direct, high-quality integrated services for
17 all forms of TB, as described by the World Health
18 Organization, which call for the coordination of ac-
19 tive case finding, treatment of all forms of TB dis-
20 ease and infection, patient support, and TB preven-
21 tion;

22 “(3) treating individuals co-infected with HIV
23 and other co-morbidities, and other individuals with
24 TB who may be at risk of stigma;

1 “(4) strengthening the capacity of health sys-
 2 tems to detect, prevent, and treat TB, including
 3 MDR–TB and XDR–TB, as described in the latest
 4 international guidance related to TB;

5 “(5) researching and developing innovative
 6 diagnostics, drug therapies, and vaccines, and pro-
 7 gram-based research;

8 “(6) support for the Stop Tuberculosis Partner-
 9 ship’s Global Drug Facility, the Global Alliance for
 10 Tuberculosis Drug Development, and other organiza-
 11 tions promoting the development of new products
 12 and drugs for TB; and

13 “(7) ensuring that TB programs can serve as
 14 key platforms for supporting national respiratory
 15 pandemic response against existing and new infec-
 16 tious respiratory disease.

17 “(g) ASSISTANCE FOR THE WORLD HEALTH ORGA-
 18 NIZATION AND THE STOP TUBERCULOSIS PARTNER-
 19 SHIP.—In carrying out this section, the President is au-
 20 thorized—

21 “(1) to provide resources to the World Health
 22 Organization and the Stop Tuberculosis Partnership
 23 to improve the capacity of countries with high bur-
 24 dens or rates of TB and other affected countries to
 25 implement the End TB Strategy, the Stop TB Glob-

1 al Plan to End TB, their own national strategies
2 and plans, other global efforts to control MDR-TB
3 and XDR-TB; and

4 “(2) to leverage the contributions of other do-
5 nors for the activities described in paragraph (1).

6 “(h) ANNUAL REPORT ON TB ACTIVITIES.—Not
7 later than December 15 of each year until the earlier of
8 the date on which the goals specified in subsection
9 (a)(2)(A) are met or the last day of 2032, the President
10 shall submit an annual report to the appropriate congres-
11 sional committees that describes United States foreign as-
12 sistance to control TB and the impact of such efforts, in-
13 cluding—

14 “(1) the number of individuals with active TB
15 disease that were diagnosed and treated, including
16 the rate of treatment completion and the number re-
17 ceiving patient support;

18 “(2) the number of persons with MDR-TB and
19 XDR-TB that were diagnosed and treated, includ-
20 ing the rate of completion, in countries receiving
21 United States bilateral foreign assistance for TB
22 control programs;

23 “(3) the number of people trained by the
24 United States Government in TB surveillance and
25 control;

1 “(4) the number of individuals with active TB
2 disease identified as a result of engagement with the
3 private sector and other nongovernmental partners
4 in countries receiving United States bilateral foreign
5 assistance for TB control programs;

6 “(5) a description of the collaboration and co-
7 ordination of United States anti-TB efforts with the
8 World Health Organization, the Stop TB Partner-
9 ship, the Global Fund to Fight AIDS, Tuberculosis
10 and Malaria, and other major public and private en-
11 tities;

12 “(6) a description of the collaboration and co-
13 ordination among the United States Agency for
14 International Development and other United States
15 departments and agencies, including the Centers for
16 Disease Control and Prevention and the Office of
17 the Global AIDS Coordinator, for the purposes of
18 combating TB and, as appropriate, its integration
19 into primary care;

20 “(7) the constraints on implementation of pro-
21 grams posed by health workforce shortages, health
22 system limitations, barriers to digital health imple-
23 mentation, other challenges to successful implemen-
24 tation, and strategies to address such constraints;

1 “(8) a breakdown of expenditures for patient
2 services supporting TB diagnosis, treatment, and
3 prevention, including procurement of drugs and
4 other commodities, drug management, training in di-
5 agnosis and treatment, health systems strengthening
6 that directly impacts the provision of TB services,
7 and research; and

8 “(9) for each country, and when practicable,
9 each project site receiving bilateral United States as-
10 sistance for the purpose of TB prevention, treat-
11 ment, and control—

12 “(A) a description of progress toward the
13 adoption and implementation of the most recent
14 World Health Organization guidelines to im-
15 prove diagnosis, treatment, and prevention of
16 TB for adults and children, disaggregated by
17 sex, including the proportion of health facilities
18 that have adopted the latest World Health Or-
19 ganization guidelines on strengthening moni-
20 toring systems and preventative, diagnostic, and
21 therapeutic methods, including the use of rapid
22 diagnostic tests and orally administered TB
23 treatment regimens;

24 “(B) the number of individuals screened
25 for TB disease and the number evaluated for

1 TB infection using active case finding outside
2 of health facilities;

3 “(C) the number of individuals with active
4 TB disease that were diagnosed and treated, in-
5 cluding the rate of treatment completion and
6 the number receiving patient support;

7 “(D) the number of adults and children,
8 including people with HIV and close contacts,
9 who are evaluated for TB infection, the number
10 of adults and children started on treatment for
11 TB infection, and the number of adults and
12 children completing such treatment,
13 disaggregated by sex and, as possible, income or
14 wealth quintile;

15 “(E) the establishment of effective TB in-
16 fection control in all relevant congregant set-
17 tings, including hospitals, clinics, and prisons;

18 “(F) a description of progress in imple-
19 menting measures to reduce TB incidence, in-
20 cluding actions—

21 “(i) to expand active case finding and
22 contact tracing to reach vulnerable groups;
23 and

1 “(ii) to expand TB preventive ther-
2 apy, engagement of the private sector, and
3 diagnostic capacity;

4 “(G) a description of progress to expand
5 diagnosis, prevention, and treatment for all
6 forms of TB, including in pregnant women,
7 children, and individuals and groups at greater
8 risk of TB, including migrants, prisoners, min-
9 ers, people exposed to silica, and people living
10 with HIV/AIDS, disaggregated by sex;

11 “(H) the rate of successful completion of
12 TB treatment for adults and children,
13 disaggregated by sex, and the number of indi-
14 viduals receiving support for treatment comple-
15 tion;

16 “(I) the number of people, disaggregated
17 by sex, receiving treatment for MDR-TB, the
18 proportion of those treated with the latest regi-
19 mens endorsed by the World Health Organiza-
20 tion, factors impeding scale up of such treat-
21 ment, and a description of progress to expand
22 community-based MDR-TB care;

23 “(J) a description of TB commodity pro-
24 curement challenges, including shortages,

1 stockouts, or failed tenders for TB drugs or
2 other commodities;

3 “(K) the proportion of health facilities
4 with specimen referral linkages to quality diag-
5 nostic networks, including established testing
6 sites and reference labs, to ensure maximum ac-
7 cess and referral for second line drug resistance
8 testing, and a description of the turnaround
9 time for test results;

10 “(L) the number of people trained by the
11 United States Government to deliver high-qual-
12 ity TB diagnostic, preventative, monitoring,
13 treatment, and care services;

14 “(M) a description of how supported activi-
15 ties are coordinated with—

16 “(i) country national TB plans and
17 strategies; and

18 “(ii) TB control efforts supported by
19 the Global Fund to Fight AIDS, Tuber-
20 culosis, and Malaria, and other inter-
21 national assistance programs and funds,
22 including in the areas of program develop-
23 ment and implementation; and

24 “(N) for the first 3 years of the report re-
25 quired under this subsection, a description of

1 the progress in recovering from the negative im-
 2 pact of COVID–19 on TB, including—

3 “(i) whether there has been the devel-
 4 opment and implementation of a com-
 5 prehensive plan to recover TB activities
 6 from diversion of resources;

7 “(ii) the continued use of bidirectional
 8 TB–COVID testing; and

9 “(iii) progress on increased diagnosis
 10 and treatment of active TB.

11 “(i) ANNUAL REPORT ON TB RESEARCH AND DE-
 12 VELOPMENT.—The President, in coordination with the
 13 National Institutes of Health, the Centers for Disease
 14 Control and Prevention, the Biomedical Advanced Re-
 15 search and Development Authority, the Food and Drug
 16 Administration, the National Science Foundation, and the
 17 Office of the Global AIDS Coordinator, shall submit to
 18 the appropriate congressional committees until 2032 an
 19 annual report that—

20 “(1) describes the current progress and chal-
 21 lenges to the development of new tools for the pur-
 22 pose of TB prevention, treatment, and control;

23 “(2) identifies critical gaps and emerging prior-
 24 ities for research and development, including for
 25 rapid and point-of-care diagnostics, shortened treat-

1 ments and prevention methods, telehealth solutions
 2 for prevention and treatment, and vaccines; and

3 “(3) describes research investments by type,
 4 funded entities, and level of investment.

5 “(j) EVALUATION REPORT.—Not later than 3 years
 6 after the date of the enactment of the Health Equity and
 7 Accountability Act of 2026, and 5 years thereafter, the
 8 Comptroller General of the United States shall submit a
 9 report to the appropriate congressional committees that
 10 evaluates the performance and impact on TB prevention,
 11 diagnosis, treatment, and care efforts that are supported
 12 by United States bilateral assistance funding, including
 13 recommendations for improving such programs.”.

14 **Subtitle I—Osteoarthritis and**
 15 **Musculoskeletal Diseases**

16 **SEC. 7801. OSTEOARTHRITIS AND OTHER MUSCULO-**
 17 **SKELETAL HEALTH-RELATED ACTIVITIES OF**
 18 **THE CENTERS FOR DISEASE CONTROL AND**
 19 **PREVENTION.**

20 (a) EDUCATION AND AWARENESS ACTIVITIES.—The
 21 Secretary of Health and Human Services, acting through
 22 the Director of the Centers for Disease Control and Pre-
 23 vention, shall direct the National Center for Chronic Dis-
 24 ease Prevention and Health Promotion to conduct and ex-

1 pand the Health Community Program and Arthritis Pro-
2 gram to educate the public on—

3 (1) the causes of, preventive health actions for,
4 and effects of arthritis, lupus, and other musculo-
5 skeletal conditions in minority patient populations;
6 and

7 (2) the effects of such conditions on other
8 comorbidities including obesity, hypertension, and
9 cardiovascular disease.

10 (b) PROGRAMS ON ARTHRITIS AND MUSCULO-
11 SKELETAL CONDITIONS.—Education and awareness pro-
12 grams of the Centers for Disease Control and Prevention
13 on arthritis and other musculoskeletal conditions in minor-
14 ity communities shall—

15 (1) be culturally and linguistically appropriate
16 to minority patients, targeting musculoskeletal
17 health promotion and prevention programs of each
18 major ethnic group, including—

19 (A) Native Americans and Alaska Natives;

20 (B) Asian Americans;

21 (C) African Americans and Blacks;

22 (D) Hispanic and Latino Americans; and

23 (E) Native Hawaiians and Pacific Island-
24 ers; and

1 (2) include public awareness campaigns directed
2 toward these patient populations that emphasize the
3 importance of musculoskeletal health, physical activ-
4 ity, diet and healthy lifestyle, and weight reduction
5 for overweight and obese patients.

6 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
7 out this section, there are authorized to be appropriated
8 such sums as are necessary for fiscal year 2027 and each
9 subsequent fiscal year.

10 **SEC. 7802. GRANTS FOR COMPREHENSIVE OSTEO-**
11 **ARTHRITIS AND MUSCULOSKELETAL DIS-**
12 **EASE HEALTH EDUCATION WITHIN HEALTH**
13 **PROFESSIONS SCHOOLS.**

14 (a) PROGRAM AUTHORIZED.—The Secretary of
15 Health and Human Services (in this section referred to
16 as the “Secretary”), in coordination with the Secretary of
17 Education, shall award grants, on a competitive basis, to
18 academic health science centers, health professions
19 schools, and institutions of higher education to enable
20 such centers, schools, and institutions to provide people
21 with comprehensive education on arthritis and musculo-
22 skeletal health, particularly—

- 23 (1) obesity-related musculoskeletal diseases;
24 (2) arthritis and osteoarthritis;

1 (3) arthritis and musculoskeletal health dispari-
2 ties; and

3 (4) the relationship between arthritis and mus-
4 culoskeletal diseases and metabolic activity, psycho-
5 logical health, and comorbidities such as diabetes,
6 cardiovascular disease, lupus, and hypertension.

7 (b) DURATION.—Grants awarded under this section
8 shall be for a period of 5 years.

9 (c) APPLICATIONS.—An academic health science cen-
10 ter, health professions school, or institution of higher edu-
11 cation seeking a grant under this section shall submit an
12 application to the Secretary at such time, in such manner,
13 and containing such information as the Secretary may re-
14 quire.

15 (d) PRIORITY.—In awarding grants under this sec-
16 tion, the Secretary shall give priority to an institution of
17 higher education that—

18 (1) has an enrollment of needy students, as de-
19 fined in section 318(b) of the Higher Education Act
20 of 1965 (20 U.S.C. 1059e(b));

21 (2) is a Hispanic-serving institution, as defined
22 in section 502(a) of such Act (20 U.S.C. 1101a(a));

23 (3) is a Tribal College or University, as defined
24 in section 316(b) of such Act (20 U.S.C. 1059c(b));

1 (4) is an Alaska Native-serving institution, as
2 defined in section 317(b) of such Act (20 U.S.C.
3 1059d(b));

4 (5) is a Native Hawaiian-serving institution, as
5 defined in section 317(b) of such Act (20 U.S.C.
6 1059d(b));

7 (6) is a Predominately Black Institution, as de-
8 fined in section 318(b) of such Act (20 U.S.C.
9 1059e(b));

10 (7) is a Native American-serving, nontribal in-
11 stitution, as defined in section 319(b) of such Act
12 (20 U.S.C. 1059f(b));

13 (8) is an Asian American and Native American
14 Pacific Islander-serving institution, as defined in
15 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

16 (9) is a minority institution, as defined in sec-
17 tion 365 of such Act (20 U.S.C. 1067k), with an en-
18 rollment of needy students, as defined in section 312
19 of such Act (20 U.S.C. 1058).

20 (e) USES OF FUNDS.—An academic health science
21 center, health professions school, or institution of higher
22 education receiving a grant under this section may use the
23 grant funds to integrate issues relating to comprehensive
24 arthritis and musculoskeletal health into the academic or
25 support sectors of the center, school, or institution in

1 order to reach a large number of students, by carrying
2 out 1 or more of the following activities:

3 (1) Developing educational content for issues
4 relating to comprehensive arthritis and musculo-
5 skeletal health education that will be incorporated
6 into first-year orientation or core courses.

7 (2) Creating innovative technology-based ap-
8 proaches to deliver arthritis and musculoskeletal
9 health education to students, faculty, and staff.

10 (3) Developing and employing peer-outreach
11 and education programs to generate discussion, edu-
12 cate, and raise awareness among students about
13 issues relating to arthritis and musculoskeletal
14 health disorders, and their relationship to diabetes,
15 hypertension, cardiovascular disease, psychological
16 health, and other comorbid conditions.

17 (f) REPORT TO CONGRESS.—

18 (1) IN GENERAL.—Not later than 1 year after
19 the date of the enactment of this Act, and annually
20 thereafter for a period of 5 years, the Secretary shall
21 prepare and submit to the appropriate committees of
22 Congress a report on the activities to provide health
23 professions students with comprehensive arthritis
24 and musculoskeletal health education funded under
25 this section.

1 (2) REPORT ELEMENTS.—The report described
2 in paragraph (1) shall include information about—

3 (A) the number of entities that are receiv-
4 ing a grant under this section;

5 (B) the specific activities supported by
6 grants under this section;

7 (C) the number of students served by pro-
8 grams supported by grants under this section;
9 and

10 (D) the status of evaluations of such pro-
11 grams.

12 (g) DEFINITION OF INSTITUTION OF HIGHER EDU-
13 CATION.—In this section, the term “institution of higher
14 education” has the meaning given such term in section
15 101 of the Higher Education Act of 1965 (20 U.S.C.
16 1001).

17 **Subtitle J—Sleep and Circadian** 18 **Rhythm Disorders**

19 **SEC. 7901. SLEEP AND CIRCADIAN RHYTHM DISORDERS RE-**
20 **SEARCH ACTIVITIES OF THE NATIONAL IN-**
21 **STITUTES OF HEALTH.**

22 (a) IN GENERAL.—The Director of the National In-
23 stitutes of Health, acting through the Director of the Na-
24 tional Heart, Lung, and Blood Institute, shall—

1 (1) continue to expand research activities ad-
2 dressing sleep health disparities; and

3 (2) continue implementation of the NIH Sleep
4 Disorders Research Plan across all institutes and
5 centers of the National Institutes of Health to im-
6 prove treatment and prevention of sleep health dis-
7 parities.

8 (b) REQUIRED RESEARCH ACTIVITIES.—In con-
9 ducting or supporting research relating to sleep and circa-
10 dian rhythm, the Director of the National Heart, Lung,
11 and Blood Institute shall—

12 (1) advance epidemiology and clinical research
13 to achieve a more complete understanding of dispari-
14 ties in domains of sleep health and across population
15 subgroups for which cardiovascular and metabolic
16 health disparities exist, including—

17 (A) prevalence and severity of sleep apnea;

18 (B) habitual sleep duration;

19 (C) sleep timing and regularity; and

20 (D) insomnia;

21 (2) develop study designs and analytical ap-
22 proaches to explain and predict multilevel and life-
23 course determinants of sleep health and to elucidate
24 the sleep-related causes of cardiovascular and meta-

1 bolic health disparities across the age spectrum, in-
 2 cluding such determinants and causes that are—

3 (A) environmental;

4 (B) biological or genetic;

5 (C) psychosocial;

6 (D) societal;

7 (E) political; or

8 (F) economic;

9 (3) determine the contribution of sleep impair-
 10 ments such as sleep apnea, insufficient sleep dura-
 11 tion, irregular sleep schedules, and insomnia to un-
 12 explained disparities in cardiovascular and metabolic
 13 risk and disease outcomes;

14 (4) develop study designs, data sampling and
 15 collection tools, and analytical approaches to opti-
 16 mize understanding of mediating and moderating
 17 factors, and feedback mechanisms coupling sleep to
 18 cardiovascular and metabolic health disparities;

19 (5) advance research to understand cultural
 20 and linguistic barriers (on the person, provider, or
 21 system level) to access to care, medical diagnosis,
 22 and treatment of sleep disorders in diverse popu-
 23 lation groups;

24 (6) develop and test multilevel interventions (in-
 25 cluding sleep health education in diverse commu-

1 nities) to reduce disparities in sleep health that will
 2 impact the ability to improve disparities in cardio-
 3 vascular and metabolic risk or disease;

4 (7) create opportunities to integrate sleep and
 5 health disparity science by strategically utilizing re-
 6 sources (involving existing or anticipated cohorts)
 7 and exchanging scientific data and ideas (including
 8 through cross-over into scientific meetings); and

9 (8) enhance the diversity and foster career de-
 10 velopment of young investigators involved in sleep
 11 and health disparities science.

12 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
 13 out this section, there are authorized to be appropriated
 14 such sums as may be necessary for fiscal year 2027 and
 15 each subsequent fiscal year.

16 **SEC. 7902. SLEEP AND CIRCADIAN RHYTHM HEALTH DIS-**
 17 **PARITIES-RELATED ACTIVITIES OF THE CEN-**
 18 **TERS FOR DISEASE CONTROL AND PREVEN-**
 19 **TION.**

20 (a) IN GENERAL.—The Director of the Centers for
 21 Disease Control and Prevention shall conduct, support,
 22 and expand public health strategies and prevention, diag-
 23 nosis, surveillance, and public and professional awareness
 24 activities regarding sleep and circadian rhythm disorders.

1 (b) REQUIRED SURVEILLANCE AND EDUCATION
2 AWARENESS ACTIVITIES.—In conducting or supporting
3 research relating to sleep and circadian rhythm disorders
4 surveillance and education awareness activities, the Direc-
5 tor of the Centers for Disease Control and Prevention
6 shall—

7 (1) ensure that such activities are culturally
8 and linguistically appropriate to minority patients,
9 targeting sleep and circadian rhythm health pro-
10 motion and prevention programs of each major eth-
11 nic group, including—

12 (A) Native Americans and Alaska Natives;

13 (B) Asian Americans;

14 (C) African Americans and Blacks;

15 (D) Hispanic and Latino-Americans; and

16 (E) Native Hawaiians and Pacific Island-
17 ers;

18 (2) collect and compile national and State sur-
19 veillance data on sleep disorders health disparities;

20 (3) continue to develop and implement new
21 sleep questions in public health surveillance systems
22 to increase public awareness of sleep health and
23 sleep disorders and their impact on health;

24 (4) publish monthly reports highlighting geo-
25 graphic, racial, and ethnic disparities in sleep health,

1 as well as relationships between insufficient sleep
2 and chronic disease, health risk behaviors, and other
3 outcomes as determined necessary by the Director;
4 and

5 (5) include public awareness campaigns that in-
6 form patient populations from major ethnic groups
7 about the prevalence of sleep and circadian rhythm
8 disorders and emphasize the importance of sleep
9 health.

10 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
11 out this section, there are authorized to be appropriated
12 such sums as may be necessary for fiscal year 2027 and
13 each subsequent fiscal year.

14 **SEC. 7903. GRANTS FOR COMPREHENSIVE SLEEP AND CIR-**
15 **CADIAN HEALTH EDUCATION WITHIN**
16 **HEALTH PROFESSIONS SCHOOLS.**

17 (a) PROGRAM AUTHORIZED.—The Secretary of
18 Health and Human Services (referred to in this section
19 as the “Secretary”), in coordination with the Secretary of
20 Education, shall award grants, on a competitive basis, to
21 academic health science centers, health professions
22 schools, and institutions of higher education to enable
23 such centers, schools, and institutions to provide people
24 with comprehensive education on sleep and circadian
25 health, particularly—

- 1 (1) poor sleep health;
- 2 (2) sleep disorders;
- 3 (3) sleep health disparities; and
- 4 (4) the relationship between sleep and circadian
- 5 health on metabolic activity, neurological activity,
- 6 comorbidities, and other diseases.

7 (b) DURATION.—Grants awarded under this section
8 shall be for a period of 5 years.

9 (c) APPLICATIONS.—An academic health science cen-
10 ter, health professions school, or institution of higher edu-
11 cation seeking a grant under this section shall submit an
12 application to the Secretary at such time, in such manner,
13 and containing such information as the Secretary may re-
14 quire.

15 (d) PRIORITY.—In awarding grants under this sec-
16 tion, the Secretary shall give priority to an institution of
17 higher education that—

18 (1) has an enrollment of needy students, as de-
19 fined in section 318(b) of the Higher Education Act
20 of 1965 (20 U.S.C. 1059e(b));

21 (2) is a Hispanic-serving institution, as defined
22 in section 502(a) of such Act (20 U.S.C. 1101a(a));

23 (3) is a Tribal College or University, as defined
24 in section 316(b) of such Act (20 U.S.C. 1059c(b));

1 (4) is an Alaska Native-serving institution, as
2 defined in section 317(b) of such Act (20 U.S.C.
3 1059d(b));

4 (5) is a Native Hawaiian-serving institution, as
5 defined in section 317(b) of such Act (20 U.S.C.
6 1059d(b));

7 (6) is a Predominately Black Institution, as de-
8 fined in section 318(b) of such Act (20 U.S.C.
9 1059e(b));

10 (7) is a Native American-serving, nontribal in-
11 stitution, as defined in section 319(b) of such Act
12 (20 U.S.C. 1059f(b));

13 (8) is an Asian American and Native American
14 Pacific Islander-serving institution, as defined in
15 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

16 (9) is a minority institution, as defined in sec-
17 tion 365 of such Act (20 U.S.C. 1067k), with an en-
18 rollment of needy students, as defined in section 312
19 of such Act (20 U.S.C. 1058).

20 (e) USES OF FUNDS.—An academic health science
21 center, health professions school, or institution of higher
22 education receiving a grant under this section may use the
23 grant funds to integrate issues relating to comprehensive
24 sleep and circadian health into the academic or support
25 sectors of the center, school, or institution, in order to

1 reach a large number of students, by carrying out 1 or
2 more of the following activities:

3 (1) Developing educational content for issues
4 relating to comprehensive sleep and circadian health
5 education that will be incorporated into first-year
6 orientation or core courses.

7 (2) Creating innovative technology-based ap-
8 proaches to deliver sleep health education to stu-
9 dents, faculty, and staff.

10 (3) Developing and employing peer-outreach
11 and education programs to generate discussion, edu-
12 cate, and raise awareness among students about
13 issues relating to poor quality sleep, sleep and circa-
14 dian disorders, and the role sleep health plays in
15 other diseases and comorbidities.

16 (f) REPORT TO CONGRESS.—

17 (1) IN GENERAL.—Not later than 1 year after
18 the date of the enactment of this Act, and annually
19 thereafter for a period of 5 years, the Secretary shall
20 prepare and submit to the appropriate committees of
21 Congress a report on the activities to provide health
22 professions students with comprehensive sleep and
23 circadian health education funded under this section.

24 (2) REPORT ELEMENTS.—The report described
25 in paragraph (1) shall include information about—

1 (A) the number of entities that are receiv-
2 ing a grant under this section;

3 (B) the specific activities supported by
4 grants under this section;

5 (C) the number of students served by pro-
6 grams supported by grants under this section;
7 and

8 (D) the status of evaluations of programs
9 supported by such grants.

10 (g) DEFINITION OF INSTITUTION OF HIGHER EDU-
11 CATION.—In this section, the term “institution of higher
12 education” has the meaning given such term in section
13 101 of the Higher Education Act of 1965 (20 U.S.C.
14 1001).

15 **SEC. 7904. REPORT ON IMPACT OF SLEEP AND CIRCADIAN**
16 **HEALTH DISORDERS IN VULNERABLE AND**
17 **RACIAL/ETHNIC POPULATIONS.**

18 (a) IN GENERAL.—Not later than 1 year after the
19 date of enactment of this Act, the Secretary of Health and
20 Human Services shall submit to Congress and the Presi-
21 dent a report on the impact of sleep and circadian health
22 disorders for racial and ethnic minority communities and
23 other vulnerable populations.

24 (b) CONTENTS.—The report under subsection (a)
25 shall include information on the—

1 (1) progress that has been made in reducing
 2 the impact of sleep and circadian health disorders in
 3 such communities and populations;

4 (2) opportunities that exist to make additional
 5 progress in reducing the impact of sleep and circa-
 6 dian health disorders in such communities and popu-
 7 lations;

8 (3) challenges that may impede such additional
 9 progress; and

10 (4) Federal funding necessary to achieve sub-
 11 stantial reductions in sleep and circadian health dis-
 12 orders in racial and ethnic minority communities.

13 **Subtitle K—Kidney Disease Re-**
 14 **search, Surveillance, Preven-**
 15 **tion, and Treatment**

16 **SEC. 7901A. KIDNEY DISEASE RESEARCH IN MINORITY POP-**
 17 **ULATIONS.**

18 (a) IN GENERAL.—

19 (1) RESEARCH AND TRAINING CENTERS.—Sec-
 20 tion 431(c)(3) of the Public Health Service Act (42
 21 U.S.C. 285c–5(c)(3)) is amended—

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

24 (B) in subparagraph (C), by striking
 25 “and” at the end; and

1 (C) by adding at the end the following:

2 “(D) improving data science through im-
3 provement in bioinformatics, data integration,
4 and data sharing;

5 “(E) defining the chronic kidney disease
6 mechanism and identifying new therapeutic tar-
7 gets for chronic kidney disease using specific
8 tools, including mapping the genetic architec-
9 ture of kidney function and disease and trans-
10 lating genetic maps to disease-causing genes
11 and mechanisms, especially among minority
12 populations;

13 “(F) improving models of human disease
14 including better humanized animal models, im-
15 proved reproducibility, and functional character-
16 ization of kidney organoids, and accelerating
17 the development of in vivo imaging technologies;
18 and

19 “(G) developing cell-specific drug delivery
20 systems and gene editing, including targeted
21 systems for the delivery of therapeutic com-
22 pounds to specific kidney compartments or cell
23 types and accelerating the implementation of
24 gene editing and gene therapy for the treatment
25 of kidney diseases in vivo; and”.

1 (2) INCLUSION OF MINORITY PARTICIPANTS.—

2 In conducting and supporting research described in
3 the amendment made by paragraph (1), the Director
4 of the National Institutes of Health shall work with
5 the Director of the National Institute on Minority
6 Health and Health Disparities to improve the num-
7 ber of minority participants as study subjects in
8 clinical trials. Such work may include—

9 (A) developing and sustaining clinical trial
10 consortia that can recruit patients with chronic
11 kidney disease to ensure adequate capacity for
12 assessment of kidney outcomes and increase the
13 enrollment of underrepresented populations;

14 (B) encouraging the use of novel designs in
15 clinical trials to enhance the recruitment and
16 retention of underrepresented populations which
17 will enhance the generalizability of study find-
18 ings;

19 (C) supporting outreach initiatives that in-
20 corporate acknowledgment of both historical
21 and current grounds for participation reluc-
22 tance, and that prioritize demonstrating trust-
23 worthiness, in order to enhance the ability to
24 promote and effectively convey the benefits of
25 clinical research participation;

1 (D) completing clinical trials that test
 2 interventions to improve patient quality of life
 3 and address patient-reported outcomes; and

4 (E) encouraging inclusion of persons with
 5 chronic kidney disease in clinical trials of treat-
 6 ments for nonkidney diseases.

7 (b) REPORT; COMPREHENSIVE PLAN.—Section 429
 8 of the Public Health Services Act (42 U.S.C. 285c–3) is
 9 amended by adding at the end the following:

10 “(c) REPORT BY KIDNEY, UROLOGIC, AND HEMATO-
 11 LOGIC DISEASES COORDINATING COMMITTEE.—

12 “(1) IN GENERAL.—The Kidney, Urologic, and
 13 Hematologic Diseases Coordinating Committee, in
 14 coordination with the Chronic Kidney Disease Initia-
 15 tive at the Centers for Disease Control and Preven-
 16 tion, shall—

17 “(A) prepare and submit to the Congress,
 18 not later than 6 months after the date of enact-
 19 ment of this subsection, a report on Federal re-
 20 search and public health activities with respect
 21 to kidney disease in minority populations; and

22 “(B) develop and submit to the Congress,
 23 the Secretary, the Director of the National In-
 24 stitutes of Health, and the Advisory Board es-
 25 tablished under section 430 for the diseases for

1 which the Committee was established, not later
2 than 1 year after the date of enactment of this
3 subsection, an effective and comprehensive Fed-
4 eral plan (including all appropriate Federal
5 health programs) to address kidney disease in
6 minority populations.

7 “(2) CONTENTS.—The report under paragraph
8 (1)(A) shall at minimum address each of the fol-
9 lowing:

10 “(A) Research on kidney disease in minor-
11 ity populations, including such research on—

12 “(i) genetic, behavioral, and environ-
13 mental factors;

14 “(ii) prevention and complications
15 among individuals within these populations
16 who have already developed kidney disease;

17 “(iii) the delivery of evidenced-based
18 care for all chronic kidney disease stages,
19 especially in underrepresented and under-
20 served populations;

21 “(iv) expanding support for a root-
22 cause analysis approach to disparities, in-
23 cluding causes, detection, and management
24 of chronic kidney disease for underserved
25 populations;

1 “(v) developing research teams that
2 engage with community organizations to
3 develop and implement interventions which
4 halt or delay development and progression
5 of chronic kidney disease; and

6 “(vi) continued support of observa-
7 tional studies of kidney disease measures
8 and outcomes.

9 “(B) Surveillance and data collection on
10 kidney disease in minority populations, includ-
11 ing with respect to—

12 “(i) efforts to better determine the
13 prevalence of kidney disease among Asian-
14 American, Native Hawaiian, and Pacific
15 Islander subgroups; and

16 “(ii) efforts to coordinate data collec-
17 tion on the American Indian population.

18 “(C) Community-based interventions to ad-
19 dress kidney disease targeting minority popu-
20 lations, including—

21 “(i) the evidence bases for such inter-
22 ventions;

23 “(ii) the cultural appropriateness of
24 such interventions; and

1 “(iii) efforts to educate the public on
2 the causes and consequences of kidney dis-
3 ease.

4 “(D) Education and training programs for
5 health professionals (including community
6 health workers) on the prevention and manage-
7 ment of kidney disease and its related complica-
8 tions that are supported by the Health Re-
9 sources and Services Administration, including
10 such programs supported by the Bureau of
11 Health Workforce, the Bureau of Primary
12 Health Care, and the Health Systems Bureau.
13 This shall include—

14 “(i) identification of effective strate-
15 gies to increase implementation of proven
16 therapies to slow chronic kidney disease in-
17 cidence and progression, especially in high-
18 risk underrepresented populations; and

19 “(ii) identification of effective practice
20 improvement strategies in large and small
21 health systems to reduce chronic kidney
22 disease incidence and progression.”.

23 **SEC. 7901A-1. KIDNEY DISEASE ACTION PLAN.**

24 (a) IN GENERAL.—The Director of the Centers for
25 Disease Control and Prevention shall conduct, support,

1 and expand public health strategies, prevention, diagnosis,
2 surveillance, and public and professional awareness activi-
3 ties regarding kidney disease.

4 (b) NATIONAL ACTION PLAN.—

5 (1) DEVELOPMENT.—Pursuant to section 426
6 of the Public Health Service Act (42 U.S.C. 285c),
7 not later than 2 years after the date of the enact-
8 ment of this Act, the Director of the National Insti-
9 tute of Diabetes and Digestive and Kidney Diseases,
10 in consultation with the Director of the National In-
11 stitute on Minority Health and Health Disparities
12 and the Director of the Centers for Disease Control
13 and Prevention, shall develop a national action plan
14 to address kidney disease in the United States with
15 participation from patients, caregivers, health pro-
16 fessionals, patient advocacy organizations, research-
17 ers, providers, public health professionals, and other
18 stakeholders.

19 (2) CONTENTS.—At a minimum, such plan
20 shall include recommendations for—

21 (A) public health interventions for the pur-
22 pose of implementation of the national plan;

23 (B) biomedical, health services, and public
24 health research on kidney disease; and

1 (C) inclusion of kidney disease in the
2 health data collections of all Federal agencies.

3 (c) KIDNEY DISEASE PREVENTION PROGRAMS.—The
4 Director of the Centers for Disease Control and Preven-
5 tion, through the Chronic Kidney Disease Initiative, shall
6 carry out the following:

7 (1) Conduct public education and awareness ac-
8 tivities with patient and professional organizations
9 to stimulate earlier diagnosis and improve patient
10 outcomes from treatment of kidney disease. To the
11 extent known and relevant, such public education
12 and awareness activities shall reflect differences in
13 kidney disease by cause (such as hypertension, dia-
14 betes, lupus nephritis, COVID–19, and polycystic
15 kidney disease) and include a focus on outreach to
16 undiagnosed and, as appropriate, minority popu-
17 lations.

18 (2) Supplement and expand upon the activities
19 of the Centers for Disease Control and Prevention
20 by making grants to nonprofit organizations, State
21 and local jurisdictions, and Indian Tribes for the
22 purpose of reducing the burden of kidney disease,
23 especially in disproportionately impacted commu-
24 nities, through public health interventions and re-
25 lated activities.

1 (3) Coordinate with the National Institute of
2 Diabetes and Digestive and Kidney Diseases, the In-
3 dian Health Service, the Health Resources and Serv-
4 ices Administration, and the Department of Vet-
5 erans Affairs to develop pilot programs to dem-
6 onstrate best practices for the diagnosis and man-
7 agement of kidney disease.

8 (4) Develop improved techniques and identify
9 best practices, in coordination with the Secretary of
10 Veterans Affairs, for assisting kidney disease pa-
11 tients.

12 (d) DATA COLLECTION.—Not later than 180 days
13 after the date of enactment of this Act, the Director of
14 the National Institute of Diabetes and Digestive and Kid-
15 ney Diseases and the Director of the Centers for Disease
16 Control and Prevention, acting jointly, shall assess the
17 depth and quality of information on kidney disease that
18 is collected in surveys and population studies conducted
19 by the Centers for Disease Control and Prevention, includ-
20 ing whether there are additional opportunities for informa-
21 tion to be collected in the National Health and Nutrition
22 Examination Survey, the National Health Interview Sur-
23 vey, and the Behavioral Risk Factor Surveillance System
24 surveys. The Director of the National Institute of Diabetes
25 and Digestive and Kidney Diseases shall include the re-

1 sults of such assessment in the national action plan under
 2 subsection (b).

3 (e) AUTHORIZATION OF APPROPRIATIONS.—There
 4 are authorized to be appropriated to carry out this section
 5 \$1,000,000 for fiscal year 2027, \$1,000,000 for fiscal year
 6 2028, \$1,000,000 for fiscal year 2029, \$1,000,000 for fis-
 7 cal year 2030, and \$1,000,000 for fiscal year 2031.

8 **SEC. 7901A-2. PROVIDING FOR STAFF-ASSISTED HOME DI-**
 9 **ALYSIS FOR CERTAIN HEMODIALYSIS AND**
 10 **PERITONEAL DIALYSIS PATIENTS.**

11 (a) IN GENERAL.—Section 1881(b)(14) of the Social
 12 Security Act (42 U.S.C. 1395rr(b)(14)) is amended by
 13 adding at the end the following new subparagraph:

14 “(J)(i) With respect to staff-assisted home
 15 dialysis (as defined in clause (iv)(IV)) furnished
 16 on or after the date that is 1 year after the
 17 date of the enactment of this subparagraph,
 18 subject to the succeeding provisions of this sub-
 19 paragraph, the Secretary shall increase the sin-
 20 gle payment that would otherwise apply under
 21 this paragraph for renal dialysis services by the
 22 add-on payment amount established pursuant
 23 to clause (iii).

24 “(ii)(I) Subject to subclause (II), staff-as-
 25 sisted home dialysis may only be furnished—

1 “(aa) with respect to an initializing
 2 patient (as defined in clause (iv)(I)) or a
 3 returning patient (as defined in clause
 4 (iv)(III)), for a period of up to 90 days, re-
 5 ferred to as the ‘initial period’, which may
 6 be extended as determined necessary by
 7 the care team of the individual in not more
 8 than 2 intervals of up to 30 days each,
 9 each of which is referred to as an ‘ex-
 10 tended interval’; and

11 “(bb) with respect to a temporary as-
 12 sistance patient (as defined in clause
 13 (iv)(V)), for any 30-day period as deter-
 14 mined necessary by the care team of the
 15 individual, notwithstanding whether such
 16 an individual receives any routine dialysis
 17 respite care during such period.

18 “(II) Notwithstanding subclause (I), staff-
 19 assisted home dialysis may be furnished for as
 20 long as the Secretary determines appropriate to
 21 an individual who—

22 “(aa) is blind;

23 “(bb) has a cognitive or neurological
 24 impairment (including a stroke, Alz-
 25 heimer’s Disease, dementia, amyotrophic

1 lateral sclerosis, or any other impairment
2 determined by the Secretary); or

3 “(cc) has any other illness or injury
4 that reduces mobility (including cerebral
5 palsy, spinal cord injuries, an injury or ill-
6 ness that requires the individual to be on
7 a ventilator, or any other illness or injury
8 determined by the Secretary).

9 “(iii) The Secretary shall, by regulation, estab-
10 lish an add-on payment amount for staff-assisted
11 home dialysis to determine the amounts payable to
12 a qualified provider (as defined in clause (iv)(II)) for
13 assisting in the furnishing of staff-assisted home di-
14 alysis on a frequency as determined by the Secretary
15 and in consultation with clinicians, patients, and
16 care partners to ensure maximum patient choice, ac-
17 cess, and flexibility. In establishing the add-on pay-
18 ment under this clause, the Secretary shall consult
19 with stakeholders, including providers of renal dialy-
20 sis services, individuals receiving home dialysis,
21 qualified providers, private insurance payers, and
22 Medicare Advantage plans under part C.

23 “(iv) In this subparagraph:

24 “(I) The term ‘initializing patient’ means
25 an individual who initiates a home dialysis mo-

1 dality, including home hemodialysis and peri-
2 toneal dialysis.

3 “(II) The term ‘qualified provider’ means
4 a trained professional (as determined by the
5 Secretary, including a registered or licensed
6 practical nurse and a certified patient care
7 technician) who—

8 “(aa) furnishes renal dialysis services;

9 “(bb) meets requirements (as deter-
10 mined by the Secretary) that ensure com-
11 petency in patient care and modality
12 usage; and

13 “(cc) during a period described in
14 clause (ii)(I), provides in-person assistance
15 to an individual for an appropriate number
16 of dialysis sessions, as determined by the
17 care team of the individual based on the
18 needs of the individual, caregiver avail-
19 ability, prescription, and mode of home di-
20 alysis.

21 “(III) The term ‘returning patient’ means
22 an individual who is returning to home dialysis
23 after a period of hospitalization or other non-
24 home dialysis modality.

1 “(IV)(aa) The term ‘staff-assisted home
2 dialysis’ means dialysis furnished by the indi-
3 vidual in a home, residence, or other approved
4 setting with the assistance of a qualified pro-
5 vider, the frequency of which is determined by
6 the qualified provider in coordination with the
7 individual, the care partner, and the care team
8 of the individual and outlined in a patient plan
9 of care.

10 “(bb) In this subclause, the term ‘care
11 partner’ means a friend or family member who
12 is designated by the individual who is trained to
13 assist the individual with the furnishing of
14 home dialysis.

15 “(cc) In this subclause, the term ‘patient
16 plan of care’ has the meaning given such term
17 in section 494.90 of title 42, Code of Federal
18 Regulations (or any successor regulations).

19 “(V) The term ‘temporary assistance pa-
20 tient’ means an individual who is receiving
21 home dialysis and is temporarily unable to per-
22 form functions necessary to self-furnish unas-
23 sisted home dialysis due to illness, injury, care-
24 giver unavailability, or other temporary cir-
25 cumstances not to exceed 30 days.”.

1 (b) PATIENT EDUCATION AND TRAINING RELATING
2 TO STAFF-ASSISTED HOME DIALYSIS.—

3 (1) IN GENERAL.—Section 1881(b)(5) of the
4 Social Security Act (42 U.S.C. 1395rr(b)(5)) is
5 amended—

6 (A) in subparagraph (C), by striking at the
7 end “and”;

8 (B) in subparagraph (D), by striking the
9 period at the end and inserting a semicolon;
10 and

11 (C) by adding at the end the following new
12 subparagraphs:

13 “(E) educate individuals on the oppor-
14 tunity to receive staff-assisted home dialysis (as
15 defined in paragraph (14)(J)(iv)(IV)) during
16 the periods described in paragraph (14)(J)(ii);
17 and

18 “(F) provide for registered or licensed
19 nurses, certified patient care technicians, or
20 other qualified providers (as determined by a
21 physician) to train individuals and their care
22 partners in skills and procedures needed to fur-
23 nish staff-assisted home dialysis, including—

24 “(i) in a group-training environment
25 with other individuals and their care part-

1 ners when appropriate and in accordance
2 with Federal regulations (concerning the
3 privacy of individually identifiable health
4 information) promulgated under section
5 264(c) of the Health Insurance Portability
6 and Accountability Act of 1996;

7 “(ii) via telehealth (following an initial
8 period of in-person competency training, in
9 accordance with standards specified by the
10 Secretary);

11 “(iii) through interdisciplinary team
12 training (as described in the interpretive
13 guidance relating to tag number V590 of
14 ‘Advance Copy—End Stage Renal Disease
15 (ESRD) Program Interpretive Guidance
16 Version 1.1’ (published on October 3,
17 2008)); and

18 “(iv) in the home or residence of an
19 individual, in a dialysis facility, in a stand-
20 alone training facility, or the place in
21 which the individual has been approved to
22 perform home dialysis by the care team.”.

23 (2) EFFECTIVE DATE.—The amendments made
24 by this subsection shall take effect on the date that
25 is 1 year after the date of the enactment of this Act.

1 (c) OTHER PROVISIONS.—

2 (1) ANTI-KICKBACK STATUTE.—Section
3 1128B(b)(3) of the Social Security Act (42 U.S.C.
4 1320a–7b(b)(3)) is amended—

5 (A) by moving subparagraphs (J) and (K)
6 2 ems to the left;

7 (B) in subparagraph (K), by striking
8 “and” at the end;

9 (C) in subparagraph (L), by striking the
10 period at the end and inserting “; and”; and

11 (D) by adding at the end the following new
12 subparagraph:

13 “(M) any remuneration relating to the fur-
14 nishing of staff-assisted home dialysis (as de-
15 fined in section 1881(b)(14)(J)(iv)(IV)).”.

16 (2) STUDY.—Not later than 2 years after the
17 date of the enactment of this Act, the Secretary of
18 Health and Human Services (in this subsection re-
19 ferred to as the “Secretary”) shall submit to the
20 Committee on Finance of the Senate and the Com-
21 mittees on Energy and Commerce and Ways and
22 Means of the House of Representatives a report
23 that—

24 (A) examines racial disparities in the utili-
25 zation of home dialysis (as defined in section

1 1881(b)(14)(J)(iv)(IV) of the Social Security
2 Act (42 U.S.C. 1395rr(b)(14)(J)(iv)(IV)), as
3 added by subsection (a)), and makes rec-
4 ommendations on how to improve access to
5 home dialysis for communities of color;

6 (B) examines coverage for, and utilization
7 of, home dialysis in rural communities, and
8 makes recommendations on how to improve ac-
9 cess to home dialysis for such rural commu-
10 nities; and

11 (C) analyzes clinical and quality of life out-
12 comes for patients, disaggregated by geographic
13 and demographic indicators, who receive dif-
14 ferent dialysis modalities, including staff-as-
15 sisted home dialysis, unassisted home dialysis,
16 and dialysis furnished in a facility.

17 (3) PATIENT DECISION TOOL.—Not later than
18 December 31, 2027, for the purposes of section
19 1881(b)(14)(J) of the Social Security Act (42
20 U.S.C. 1395rr(b)(14)(J)), as added by subsection
21 (a), the Secretary shall convene a patient panel to
22 develop a patient-centered decision tool to assist di-
23 alysis patients in evaluating their lifestyle and goals
24 and in choosing the dialysis setting and modality.
25 Such tool shall include an acknowledgment that the

1 patient is capable of home dialysis and wants home
 2 dialysis, if that is the modality such patient chooses.

3 (4) PATIENT QUALITY OF LIFE METRIC.—Sec-
 4 tion 1881(h)(2)(A)(iv) of the Social Security Act (42
 5 U.S.C. 1395rr(h)(2)(A)(iv)) is amended—

6 (A) in subclause (II), by striking “and” at
 7 the end;

8 (B) in subclause (III), by striking the pe-
 9 riod at the end and inserting “; and”; and

10 (C) by adding at the end the following new
 11 subclause:

12 “(IV) patient quality of life for
 13 all individuals utilizing dialysis re-
 14 gardless of modality, with the intent
 15 of measuring and improving patient
 16 quality of life on dialysis.”.

17 **SEC. 7901A-3. INCREASING KIDNEY TRANSPLANTS IN MI-**
 18 **NORITY POPULATIONS.**

19 (a) IN GENERAL.—The Director of the National In-
 20 stitutes of Health shall expand, intensify, and support on-
 21 going research and other activities with respect to kidney
 22 transplants in minority populations.

23 (b) CMS DATA COLLECTION AND REPORTING.—The
 24 Centers for Medicare & Medicaid Services shall collect and
 25 report annual data on dialysis facility and nephrologist

1 performance on transplant referral, with an emphasis on
2 data relating to patients of color.

3 (c) OPTN DATA COLLECTION AND REPORTING.—
4 The Organ Procurement and Transplantation Network
5 shall collect and the Scientific Registry of Transplant Re-
6 cipients shall report annual data, broken down by demo-
7 graphic and socioeconomic characteristics, on individual
8 transplant center performance as it relates to patients re-
9 ferred, evaluated, waitlisted, and successfully trans-
10 planted.

11 (d) TRANSPLANT CENTER DATA.—Each organ trans-
12 plant center shall report on the percent of appropriate
13 waitlisted patients (including socioeconomic and demo-
14 graphic data) giving and receiving annual informed con-
15 sent for offers for suboptimal kidneys (such as kidneys
16 with a kidney donor profile index of greater than 85 per-
17 cent or kidney age 50 with diabetes, or age greater than
18 60).

19 (e) ORGAN PROCUREMENT ORGANIZATION DATA.—
20 Each organ procurement organization shall report annual
21 data on referrals, refusals (patient or doctor), and accept-
22 ance of organs by hospital, ZIP Code, race, ethnicity, and
23 age strata except as prohibited by need for confidentiality.

1 (f) DATA TRANSPARENCY FOR PATIENTS.—Each
2 organ transplant center shall provide to each patient of
3 such center, on an annual basis—

4 (1) the number of times an organ was offered
5 to the patient, declined, and transplanted into an-
6 other patient from organs within a 500-mile radius;
7 and

8 (2) the number of times an organ was offered
9 to and declined for the patient from a low-risk donor
10 which was subsequently transplanted into another
11 patient.

12 (g) IMPROVED TRANSPLANTATION EDUCATION.—
13 The Centers for Medicare & Medicaid Services shall certify
14 a nonbiased, third-party organization to accredit organ
15 transplant education.

16 (h) RESEARCH.—Research under subsection (a) shall
17 include investigation into—

18 (1) the causes of lower rates of kidney trans-
19 plants in minority populations, including socio-
20 economic, geographic, clinical, environmental, ge-
21 netic, and other factors that may contribute to lower
22 rates of kidney transplants in minority populations;
23 and

24 (2) possible interventions to increase kidney
25 transplants.

1 (i) REPORT; COMPREHENSIVE PLAN.—

2 (1) IN GENERAL.—The Secretary of Health and
3 Human Services shall—

4 (A) prepare and submit to the Congress,
5 not later than 6 months after the date of enact-
6 ment of this section, a report on Federal re-
7 search and public health activities with respect
8 to kidney transplants as a treatment for end-
9 stage renal disease in minority populations; and

10 (B) develop and submit to the Congress,
11 not later than 1 year after the date of enact-
12 ment of this section, an effective and com-
13 prehensive Federal plan (including all appro-
14 priate Federal health programs) to increase the
15 number of kidney transplants in minority popu-
16 lations.

17 (2) CONTENTS.—The report under paragraph
18 (1)(A) shall at a minimum address each of the fol-
19 lowing:

20 (A) Research on kidney transplants in mi-
21 nority populations, including such research on
22 financial, insurance coverage, genetic, behav-
23 ioral, and environmental factors.

1 (B) Surveillance and data collection on
2 kidney transplants in minority populations, in-
3 cluding with respect to—

4 (i) efforts to increase kidney trans-
5 plants among Asian-American, Native Ha-
6 waiian, and Pacific Islander subgroups
7 with end-stage renal disease; and

8 (ii) efforts to increase kidney trans-
9 plants in the American Indian population.

10 (C) Community-based efforts to increase
11 kidney transplants targeting minority popu-
12 lations, including—

13 (i) the evidence base for such in-
14 creases;

15 (ii) the cultural appropriateness of
16 such increases; and

17 (iii) efforts to educate the public on
18 kidney transplants.

19 (D) Education and training programs for
20 health professionals (including community
21 health workers) on the kidney transplants that
22 are supported by the Health Resources and
23 Services Administration, including such pro-
24 grams supported by the Bureau of Health

1 Workforce, the Bureau of Primary Health Care,
2 and the Health Systems Bureau.

3 **SEC. 7901A-4. ENVIRONMENTAL AND OCCUPATIONAL**
4 **HEALTH PROGRAMS.**

5 The Director of the Centers for Disease Control and
6 Prevention shall—

7 (1) support research into the environmental and
8 occupational causes and biological mechanisms that
9 contribute to kidney disease; and

10 (2) develop and disseminate public health inter-
11 ventions that will lessen the impact of environmental
12 and occupational causes of kidney disease.

13 **SEC. 7901A-5. UNDERSTANDING THE TREATMENT PAT-**
14 **TERNS ASSOCIATED WITH PROVIDING CARE**
15 **AND TREATMENT OF KIDNEY FAILURE IN MI-**
16 **NORITY POPULATIONS.**

17 (a) STUDY.—The Secretary of Health and Human
18 Services (in this section referred to as the “Secretary”)
19 shall conduct a study on treatment patterns associated
20 with providing care, under the Medicare program under
21 title XVIII of the Social Security Act (42 U.S.C. 1395
22 et seq.), under the Medicaid program under title XIX of
23 such Act (42 U.S.C. 1396 et seq.), and through private
24 health insurance, to minority populations that are dis-
25 proportionately affected by kidney failure.

1 (b) REPORT.—Not later than 1 year after the date
2 of the enactment of this Act, the Secretary shall submit
3 to Congress a report on the study conducted under sub-
4 section (a), together with such recommendations as the
5 Secretary determines to be appropriate.

6 **SEC. 7901A–6. ENCOURAGING KIDNEY CARE WORKFORCE IN**
7 **UNDERSERVED AREAS.**

8 (a) DEFINITION OF PRIMARY HEALTH SERVICES.—
9 Section 331(a)(3)(D) of the Public Health Service Act (42
10 U.S.C. 254d(a)(3)(D)) is amended by inserting “nephrol-
11 ogy,” after “dentistry,”.

12 (b) NATIONAL HEALTH SERVICE CORPS SCHOLAR-
13 SHIP PROGRAM.—Section 338A(a)(2) of the Public Health
14 Service Act (42 U.S.C. 254l(a)(2)) is amended by insert-
15 ing “, which may include kidney health professionals” be-
16 fore the period at the end.

17 (c) NATIONAL HEALTH SERVICE CORPS LOAN RE-
18 PAYMENT PROGRAM.—Section 338B(a)(2) of the Public
19 Health Service Act (42 U.S.C. 254l–1(a)(2)) is amended
20 by inserting “, which may include kidney health profes-
21 sionals” before the period at the end.

1 **SEC. 7901A-7. THE JACK REYNOLDS MEMORIAL MEDIGAP**
 2 **EXPANSION ACT; MEDIGAP COVERAGE FOR**
 3 **BENEFICIARIES WITH END-STAGE RENAL DIS-**
 4 **EASE.**

5 (a) GUARANTEED AVAILABILITY OF MEDIGAP POLI-
 6 CIES TO ALL ESRD MEDICARE BENEFICIARIES.—

7 (1) IN GENERAL.—Section 1882(s) of the So-
 8 cial Security Act (42 U.S.C. 1395ss(s)) is amend-
 9 ed—

10 (A) in paragraph (2)—

11 (i) in subparagraph (A), by striking
 12 “is 65” and all that follows through the
 13 period at the end and inserting the fol-
 14 lowing: “is—

15 “(i) 65 years of age or older and is
 16 enrolled for benefits under part B; or

17 “(ii) is entitled to benefits under
 18 226A(b) and is enrolled for benefits under
 19 part B.”; and

20 (ii) in subparagraph (D), in the mat-
 21 ter preceding clause (i), by inserting “(or
 22 is entitled to benefits under 226A(b))”
 23 after “is 65 years of age or older”; and

24 (B) in paragraph (3)(B)—

1 (i) in clause (ii), by inserting “(or is
2 entitled to benefits under 226A(b))” after
3 “is 65 years of age or older”; and

4 (ii) in clause (vi), by inserting “(or
5 under 226A(b))” after “at age 65”.

6 (2) EFFECTIVE DATE.—The amendments made
7 by paragraph (1) shall apply to Medicare supple-
8 mental policies effective on or after January 1,
9 2027.

10 (b) ADDITIONAL ENROLLMENT PERIOD FOR CER-
11 TAIN INDIVIDUALS.—

12 (1) ONE-TIME ENROLLMENT PERIOD.—

13 (A) IN GENERAL.—In the case of an indi-
14 vidual described in paragraph (2), the Secretary
15 of Health and Human Services shall establish a
16 one-time enrollment period during which such
17 an individual may enroll in any Medicare sup-
18 plemental policy under section 1882 of the So-
19 cial Security Act (42 U.S.C. 1395ss) of the in-
20 dividual’s choosing.

21 (B) ENROLLMENT PERIOD.—The enroll-
22 ment period established under subparagraph
23 (A) shall begin on January 1, 2027, and shall
24 end June 30, 2027.

1 (2) INDIVIDUAL DESCRIBED.—An individual de-
 2 scribed in this paragraph is an individual who—

3 (A) is entitled to hospital insurance bene-
 4 fits under part A of title XVIII of the Social
 5 Security Act (42 U.S.C. 1395c et seq.) or under
 6 section 226A(b) of such Act (42 U.S.C. 426-
 7 1(b));

8 (B) is enrolled for benefits under part B of
 9 such title XVIII (42 U.S.C. 1395j et seq.); and

10 (C) would not, but for the provisions of,
 11 and amendments made by, subsection (a) be eli-
 12 gible for the guaranteed issue of a Medicare
 13 supplemental policy under paragraph (2) or (3)
 14 of section 1882(s) of such Act (42 U.S.C.
 15 1395ss(s)).

16 **Subtitle L—Diversity in Clinical** 17 **Trials**

18 **SEC. 7901B. FDA REVIEW OF CLINICAL TRIAL BEST PRAC-** 19 **TICES.**

20 The Commissioner of Food and Drugs shall—

21 (1) aggregate information on the accumulated
 22 experience of sponsors of drugs that develop and
 23 execute clinical trial diversity plans during drug de-
 24 velopment;

1 (2) include in such aggregated information an
 2 analysis from the perspectives of the Food and Drug
 3 Administration and such sponsors of which actions
 4 worked or which did not work to enhance clinical
 5 trial diversity;

6 (3) not later than September 30, 2027, convene
 7 a public meeting, including representatives from the
 8 regulated industry and patient organizations, to dis-
 9 cuss findings and recommendations for specific ac-
 10 tions that have led to measurable improvements in
 11 the representation of racial and ethnic populations
 12 in clinical research; and

13 (4) not later than September 30, 2028, update
 14 the guidance of the Food and Drug Administration
 15 titled “Enhancing the Diversity of Clinical Trial
 16 Populations—Eligibility Criteria, Enrollment Prac-
 17 tices, and Trial Designs” to align such guidance
 18 with findings and recommendations that were dis-
 19 cussed at the meeting under paragraph (3).

20 **SEC. 7901B-1. DIVERSIFYING INVESTIGATIONS VIA EQUI-**
 21 **TABLE RESEARCH STUDIES FOR EVERYONE**
 22 **TRIALS ACT.**

23 (a) ENCOURAGEMENT OF CLINICAL TRIAL ENROLL-
 24 MENT BY RACIALLY AND ETHNICALLY DIVERSE POPU-
 25 LATIONS.—

1 (1) NO COST PROVISION OF DIGITAL HEALTH
2 TECHNOLOGIES.—The free provision of digital
3 health technologies by drug or device manufacturers
4 to their clinical trial participants shall not be consid-
5 ered a violation of section 1128A of the Social Secu-
6 rity Act (commonly known as the “Civil Monetary
7 Penalties Law”) (42 U.S.C. 1320a–7a), section
8 1128B of the Social Security Act (42 U.S.C. 1320a–
9 7b), or sections 3729 through 3733 of title 31,
10 United States Code (commonly known as the “False
11 Claims Act”), provided that—

12 (A) the use of digital health technologies
13 will facilitate in any phase of clinical develop-
14 ment the inclusion of diversity of patient popu-
15 lations, such as underrepresented racial and
16 ethnic minorities, low-income populations, and
17 the elderly;

18 (B) the digital health technologies will fa-
19 cilitate individuals’ participation, or are nec-
20 essary to such participation;

21 (C) all features of the digital health tech-
22 nologies that are unrelated to use in the clinical
23 trial are disabled or only allowed to remain acti-
24 vated to model real-world usage of the digital
25 technology; and

1 (D) the clinical trial sponsor requires par-
2 ticipants to return, purchase, or disable the dig-
3 ital health technologies by the conclusion of the
4 trial.

5 (2) GRANTS AND CONTRACTS.—

6 (A) IN GENERAL.—The Secretary of
7 Health and Human Services (in this section re-
8 ferred to as the “Secretary”) may issue grants
9 to, and enter into contracts with, entities to
10 support community education, outreach, and re-
11 cruitment activities for clinical trials with re-
12 spect to drugs, including vaccines for diseases
13 or conditions which have a disproportionate im-
14 pact on underrepresented populations (including
15 on racial and ethnic minority populations), in-
16 cluding for the diagnosis, prevention, or treat-
17 ment of COVID–19. Such activities may in-
18 clude—

19 (i) working with community clinical
20 trial sites, including community health cen-
21 ters, academic health centers, and other fa-
22 cilities;

23 (ii) training health care personnel in-
24 cluding potential clinical trial investigators,
25 with a focus on significantly increasing the

1 number of underrepresented racial and
2 ethnic minority health care personnel who
3 are clinical trial investigators at the com-
4 munity sites for ongoing clinical trials;

5 (iii) engaging community stakeholders
6 to encourage participation in clinical trials,
7 especially in underrepresented racial and
8 ethnic minority communities; and

9 (iv) fostering partnerships with com-
10 munity-based organizations serving under-
11 represented racial and ethnic minority pop-
12 ulations, including labor organizations and
13 frontline health care workers.

14 (B) PRIORITY FOR GRANT AND CONTRACT
15 AWARDS.—In awarding grants and contracts
16 under this paragraph, the Secretary shall
17 prioritize entities that—

18 (i) develop educational, recruitment,
19 and training materials in multiple lan-
20 guages; or

21 (ii) undertake clinical trial outreach
22 efforts in more diverse racial and ethnic
23 communities that are traditionally under-
24 represented in clinical trials, such as Trib-
25 al areas.

1 (C) AUTHORIZATION OF APPROPRIA-
2 TIONS.—There is authorized to be appropriated
3 for fiscal years 2027 and 2028 such sums as
4 may be necessary to carry out this paragraph.

5 (b) CLARIFICATION THAT CERTAIN REMUNERATION
6 RELATED TO PARTICIPATION IN CLINICAL TRIALS DOES
7 NOT CONSTITUTE REMUNERATION UNDER THE FED-
8 ERAL CIVIL MONEY PENALTIES LAW.—

9 (1) IN GENERAL.—Section 1128A(i)(6)(F) of
10 the Social Security Act (42 U.S.C. 1320a–
11 7a(i)(6)(F)) is amended by inserting “(including re-
12 munerated offered or transferred to an individual to
13 promote the participation in an approved clinical
14 trial, as defined in subsection (d) of the first section
15 2709 of the Public Health Service Act (42 U.S.C.
16 300gg–8) (relating to coverage for individuals par-
17 ticipating in approved clinical trials), as so des-
18 ignated by section 1563(c)(10)(C) of the Patient
19 Protection and Affordable Care Act, that is reg-
20 istered with the database of clinical trials main-
21 tained by the National Library of Medicine (or any
22 successor database), so long as such remuneration
23 facilitates equitable inclusion of patients from all rel-
24 evant demographic and socioeconomic populations
25 and is related to patient participation in the ap-

1 proved clinical trial)” after “promotes access to
2 care”.

3 (2) EFFECTIVE DATE.—The amendment made
4 by paragraph (1) shall apply to remuneration pro-
5 vided on or after the date of the enactment of this
6 Act.

7 (c) NATIONAL ACADEMY OF MEDICINE STUDY.—

8 (1) IN GENERAL.—The Secretary shall seek to
9 enter into an arrangement with the National Acad-
10 emy of Medicine under which the National Academy
11 agrees to study and propose a design for a national
12 interoperable data platform to improve access to
13 health data, and other relevant data needs, during
14 public health emergencies.

15 (2) REPORT.—The arrangement under para-
16 graph (1) shall provide that the National Academy
17 of Medicine, not later than 180 days after the date
18 of enactment of this Act, shall submit a report to
19 the Secretary and Congress on the results of the
20 study under paragraph (1) and the design proposed
21 based on such study.

22 **SEC. 7901B-2. CLINICAL TRIAL DIVERSITY.**

23 (a) DIVERSITY REQUIREMENTS FOR APPLICATIONS
24 FOR FEDERAL FUNDING FOR CLINICAL TRIALS.—

1 (1) APPLICATIONS.—Beginning on the date of
2 the enactment of this Act, the Secretary of Health
3 and Human Services, acting through the Director of
4 the National Institutes of Health (in this subsection
5 referred to as the “Secretary”), shall require that an
6 entity seeking to conduct a clinical trial investigating
7 a drug or device (as those terms are defined in sec-
8 tion 201 of the Federal Food, Drug, and Cosmetic
9 Act (21 U.S.C. 321)) or biological product (as de-
10 fined in section 351(i) of the Public Health Service
11 Act (42 U.S.C. 262(i))) that is funded by the Na-
12 tional Institutes of Health and conducted at any na-
13 tional research institute or national center, submit
14 an application (or renewal thereof) for such funding
15 that includes—

16 (A) clear and measurable goals for the re-
17 cruitment and retention of participants that re-
18 flect—

19 (i) the race, ethnicity, age, and gender
20 or sex of patients with the disease or con-
21 dition being investigated; or

22 (ii) the race, ethnicity, age, and gen-
23 der or sex of the general population of the
24 United States if the prevalence of the dis-
25 ease or condition is not known;

1 (B) a rationale for the goals specified
2 under subparagraph (A) that specifies—

3 (i) how investigators will calculate the
4 number of participants for each population
5 category that reflect the population groups
6 specified in subparagraph (A); and

7 (ii) strategies that will be used to en-
8 roll and retain participants across the dif-
9 ferent racial, ethnic, age, and gender or
10 sex categories;

11 (C) a detailed plan for how the clinical
12 trial will achieve the goals specified under sub-
13 paragraph (A) that specifies—

14 (i) the requirements for researchers,
15 in conducting the trial to analyze the popu-
16 lation groups specified in subparagraph
17 (A) separately;

18 (ii) the role of community partners or
19 community institutional review boards in
20 reviewing the plans; and

21 (iii) how the trial will recruit a study
22 population that is—

23 (I) in proportion to the preva-
24 lence of the disease or condition in
25 such groups relative to the prevalence

1 of the disease or condition in the over-
2 all population of the United States;

3 (II) in sufficient numbers to ob-
4 tain clinically and statistically mean-
5 ingful determinations of the safety
6 and effectiveness of the drug being
7 studied in the respective race, eth-
8 nicity, age, and gender or sex groups;
9 and

10 (III) consistent with the guidance
11 under section 505(b)(1) of the Fed-
12 eral Food, Drug, and Cosmetic Act
13 (21 U.S.C. 355(b)(1)) and guidance
14 issued by the National Institutes of
15 Health on the inclusion of women and
16 minorities in clinical trials;

17 (D) the entity's plan for implementing, or
18 an explanation of why the entity cannot imple-
19 ment, alternative clinical trial follow-up require-
20 ments that are less burdensome for trial partici-
21 pants, such as—

22 (i) requiring fewer follow-up visits;

23 (ii) allowing phone follow-up or home
24 visits by nurse trial coordinators (in lieu of
25 in-person visits by patients);

1 (iii) allowing for online follow-up op-
2 tions;

3 (iv) permitting the patient's primary
4 care provider to perform some of the fol-
5 low-up visit requirements and to reimburse
6 the patient for any out-of-pocket costs in-
7 curred by the patient for such follow-up
8 visits;

9 (v) allowing for weekend hours for re-
10 quired follow-up visits;

11 (vi) allowing virtual or telemedicine
12 visits;

13 (vii) use of wearable technology to
14 record key health parameters; and

15 (viii) use of alternate labs or imaging
16 centers, which may be closer to the resi-
17 dence of the patients participating in the
18 trial; and

19 (E) the entity's education and training re-
20 quirements for researchers and other individ-
21 uals conducting or supporting the clinical trial
22 with respect to diversity and health inequities in
23 underrepresented populations, including a re-
24 quirement to consult with, and review materials
25 made available by, such committees, task forces,

1 and working groups other entities the Secretary
2 determines are appropriate, including the fol-
3 lowing:

4 (i) The Equity Committee of the Na-
5 tional Institutes of Health.

6 (ii) The National Advisory Council on
7 Minority Health and Health Disparities.

8 (iii) The Advisory Committee on Re-
9 search on Women's Health.

10 (iv) The Sexual & Gender Minority
11 Research Coordinating Committee of the
12 National Institutes of Health.

13 (v) The Tribal Health Research Co-
14 ordinating Committee of the National In-
15 stitutes of Health.

16 (2) TERMS.—

17 (A) IN GENERAL.—As a condition on the
18 receipt of funding through the National Insti-
19 tutes of Health, as described in paragraph (1),
20 with respect to a clinical trial, the sponsor of
21 the clinical trial shall agree to terms requiring
22 that—

23 (i) the aggregate demographic infor-
24 mation of trial participants be shared on
25 an annual basis with the Secretary while

1 participant recruitment and data collection
2 in such trial is ongoing, and that such in-
3 formation is provided with respect to—

4 (I) underrepresented populations,
5 including populations grouped by race,
6 ethnicity, age, sex, gender identity
7 and expression, geographic region,
8 primary written and spoken language,
9 disability status, sexual orientation,
10 socioeconomic status, occupation, and
11 other relevant factors; and

12 (II) such populations that reflect
13 the prevalence of the disease or condi-
14 tion that is the subject of the clinical
15 trial involved (as available and as ap-
16 propriate to the scientific objective for
17 the study, as determined by the Direc-
18 tor of the National Institutes of
19 Health);

20 (ii) the sponsor submits to the pro-
21 gram officer and grants management spe-
22 cialist of the specific National Institutes of
23 Health national research institute or na-
24 tional center, as frequently as such officer
25 or specialist determines necessary, the re-

1 tention rate of participants in the clinical
2 trial, disaggregated by race, ethnicity, gen-
3 der or sex, and age;

4 (iii) both the clinical trial researchers
5 and the applicant reviewers complete edu-
6 cation and training programs on diversity
7 in clinical trials; and

8 (iv) at the conclusion of the trial, the
9 sponsor submits to the Secretary the num-
10 ber of participants in the trial,
11 disaggregated by race, ethnicity, age, and
12 gender or sex.

13 (B) PRIVACY PROTECTIONS.—Any data
14 shared under subparagraph (A) may not in-
15 clude any individually identifiable information
16 or protected health information with respect to
17 clinical trial participants and shall only be dis-
18 closed to the extent allowed under Federal pri-
19 vacy laws.

20 (3) EXCEPTION.—In lieu of submitting an ap-
21 plication under paragraph (1) and documentation of
22 goals as required by subparagraph (A) of such para-
23 graph, an applicant may provide reasoning (other
24 than cost) for why the recruitment of each of the
25 population groups specified in subparagraph (A) of

1 paragraph (1) is not necessary and why such re-
2 cruitment is not scientifically justified or possible.

3 (4) PUBLICATION.—The Secretary shall—

4 (A) publish on a public website of the Na-
5 tional Institutes of Health, upon receipt of an
6 application to which paragraph (1) applies or
7 reasoning under paragraph (3)—

8 (i) a summary of the disease being
9 targeted in the clinical trial that is the
10 subject of the application and the preva-
11 lence of such disease across race, ethnicity,
12 gender or sex, age, and clinical trial rep-
13 resentation in each such category;

14 (ii) the goals specified in such applica-
15 tion, as required by paragraph (1)(A); or

16 (iii) the reasoning described in para-
17 graph (3); and

18 (B) ensure that, in publishing information
19 relating to an application or reasoning under
20 subparagraph (A), the design of the study in-
21 volved is not disclosed.

22 (5) REMEDIATION.—

23 (A) IN GENERAL.—In the case of a clinical
24 trial subject to paragraph (1) that fails to meet
25 the condition specified pursuant to paragraph

1 (1) by such date as may be agreed upon by the
2 sponsor of the trial and the program officer and
3 grants management specialist of the specific
4 National Institutes of Health national research
5 institute or national center, the Secretary shall
6 require the sponsor of that clinical trial, not
7 later than 60 days after such date occurs—

8 (i) to develop, in consultation with the
9 Secretary and advocacy and community-
10 based organizations representing individ-
11 uals who are members of relevant demo-
12 graphic groups specified in paragraph
13 (1)(A), a strategic plan to increase partici-
14 pation in such clinical trial of such individ-
15 uals; and

16 (ii) to submit to the Secretary, such
17 strategic plan.

18 (B) PUBLICATION.—The Secretary shall
19 make publicly available on the website of the
20 National Institutes of Health, the strategic plan
21 received under subparagraph (A) as soon as
22 possible after receipt. The Secretary shall en-
23 sure that, in publishing such plan under the
24 preceding sentence, the design of the study in-
25 volved is not disclosed.

1 (C) IMPLEMENTATION.—The sponsor of
2 the clinical trial that is the subject of the stra-
3 tegic plan published under subparagraph (B),
4 shall, not later than 60 days after such date as
5 may be agreed upon by the sponsor of the trial
6 and the appropriate program officer and grants
7 management specialist of the National Insti-
8 tutes of Health, implement the strategic plan.

9 (D) TECHNICAL ASSISTANCE.—The Sec-
10 retary may provide technical assistance to a
11 sponsor of a clinical trial, as necessary for the
12 sponsor to meet the requirements of subpara-
13 graph (C).

14 (6) PENALTIES IN CASE OF FAILURE OF REME-
15 DIATION.—

16 (A) IN GENERAL.—In the case of a clinical
17 trial subject to paragraph (1) that, after the
18 close of the 60-day period specified in para-
19 graph (5)(C), continues to fail to meet the con-
20 dition specified pursuant to paragraph (1)(A),
21 the Secretary shall—

22 (i) hold the noncompeting continu-
23 ation of funding received through the grant
24 involved;

1 (ii) apply specific conditions on the
2 award of funds to such sponsor to conduct
3 such clinical trial; or

4 (iii) terminate such funding.

5 (B) WAIVER.—

6 (i) IN GENERAL.—In the case of a
7 clinical trial subject to the penalty under
8 subparagraph (A) that fails to meet the
9 condition referred to in such subpara-
10 graph, the sponsor of such clinical trial
11 may, prior to the conclusion of the 60-day
12 period referred to in subparagraph (A),
13 submit an application to the relevant pro-
14 gram officer and grants specialist request-
15 ing a waiver of such condition. Such an ap-
16 plication shall specify reasoning for why
17 the recruitment of each of the population
18 groups specified in subparagraph (A) of
19 paragraph (1) is not necessary or why such
20 recruitment is not scientifically justified or
21 possible.

22 (ii) REVIEW.—Not later than 30 days
23 after a date agreed upon by the sponsor of
24 the trial and the appropriate program offi-
25 cer and grants management specialist of

1 the National Institutes of Health, the Sec-
2 retary shall—

3 (I) complete the review of such
4 application; and

5 (II) make a determination to ap-
6 prove or deny the application.

7 (iii) NO ADDITIONAL PENALTIES.—No
8 additional penalties may be applied with
9 respect to a sponsor of a clinical trial
10 under subparagraph (A) during the 30-day
11 period specified in clause (ii).

12 (C) TERMINATION OF FUNDING.—In the
13 case of a clinical trial described in subpara-
14 graph (B)(i), the Secretary may elect to termi-
15 nate funding described in paragraph (1) for the
16 clinical trial if no request for a waiver under
17 subparagraph (B) is received by the conclusion
18 60-day period referred to in subparagraph (A).

19 (7) WAIVER FOR CERTAIN CLINICAL TRIALS.—

20 (A) IN GENERAL.—In the case of a clinical
21 trial that received funding through the National
22 Institutes of Health and is ongoing as of the
23 date of the enactment of this Act, the sponsor
24 of such clinical trial is exempt from the require-

ments of (and associated penalties imposed by)
this section.

(B) REPORT.—The Secretary shall include
in the triennial report required to be submitted
under section 403 of the Public Health Service
Act (42 U.S.C. 283), a list of all clinical trials
receiving funding through the National Insti-
tutes of Health—

(i) that requested and received waiv-
ers under this subsection; or

(ii) with respect to which funding has
been terminated pursuant to this sub-
section.

(8) NONDISCRIMINATION.—Section 1557 of the
Patient Protection and Affordable Care Act (42
U.S.C. 18116) shall apply with respect to a clinical
trial subject to paragraph (1).

(b) ELIMINATING COST BARRIERS.—

(1) STUDY ON MODERNIZATION OF HUMAN
SUBJECT REGULATIONS.—Not later than 2 years
after the date of the enactment of this Act, the Sec-
retary of Health and Human Services, acting
through the Director of the National Institutes of
Health (referred to in this subsection as the “Sec-
retary”), shall conduct and complete a study on—

1 (A) the need for review of human subject
2 regulations specified in part 46 of title 45, Code
3 of Federal Regulations (or successor regula-
4 tions), and related guidance;

5 (B) the modernization of such regulations
6 and guidance to establish updated guidelines for
7 reimbursement of out-of-pocket expenses of
8 human subjects, compensation of human sub-
9 jects for time spent participating in the clinical
10 trial, and incentives for recruitment of human
11 subjects; and

12 (C) the need for updated safe harbor rules
13 under section 1001.952 of title 42, Code of
14 Federal Regulations (or successor regulations),
15 and section 1128B of the Social Security Act
16 (commonly referred to as the Federal Anti-
17 Kickback Statute (42 U.S.C. 1320a–7b)) with
18 respect to the assistance provided under this
19 subsection.

20 (2) REIMBURSEMENT FOR COSTS ASSOCIATED
21 WITH CLINICAL TRIAL PARTICIPATION.—As a condi-
22 tion on receipt of any funding provided through the
23 National Institutes of Health to conduct a clinical
24 trial investigating a drug or device (as those terms
25 are defined in section 201 of the Federal Food,

1 Drug, and Cosmetic Act (21 U.S.C. 321)) or biological
2 cal product (as defined in section 351(i) of the Pub-
3 lic Health Service Act (42 U.S.C. 262(i))), the Sec-
4 retary shall require that the sponsor of such clinical
5 trial—

6 (A) works with institutional review boards
7 and program officers of the National Institutes
8 of Health to determine when reimbursement for
9 the costs associated with clinical trial participa-
10 tion is warranted; and

11 (B) subject to paragraph (3), provides to
12 clinical trial participants reimbursement for ex-
13 penses (using funds other than funds supplied
14 through the National Institutes of Health) in-
15 curred as a result of that participation, which
16 may include—

- 17 (i) missed or forgone salary;
18 (ii) language assistance, including in-
19 terpreter services;
20 (iii) food expenses;
21 (iv) childcare expenses;
22 (v) lodging expenses;
23 (vi) transportation expenses; or
24 (vii) other expenses as identified by
25 the participant, subject to review by the

1 clinical trial sponsor, at its discretion, on a
2 case-by-case basis.

3 (3) PROVISION OF COSTS ASSOCIATED WITH
4 CLINICAL TRIAL PARTICIPATION.—

5 (A) APPLICATION AND DOCUMENTA-
6 TION.—

7 (i) IN GENERAL.—A sponsor of a clin-
8 ical trial to which subsection (a)(1) applies,
9 may require that, in order to receive reim-
10 bursement as described in paragraph (2), a
11 participant complete an application and
12 share with the sponsor such documentation
13 of expenses described in such paragraph,
14 as the sponsor may require.

15 (ii) TIMING.—Not later than 30 days
16 after the date on which a sponsor of a clin-
17 ical trial receives an application under
18 clause (i), the sponsor shall—

19 (I) review the application; and

20 (II) provide for reimbursement of
21 eligible expenses documented in such
22 application, as determined at the dis-
23 cretion of the clinical trial sponsor on
24 a case-by-case basis.

1 (B) ENFORCEMENT.—A sponsor of a clin-
2 ical trial to which subsection (a)(1) applies,
3 shall submit on an annual basis, as part of the
4 progress reports submitted to the Secretary
5 pursuant to section 402(j) of the Public Health
6 Service Act (42 U.S.C. 282(j)), during the data
7 collection period of the clinical trial, to the Sec-
8 retary an accounting of the reimbursements
9 made to clinical trial participants under sub-
10 paragraph (A). Such data shall—

11 (i) include relevant aggregate data
12 with respect to each population group spec-
13 ified in subsection (a)(2)(A)(i) when such
14 data will not compromise the identities of
15 study participants and in a manner con-
16 sistent with applicable privacy protections;
17 and

18 (ii) not later than 6 months after re-
19 ceipt by the Secretary, be published on a
20 public website of the National Institutes of
21 Health.

22 (c) PUBLIC AWARENESS AND EDUCATION CAM-
23 PAIGN.—

24 (1) NATIONAL CAMPAIGN.—The Secretary of
25 Health and Human Services, acting through the Di-

1 rector of the National Institutes of Health and the
2 Commissioner of Food and Drugs (referred to in
3 this subsection as the “Secretary”), in consultation
4 with the stakeholders specified in paragraph (5),
5 shall carry out a national campaign to increase the
6 awareness and knowledge of individuals in the
7 United States with respect to the need for diverse
8 clinical trials among the demographic groups identi-
9 fied pursuant to subsection (a)(1)(A).

10 (2) REQUIREMENTS.—The national campaign
11 conducted shall include—

12 (A) the development and distribution of
13 written educational materials, and the develop-
14 ment and placing of public service announce-
15 ments, that are intended to encourage individ-
16 uals who are members of the demographic
17 groups identified pursuant to subsection
18 (a)(2)(A)(i)(I) to seek to participate in clinical
19 trials;

20 (B) such efforts as are reasonable and nec-
21 essary to ensure meaningful access by con-
22 sumers with limited English proficiency;

23 (C) the development and distribution of
24 best practices and training for recruiting under-
25 represented study populations, including a

1 method for sharing such best practices among
2 clinical trial sponsors, providers, community-
3 based organizations who assist with recruit-
4 ment, and with the public; and

5 (D) the conduct of focus groups to better
6 understand the concerns and fears of certain
7 underrepresented groups who may be reluctant
8 to participate in clinical trials.

9 (3) HEALTH INEQUITIES.—In developing the
10 national campaign under paragraph (1), the Sec-
11 retary shall recognize and address—

12 (A) health inequities among individuals
13 who are members of the population groups
14 specified in subsection (a)(2)(A)(i) with respect
15 to access to care and participation in clinical
16 trials; and

17 (B) any barriers in access to care and par-
18 ticipation in clinical trials that are specific to
19 individuals who are members of such groups.

20 (4) GRANTS.—The Secretary shall establish a
21 program to award grants to nonprofit private enti-
22 ties, including community-based organizations and
23 faith communities, institutions of higher education
24 eligible to receive funds under section 371 of the
25 Higher Education Act of 1965 (20 U.S.C. 1067q)

1 and national organizations that serve underrep-
2 resented populations and community pharmacies to
3 enable such entities—

4 (A) to test alternative outreach and edu-
5 cation strategies to increase the awareness and
6 knowledge of individuals in the United States,
7 with respect to the need for diverse clinical
8 trials that reflect the race, ethnicity, age, and
9 gender or sex of patients with the disease or
10 condition being investigated; and

11 (B) to cover administrative costs of such
12 entities in assisting in diversifying clinical trials
13 subject to subsection (a).

14 (5) STAKEHOLDERS SPECIFIED.—The stake-
15 holders specified in this paragraph are the following:

16 (A) Representatives of the Health Re-
17 sources Services Administration, the Office of
18 Minority Health of the Department of Health
19 and Human Services, the Centers for Disease
20 Control and Prevention, and the National Insti-
21 tutes of Health.

22 (B) Community-based resources and advo-
23 cates.

24 (6) AUTHORIZATION OF APPROPRIATIONS.—

25 There is authorized to be appropriated to carry out

1 this subsection \$10,000,000 for each of fiscal years
2 2027 through 2031.

3 (d) DEFINITIONS.—In this section:

4 (1) CLINICAL TRIAL.—The term “clinical trial”
5 means a research study in which one or more human
6 subjects are prospectively assigned to one or more
7 interventions (which may include placebo or other
8 control) to evaluate the effects of those interventions
9 on health-related biomedical or behavioral outcomes.

10 (2) SPONSOR.—The term “sponsor” has the
11 meaning given such term in section 50.3 of title 21,
12 Code of Federal Regulations (or successor regula-
13 tions).

14 **SEC. 7901B-3. PATIENT EXPERIENCE DATA.**

15 (a) POLICY.—Section 569C of the Federal Food,
16 Drug, and Cosmetic Act (21 U.S.C. 360bbb-8c) is amend-
17 ed—

18 (1) by redesignating subsections (b) and (c) as
19 subsections (c) and (d), respectively; and

20 (2) by inserting after subsection (a) the fol-
21 lowing:

22 “(b) COLLECTION, SUBMISSION, AND USE OF
23 DATA.—

24 “(1) IN GENERAL.—The Secretary shall—

1 “(A) for any drug for which an exemption
2 is granted for investigational use under section
3 505(i) of this Act or section 351(a) of the Pub-
4 lic Health Service Act, require the sponsor of
5 the drug to collect standardized patient experi-
6 ence data as part of the clinical trials conducted
7 pursuant to such exemption;

8 “(B) require any application for the ap-
9 proval or licensing of such drug under section
10 505(b) of this Act or section 351(a) of the Pub-
11 lic Health Service Act to include—

12 “(i) the standardized patient experi-
13 ence data so collected; and

14 “(ii) such related information as the
15 Secretary may require; and

16 “(C) consider patient experience data and
17 related information that is submitted pursuant
18 to subparagraph (B) in deciding whether to ap-
19 prove or license, as applicable, the drug in-
20 volved.

21 “(2) APPLICABILITY.—Paragraph (1) applies
22 only with respect to drugs for which a request for
23 an exemption described in paragraph (1)(A) is sub-
24 mitted on or after the date of the enactment of the
25 Health Equity and Accountability Act of 2026, or an

1 application under section 505(b) of this Act or sec-
 2 tion 351(a) of the Public Health Service Act is filed,
 3 as applicable, on or after the day that is 2 years
 4 after the date of the enactment of the Health Equity
 5 and Accountability Act of 2026.”.

6 (b) REGULATIONS.—Not later than 1 year after the
 7 date of the enactment of this Act, the Secretary of Health
 8 and Human Services, acting through the Commissioner of
 9 Food and Drugs, shall promulgate final regulations to im-
 10 plement section 569C(b) of the Federal Food, Drug, and
 11 Cosmetic Act, as added by this section.

12 **Subtitle M—Additional Provisions**
 13 **Addressing High-impact Minor-**
 14 **ity Diseases**

15 **SEC. 7901C. MEDICARE COVERAGE OF MULTI-CANCER**
 16 **EARLY DETECTION SCREENING TESTS.**

17 (a) COVERAGE.—Section 1861 of the Social Security
 18 Act (42 U.S.C. 1395x), as amended by sections 2007,
 19 4221, 4251, 6101, and 7419, is amended—

20 (1) in subsection (s)(2)—

21 (A) in subparagraph (MM), by striking
 22 “and” at the end;

23 (B) by inserting “and” at the end of sub-
 24 paragraph (NN); and

1 (C) by adding at the end the following new
 2 subparagraph:

3 “(OO) multi-cancer early detection screen-
 4 ing tests (as defined in subsection (ttt));”; and
 5 (2) by adding at the end the following new sub-
 6 section:

7 “(ttt) MULTI-CANCER EARLY DETECTION SCREEN-
 8 ING TESTS.—The term ‘multi-cancer early detection
 9 screening test’ means any of the following tests, approved
 10 or cleared by the Food and Drug Administration, fur-
 11 nished to an individual for the purpose of early detection
 12 of cancer across many cancer types (as categorized in the
 13 Annual Report to the Nation on the Status of Cancer
 14 issued by the National Cancer Institute):

15 “(1) A genomic sequencing blood or blood prod-
 16 uct test that includes the analysis of cell-free nucleic
 17 acids.

18 “(2) Such other equivalent tests (which are
 19 based on urine or another sample of biological mate-
 20 rial) as the Secretary determines appropriate.”.

21 (b) PAYMENT AND FREQUENCY LIMIT.—

22 (1) PAYMENT UNDER FEE SCHEDULE.—Section
 23 1833(h) of the Social Security Act (42 U.S.C.
 24 1395l(h)) is amended—

1 (A) in paragraph (1)(A), by inserting after
 2 “(including” the following: “multi-cancer early
 3 detection screening tests under section
 4 1861(ttt) and including”; and

5 (B) by adding at the end the following new
 6 paragraph:

7 “(10) No payment may be made under this
 8 part for a multi-cancer early detection screening test
 9 (as defined in section 1861(ttt)) for an individual if
 10 such a test was furnished to the individual during
 11 the previous 11 months.”.

12 (2) CONFORMING AMENDMENT.—Section
 13 1862(a) of the Social Security Act (42 U.S.C.
 14 1395y(a)) is amended—

15 (A) in paragraph (1)—

16 (i) in subparagraph (O), by striking
 17 “and” at the end;

18 (ii) in subparagraph (P), by striking
 19 the semicolon at the end and inserting “,
 20 and”; and

21 (iii) by adding at the end the fol-
 22 lowing new subparagraph:

23 “(Q) in the case of multi-cancer early de-
 24 tection screening tests (as defined in section
 25 1861(ttt)), which are performed more fre-

1 quently than is covered under section
2 1833(h)(10);” and

3 (B) in paragraph (7), by striking “or (P)”
4 and inserting “(P), or (Q)”.

5 (c) **RULE OF CONSTRUCTION RELATING TO OTHER**
6 **CANCER SCREENING TESTS.**—Nothing in this section, in-
7 cluding the amendments made by this section, shall be
8 construed—

9 (1) in the case of an individual who undergoes
10 a multi-cancer early detection screening test, to af-
11 fect coverage under part B for other cancer screen-
12 ing tests covered under this section, such as screen-
13 ing tests for breast, cervical, colorectal, lung, or
14 prostate cancer; or

15 (2) in the case of an individual who undergoes
16 another cancer screening test, to affect coverage for
17 a multi-cancer early detection screening test or the
18 use of such a test as a diagnostic or confirmatory
19 test for a result of the other cancer screening test.

20 **SEC. 7901C–1. AMPUTATION REDUCTION AND COMPASSION**
21 **ACT.**

22 (a) **PERIPHERAL ARTERY DISEASE EDUCATION PRO-**
23 **GRAM.**—Part P of title III of the Public Health Service
24 Act (42 U.S.C. 280g et seq.), as amended by section 7504,
25 is amended by adding at the end the following:

1 **“SEC. 399V-14. PERIPHERAL ARTERY DISEASE EDUCATION**
2 **PROGRAM.**

3 “(a) ESTABLISHMENT.—The Secretary, acting
4 through the Director of the Centers for Disease Control
5 and Prevention, in collaboration with the Administrator
6 of the Centers for Medicare & Medicaid Services and the
7 Administrator of the Health Resources and Services Ad-
8 ministration, shall establish and coordinate a peripheral
9 artery disease education program to support, develop, and
10 implement educational initiatives and outreach strategies
11 that inform health care professionals and the public about
12 the existence of peripheral artery disease and methods to
13 reduce amputations related to such disease, particularly
14 with respect to at-risk populations.

15 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
16 is authorized to be appropriated to carry out this section
17 such sums as may be necessary for each of fiscal years
18 2027 through 2031.”.

19 (b) MEDICARE COVERAGE OF PERIPHERAL ARTERY
20 DISEASE SCREENING TESTS FURNISHED TO AT-RISK
21 BENEFICIARIES WITHOUT IMPOSITION OF COST SHARING
22 REQUIREMENTS.—

23 (1) IN GENERAL.—Section 1861 of the Social
24 Security Act (42 U.S.C. 1395x), as amended by sec-
25 tions 2007, 4221, 4251, 6101, 7419, and 7901C, is
26 amended—

1 (A) in subsection (s)(2)—

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

3 “and” at the end;

4 (ii) in subparagraph (OO), by striking

5 the period at the end and inserting “;

6 and”; and

7 (iii) by adding at the end the fol-

8 lowing new subparagraph:

9 “(PP) peripheral artery disease screening

10 tests furnished to at-risk beneficiaries (as such

11 terms are defined in subsection (uuu)).”; and

12 (B) by adding at the end the following new

13 subsection:

14 “(uuu) PERIPHERAL ARTERY DISEASE SCREENING

15 TEST; AT-RISK BENEFICIARY.—(1) The term ‘peripheral

16 artery disease screening test’ means—

17 “(A) noninvasive physiologic studies of extrem-

18 ity arteries (commonly referred to as ankle-brachial

19 index testing);

20 “(B) arterial duplex scans of lower extremity

21 arteries vascular; and

22 “(C) such other items and services as the Sec-

23 retary determines, in consultation with relevant

24 stakeholders, to be appropriate for screening for pe-

25 ripheral artery disease for at-risk beneficiaries.

1 “(2) The term ‘at-risk beneficiary’ means an indi-
 2 vidual entitled to, or enrolled for, benefits under part A
 3 and enrolled for benefits under part B—

4 “(A) who is 65 years of age or older;

5 “(B) who is at least 50 years of age but not
 6 older than 64 years of age with risk factors for ath-
 7 erosclerosis (such as diabetes mellitus, a history of
 8 smoking, hyperlipidemia, and hypertension) or a
 9 family history of peripheral artery disease;

10 “(C) who is younger than 50 years of age with
 11 diabetes mellitus and 1 additional risk factor for
 12 atherosclerosis; or

13 “(D) with a known atherosclerotic disease in
 14 another vascular bed such as coronary, carotid, sub-
 15 clavian, renal, or mesenteric artery stenosis, or ab-
 16 dominal aortic aneurysm.

17 “(3) The Secretary shall, in consultation with appro-
 18 priate organizations, establish standards regarding the
 19 frequency for peripheral artery disease screening tests de-
 20 scribed in subsection (s)(2)(PP) for purposes of coverage
 21 under this title.”.

22 (2) INCLUSION OF PERIPHERAL ARTERY DIS-
 23 EASE SCREENING TESTS IN INITIAL PREVENTIVE
 24 PHYSICAL EXAMINATION.—Section 1861(ww)(2) of

1 the Social Security Act (42 U.S.C. 1395x(w)(2)) is
 2 amended—

3 (A) in subparagraph (N), by moving the
 4 margins of such subparagraph 2 ems to the
 5 left;

6 (B) by redesignating subparagraph (O) as
 7 subparagraph (P); and

8 (C) by inserting after subparagraph (N)
 9 the following new subparagraph:

10 “(O) Peripheral artery disease screening
 11 tests furnished to at-risk beneficiaries (as such
 12 terms are defined in subsection (uuu)).”.

13 (3) PAYMENT.—

14 (A) IN GENERAL.—Section 1833(a) of the
 15 Social Security Act (42 U.S.C. 1395l(a)), as
 16 amended by sections 4251(c)(3), 6101(a)(4),
 17 and 7419, is amended—

18 (i) in paragraph (1)—

19 (I) in subparagraph (N), by in-
 20 serting “and other than peripheral ar-
 21 tery disease screening tests furnished
 22 to at-risk beneficiaries (as such terms
 23 are defined in section 1861(uuu))”
 24 after “other than personalized preven-

1 tion plan services (as defined in sec-
2 tion 1861(hhh)(1))”;

3 (II) by striking “and” before
4 “(KK)”;

5 (III) by inserting before the
6 semicolon at the end the following: “,
7 and (LL) with respect to peripheral
8 artery disease screening tests fur-
9 nished to at-risk beneficiaries (as such
10 terms are defined in section
11 1861(uuu)), the amount paid shall be
12 100 percent of the lesser of the actual
13 charge for the services or the amount
14 determined under the payment basis
15 determined under section 1848”; and
16 (ii) in paragraph (2)—

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

19 (II) in subparagraph (H), by in-
20 serting “ and” at the end; and

21 (III) by inserting after subpara-
22 graph (H) the following new subpara-
23 graph:

24 “(I) with respect to peripheral artery dis-
25 ease screening tests (as defined in paragraph

(1) of section 1861(uuu)) furnished by an outpatient department of a hospital to at-risk beneficiaries (as defined in paragraph (2) of such section), the amount determined under paragraph (1)(EE),”.

(B) NO DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 7419(a)(5)(A)(iii), is amended, in the first sentence—

(i) by striking “and” before “(14)”;

and

(ii) by inserting “, and (15) such deductible shall not apply with respect to peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in section 1861(uuu))” before the period at the end.

(C) EXCLUSION FROM PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended—

(i) by striking “, or personalized” and inserting “, personalized”; and

1 (ii) by inserting “, or peripheral ar-
 2 tery disease screening tests furnished to
 3 at-risk beneficiaries (as such terms are de-
 4 fined in section 1861(uuu))” after “per-
 5 sonalized prevention plan services (as de-
 6 fined in section 1861(hhh)(1))”.

7 (D) PAYMENT UNDER PHYSICIAN FEE
 8 SCHEDULE.—Section 1848(j)(3) of the Social
 9 Security Act (42 U.S.C. 1395w–4(j)(3)), as
 10 amended by section 4251(c)(4), is amended by
 11 inserting “, (2)(PP),” after “(2)(KK)”.

12 (4) EXCLUSION FROM COVERAGE AND MEDI-
 13 CARE AS SECONDARY PAYER FOR TESTS PERFORMED
 14 MORE FREQUENTLY THAN ALLOWED.—Section
 15 1862(a)(1) of the Social Security Act (42 U.S.C.
 16 1395y(a)(1)), as amended by subsection (b)(2), is
 17 amended—

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

20 (B) in subparagraph (Q), by striking the
 21 semicolon at the end and inserting “, and”; and

22 (C) by adding at the end the following new
 23 subparagraph:

24 “(R) in the case of peripheral artery dis-
 25 ease screening tests furnished to at-risk bene-

1 ficiaries (as such terms are defined in section
2 1861(uuu)), which are performed more fre-
3 quently than is covered under such section;”.

4 (5) AUTHORITY TO MODIFY OR ELIMINATE COV-
5 ERAGE OF CERTAIN PREVENTIVE SERVICES.—Sec-
6 tion 1834(n) of the Social Security Act (42 U.S.C.
7 1395m(n)) is amended—

8 (A) by redesignating subparagraphs (A)
9 and (B) of paragraph (1) as clauses (i) and (ii),
10 respectively, and moving the margins of such
11 clauses, as so redesignated, 2 ems to the right;

12 (B) by redesignating paragraphs (1) and
13 (2) as subparagraphs (A) and (B), respectively,
14 and moving the margins of such subparagraphs,
15 as so redesignated, 2 ems to the right;

16 (C) by striking “CERTAIN PREVENTIVE
17 SERVICES” and all that follows through “any
18 other provision of this title” and inserting:
19 “CERTAIN PREVENTIVE SERVICES.—

20 “(1) IN GENERAL.—Notwithstanding any other
21 provision of this title”; and

22 (D) by adding at the end the following new
23 paragraph:

24 “(2) INAPPLICABILITY.—The Secretarial au-
25 thority described in paragraph (1) shall not apply

1 with respect to preventive services described in sec-
 2 tion 1861(ww)(2)(O).”.

3 (6) EFFECTIVE DATE.—The amendments made
 4 by this subsection shall apply with respect to items
 5 and services furnished on or after January 1, 2027.

6 (c) MEDICAID COVERAGE OF PERIPHERAL ARTERY
 7 DISEASE SCREENING TESTS FURNISHED TO AT-RISK
 8 BENEFICIARIES WITHOUT IMPOSITION OF COST SHARING
 9 REQUIREMENTS.—

10 (1) IN GENERAL.—Section 1905 of the Social
 11 Security Act (42 U.S.C. 1396d), as amended by sec-
 12 tion 5406(f) and 7419(a)(3)(A)(ii), is amended—

13 (A) in subsection (a)—

14 (i) in paragraph (33), by striking
 15 “and” after the semicolon;

16 (ii) by redesignating paragraph (34)
 17 as paragraph (35); and

18 (iii) by inserting after paragraph (33)
 19 the following new paragraph:

20 “(34) peripheral artery disease screening tests
 21 furnished to at-risk beneficiaries (as such terms are
 22 defined in subsection (ss)); and”; and

23 (B) by adding at the end the following new
 24 subsection:

1 “(ss) PERIPHERAL ARTERY DISEASE SCREENING
2 TEST; AT-RISK BENEFICIARY.—

3 “(1) PERIPHERAL ARTERY DISEASE SCREENING
4 TEST.—The term ‘peripheral artery disease screen-
5 ing test’ means—

6 “(A) noninvasive physiologic studies of ex-
7 tremity arteries (commonly referred to as ankle-
8 brachial index testing);

9 “(B) arterial duplex scans of lower extrem-
10 ity arteries vascular; and

11 “(C) such other items and services as the
12 Secretary determines, in consultation with rel-
13 evant stakeholders, to be appropriate for
14 screening for peripheral artery disease for at-
15 risk beneficiaries.

16 “(2) AT-RISK BENEFICIARY.—The term ‘at-risk
17 beneficiary’ means an individual enrolled under a
18 State plan (or a waiver of such plan)—

19 “(A) who is 65 years of age or older;

20 “(B) who is at least 50 years of age but
21 not older than 64 years of age with risk factors
22 for atherosclerosis (such as diabetes mellitus, a
23 history of smoking, hyperlipidemia, and hyper-
24 tension) or a family history of peripheral artery
25 disease;

1 “(C) who is younger than 50 years of age
2 with diabetes mellitus and one additional risk
3 factor for atherosclerosis; or

4 “(D) with a known atherosclerotic disease
5 in another vascular bed such as coronary, ca-
6 rotid, subclavian, renal, or mesenteric artery
7 stenosis, or abdominal aortic aneurysm.

8 “(3) FREQUENCY.—The Secretary shall, in con-
9 sultation with appropriate organizations, establish
10 standards regarding the frequency for peripheral ar-
11 tery disease screening tests described in subsection
12 (a)(34) for purposes of coverage under a State plan
13 under this title.”.

14 (2) NO COST SHARING.—

15 (A) IN GENERAL.—Subsections (a)(2) and
16 (b)(2) of section 1916 of the Social Security
17 Act (42 U.S.C. 1396o), as amended by section
18 7305(b)(1), are each amended—

19 (i) in subparagraph (K), by striking
20 “or” after the comma at the end;

21 (ii) in subparagraph (L), by striking
22 “; and” and inserting “, or”; and

23 (iii) by adding at the end the fol-
24 lowing new subparagraph:

1 “(M) peripheral artery disease screening
 2 tests furnished to at-risk beneficiaries (as such
 3 terms are defined in section 1905(ss)); and”.

4 (B) APPLICATION TO ALTERNATIVE COST
 5 SHARING.—Section 1916A(b)(3)(B) of the So-
 6 cial Security Act (42 U.S.C. 1396o-
 7 1(b)(3)(B)), as amended by section 7305(b)(2),
 8 is amended by adding at the end the following
 9 new clause:

10 “(xv) Peripheral artery disease screen-
 11 ing tests furnished to at-risk beneficiaries
 12 (as such terms are defined in section
 13 1905(ss)).”.

14 (3) MANDATORY COVERAGE.—Section
 15 1902(a)(10)(A) of the Social Security Act (42
 16 U.S.C. 1396a(a)(10)(A)), as amended by section
 17 2007(d)(2), is amended by striking “and (32)” and
 18 inserting “(32), and (34)”.

19 (d) REQUIREMENT FOR GROUP HEALTH PLANS AND
 20 HEALTH INSURANCE ISSUERS OFFERING GROUP OR IN-
 21 DIVIDUAL HEALTH INSURANCE COVERAGE TO PROVIDE
 22 COVERAGE FOR PERIPHERAL ARTERY DISEASE SCREEN-
 23 ING TESTS FURNISHED TO AT-RISK ENROLLEES WITH-
 24 OUT IMPOSITION OF COST SHARING REQUIREMENTS.—

1 (1) IN GENERAL.—Section 2713 of the Public
2 Health Service Act (42 U.S.C. 300gg–13), as
3 amended by section 7419(a)(1)(A), is further
4 amended—

5 (A) by adding at the end of subsection
6 (a)(1) of such section, as redesignated by sec-
7 tion 7419(a)(1)(A), the following:

8 “(F) with respect to at-risk enrollees, pe-
9 ripheral artery disease screening tests.

10 “(2) FREQUENCY.—The Secretary, in consulta-
11 tion with appropriate organizations, shall establish
12 standards regarding the frequency for peripheral ar-
13 tery disease screening tests for purposes of coverage
14 under this section.

15 “(3) CLARIFICATION REGARDING BREAST CAN-
16 CER SCREENING, MAMMOGRAPHY, AND PREVENTION
17 RECOMMENDATIONS.—For the purposes of this Act,
18 and for the purposes of any other provision of law,
19 the current recommendations of the United States
20 Preventive Services Task Force regarding breast
21 cancer screening, mammography, and prevention
22 shall be considered the most current other than
23 those issued in or around November 2009.

24 “(4) DEFINITIONS.—In this subsection:

“(A) AT-RISK ENROLLEE.—The term ‘at-risk enrollee’ means an individual enrolled in a group health plan or group or individual health insurance coverage—

“(i) who is 65 years of age or older;

“(ii) who is at least 50 years of age but not older than 64 years of age with risk factors for atherosclerosis (such as diabetes mellitus, a history of smoking, hyperlipidemia, and hypertension) or a family history of peripheral artery disease;

“(iii) who is younger than 50 years of age with diabetes mellitus and one additional risk factor for atherosclerosis; or

“(iv) with a known atherosclerotic disease in another vascular bed such as coronary, carotid, subclavian, renal, or mesenteric artery stenosis, or abdominal aortic aneurysm.

“(B) PERIPHERAL ARTERY DISEASE SCREENING TEST.—The term ‘peripheral artery disease screening test’ means—

“(i) noninvasive physiologic studies of extremity arteries (commonly referred to as ankle-brachial index testing);

1 “(ii) arterial duplex scans of lower ex-
2 tremity arteries vascular; and

3 “(iii) such other items and services as
4 the Secretary determines, in consultation
5 with relevant stakeholders, to be appro-
6 priate for screening for peripheral artery
7 disease for at-risk enrollees.

8 “(5) RULE OF CONSTRUCTION.—Nothing in
9 this subsection shall be construed to prohibit a plan
10 or issuer from providing coverage for services in ad-
11 dition to those recommended by the United States
12 Preventive Services Task Force or to deny coverage
13 for services that are not recommended by such Task
14 Force.”; and

15 (B) in subsection (b)(1)—

16 (i) by striking “subsection (a)(1) or
17 (a)(2) or a guideline under subsection
18 (a)(3)” and inserting “subparagraph (A)
19 or (B) of subsection (a)(1) or a guideline
20 under subparagraph (C) of such sub-
21 section”; and

22 (ii) by striking “described in sub-
23 section (a)” and inserting “described in
24 subsection (a)(1)”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by paragraph (1) shall apply with respect to plan
3 years beginning on or after January 1, 2027.

4 (e) DISALLOWANCE OF PAYMENT FOR NONTRAU-
5 MATIC AMPUTATION SERVICES FURNISHED WITHOUT
6 ANATOMICAL TESTING SERVICES.—Section 1834 of the
7 Social Security Act (42 U.S.C. 1395m), as amended by
8 section 4221(b)(2), is amended by adding at the end the
9 following new subsection:

10 “(bb) DISALLOWANCE OF PAYMENT FOR NONTRAU-
11 MATIC AMPUTATION SERVICES FURNISHED WITHOUT
12 ANATOMICAL TESTING SERVICES.—

13 “(1) IN GENERAL.—In the case of nontrau-
14 matic amputation services furnished by a supplier on
15 or after January 1, 2027, to an individual entitled
16 to, or enrolled for, benefits under part A and en-
17 rolled for benefits under this part, for which pay-
18 ment is made under this part, payment may only be
19 made under this part if—

20 “(A) such supplier furnishes anatomical
21 testing services to such individual during the 3-
22 month period preceding the date on which such
23 nontraumatic amputation services is furnished;
24 or

“(B) such individual has a pre-existing dysfunctional or unsalvageable limb, life-threatening sepsis, intractable infection, extensive gangrene or necrotic tissue loss beyond salvage, a poor functional status, severe dementia, or a short life expectancy after shared decision making with a health care team and patient, family, or caregiver.

“(2) DEFINITIONS.—In this subsection:

“(A) ANATOMICAL TESTING SERVICES.—The term ‘anatomical testing services’ means arterial duplex scanning, computed tomography angiography, and magnetic resonance angiography.

“(B) NONTRAUMATIC AMPUTATION SERVICES.—The term ‘nontraumatic amputation services’ means amputations as a result of atherosclerotic vascular disease or a related comorbidity of such disease (including diabetes).”.

(f) DEVELOPMENT AND IMPLEMENTATION OF QUALITY MEASURES.—

(1) DEVELOPMENT.—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall, in consultation with relevant stakeholders, develop quality measures for

1 nontraumatic, lower-limb, major amputation that
2 utilize appropriate diagnostic screening (including
3 peripheral artery disease screening) in order to en-
4 courage alternative treatments (including
5 revascularization) in lieu of such an amputation.

6 (2) IMPLEMENTATION.—After appropriate test-
7 ing and validation of the measures developed under
8 paragraph (1), the Secretary shall incorporate such
9 measures in quality reporting programs for appro-
10 priate providers of services and suppliers under the
11 Medicare program under title XVIII of the Social
12 Security Act (42 U.S.C. 1395 et seq.), including for
13 purposes of—

14 (A) the merit-based incentive payment sys-
15 tem under section 1848(q) of such Act (42
16 U.S.C. 1395w-4(q));

17 (B) incentive payments for participation in
18 eligible alternative payment models under sec-
19 tion 1833(z) of such Act (42 U.S.C. 1395l(z));

20 (C) the shared savings program under sec-
21 tion 1899 of such Act (42 U.S.C. 1395jjj);

22 (D) models under section 1115A of such
23 Act (42 U.S.C. 1315a); and

24 (E) such other payment systems or models
25 as the Secretary may specify.

1 **SEC. 7901C-2. ELIMINATING THE COINSURANCE REQUIRE-**
 2 **MENT FOR CERTAIN COLORECTAL CANCER**
 3 **SCREENING TESTS FURNISHED UNDER THE**
 4 **MEDICARE PROGRAM.**

5 Section 1833(dd) of the Social Security Act (42
 6 U.S.C. 1395l(dd)) is amended—

7 (1) in paragraph (1), by striking “and before
 8 January 1, 2030,”; and

9 (2) in paragraph (2), by striking subparagraph
 10 (C) and inserting the following:

11 “(C) for 2027 and each subsequent year,
 12 100 percent.”.

13 **SEC. 7901C-3. EXPANDING THE AVAILABILITY OF MEDICAL**
 14 **NUTRITION THERAPY SERVICES UNDER THE**
 15 **MEDICARE PROGRAM.**

16 (a) IN GENERAL.—Section 1861 of the Social Secu-
 17 rity Act (42 U.S.C. 1395x) is amended—

18 (1) in subsection (s)(2)(V), by striking “in the
 19 case of” and all that follows through “organiza-
 20 tions”; and

21 (2) in subsection (vv)—

22 (A) in paragraph (1)—

23 (i) by striking “disease management”
 24 and inserting “the prevention, manage-
 25 ment, or treatment of a disease or condi-
 26 tion specified in paragraph (4)”; and

1 (ii) by striking “by a physician” and
 2 all that follows through the period at the
 3 end and inserting the following: “by a—
 4 “(A) physician (as defined in subsection
 5 (r)(1));
 6 “(B) physician assistant;
 7 “(C) nurse practitioner;
 8 “(D) clinical nurse specialist (as defined in
 9 subsection (aa)(5)(B)); or
 10 “(E) in the case of such services furnished
 11 to manage such a disease or condition that is
 12 an eating disorder, a clinical psychologist (as
 13 defined by the Secretary).

14 Such term shall not include any services furnished
 15 to an individual for the prevention, management, or
 16 treatment of a renal disease if such individual is re-
 17 ceiving maintenance dialysis for which payment is
 18 made under section 1881.”; and

19 (B) by adding at the end the following new
 20 paragraph:

21 “(4) For purposes of paragraph (1), the dis-
 22 eases and conditions specified in this paragraph are
 23 the following:

24 “(A) Diabetes and prediabetes.

25 “(B) A renal disease.

1 “(C) Obesity (as defined for purposes of
2 subsection (yy)(2)(C) or as otherwise defined by
3 the Secretary).

4 “(D) Hypertension.

5 “(E) Dyslipidemia.

6 “(F) Malnutrition.

7 “(G) Eating disorders.

8 “(H) Cancer.

9 “(I) Gastrointestinal diseases, including ce-
10 liac disease.

11 “(J) HIV.

12 “(K) AIDS.

13 “(L) Cardiovascular disease.

14 “(M) Any other disease or condition—

15 “(i) specified by the Secretary relating
16 to unintentional weight loss;

17 “(ii) for which the Secretary deter-
18 mines the services described in paragraph
19 (1) to be medically necessary and appro-
20 priate for the prevention, management, or
21 treatment of such disease or condition,
22 consistent with any applicable rec-
23 ommendations of the United States Pre-
24 ventive Services Task Force; or

1 “(iii) for which the Secretary deter-
2 mines the services described in paragraph
3 (1) are medically necessary, consistent with
4 either protocols established by registered
5 dietitians or nutrition professional organi-
6 zations or with accepted clinical guidelines
7 identified by the Secretary.”.

8 (b) EXCLUSION MODIFICATION.—Section 1862(a)(1)
9 of the Social Security Act (42 U.S.C. 1395y(a)(1)), as
10 amended by sections 7901C(b)(2) and 7901C–1(b)(4), is
11 amended—

12 (1) in subparagraph (Q), by striking “and” at
13 the end;

14 (2) in subparagraph (R), by striking the semi-
15 colon at the end and inserting “, and”; and

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

18 “(S) in the case of medical nutrition ther-
19 apy services (as defined in section 1861(vv)),
20 which are not furnished for the prevention,
21 management, or treatment of a disease or con-
22 dition specified in paragraph (4) of such sec-
23 tion;”.

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply with respect to items and services
 3 furnished on or after January 1, 2027.

4 **SEC. 7901C–4. ENCOURAGING THE DEVELOPMENT AND USE**
 5 **OF DISARM ANTIMICROBIAL DRUGS.**

6 (a) ADDITIONAL PAYMENT FOR DISARM ANTI-
 7 MICROBIAL DRUGS UNDER MEDICARE.—

8 (1) IN GENERAL.—Section 1886(d)(5) of the
 9 Social Security Act (42 U.S.C. 1395ww(d)(5)) is
 10 amended by adding at the end the following new
 11 subparagraph:

12 “(N)(i)(I) Effective for discharges begin-
 13 ning on or after October 1, 2027, or such soon-
 14 er date as specified by the Secretary, subject to
 15 subclause (II), the Secretary shall, after notice
 16 and opportunity for public comment (in the
 17 publications required by subsection (e)(5) for a
 18 fiscal year or otherwise), provide for an addi-
 19 tional payment under a mechanism (separate
 20 from the mechanism established under subpara-
 21 graph (K)), with respect to such discharges in-
 22 volving any DISARM antimicrobial drug, in an
 23 amount equal to—

24 “(aa) the amount payable under sec-
 25 tion 1847A for such drug during the cal-

1 endar quarter in which the discharge oc-
2 curred; or

3 “(bb) if no amount for such drug is
4 determined under section 1847A, an
5 amount to be determined by the Secretary
6 in a manner similar to the manner in
7 which payment amounts are determined
8 under section 1847A based on information
9 submitted by the manufacturer or sponsor
10 of such drug (as required under clause
11 (v)).

12 “(II) In determining the amount payable
13 under section 1847A for purposes of items (aa)
14 and (bb) of subclause (I), subparagraphs (A)
15 and (B) of subsection (b)(1) of such section
16 shall be applied by substituting ‘102 percent’
17 for ‘106 percent’ each place it appears and
18 paragraph (8)(B) of such section shall be ap-
19 plied by substituting ‘2 percent’ for ‘6 percent’.

20 “(ii) For purposes of this subparagraph, a DIS-
21 ARM antimicrobial drug is—

22 “(I) a drug—

23 “(aa) that—

24 “(AA) is approved by the Food
25 and Drug Administration;

1 “(BB) is designated by the Food
2 and Drug Administration as a quali-
3 fied infectious disease product under
4 subsection (d) of section 505E of the
5 Federal Food, Drug, and Cosmetic
6 Act (21 U.S.C. 355f(d)); and

7 “(CC) has received an extension
8 of its exclusivity period pursuant to
9 subsection (a) of such section; and

10 “(bb) that has been designated by the
11 Secretary pursuant to the process estab-
12 lished under clause (iv)(I)(bb); or

13 “(II) an antibacterial or antifungal biologi-
14 cal product—

15 “(aa) that is licensed for use, or an
16 antibacterial or antifungal biological prod-
17 uct for which an indication is first licensed
18 for use, by the Food and Drug Administra-
19 tion on or after June 5, 2014, under sec-
20 tion 351(a) of the Public Health Service
21 Act for human use to treat serious or life-
22 threatening infections, as determined by
23 the Food and Drug Administration, includ-
24 ing those caused by, or likely to be caused
25 by—

1 “(AA) an antibacterial or
 2 antifungal resistant pathogen, includ-
 3 ing novel or emerging infectious
 4 pathogens; or

5 “(BB) a qualifying pathogen (as
 6 defined under section 505E(f) of the
 7 Federal Food, Drug, and Cosmetic
 8 Act (21 U.S.C. 355f(f))); and

9 “(bb) has been designated by the Sec-
 10 retary pursuant to the process established
 11 under clause (iv)(I)(bb).

12 “(iii) The mechanism established pursuant to
 13 clause (i) shall provide that the additional payment
 14 under clause (i) shall—

15 “(I) with respect to a discharge, only be
 16 made to a subsection (d) hospital that, as deter-
 17 mined by the Secretary—

18 “(aa) is participating in the National
 19 Healthcare Safety Network Antimicrobial
 20 Use and Resistance Module of the Centers
 21 for Disease Control and Prevention; and

22 “(bb) has an antimicrobial steward-
 23 ship program that aligns with the Core
 24 Elements of Hospital Antibiotic Steward-
 25 ship Programs of the Centers for Disease

1 Control and Prevention or the Anti-
2 microbial Stewardship Standard set by the
3 Joint Commission; and

4 “(II) apply to discharges occurring on or
5 after October 1 of the year in which the drug
6 or biological product is designated by the Sec-
7 retary as a DISARM antimicrobial drug.

8 For purposes of this clause, in the case of a similar
9 reporting program described in item (aa), a sub-
10 section (d) hospital shall be treated as participating
11 in such a program if the entity maintaining such
12 program identifies to the Secretary such hospital as
13 so participating.

14 “(iv)(I) The mechanism established
15 pursuant to clause (i) shall provide for a
16 process for—

17 “(aa) a manufacturer or sponsor
18 of a drug or biological product to re-
19 quest the Secretary to designate the
20 drug or biological product as a DIS-
21 ARM antimicrobial drug; and

22 “(bb) the designation (and re-
23 moval of such designation) by the Sec-
24 retary of drugs and biological prod-
25 ucts as DISARM antimicrobial drugs.

1 “(II) A designation of a drug or bio-
2 logical product as a DISARM anti-
3 microbial drug may be revoked by the Sec-
4 retary if the Secretary determines that—

5 “(aa) the drug or biological prod-
6 uct no longer meets the requirements
7 for a DISARM antimicrobial drug
8 under clause (ii);

9 “(bb) the request for such des-
10 ignation contained an untrue state-
11 ment of material fact; or

12 “(cc) clinical or other information
13 that was not available to the Sec-
14 retary at the time such designation
15 was made shows that—

16 “(AA) such drug or biologi-
17 cal product is unsafe for use or
18 not shown to be safe for use for
19 individuals who are entitled to
20 benefits under part A; or

21 “(BB) an alternative to such
22 drug or biological product is an
23 advance that substantially im-
24 proves the diagnosis or treatment
25 of such individuals.

1 “(III) Not later than October 1, 2026,
2 the Secretary shall publish in the Federal
3 Register a list of the DISARM anti-
4 microbial drugs designated under this sub-
5 paragraph pursuant to the process estab-
6 lished under subclause (I)(bb). The Sec-
7 retary shall annually update such list.

8 “(v)(I) For purposes of determining addi-
9 tional payment amounts under clause (i), a
10 manufacturer or sponsor of a drug or biological
11 product that submits a request described in
12 clause (iv)(I)(aa) shall submit to the Secretary
13 information described in section
14 1927(b)(3)(A)(iii).

15 “(II) The penalties for failure to pro-
16 vide timely information under clause (i) of
17 subparagraph (C) section 1927(b)(3) and
18 for providing false information under
19 clause (ii) of such subparagraph shall
20 apply to manufacturers and sponsors of a
21 drug or biological product under this sec-
22 tion with respect to information under sub-
23 clause (I) in the same manner as such pen-
24 alties apply to manufacturers under such

1 clauses with respect to information under
2 subparagraph (A) of such section.

3 “(vi)(I) The mechanism established pursu-
4 ant to clause (i) shall provide that—

5 “(aa) except as provided in item (bb),
6 no additional payment shall be made under
7 this subparagraph for discharges involving
8 a DISARM antimicrobial drug if any addi-
9 tional payments have been made for dis-
10 charges involving such drug as a new med-
11 ical service or technology under subpara-
12 graph (K);

13 “(bb) additional payments may be
14 made under this subparagraph for dis-
15 charges involving a DISARM antimicrobial
16 drug if any additional payments have been
17 made for discharges occurring prior to the
18 date of enactment of this subparagraph in-
19 volving such drug as a new medical service
20 or technology under subparagraph (K);
21 and

22 “(cc) no additional payment shall be
23 made under subparagraph (K) for dis-
24 charges involving a DISARM antimicrobial
25 drug as a new medical service or tech-

1 nology if any additional payments for dis-
2 charges involving such drug have been
3 made under this subparagraph.

4 “(2) CONFORMING AMENDMENT.—Section
5 1886(d)(5)(K)(ii)(III) of the Social Security Act (42
6 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by
7 striking ‘provide’ and inserting ‘subject to subpara-
8 graph (N)(vi), provide’.”.

9 (b) AUTHORIZATION OF APPROPRIATIONS FOR THE
10 CENTERS FOR DISEASE CONTROL AND PREVENTION.—
11 There is authorized to be appropriated to the Centers for
12 Disease Control and Prevention \$500,000,000, to remain
13 available until expended, to support the establishment and
14 implementation of antimicrobial stewardship programs
15 and data reporting capabilities to the Antimicrobial Use
16 and Resistance option of the CDC National Healthcare
17 Safety Network, especially in critical access hospitals,
18 rural hospitals, and community hospitals, to support de-
19 tection, surveillance, containment, and prevention of re-
20 sistant pathogens in the United States and overseas.

21 (c) STUDY AND REPORTS ON REMOVING BARRIERS
22 TO THE DEVELOPMENT OF DISARM ANTIMICROBIAL
23 DRUGS.—

24 (1) STUDY.—The Comptroller General of the
25 United States (in this subsection referred to as the

1 “Comptroller General”), in consultation with the Di-
2 rector of the National Institutes of Health, the Com-
3 missioner of Food and Drugs, the Administrator of
4 the Centers for Medicare & Medicaid Services, and
5 the Director of the Centers for Disease Control and
6 Prevention, shall conduct a study over a 5-year pe-
7 riod of the barriers that prevent the development of
8 DISARM antimicrobial drugs (as defined in section
9 1886(d)(5)(N)(ii) of the Social Security Act, as
10 added by subsection (a)), including—

11 (A) patient outcomes in conjunction with
12 the use of DISARM drugs, including—

13 (i) duration of stay in the intensive
14 care unit;

15 (ii) recidivism within 30 days; and

16 (iii) measures of additional follow-up
17 care;

18 (B) the effectiveness of antimicrobial stew-
19 ardship and surveillance programs, including—

20 (i) changes in the percentage of hos-
21 pitals in the United States with an anti-
22 microbial stewardship program in place
23 that aligns with the Core Elements of Hos-
24 pital Antibiotic Stewardship Programs, as

outlined by the Centers for Disease Control
and Prevention;

(ii) changes in inpatient care of
clostridioides difficile infection; and

(iii) changes in inpatient rates of re-
sistance to key pathogens; and

(C) considerations relating to Medicare
payment reform, including—

(i) changes in the number of qualified
antimicrobial products approved;

(ii) changes in wholesale acquisition
cost of individual qualified antimicrobial
products over time;

(iii) changes in year-over-year volume
of individual qualified antimicrobial prod-
ucts sold; and

(iv) the overall cost of qualified anti-
microbial products to the Medicare pro-
gram as a proportion of total Medicare
part A spending.

(2) REPORT.—Not later than 5 years after the
date of the enactment of this section, the Comp-
troller General shall submit to Congress a report
containing the results of the study conducted under
paragraph (1), together with recommendations for

1 such legislation and administrative action as the
2 Comptroller General determines appropriate.

3 **SEC. 7901C-5. TREAT AND REDUCE OBESITY ACT.**

4 (a) AUTHORITY TO EXPAND HEALTH CARE PRO-
5 VIDERS QUALIFIED TO FURNISH INTENSIVE BEHAVIORAL
6 THERAPY.—Section 1861(ddd) of the Social Security Act
7 (42 U.S.C. 1395x(ddd)) is amended by adding at the end
8 the following new paragraph:

9 “(4)(A) Subject to subparagraph (B), the Sec-
10 retary may, in addition to qualified primary care
11 physicians and other primary care practitioners,
12 cover intensive behavioral therapy for obesity fur-
13 nished by any of the following:

14 “(i) A physician (as defined in subsection
15 (r)(1)) who is not a qualified primary care phy-
16 sician.

17 “(ii) Any other appropriate health care
18 provider (including a physician assistant, nurse
19 practitioner, or clinical nurse specialist (as
20 those terms are defined in subsection (aa)(5)),
21 a clinical psychologist, a registered dietitian or
22 nutrition professional (as defined in subsection
23 (vv))).

1 “(iii) An evidence-based, community-based
2 lifestyle counseling program approved by the
3 Secretary.

4 “(B) In the case of intensive behavioral therapy
5 for obesity furnished by a provider described in
6 clause (ii) or (iii) of subparagraph (A), the Secretary
7 may only cover such therapy if such therapy is fur-
8 nished—

9 “(i) upon referral from, and in coordina-
10 tion with, a physician or primary care practi-
11 tioner operating in a primary care setting or
12 any other setting specified by the Secretary;
13 and

14 “(ii) in an office setting, a hospital out-
15 patient department, a community-based site
16 that complies with the Federal regulations con-
17 cerning the privacy of individually identifiable
18 health information promulgated under section
19 264(c) of the Health Insurance Portability and
20 Accountability Act of 1996, or another setting
21 specified by the Secretary.

22 “(C) In order to ensure a collaborative effort,
23 the coordination described in subparagraph (B)(i)
24 shall include the health care provider or lifestyle
25 counseling program communicating to the referring

1 physician or primary care practitioner any rec-
 2 ommendations or treatment plans made regarding
 3 the therapy.”.

4 (b) MEDICARE PART D COVERAGE OF OBESITY
 5 MEDICATION.—

6 (1) IN GENERAL.—Section 1860D–2(e)(2)(A)
 7 of the Social Security Act (42 U.S.C. 1395w–
 8 102(e)(2)(A)) is amended, in the first sentence—

9 (A) by striking “and other than” and in-
 10 serting “other than”; and

11 (B) by inserting after “benzodiazepines,”
 12 the following: “and other than subparagraph
 13 (A) of such section if the drug is used for the
 14 treatment of obesity (as defined in section
 15 1861(yy)(2)(C)) or for weight loss management
 16 for an individual who is overweight (as defined
 17 in section 1861(yy)(2)(F)(i)) and has 1 or more
 18 related comorbidities,”.

19 (2) EFFECTIVE DATE.—The amendments made
 20 by paragraph (1) shall apply to plan years beginning
 21 on or after the date that is 2 years after the date
 22 of the enactment of this section.

23 (c) REPORT TO CONGRESS.—

24 (1) IN GENERAL.—Not later than the date that
 25 is 1 year after the date of the enactment of this sec-

1 tion, and every 2 years thereafter, the Secretary of
2 Health and Human Services shall submit a report to
3 Congress describing the steps the Secretary has
4 taken to implement the provisions of, and amend-
5 ments made by, this section.

6 (2) RECOMMENDATIONS.—Such report shall
7 also include recommendations for better coordination
8 and leveraging of programs within the Department
9 of Health and Human Services and other Federal
10 agencies that relate in any way to supporting appro-
11 priate research and clinical care (such as any inter-
12 actions between physicians and other health care
13 providers and their patients) to treat, reduce, and
14 prevent obesity in the adult population.

15 **SEC. 7901C-6. INCENTIVES, IMPROVEMENTS, AND OUT-**
16 **REACH TO INCREASE DIVERSITY IN ALZ-**
17 **HEIMER’S DISEASE RESEARCH.**

18 (a) IMPROVING ACCESS FOR AND OUTREACH TO
19 UNDERREPRESENTED POPULATIONS.—

20 (1) EXPANDING ACCESS TO ALZHEIMER’S RE-
21 SEARCH CENTERS.—

22 (A) IN GENERAL.—Section 445(a)(1) of
23 the Public Health Service Act (42 U.S.C. 285e-
24 2(a)(1)) is amended—

1 (i) by striking “(a)(1) The Director of
2 the Institute may” and inserting the fol-
3 lowing:

4 “(a)(1) The Director of the Institute—
5 “(A) may;”.

6 (ii) by striking “disease.” and insert-
7 ing “disease; and”; and

8 (iii) by adding at the end the fol-
9 lowing:

10 “(B) beginning January 1, 2027, shall
11 enter into cooperative agreements and make
12 grants to public or private nonprofit entities
13 under this subsection for the planning, estab-
14 lishment, and operation of new such centers
15 that are located in areas with a higher con-
16 centration of minority groups (as determined
17 under section 444(d)(3)(D)), such as entities
18 that are historically Black colleges and univer-
19 sities, Hispanic-serving institutions, Tribal col-
20 leges and universities, or centers of excellence
21 for other minority populations.”.

22 (B) USE OF FUNDING FOR CLINICS TO OP-
23 ERATE CLINICAL TRIALS.—Section 445(b) of
24 the Public Health Service Act (42 U.S.C. 285e—

1 2(b)) is amended by adding at the end the fol-
2 lowing:

3 “(3) Federal payments made under a coopera-
4 tive agreement or grant under subsection (a) from
5 funds made available under section 7901C–6(g) of
6 the Health Equity and Accountability Act of 2026
7 shall, with respect to Alzheimer’s disease, be used in
8 part to establish and operate diagnostic and treat-
9 ment clinics designed—

10 “(A) to meet the special needs of minority
11 and rural populations and other underserved
12 populations; and

13 “(B) to operate clinical trials.”.

14 (2) OUTREACH.—

15 (A) ALZHEIMER’S DISEASE CENTERS.—

16 Section 445(b) of the Public Health Service Act
17 (42 U.S.C. 285e–2(b)), as amended by para-
18 graph (1)(B), is amended by adding at the end
19 the following:

20 “(4) Federal payments made under a coopera-
21 tive agreement or grant under subsection (a) shall
22 be used to establish engagement centers to carry out
23 public outreach, education efforts, and dissemination
24 of information for members of minority groups

1 about clinical trial participation. Activities funded
 2 pursuant to the preceding sentence shall include—

3 “(A) using established mechanisms to en-
 4 courage members of minority groups to partici-
 5 pate in clinical trials on Alzheimer’s disease;

6 “(B) expanding education efforts to make
 7 members of minority groups aware of ongoing
 8 clinical trials;

9 “(C) working with trial sponsors to in-
 10 crease the number of recruitment events for
 11 members of minority groups;

12 “(D) conducting outreach to national,
 13 State, and local physician professional organiza-
 14 tions, especially for members of such organiza-
 15 tions who are primary care physicians or physi-
 16 cians who specialize in dementia, to increase
 17 awareness of clinical research opportunities for
 18 members of minority groups; and

19 “(E) using community-based participatory
 20 research methodologies to engage with minority
 21 populations.”.

22 (B) RESOURCE CENTERS FOR MINORITY
 23 AGING RESEARCH.—Section 444(c) of the Pub-
 24 lic Health Service Act (42 U.S.C. 285e–1(c)) is
 25 amended—

- 1 (i) by striking “(c) The Director” and
 2 inserting “(c)(1) The Director”; and
 3 (ii) by adding at the end the following
 4 new paragraph:

5 “(2) The Director of the Institute, acting
 6 through the Resource Centers for Minority Aging
 7 Research of the Institute, shall carry out public out-
 8 reach, education efforts, and dissemination of infor-
 9 mation for members of minority groups about par-
 10 ticipation in clinical research on Alzheimer’s disease
 11 carried out or supported under this subpart.”.

12 (b) INCENTIVES TO INCREASE DIVERSITY IN ALZ-
 13 HEIMER’S DISEASE RESEARCH THROUGH PRINCIPAL IN-
 14 VESTIGATORS AND RESEARCHERS FROM UNDERREP-
 15 RESENTED POPULATIONS.—

16 (1) ALZHEIMER’S CLINICAL RESEARCH AND
 17 TRAINING AWARDS.—Section 445I of the Public
 18 Health Service Act (42 U.S.C. 285e–10a) is amend-
 19 ed by adding at the end the following:

20 “(d) ENHANCING THE PARTICIPATION OF PRINCIPAL
 21 INVESTIGATORS AND RESEARCHERS WHO ARE MEMBERS
 22 OF UNDERREPRESENTED POPULATIONS.—

23 “(1) IN GENERAL.—The Director of the Insti-
 24 tute shall enhance diversity in the conduct or sup-
 25 port of clinical research on Alzheimer’s disease

1 under this subpart by encouraging the participation
 2 of individuals from groups that are underrepresented
 3 in the biomedical, clinical, behavioral, and social
 4 sciences as principal investigators of such clinical re-
 5 search, as researchers for such clinical research, or
 6 both.

7 “(2) TRAINING FOR PRINCIPAL INVESTIGA-
 8 TORS.—The Director of the Institute shall provide
 9 training for principal investigators who are members
 10 of a minority group with respect to skills for—

11 “(A) the design and conduct of clinical re-
 12 search and clinical protocols;

13 “(B) applying for grants for clinical re-
 14 search; and

15 “(C) such other areas as the Director of
 16 the Institute determines to be appropriate.”.

17 (2) SENIOR RESEARCHER AWARDS.—Section
 18 445B(a) of the Public Health Service Act (42
 19 U.S.C. 285e–4(a)) is amended by inserting “, in-
 20 cluding senior researchers who are members of a mi-
 21 nority group” before the period at the end of the
 22 first sentence.

23 (c) INCENTIVES TO INCREASE DIVERSITY IN ALZ-
 24 HEIMER’S DISEASE RESEARCH THROUGH TRIAL SITES.—

1 Section 444(d) of the Public Health Service Act (42
2 U.S.C. 285e–1(d)) is amended—

3 (1) by striking “(d) The Director” and insert-
4 ing “(d)(1) The Director”; and

5 (2) by adding at the end the following:

6 “(2) In conducting or supporting clinical re-
7 search on Alzheimer’s disease for purposes of this
8 subpart, in addition to requirements otherwise im-
9 posed under this title, including under section 492B,
10 the Director of the Institute shall increase the par-
11 ticipation of members of minority groups in such
12 clinical research through one or more of the activi-
13 ties described in paragraph (3).

14 “(3)(A) The Director of the Institute shall pro-
15 vide incentives for the support of clinical research on
16 Alzheimer’s disease with clinical trial sites estab-
17 lished in areas with a higher concentration of minor-
18 ity groups, including rural areas if practicable.

19 “(B) In determining whether to conduct or sup-
20 port clinical research on Alzheimer’s disease, the Di-
21 rector of the Institute shall encourage the conduct of
22 clinical research with clinical trial sites in areas de-
23 scribed in subparagraph (A) as a higher-level pri-
24 ority criterion among the criteria established to

1 evaluate whether to conduct or support clinical re-
2 search.

3 “(C) In determining the amount of funding to
4 be provided for the conduct or support of such clin-
5 ical research, the Director of the Institute shall pro-
6 vide additional funding for the conduct of such clin-
7 ical research with clinical trial sites in areas de-
8 scribed in subparagraph (A).

9 “(D) In determining whether an area is an area
10 with a higher concentration of minority groups, the
11 Director of the Institute—

12 “(i) shall consider the most recent data
13 collected by the Bureau of the Census; and

14 “(ii) may also consider—

15 “(I) data from the Centers for Medi-
16 care & Medicaid Services on the incidence
17 of Alzheimer’s disease in the United States
18 by region; and

19 “(II) such other data as the Director
20 determines appropriate.

21 “(4) In order to facilitate the participation of
22 members of minority groups in clinical research sup-
23 ported under this subpart, in addition to activities
24 described in paragraph (3), the Director of the Insti-
25 tute shall—

1 “(A) ensure that such clinical research
2 uses community-based participatory research
3 methodologies; and

4 “(B) encourage the use of remote health
5 technologies, including telehealth, remote pa-
6 tient monitoring, and mobile technologies, that
7 reduce or eliminate barriers to participation of
8 members of minority groups in such clinical re-
9 search.

10 “(5)(A) Clinical research on Alzheimer’s disease
11 conducted or supported under this subpart shall en-
12 sure that such research includes outreach activities
13 designed to increase the participation of members of
14 minority groups in such research.

15 “(B)(i) Each applicant for a grant under this
16 subpart for clinical research on Alzheimer’s disease
17 shall submit to the Director of the Institute in the
18 application for such grant—

19 “(I) a budget for outreach activities to
20 members of minority populations with respect
21 to participation in such clinical research; and

22 “(II) a description of the plan to conduct
23 such outreach.

24 “(ii) The Director of the Institute shall encour-
25 age applicants for, and recipients of, grants under

1 this subpart to conduct clinical research on Alz-
 2 heimer’s disease to engage with community-based or-
 3 ganizations to increase participation of minority pop-
 4 ulations in such research.

5 “(6) For purposes of this subpart:

6 “(A) The term ‘clinical research’ includes a
 7 clinical trial.

8 “(B) The term ‘minority group’ has the
 9 meaning given such term under section
 10 492B(g).”.

11 (d) PARTICIPANT ELIGIBILITY CRITERIA.—Section
 12 445I of the Public Health Service Act (42 U.S.C. 285e–
 13 10a), as amended by subsection (b)(1), is amended by
 14 adding at the end the following:

15 “(e) PARTICIPANT ELIGIBILITY CRITERIA.—The Di-
 16 rector of the Institute shall take such actions as are nec-
 17 essary to ensure that clinical research on Alzheimer’s dis-
 18 ease conducted or supported under this subpart is de-
 19 signed with eligibility criteria that ensure the clinical trial
 20 population reflects the diversity of the prospective patient
 21 population. Such actions may include the following:

22 “(1) EXAMINATION OF CRITERIA.—

23 “(A) IN GENERAL.—An examination of
 24 each exclusion criterion to determine if the cri-

1 terion is necessary to ensure the safety of trial
2 participants or to achieve the study objectives.

3 “(B) MODIFICATION OF CRITERIA.—In the
4 case of an exclusion criterion that is not nec-
5 essary to ensure the safety of trial participants
6 or to achieve the study objectives—

7 “(i) encouraging the modification or
8 elimination of the criterion; or

9 “(ii) encouraging tailoring the cri-
10 terion as narrowly as possible to avoid un-
11 necessary limits to the population of the
12 clinical study.

13 “(2) REQUIREMENT FOR STRONG JUSTIFICA-
14 TION FOR EXCLUSION.—A review of each exclusion
15 criterion to ensure that populations are included in
16 clinical trials, such as older adults, individuals with
17 a mild form of disease, individuals at the extremes
18 of the weight range, or children, unless there is a
19 strong clinical or scientific justification to exclude
20 them.

21 “(3) USE OF ADAPTIVE DESIGN.—Encouraging
22 the use of an adaptive clinical trial design that—

23 “(A) starts with a defined population
24 where there are concerns about safety; and

1 “(B) may expand to a broader population
2 based on initial data from the trial and external
3 data.”.

4 (e) RESOURCE CENTER FOR SUCCESSFUL STRATE-
5 GIES TO INCREASE PARTICIPATION OF UNDERREP-
6 RESENTED POPULATIONS IN ALZHEIMER’S DISEASE
7 CLINICAL RESEARCH.—Section 444 of the Public Health
8 Service Act (42 U.S.C. 285e–1) is amended by adding at
9 the end the following:

10 “(e)(1) The Director of the Institute, acting through
11 the Office of Special Populations and in consultation with
12 the Division of Extramural Activities, shall support re-
13 source information and technical assistance to grantees
14 under section 445 (relating to Alzheimer’s disease cen-
15 ters), other grantees, and prospective grantees, designed
16 to increase the participation of minority populations in
17 clinical research on Alzheimer’s disease conducted or sup-
18 ported under this subpart.

19 “(2) The resource information and technical assist-
20 ance provided under paragraph (1) shall include the main-
21 tenance of a central resource library in order to collect,
22 prepare, analyze, and disseminate information relating to
23 strategies and best practices used by recipients of grants
24 under this subpart and other researchers in the develop-
25 ment of the clinical research designed to increase the par-

1 ticipation of minority populations in such clinical re-
2 search.”.

3 (f) ANNUAL REPORTS.—Section 444 of the Public
4 Health Service Act (42 U.S.C. 285e–1), as amended by
5 subsection (e), is amended by adding at the end the fol-
6 lowing:

7 “(f)(1)(A) The Director of the Institute shall submit
8 annual reports to the Congress on the impact of the
9 amendments made to this subpart by the Health Equity
10 and Accountability Act of 2026.

11 “(B) The Secretary shall transmit a copy of each
12 such report to the Advisory Council on Alzheimer’s Re-
13 search, Care, and Services established under section 2(e)
14 of the National Alzheimer’s Project Act.

15 “(2) In each report under paragraph (1), the
16 Director of the Institute shall include information
17 and data on the following matters with respect to
18 clinical trials on Alzheimer’s disease conducted dur-
19 ing the preceding year:

20 “(A) The number of participants who are
21 members of a minority group in such clinical
22 trials.

23 “(B) The number of such clinical trials for
24 which incentives under subsection (d)(3) were
25 made available, the nature of such incentives,

1 the amount of increased funding (if any) made
2 available for research on Alzheimer’s disease,
3 and the training provided to principal investiga-
4 tors who are members of a minority group and
5 the amount of funding (if any) for such train-
6 ing.

7 “(C) The number of such clinical trials for
8 which the principal investigator is a member of
9 a minority group.

10 “(D) The number of such clinical trials for
11 which a significant percentage of researchers
12 are members of a minority group.

13 “(E) Modifications to patient eligibility cri-
14 teria in clinical trial designs under section
15 445I(e).

16 “(F) Outreach and education efforts con-
17 ducted under section 445(b)(4).

18 “(3) The Director of the Institute shall make
19 each report under paragraph (1) available to the
20 public, including through posting on the appropriate
21 website of the Department of Health and Human
22 Services.”.

23 (g) AUTHORIZATION OF APPROPRIATIONS.—For each
24 of fiscal years 2027 through 2031, there is authorized to
25 be appropriated to the Secretary of Health and Human

1 Services \$60,000,000 to carry out the amendments made
2 by this section, to remain available until expended.

3 **SEC. 7901C-7. STOMACH CANCER PREVENTION AND EARLY**
4 **DETECTION ACT.**

5 (a) NCI REVIEW ON CURRENT STATE OF STOMACH
6 CANCER INCIDENCE, PREVENTION, SCREENING, AWARE-
7 NESS, AND FUTURE PUBLIC HEALTH IMPORTANCE.—

8 (1) REVIEW.—The Director of the National
9 Cancer Institute shall conduct a review of—

10 (A) the current incidence of stomach can-
11 cer in the United States;

12 (B) the risk factors for stomach cancer, in-
13 cluding the incidence of such risk factors
14 among high-risk populations and the general
15 public;

16 (C) the optimal age range to test for and
17 treat *Helicobacter pylori* (*H. pylori*) infection,
18 as a risk factor, for the purpose of primary pre-
19 vention in high-risk populations and the general
20 population;

21 (D) the availability and frequency of
22 screening for stomach cancer, including utiliza-
23 tion and effectiveness, among high-risk popu-
24 lations;

1 (E) the availability and effectiveness of
2 endoscopic screenings in high-risk populations;

3 (F) the availability and effectiveness of
4 endoscopic resection and surveillance endoscopy
5 for patients with confirmed gastric intestinal
6 metaplasia (GIM) with high-grade dysplasia
7 and early gastric cancer;

8 (G) the benefits of surveillance endoscopy
9 for patients at elevated risk, including patients
10 with gastric intestinal metaplasia (GIM) who
11 are at increased risk of gastric cancer due to
12 ethnic background, family history, or other risk
13 stratification parameters such as smoking and
14 *H. pylori* infection;

15 (H) current awareness and education
16 about stomach cancer risk factors, prevention,
17 symptoms, screening, and treatment options
18 among high-risk populations and the general
19 public; and

20 (I) current Federal efforts to increase
21 awareness and education of stomach cancer
22 among high-risk populations and the general
23 public.

1 (2) REPORT.—Not later than 18 months after
2 the date of enactment of this Act, the Director of
3 the National Cancer Institute shall—

4 (A) submit to the Congress a report on the
5 results of the review under paragraph (1); and

6 (B) include in such report recommenda-
7 tions for—

8 (i) establishing a clear definition of
9 high-risk populations in the United States;

10 (ii) informing researchers, clinicians,
11 physicians, patients, and other relevant
12 stakeholders on—

13 (I) identifying high-risk individ-
14 uals; and

15 (II) effective methods for detect-
16 ing precancerous lesions and early
17 gastric cancer;

18 (iii) establishing routine screening
19 guidelines for stomach cancer; and

20 (iv) actions to improve research on,
21 prevention and early diagnosis of, and
22 screening and treatment for stomach can-
23 cer.

1 (b) DEPARTMENT OF DEFENSE STUDY ON STOMACH
2 CANCER INCIDENCE AND RISK FACTORS AMONG MILI-
3 TARY PERSONNEL.—

4 (1) STUDY.—The Secretary of Defense, in co-
5 ordination with the Director of the National Cancer
6 Institute and the Director of the Centers for Disease
7 Control and Prevention, shall conduct a study on the
8 incidence, risk factors, prevention, and early detec-
9 tion of stomach cancer among members of the
10 Armed Forces and former members of the Armed
11 Forces.

12 (2) ELEMENTS.—The study under paragraph
13 (1) shall include—

14 (A) an examination of—

15 (i) the incidence, prevalence, and mor-
16 tality rates of stomach cancer among mem-
17 bers of the Armed Forces serving on active
18 duty and former members of the Armed
19 Forces who served on active duty;

20 (ii) the identification of service-related
21 or deployment-related risk factors, includ-
22 ing exposure to burn pits, hazardous
23 chemicals, contaminated water, occupa-
24 tional hazards, and endemic infections
25 such as *Helicobacter pylori* (*H. pylori*);

(iii) disparities in stomach cancer outcomes based on race, ethnicity, gender, Armed Force, or geographic deployment history within military populations;

(iv) the availability and use of stomach cancer screening, diagnostic, and treatment services within the military health system and the health system of the Department of Veterans Affairs; and

(v) opportunities to improve prevention and early detection strategies within the military health system and the health system of the Department of Veterans Affairs; and

(B) relevant coordination with the Surveillance, Epidemiology, and End Results Program and other national cancer registries to ensure comprehensive data collection and analysis.

(3) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Defense shall submit to Congress a report on the findings of the study under paragraph (1), including—

(A) policy and programmatic recommendations to reduce stomach cancer incidence and

mortality among members of the Armed Forces
and former members of the Armed Forces; and

(B) proposed strategies for integrating
stomach cancer awareness, screening, and treat-
ment protocols into the military health system
and the health system of the Department of
Veterans Affairs.

Subtitle N—Health Equity and Rare Disease Act

SEC. 7901D. SHORT TITLE.

This subtitle may be cited as the “Health Equity and
Rare Disease Act” or the “HEARD Act”.

SEC. 7901D–1. NIH EXPANSION, INTENSIFICATION, AND CO- ORDINATION OF RESEARCH ON RARE DIS- EASES HEALTH EQUITY.

Part B of title IV of the Public Health Service Act
(42 U.S.C. 284 et seq.) is amended by adding at the end
the following:

“SEC. 409K. RARE DISEASES HEALTH EQUITY.

“(a) EXPANSION, INTENSIFICATION, AND COORDINA-
TION OF ACTIVITIES.—

“(1) IN GENERAL.—The Director of NIH shall
expand, intensify, and coordinate research and other
activities of the National Institutes of Health with
respect to rare diseases health equity.

1 “(2) ALLOCATIONS BY DIRECTOR OF NIH.—

2 With respect to amounts appropriated to carry out
3 this section for a fiscal year, the Director of NIH
4 shall allocate the amounts among the national re-
5 search institutes that are carrying out paragraph
6 (1).

7 “(b) COORDINATING COMMITTEE.—

8 “(1) IN GENERAL.—The Secretary shall main-
9 tain a coordinating committee with respect to rare
10 diseases health equity (referred to in this section as
11 the ‘Coordinating Committee’) to coordinate activi-
12 ties across the National Institutes and with other
13 Federal health programs and activities relating to
14 rare diseases health equity.

15 “(2) COMPOSITION.—The Coordinating Com-
16 mittee shall be composed of—

17 “(A) the directors (or their designees) of
18 each of the national research institutes involved
19 in research with respect to rare diseases and
20 minority health or health equity; and

21 “(B) representatives of all other Federal
22 departments and agencies whose programs in-
23 volve health functions or responsibilities rel-
24 evant to such rare diseases, including the Cen-

1 ters for Disease Control and Prevention and the
2 Food and Drug Administration.

3 “(3) CHAIR.—

4 “(A) IN GENERAL.—With respect to rare
5 diseases health equity, the Chair of the Coordinating
6 Committee shall serve as the principal
7 advisor to the Secretary, the Assistant Secretary
8 for Health, and the Director of NIH,
9 and shall provide advice to the Director of the
10 Centers for Disease Control and Prevention, the
11 Commissioner of Food and Drugs, and other
12 relevant agencies.

13 “(B) DIRECTOR OF NIH.—The Chair of
14 the Coordinating Committee shall be directly responsible
15 to the Director of NIH.

16 “(c) PLAN FOR NIH ACTIVITIES.—

17 “(1) IN GENERAL.—Not later than 1 year after
18 the date of the enactment of this section, the Coordinating
19 Committee shall develop a plan for conducting and supporting
20 research and education on rare diseases health equity, and rare
21 diseases or conditions in minority populations, through the
22 national research institutes. The Coordinating Committee
23 shall periodically review and revise the plan. The
24 plan shall—
25

1 “(A) provide for a broad range of research
2 and education activities relating to biomedical,
3 psychosocial, and rehabilitative issues, including
4 studies of the disproportionate impact of such
5 diseases or conditions on minority populations;

6 “(B) identify priorities among the pro-
7 grams and activities of the National Institutes
8 of Health regarding such diseases or conditions;
9 and

10 “(C) reflect input from a broad range of
11 scientists, patients, and advocacy groups.

12 “(2) CERTAIN ELEMENTS OF PLAN.—The plan
13 under paragraph (1) shall, with respect to rare dis-
14 eases or conditions in minority populations, provide
15 for the following as appropriate:

16 “(A) Research to determine the reasons
17 underlying the incidence and prevalence of the
18 diseases or conditions, including among sub-
19 populations.

20 “(B) Basic research concerning the eti-
21 ology and causes of the diseases or conditions.

22 “(C) Epidemiological studies to address
23 the frequency and natural history of the dis-
24 eases or conditions, including any differences

1 among the sexes and among racial and ethnic
2 groups.

3 “(D) The development of improved screen-
4 ing techniques.

5 “(E) Clinical research for the development
6 and evaluation of new treatments, including
7 new biological agents.

8 “(F) Information and education programs
9 for health care professionals and the public.

10 “(3) IMPLEMENTATION OF PLAN.—The Direc-
11 tor of NIH shall ensure that programs and activities
12 of the National Institutes of Health regarding rare
13 diseases or conditions in minority populations are
14 implemented in accordance with the plan under
15 paragraph (1).

16 “(d) DEFINITIONS.—In this section:

17 “(1) The term ‘minority’ has the meaning given
18 such term in section 464z-3.

19 “(2) The term ‘rare disease or condition’ has
20 the meaning given such term in section 526 of the
21 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
22 360bb).”.

1 **SEC. 7901D-2. COLLABORATIVE COMPREHENSIVE PLAN TO**
2 **ADDRESS RARE DISEASES AND CONDITIONS**
3 **IN MINORITY POPULATIONS.**

4 Subpart 20 of part C of title IV of the Public Health
5 Service Act (42 U.S.C. 285t et seq.) is amended by adding
6 at the end the following:

7 **“SEC. 464z-7. COLLABORATIVE COMPREHENSIVE PLAN TO**
8 **ADDRESS RARE DISEASES AND CONDITIONS**
9 **IN MINORITY POPULATIONS.**

10 “Not later than 180 days after the date of enactment
11 of this section, the Director of NIH, the Director of the
12 Institute, the Director of the National Center for Advanc-
13 ing Translational Sciences, the Director of the National
14 Heart, Lung, and Blood Institute, and the directors of the
15 other agencies of the National Institutes of Health in col-
16 laboration (and in consultation with the advisory council
17 for the Institute) shall—

18 “(1) develop a comprehensive Federal plan to
19 address rare diseases and conditions in minority
20 populations (as those terms are defined in section
21 409K), including a strategy to increase diversity in
22 genetic programs at the program for Therapeutics
23 for Rare and Neglected Diseases at the National In-
24 stitutes of Health;

25 “(2) conduct or support through grants or co-
26 operative agreements basic, clinical, and

1 translational research on rare diseases and condi-
2 tions in minority populations, including research
3 on—

4 “(A) early detection, diagnosis, and treat-
5 ment of such diseases and conditions in such
6 populations; and

7 “(B) improving the quality of life for indi-
8 viduals with rare diseases or conditions and
9 their families;

10 “(3) conduct or support clinical training pro-
11 grams for physicians and other health care practi-
12 tioners with respect to detecting, diagnosing, and
13 treating such diseases and conditions in such popu-
14 lations; and

15 “(4) develop guidance for increasing participa-
16 tion of health professionals who are members of mi-
17 nority groups (as defined in section 464z–3) in re-
18 search conducted or supported by the National Insti-
19 tutes of Health on such diseases and conditions in
20 such populations.”.

1 **SEC. 7901D-3. GRANTS TO COLLECT AND ANALYZE DATA ON**
2 **RARE DISEASES AND CONDITIONS IN MINOR-**
3 **ITY POPULATIONS.**

4 Section 1707(b) of the Public Health Service Act (42
5 U.S.C. 300u-6(b)) is amended by adding at the end the
6 following:

7 “(11) In coordination with the Director of the
8 Centers for Disease Control and Prevention, award
9 grants to public and private nonprofit entities to—

10 “(A) collect, analyze, and report data on
11 rare diseases and conditions in minority popu-
12 lations, including on epidemiological data with
13 respect to incidence of such diseases and condi-
14 tions in such populations;

15 “(B) conduct outreach and engagement ac-
16 tivities with the minority populations impacted
17 by such rare diseases and conditions by—

18 “(i) improving health literacy with re-
19 spect to rare diseases and conditions;

20 “(ii) disseminating information on
21 health and community services related to
22 rare diseases and conditions; and

23 “(iii) providing information regarding
24 the maintenance of rare diseases and con-
25 ditions.

1 “(12) Submit to Congress, on a biannual basis
 2 (beginning not later than 2 years after the date of
 3 the enactment of the HEARD Act), a report de-
 4 scribing the activities carried out pursuant to para-
 5 graph (11).”.

6 **SEC. 7901D-4. PHYSICIAN TRAINING PROGRAMS WITH RE-**
 7 **SPECT TO RARE DISEASES.**

8 Subpart II of part C of title VII of the Public Health
 9 Service Act (42 U.S.C. 293m et seq.), as amended by sec-
 10 tion 3016, is further amended by adding at the end the
 11 following:

12 **“SEC. 749D. PHYSICIAN TRAINING PROGRAMS WITH RE-**
 13 **SPECT TO RARE DISEASES.**

14 “(a) IN GENERAL.—The Secretary shall establish a
 15 program to award grants to accredited schools of
 16 allopathic medicine, osteopathic medicine, and nursing,
 17 and other health professional training programs for the
 18 training of health care professionals—

19 “(1) to improve the provision of care to individ-
 20 uals who have rare diseases or conditions (as defined
 21 in section 526 of the Federal Food, Drug, and Cos-
 22 metic Act);

23 “(2) to improve the provision of care to such in-
 24 dividuals via telehealth; and

1 “(3) to conduct research relevant to rare dis-
2 eases and conditions.

3 “(b) ELIGIBILITY.—To be eligible for a grant under
4 subsection (a), an entity described in such subsection shall
5 submit to the Secretary an application at such time, in
6 such manner, and containing such information as the Sec-
7 retary may require.

8 “(c) REPORTING REQUIREMENTS.—

9 “(1) PERIODIC REPORTS.—Each entity awarded
10 a grant under this section shall periodically submit
11 to the Secretary a report on the status of activities
12 conducted using the grant, including a description of
13 the impact of such training on patient outcomes, as
14 applicable.

15 “(2) REPORT TO CONGRESS.—Not later than 2
16 years after the date of enactment of this section, the
17 Secretary shall submit a report to Congress on the
18 activities conducted using grants under subsection
19 (a) and any best practices identified and dissemi-
20 nated under subsection (d).

21 “(d) BEST PRACTICES.—The Secretary may identify
22 and disseminate best practices for the training described
23 in subsection (a).

1 **“SEC. 749E. HEALTH PROFESSIONALS EDUCATION ON RARE**
 2 **DISEASES AND CONDITIONS IN MINORITY**
 3 **POPULATIONS.**

4 “(a) IN GENERAL.—The Secretary may award
 5 grants, cooperative agreements, and contracts to accred-
 6 ited schools of medicine and nursing, and other health pro-
 7 fessional training programs, for the development and im-
 8 plementation of programs to provide education and train-
 9 ing to health care professionals on the causes and effects
 10 of rare diseases and conditions in minority populations.

11 “(b) DEFINITIONS.—In this section:

12 “(1) The term ‘minority’ has the meaning given
 13 such term in section 464z–3.

14 “(2) The term ‘rare disease or condition’ has
 15 the meaning given such term in section 526 of the
 16 Federal Food, Drug, and Cosmetic Act.

17 **“SEC. 749F. MENTORING PROGRAM FOR HEALTH CARE**
 18 **PROFESSIONALS SEEKING TO WORK IN RARE**
 19 **DISEASES AND CONDITIONS.**

20 “The Secretary, acting through the Administrator of
 21 the Health Resources and Services Administration, may
 22 award grants, contracts, or cooperative agreements to
 23 public and nonprofit private entities (including Tribal enti-
 24 ties) for the establishment of a mentoring program for
 25 health care professionals seeking to treat patients with
 26 rare diseases and conditions.

1 **“SEC. 749G. SCHOLARSHIP AND LOAN REPAYMENT PRO-**
2 **GRAM FOR PHYSICIANS AND GENETIC COUN-**
3 **SELORS SERVING POPULATIONS WITH RARE**
4 **DISEASES AND CONDITIONS.**

5 “(a) LOAN REPAYMENT PROGRAM.—

6 “(1) IN GENERAL.—The Secretary shall estab-
7 lish a program of entering into contracts with eligi-
8 ble individuals under which the individuals agree to
9 serve as health care professionals serving popu-
10 lations with rare diseases or conditions in consider-
11 ation of the Federal Government agreeing to pay,
12 for each year of such service, up to \$50,000 (plus
13 an amount determined by the Secretary on an an-
14 nual basis to reflect inflation) of the principal and
15 interest of the educational loans of such individuals.

16 “(2) DETERMINATION OF AMOUNT.—In making
17 a determination of the amount to pay for a year of
18 such service by an individual, the Secretary shall
19 consider the extent to which each such determina-
20 tion—

21 “(A) affects the ability of the Secretary to
22 maximize the number of contracts that can be
23 provided under the program from the amounts
24 appropriated for such contracts;

1 “(B) provides an incentive to serve as
2 health care professionals serving populations
3 with rare diseases or conditions; and

4 “(C) provides an incentive with respect to
5 the health professional involved to remain serv-
6 ing populations with rare diseases or conditions,
7 including after the completion of the period of
8 obligated service under the program.

9 “(3) ELIGIBLE INDIVIDUALS.—In this sub-
10 section, the term ‘eligible individual’ means an indi-
11 vidual who is enrolled or accepted for enrollment as
12 a full-time or part-time student in a school of medi-
13 cine.

14 “(4) APPLICABILITY OF CERTAIN PROVI-
15 SIONS.—With respect to the National Health Service
16 Corps Loan Repayment Program established in sub-
17 part III of part D of title III of this Act, the provi-
18 sions of such subpart shall, except as inconsistent
19 with paragraph (1), apply to the program estab-
20 lished in this section in the same manner and to the
21 same extent as such provisions apply to the National
22 Health Service Corps Loan Repayment Program.

23 “(b) SCHOLARSHIP PROGRAM.—

24 “(1) IN GENERAL.—The Secretary shall carry
25 out a program of entering into contracts with eligi-

1 ble individuals under which each such individual
2 agrees to serve, for a period of not less than 5 years,
3 as a health care professional primarily serving popu-
4 lations with rare diseases or conditions, in consider-
5 ation of the Federal Government agreeing to provide
6 to the individual a scholarship for attendance at a
7 school of medicine.

8 “(2) ELIGIBLE INDIVIDUALS.—In this sub-
9 section, the term ‘eligible individual’ means an indi-
10 vidual who is enrolled or accepted for enrollment as
11 a full-time or part-time student in a school of medi-
12 cine.

13 “(3) APPLICABILITY OF CERTAIN PROVI-
14 SIONS.—The provisions of subpart III of part D of
15 title III shall, except as inconsistent with this sec-
16 tion, apply to the program established in paragraph
17 (1) in the same manner and to the same extent as
18 such provisions apply to the National Health Service
19 Corps Scholarship Program established in such sub-
20 part.”.

1 **SEC. 7901D-5. INCREASING MINORITY REPRESENTATION IN**
2 **RESEARCH ON RARE DISEASES AND CONDI-**
3 **TIONS.**

4 Part G of title IV of the Public Health Service Act
5 (42 U.S.C. 288 et seq.) is amended by adding at the end
6 the following:

7 **“SEC. 487E. INCREASING MINORITY REPRESENTATION IN**
8 **RESEARCH ON RARE DISEASES AND CONDI-**
9 **TIONS.**

10 “(a) GRANT PROGRAM.—In carrying out section 487,
11 the Secretary may award grants to eligible entities in-
12 volved in research on rare diseases and minority health
13 to establish programs to increase the recruitment and re-
14 tention of members of minority groups to conduct research
15 in matters relating to the cause, diagnosis, prevention, and
16 treatment of rare diseases or conditions, including by ex-
17 panding the number of internships and mentoring oppor-
18 tunities.

19 “(b) ELIGIBLE ENTITIES.—In subsection (a), the
20 term ‘eligible entities’ means accredited schools of
21 allopathic medicine, osteopathic medicine, and nursing,
22 and other health professional training programs.”.

1 **SEC. 7901D-6. REPORT TO CONGRESS ON FEDERAL EF-**
2 **FORTS ON RARE DISEASES AND CONDITIONS**
3 **IN MINORITY POPULATIONS.**

4 Not later than 2 years after the date of enactment
5 of this Act, the Secretary of Health and Human Services,
6 acting through the Director of the National Institutes of
7 Health and in consultation with the Director of the Cen-
8 ters for Disease Control and Prevention, shall submit to
9 Congress—

10 (1) a report on research and public health ac-
11 tivities carried out by the Federal Government with
12 respect to rare diseases or conditions in minority
13 populations (as those terms are defined in section
14 409K of the Public Health Service Act, as added by
15 section 7901D-1 of this Act);

16 (2) a comprehensive list of known rare diseases
17 and conditions that impact minority populations
18 heavily or disproportionately; and

19 (3) an analysis of data gaps with respect to
20 rare diseases and conditions and the effect of such
21 diseases and conditions on minority populations.

22 **SEC. 7901D-7. RESEARCH AND AWARENESS CAMPAIGNS**
23 **WITH RESPECT TO RARE DISEASES AND CON-**
24 **DITIONS IN MINORITY POPULATIONS.**

25 Part B of title III of the Public Health Service Act
26 (42 U.S.C. 243 et seq.) is amended by inserting after sec-

tion 317Y of such Act, as added by section 7502, the following:

**“SEC. 317Z. RESEARCH AND AWARENESS CAMPAIGNS WITH
RESPECT TO RARE DISEASES AND CONDI-
TIONS IN MINORITY POPULATIONS.**

“(a) RESEARCH.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct or support research and carry out public health awareness campaigns with respect to rare diseases and conditions in minority populations (as defined in section 409K).

“(b) AWARENESS CAMPAIGN.—The Secretary shall, directly or through grants or contracts, establish a public education program in cooperation with existing national public awareness campaigns to increase awareness about rare diseases and conditions in minority populations through culturally and linguistically appropriate information campaigns about prevention and management of rare diseases and conditions.”.

**SEC. 7901D–8. FDA SURVEY AND REPORT ON CLINICAL
TRIAL DIVERSITY.**

Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall—

1 (1) conduct a survey of policies and programs
2 of the Food and Drug Administration to support an
3 increase the availability of clinical trial data on mi-
4 nority populations, with an emphasis on minority
5 populations with rare diseases and conditions; and

6 (2) submit to Congress a report containing—

7 (A) the findings of such survey;

8 (B) the Secretary’s recommendations for
9 statutory or regulatory changes to increase the
10 availability of such data;

11 (C) the Secretary’s recommendations for
12 strategies to encourage drug manufacturers to
13 address racial equity and inclusion in research
14 and development of treatments of rare diseases
15 or conditions that disproportionately impact mi-
16 nority populations; and

17 (D) the Secretary’s recommendations for
18 strategies to address research and development
19 of treatments of rare diseases or conditions that
20 disproportionately impact minority populations.

21 **SEC. 7901D-9. TRIBAL EPIDEMIOLOGY CENTER GRANT PRO-**
22 **GRAM.**

23 Title II of the Indian Health Care Improvement Act
24 (25 U.S.C. 1621 et seq.) is amended by adding at the end
25 the following:

1 **“SEC. 227. TRIBAL EPIDEMIOLOGY CENTER GRANT PRO-**
2 **GRAM.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Service, shall award grants to Tribal Epidemiology
5 Centers and Tribal and Urban Indian Health Centers to
6 support clinically and culturally appropriate research and
7 other activities with respect to rare diseases and condi-
8 tions in Native American or Tribal communities.

9 “(b) PERMISSIBLE ACTIVITIES.—The activities fund-
10 ed through a grant under subsection (a) may include co-
11 ordination of data collection on the prevention, diagnosis,
12 treatment, and care of rare diseases and conditions by
13 health care professionals serving American Indian and
14 Alaska Native populations.”.

15 **SEC. 7901D-10. MEDICARE REVIEW AND REPORT.**

16 Not later than 180 days after the date of enactment
17 of this Act, the Secretary of Health and Human Service
18 shall conduct a review of and submit to Congress a report
19 on the following:

20 (1) Regulatory barriers under the Medicare pro-
21 gram under title XVIII of the Social Security Act
22 (42 U.S.C. 1395 et seq.) that inhibit access to the
23 treatment of rare diseases for Medicare beneficiaries
24 of color, including barriers that inhibit health care
25 providers from improving care related to such dis-
26 eases for such beneficiaries.

1 (2) Requirements relating to the furnishing of
2 telehealth services under such title insofar as such
3 services relate to the treatment of rare diseases.

4 Such report shall include any recommendations deter-
5 mined appropriate by the Secretary based on such review.

6 **Subtitle O—Asunción Valdivia Heat**
7 **Illness, Injury, and Fatality Pre-**
8 **vention**

9 **SEC. 7901E. EMPLOYER DUTIES.**

10 Each employer shall—

11 (1) furnish employment and a place of employ-
12 ment free from conditions that may reasonably be
13 anticipated to cause death or serious physical harm
14 from heat stress; and

15 (2) comply with standards, regulations, rules,
16 and orders promulgated under this subtitle.

17 **SEC. 7901E-1. WORKER HEAT PROTECTION STANDARDS.**

18 (a) DESIGN OF STANDARDS.—

19 (1) IN GENERAL.—The Secretary shall promul-
20 gate a worker heat protection standard that, in ac-
21 cordance with the best available evidence, establishes
22 the maximum protective program of measures an
23 employer shall implement to regulate employees' ex-
24 posure to heat stress and prevent heat-related illness

1 and injury that attains the highest degree of health
2 and safety protection to the extent feasible.

3 (2) CONSIDERATIONS.—

4 (A) DEMONSTRABLY ACHIEVABLE MEAS-
5 URES.—The Secretary may presume that any
6 requirement substantially equivalent to a re-
7 quirement adopted by a State plan approved by
8 the Occupational Safety and Health Adminis-
9 tration pursuant to section 18(c) of the Occupa-
10 tional Safety and Health Act of 1970 (29
11 U.S.C. 667(c)) and that has been in effect for
12 at least 1 year is feasible.

13 (B) PRIORITIZING WORKER PROTEC-
14 TION.—In weighing any considerations during
15 rulemaking, the Secretary shall place pre-
16 eminent value on assuring employees a safe and
17 healthful working environment.

18 (C) AVAILABLE EXPERTISE.—If the Sec-
19 retary adopts any finding or recommendation
20 by the Institute, the American Conference of
21 Governmental Industrial Hygienists, or the Na-
22 tional Academies of Sciences, Engineering, and
23 Medicine relevant to heat stress in a rule-
24 making pursuant to this subtitle, such finding

1 or recommendation shall be considered the best
2 available evidence.

3 (D) EMPLOYER CATEGORIES.—The Sec-
4 retary may, in any rulemaking analysis or de-
5 sign of standards, cluster relevant employers in
6 any categories such as standard industry or oc-
7 cupational classifications or any common or re-
8 lated features of heat sources, conditions of em-
9 ployment, employer practices, employee charac-
10 teristics, or nature of place of employment that,
11 in the Secretary's reasonable determination, are
12 useful for designing an effective and practicable
13 program of standards, regulations, and enforce-
14 ment that maximizes the health and safety of
15 employees.

16 (3) PROTECTIVE PROGRAMS.—

17 (A) IN GENERAL.—In addition to measures
18 specified by this subtitle, the Secretary may de-
19 velop a worker heat protection standard with
20 such additional requirements that, in the Sec-
21 retary's reasonable judgment, are necessary or
22 appropriate to achieve the purposes of this sub-
23 title. Such measures may include the following:

24 (i) ENGINEERING CONTROLS.—Re-
25 quirements to eliminate hazardous levels of

1 heat stress through engineering controls,
2 such as isolation or shielding of employees
3 from sources of heat, exhaust ventilation,
4 insulation of hot surfaces, or climate-con-
5 trol technologies, as well as technology-
6 based standards that encourage the devel-
7 opment of such controls.

8 (ii) ADMINISTRATIVE CONTROLS.—Re-
9 quirements to limit exposure to hazardous
10 levels of heat stress by adjustment of work
11 procedures, work schedules, or other work
12 practices.

13 (iii) PERSONAL PROTECTIVE EQUIP-
14 MENT.—Requirements to provide, at the
15 employer's expense, personal protective
16 equipment such as water-cooled garments,
17 air-cooled garments, heat-reflective cloth-
18 ing, and cooling vests.

19 (iv) HEALTH-RELATED PROTOCOLS.—
20 Requirements to conduct medical symptom
21 monitoring, emergency response protocols,
22 medical removal protection, or training of
23 employees and supervisors in recognition of
24 symptoms of heat-related illness and ap-
25 propriate responses.

1 (v) TRAINING REQUIREMENTS.—Re-
2 quirements to train employees and super-
3 visors in topics reasonable or necessary to
4 achieve the implementation of the require-
5 ments of a standard or the purposes of
6 this subtitle, including—

7 (I) training of employees in signs
8 and symptoms of heat-related illness,
9 emergency response procedures, and
10 their rights under this subtitle; and

11 (II) training of supervisors in
12 monitoring heat conditions and envi-
13 ronmental forecasts, recognizing signs
14 of heat-related illness, and protocols
15 for responding to likely heat-related
16 illness.

17 (vi) PLANNING REQUIREMENTS.—Re-
18 quirements for a heat illness and injury
19 prevention plan that—

20 (I) is of sufficient quality to ef-
21 fectuate the purposes of this subtitle
22 and to effectuate the requirements of
23 the standard that apply to the em-
24 ployer;

1 (II) is developed, updated, and
2 implemented with the meaningful par-
3 ticipation of the employer's employees
4 and, where applicable, such employ-
5 ees' representatives, for all aspects of
6 the plan;

7 (III) is produced and maintained
8 in writing and updated in light of
9 changing conditions or practices; and

10 (IV) is made available, upon re-
11 quest, to any employee, the employee's
12 representative, and the Secretary.

13 (vii) STANDARD HEALTH AND SAFETY
14 MEASURES.—Any measures described in
15 section 6(B)(7) of the Occupational Safety
16 and Health Act of 1970 (29 U.S.C.
17 655(B)(7)).

18 (B) INNOVATIVE SOLUTIONS.—As the rel-
19 evant scientific evidence develops, technological
20 solutions improve, and environmental conditions
21 or new work practices aggravate the risk of
22 heat-related illness or injury, the Secretary may
23 modify, supplement, or revise a worker heat
24 protection standard by rule in order to improve
25 such standard in light of such changes, even if

1 it departs from long-standing past practice,
2 provided that the resulting standard is con-
3 sistent with this subtitle.

4 (C) CORE PRACTICES.—The Secretary
5 shall establish criteria under which an employer
6 who exposes or may reasonably be anticipated
7 to expose an employee to heat or heat stress
8 that is not reduced below hazardous levels by
9 engineering controls or personal protective
10 equipment shall implement a reasonable pro-
11 gram that includes—

12 (i) suitably cool potable water or ap-
13 propriate hydration, provided at employer
14 expense;

15 (ii) periodic paid rest breaks sched-
16 uled to reduce heat stress below hazardous
17 levels;

18 (iii) access to shade or suitable cool-
19 down spaces;

20 (iv) acclimatization policies; and

21 (v) such measures that are necessary
22 or appropriate to ensure effective imple-
23 mentation of the requirements of this sub-
24 paragraph.

25 (4) OTHER SPECIFICATIONS.—

1 (A) PROTECTION OF PAY.—The Secretary
2 shall require that, for any required duration
3 such as rest breaks, medical removal protection,
4 and training, an employee shall receive com-
5 pensation at the regular rate at which such em-
6 ployee is employed.

7 (B) LANGUAGE ACCESS.—Any required
8 training, poster, label, hazard alert, or written
9 plan shall be provided in English and a lan-
10 guage understood by the employees, if such is
11 not English, and prepared appropriately for the
12 vocabulary, educational level, and literacy of the
13 employees.

14 (C) TEMPORARY LABOR CAMPS.—The Sec-
15 retary shall revise the Secretary's standard for
16 temporary labor camps to the extent necessary
17 to achieve the purposes of this subtitle.

18 (5) MAINTAINING PROTECTION.—No worker
19 heat protection standard promulgated under this
20 subtitle may reduce the protection afforded employ-
21 ees by an existing worker heat protection standard.

22 (b) INITIAL STANDARDS.—Not later than 1 year
23 after the date of enactment of this Act, the Secretary shall
24 promulgate, without regard to the requirements of chap-
25 ters 5 and 6 of title 5, United States Code, subchapter

1 I of chapter 35 of title 44, United States Code (commonly
2 known as the “Paperwork Reduction Act”), or the Na-
3 tional Environmental Policy Act of 1969 (42 U.S.C. 431
4 et seq.), an interim final rule establishing a worker heat
5 protection standard and related recordkeeping and report-
6 ing requirements. Such rule shall take effect upon
7 issuance (except that it may include a reasonable delay
8 in the effective date), shall have the legal effect of an occu-
9 pational safety and health standard as defined by section
10 3(8) of the Occupational Safety and Health Act of 1970
11 (29 U.S.C. 652(8)), and shall remain in effect until super-
12 seded by a final rule promulgated pursuant to this sub-
13 title.

14 (c) RULEMAKING PROCEDURES.—For any rule-
15 making pursuant to this subtitle after publication of the
16 interim final rule in subsection (b), the following proce-
17 dures shall apply:

18 (1) IN GENERAL.—The Secretary shall, upon a
19 showing by a petitioner pursuant to paragraph (2)
20 or the Secretary’s own determination that a worker
21 heat protection standard is necessary or appropriate
22 to regulate employees’ exposure to conditions known
23 to cause or that may reasonably be anticipated to
24 cause heat-related illness or injury, promulgate any
25 worker heat protection standard in accordance with

1 the policies set forth in this section and in accord-
2 ance with section 553 of title 5, United States Code
3 (without regard to any reference in such section to
4 sections 556 and 557 of such title).

5 (2) PETITIONS FOR RULEMAKING.—Any person
6 may petition the Secretary to promulgate or modify
7 a worker heat protection standard. Not later than
8 18 months after receipt of a petition, the Secretary
9 shall either grant or deny the petition by publishing
10 a written explanation of the reasons for the Sec-
11 retary's decision. The Secretary may not deny a pe-
12 tition solely on the basis of inadequate resources or
13 insufficient time for review.

14 (3) TIMELINES.—Except as otherwise provided
15 in subsection (b), the Secretary shall observe the fol-
16 lowing schedule for rulemaking:

17 (A) PROPOSED STANDARDS.—Not later
18 than one year after granting a petition for rule-
19 making under paragraph (2), the Secretary
20 shall publish a proposed worker heat protection
21 standard consistent with this section.

22 (B) FINAL STANDARDS.—The Secretary
23 shall promulgate, not later than one year after
24 such publication, such standards with such

1 modifications as the Secretary determines ap-
2 propriate.

3 (C) EFFECT.—Standards or revisions
4 thereof shall become effective upon promulga-
5 tion, except that the Secretary may include a
6 reasonable delay in the effective date.

7 (4) TRANSPARENCY IN RULEMAKING.—For any
8 rulemaking notice pursuant to this subtitle, the Sec-
9 retary shall place in the public record not later than
10 the date of such rulemaking notice the following:

11 (A) The drafts of such rulemakings pre-
12 pared before publication and submitted by the
13 Secretary to the Office of Management and
14 Budget for any interagency review process prior
15 to publication, all documents accompanying
16 such drafts, all written comments thereon by
17 other agencies, and all written responses to
18 such written comments by the Secretary.

19 (B) A summary of the substance of any
20 changes between the text of the draft rule-
21 making that the agency provided to the Office
22 of Management and Budget under section
23 6(a)(3)(B)(i) of Executive Order 12866 (58
24 Fed. Reg. 51735; relating to regulatory plan-
25 ning and review) and the text published in the

1 Federal Register, excluding any non-substantive
2 changes such as spelling or grammatical correc-
3 tions or re-ordering of text that has no legal ef-
4 fect.

5 (C) A statement identifying any party or
6 entity at whose request any such change was
7 made.

8 (5) JUDICIAL REVIEW.—

9 (A) FILING OF PETITION.—A petition for
10 review in accordance with section 702 of title 5,
11 United States Code, of action of the Secretary
12 in promulgating any worker heat protection
13 standard or any other nationally applicable reg-
14 ulation or final action taken by the Secretary
15 pursuant to this subtitle may be filed only in
16 the United States Court of Appeals for the Dis-
17 trict of Columbia. The filing of a petition for
18 review shall not postpone the effectiveness of
19 such rule or action.

20 (B) TIMELY FILING.—Any petition for re-
21 view under this paragraph shall be filed not
22 later than sixty days after the date notice of
23 such promulgation, approval, or action appears
24 in the Federal Register.

1 (C) NOT SUBJECT TO REVIEW.—Action of
2 the Secretary with respect to which review could
3 have been obtained under this paragraph shall
4 not be subject to judicial review in civil or
5 criminal proceedings for enforcement. Failure
6 to promulgate any standard pursuant to the
7 schedule established by this section shall be
8 subject to review.

9 **SEC. 7901E-2. IMPLEMENTATION AND ENFORCEMENT.**

10 (a) IN GENERAL.—Except as otherwise provided by
11 this section—

12 (1) a worker heat protection standard shall
13 have the same legal effect as an occupational safety
14 and health standard as defined by section 3(8) of
15 the Occupational Safety and Health Act of 1970 (29
16 U.S.C. 652(8)); and

17 (2) any rule, regulation, or order promulgated
18 pursuant to this subtitle shall have the same legal
19 effect as a rule, regulation, or order promulgated
20 pursuant to the Occupational Safety and Health Act
21 of 1970 (29 U.S.C. 651 et seq.).

22 (b) ENFORCEMENT.—

23 (1) STATUTE OF LIMITATIONS FOR CITATION.—
24 No citation for any violation of section 7901E or
25 any standard, rule, regulation, or order pursuant to

1 this subtitle may be issued under this section later
2 than 4 years after the occurrence of any violation.

3 (2) REVIEW.—The Commission shall grant sub-
4 stantial deference to any reasonable interpretation
5 by the Secretary of this subtitle or any standard,
6 regulation, or order pursuant to this subtitle.

7 (c) RECORDKEEPING AND REPORTING.—

8 (1) IN GENERAL.—With regard to record-
9 keeping and reporting, the Secretary and Secretary
10 of Health and Human Services shall have the same
11 authority to prescribe regulations related to this sub-
12 title as under section 8 of the Occupational Safety
13 and Health Act (29 U.S.C. 657).

14 (2) CONSOLIDATING REQUIREMENTS.—The
15 Secretary may incorporate recordkeeping and report-
16 ing requirements under this section into existing rec-
17 ordkeeping and reporting requirements promulgated
18 pursuant to section 8 of the Occupational Safety and
19 Health Act (29 U.S.C. 657), provided that a viola-
20 tion of such a requirement with regard to implemen-
21 tation of this subtitle shall be enforced as a distinct
22 violation separate and apart from any other simulta-
23 neous violation of a requirement pursuant to the Oc-
24 cupational Safety and Health Act.

25 (d) WHISTLEBLOWER PROTECTIONS.—

1 (1) COMPLAINT.—Any employee who believes
2 that such employee has been discharged or otherwise
3 discriminated against by any person in violation of
4 section 11(c)(1) of the Occupational Safety and
5 Health Act (29 U.S.C. 660(c)(1)) with regard to any
6 matter under or related to this subtitle may, not
7 later than 180 days after such violation occurs, file
8 a complaint with the Secretary following the proce-
9 dures in paragraph (2) of such section alleging such
10 discrimination.

11 (2) ACTION.—If the Secretary fails to notify
12 the complainant of the Secretary's determination on
13 the complaint within 90 days after such determina-
14 tion pursuant to section 11(c)(3) of the Occupa-
15 tional Safety and Health Act (29 U.S.C. 660(c)(3))
16 or determines not to bring an action pursuant to
17 paragraph (2) of such section, such employee may
18 bring an action in any appropriate United States
19 District Court against such person for all appro-
20 priate relief in accordance with paragraph (2) of
21 such section as well as reasonable attorney's fees
22 and costs.

23 **SEC. 7901E-3. GENERAL PROVISIONS.**

24 (a) SEVERABILITY.—If any provision of this subtitle
25 is held invalid, the remainder of this subtitle shall not be

1 affected thereby. If the application of any provision of this
2 subtitle to any person or circumstance is held invalid, the
3 application of such provision to other persons or cir-
4 cumstances shall not be affected thereby.

5 (b) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated from sums not otherwise
7 appropriated, for each fiscal year, such sums as may be
8 necessary to carry out this subtitle.

9 **SEC. 7901E-4. AGENDA FOR FURTHER REVIEW AND ACTION.**

10 The Secretary shall update the National Agricultural
11 Workers Survey with such questions that, in the Sec-
12 retary's judgment, are useful to identify the incidence and
13 prevalence of heat-related illness and injury and assess the
14 impact of standards and enforcement pursuant to this
15 subtitle. Not later than one year after the date of enact-
16 ment of this Act, the Secretary shall submit to the Com-
17 mittee on Education and Workforce of the House of Rep-
18 resentatives and the Committee on Health, Education,
19 Labor, and Pensions of the Senate a report on the Sec-
20 retary's implementation of this section.

21 **SEC. 7901E-5. DEFINITIONS.**

22 For purposes of this subtitle:

23 (1) The term "Commission" means the Occupa-
24 tional Safety and Health Review Commission.

1 (2) The term “employee” has the meaning
2 given such term in section 3 of the Occupational
3 Safety and Health Act of 1970 (29 U.S.C. 652).

4 (3) The term “employer” has the meaning
5 given such term in section 3 of the Occupational
6 Safety and Health Act of 1970 (29 U.S.C. 652).

7 (4) The term “heat stress” means the load of
8 heat that a person experiences due to—

9 (A) sources of heat or heat retention (in-
10 cluding the combined contributions of metabolic
11 heat, environmental factors, and clothing or
12 personal protective equipment); or

13 (B) the presence of heat in a work setting.

14 (5) The term “heat-related illness” means a
15 material impairment of health that occurs due to
16 heat stress.

17 (6) The term “heat-related injury” means an
18 injury caused by exposure to heat or sources of heat
19 or occurring as a result of heat stress.

20 (7) The term “Institute” means the National
21 Institute for Occupational Safety and Health.

22 (8) The term “Secretary” means the Secretary
23 of Labor.

24 (9) The term “worker heat protection stand-
25 ard” means a standard that regulates employee ex-

1 posure to heat stress and prevents heat-related ill-
 2 ness and injury by requiring conditions or the adop-
 3 tion or use of one or more practices, means, meth-
 4 ods, operations, or processes reasonably necessary or
 5 appropriate to provide employment and places of
 6 employment that are safe or healthful.

7 **Subtitle P—New Era of Preventing** 8 **End-Stage Kidney Disease**

9 **SEC. 7901F. CENTERS OF EXCELLENCE ON RARE KIDNEY**
 10 **DISEASE RESEARCH IN THE NATIONAL INSTI-**
 11 **TUTE OF DIABETES AND DIGESTIVE AND KID-**
 12 **NEY DISEASES.**

13 Subpart 3 of part C of title IV of the Public Health
 14 Service Act (42 U.S.C. 281 et seq.) is amended by insert-
 15 ing after section 426 (42 U.S.C. 285c) the following new
 16 section:

17 **“SEC. 426A. CENTERS OF EXCELLENCE ON RARE KIDNEY**
 18 **DISEASE RESEARCH IN THE NATIONAL INSTI-**
 19 **TUTE OF DIABETES AND DIGESTIVE AND KID-**
 20 **NEY DISEASES.**

21 “(a) COOPERATIVE AGREEMENTS AND GRANTS.—

22 “(1) IN GENERAL.—The Director of the Insti-
 23 tute may enter into cooperative agreements with,
 24 and make grants to, public and private nonprofit en-
 25 tities to pay all or part of the cost of planning, es-

1 tablishing, or strengthening, and providing basic op-
2 erating support for, regional centers of excellence for
3 rare kidney diseases, including primary glomerular
4 disease. Such centers of excellence shall be known as
5 NIDDK Centers of Excellence on Rare Kidney Dis-
6 ease Research (referred to in this section as ‘Centers
7 of Excellence’).

8 “(2) PURPOSES OF CENTERS.—The purposes of
9 the Centers of Excellence funded pursuant to para-
10 graph (1) shall be—

11 “(A) to conduct research on the causes,
12 etiology, symptoms, diagnosis, progression, and
13 treatment of rare kidney diseases, including glo-
14 merular diseases;

15 “(B) to increase public awareness of rare
16 kidney diseases, particularly in rural and under-
17 served communities; and

18 “(C) to develop resources for clinical re-
19 search into, training in, and demonstration of
20 diagnostic, prevention, control, and treatment
21 methods for, rare kidney diseases.

22 “(3) POLICIES.—A cooperative agreement or
23 grant under paragraph (1) shall be entered into in
24 accordance with policies established by the Director
25 of the National Institutes of Health.

1 “(b) COORDINATION WITH OTHER INSTITUTES.—

2 The Director of the Institute shall coordinate the activities
3 under this section with similar activities that are related
4 to rare kidney disease and conducted by other national
5 research institutes, centers, and agencies of the National
6 Institutes of Health and by the Food and Drug Adminis-
7 tration.

8 “(c) USE OF FUNDS.—An entity that enters into a
9 cooperative agreement or receives a grant under sub-
10 section (a) may use funds received through such agree-
11 ment or grant—

12 “(1) to cover patient care costs required to con-
13 duct research described in subsection (a)(2)(A);

14 “(2) to provide, for the purpose described in
15 subsection (a)(2)(B)—

16 “(A) clinical training and continuing edu-
17 cation for health professionals and related per-
18 sonnel with respect to rare kidney diseases; and

19 “(B) information programs for the public,
20 with respect to rare kidney diseases; and

21 “(3) to provide, for the purpose described in
22 subsection (a)(2)(B)—

23 “(A) for education of members of the pub-
24 lic, particularly through outreach to rural and
25 underserved communities, on the diagnosis (in-

1 cluding through routine urinalysis and through
2 genetic testing), prevention, control, and treat-
3 ment of rare kidney diseases; and

4 “(B) for education of individuals diagnosed
5 with rare kidney diseases on renal diet and life-
6 style, genetic testing, and programs to promote
7 urinalysis, and on mental and emotional health
8 resources for families of rare kidney disease pa-
9 tients.

10 “(d) RESEARCH FUNDED.—Research conducted
11 using funds awarded through a cooperative agreement or
12 grant under this section—

13 “(1) shall include study of genotype-phenotype
14 relation to disease progression; and

15 “(2) with respect the populations studied in
16 such research, may not include any consideration of
17 quality-adjusted life years or disability adjusted life
18 years, or other similar mechanisms that discriminate
19 against individuals with disabilities in value and
20 cost-effectiveness assessments.

21 “(e) PERIOD OF SUPPORT; ADDITIONAL PERIODS.—
22 The period of support for a center of excellence under sub-
23 section (a) may not exceed 5 years, except that such period
24 may be extended by the Director of the Institute for addi-

1 tional periods of not more than 5 years for each center
 2 if—

3 “(1) the operations of such center have been re-
 4 viewed by an appropriate technical and scientific
 5 peer review group established by the Director of the
 6 Institute; and

7 “(2) such group has recommended to the Direc-
 8 tor of the Institute that such period should be ex-
 9 tended.

10 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
 11 carry out this section, there are authorized to be appro-
 12 priated \$6,000,000 for each of fiscal years 2027 through
 13 2031.”.

14 **SEC. 7901F-1. UNDERSTANDING AND SLOWING THE PRO-**
 15 **GRESSION OF RARE KIDNEY DISEASE**
 16 **THROUGH EARLY INTERVENTION, TESTING,**
 17 **AND TREATMENT.**

18 (a) IN GENERAL.—The Secretary of Health and
 19 Human Services (in this section referred to as the “Sec-
 20 retary”) shall conduct a study on testing, preventative
 21 care, precision medicine, and treatment, with respect to
 22 rare kidney disease. Such study shall review—

23 (1) the impact of routine urinalysis on the time-
 24 ly diagnosis of rare kidney disease and on the qual-

1 ity of patient care following a diagnosis of such dis-
2 ease;

3 (2) the quality and reliability of kidney biopsy
4 in the diagnosis of rare kidney disease;

5 (3) the utility and appropriate use of genetic
6 and genomic tests in detecting kidney disease, in-
7 cluding—

8 (A) advances in genetic and genomic test-
9 ing, and in particular testing of the APOL1
10 gene, and whether such testing may improve
11 the diagnosis and treatment of rare kidney dis-
12 ease;

13 (B) barriers to genetic and genomic test-
14 ing, such as diagnostic, predictive, presymp-
15 tomatic testing, and DNA sequencing clinical
16 services, including an analysis of any existing
17 barriers related to health insurance coverage of
18 such testing and access to genetic counselors,
19 pathologists, and other relevant professions;
20 and

21 (C) strategies to increase routine urinalysis
22 and other diagnostic testing and to improve
23 technologies to diagnose such disease, including
24 genetic testing, and to improve access to health

1 insurance coverage of such diagnostic testing
2 and technologies;

3 (4) the social, behavioral, and biological factors
4 leading to rare kidney disease;

5 (5) treatment patterns associated with pro-
6 viding care, under the Medicare program under title
7 XVIII of the Social Security Act (42 U.S.C. 1395 et
8 seq.), the Medicaid program under title XIX of such
9 Act (42 U.S.C. 1396 et seq.), and through private
10 health insurance, to populations that are dispropor-
11 tionately affected by such disease;

12 (6) access to nephrologists among populations
13 that are disproportionately affected by such disease;

14 (7) ongoing efforts and recommendations to
15 slow the progression of end-stage kidney disease in
16 populations that are disproportionately affected by
17 rare kidney disease; and

18 (8) patient trust of treating providers among
19 populations that are disproportionately affected by
20 such disease.

21 (b) REPORT.—

22 (1) IN GENERAL.—Not later than 18 months
23 after the date of the enactment of this Act, the Sec-
24 retary shall submit to Congress a report on the re-
25 sults of the study under subsection (a), together

1 with such recommendations as the Secretary deter-
2 mines to be appropriate.

3 (2) CONSULTATION.—In conducting the study
4 under subsection (a) and developing the report re-
5 quired by paragraph (1), the Secretary shall consult
6 with relevant stakeholders, including health care
7 providers, medical professional societies, State-based
8 societies, public health experts, health educators,
9 health professional organizations, drug and device
10 manufacturers, patient organizations, pharmacists,
11 payors, State and local public health departments,
12 State medical boards, and other entities with experi-
13 ence in health care, public health, nephrology, and
14 rare disease, as appropriate.

15 (c) COORDINATION.—In carrying out the activities
16 under subsections (a) and (b), the Secretary shall coordi-
17 nate with the Director of NIH, the Administrator of the
18 Centers for Medicare & Medicaid Services, the Adminis-
19 trator of the Health Resources and Services Administra-
20 tion, and the Director of the Center for Medicare and
21 Medicaid Innovation.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
23 out this section, there is authorized to be appropriated
24 \$1,000,000 for each of fiscal years 2027 through 2031.

1 **SEC. 7901F-2. PROVIDER EDUCATION.**

2 (a) PRIMARY CARE TRAINING.—Section
3 747(b)(3)(E) of the Public Health Service Act (42 U.S.C.
4 293k(b)(3)(E)) is amended—

5 (1) by striking “and individuals” and inserting
6 “, individuals”; and

7 (2) by inserting “, and individuals with kidney
8 disease (including rare kidney disease)” after “dis-
9 abilities”.

10 (b) NEPHROLOGY FELLOWSHIPS.—Section 736(b) of
11 the Public Health Service Act (42 U.S.C. 293) is amend-
12 ed—

13 (1) by redesignating paragraph (7) as para-
14 graph (8);

15 (2) in paragraph (6)(B), by striking “; and”
16 and inserting a semicolon; and

17 (3) by inserting after paragraph (6) the fol-
18 lowing:

19 “(7) to award fellowships, which may include
20 stipends, for postgraduate training in the field of ne-
21 phrology, for the purposes of—

22 “(A) increasing providers’ knowledge of
23 issues related to prevention, diagnosis, and
24 treatment of rare kidney disease for populations
25 disproportionately impacted by the disease, in-
26 cluding the prevalence of the gene APOL1;

1 “(B) improving the quality of rare kidney
2 disease prevention, diagnosis, and treatment de-
3 livered to racial and ethnic minorities; and

4 “(C) increasing the number of
5 nephrologists trained to provide care to such
6 populations; and”.

7 **SEC. 7901F-3. DELAYING KIDNEY DISEASE IMPACT.**

8 Section 1881(f) of the Social Security Act (42 U.S.C.
9 1395rr(f)) is amended by adding at the end the following
10 new paragraph:

11 “(9)(A) The Secretary shall conduct experiments to
12 evaluate methods for treating rare kidney disease, giving
13 particular attention to treatments that would delay or
14 eliminate the need for dialysis and transplant.

15 “(B) The Secretary shall conduct a comprehensive
16 study of methods to increase public awareness of rare kid-
17 ney disease.

18 “(C) The Secretary shall submit to Congress, not
19 later than 24 months after the date of the enactment of
20 the Health Equity and Accountability Act of 2026, a re-
21 port on the experiments and study conducted under sub-
22 paragraphs (A) and (B). Such report shall include rec-
23 ommendations for legislative changes that the Secretary
24 finds necessary or desirable as a result of such experi-
25 ments and study.”.

TITLE VIII—HEALTH INFORMATION TECHNOLOGY

SEC. 8001. DEFINITIONS.

In this title:

(1) **ACCESS.**—The term “access”, with respect to health information, means access described in section 164.524 of title 45, Code of Federal Regulations (or any successor regulations).

(2) **CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY.**—The term “certified EHR technology”—

(A) has the meaning given such term in section 3000 of the Public Health Service Act (42 U.S.C. 300jj);

(B) includes the health information infrastructure for interoperability, access, exchange, and use of electronic health information required under title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.); and

(C) is not limited to electronic health records maintained by doctors.

(3) **EHR.**—The term “EHR”—

(A) means an electronic health record;

(B) includes the health information infrastructure for interoperability, access, exchange,

1 and use of electronic health information re-
 2 quired under title XXX of the Public Health
 3 Service Act (42 U.S.C. 300jj et seq.); and

4 (C) is not limited to electronic health
 5 records maintained by doctors.

6 (4) ELECTRONIC HEALTH RECORD.—The term
 7 “electronic health record” has the meaning given the
 8 term “qualified electronic health record” in section
 9 3000 of the Public Health Service Act (42 U.S.C.
 10 300jj).

11 (5) INTEROPERABILITY.—The term “interoper-
 12 ability” has the meaning given such term in section
 13 3000 of the Public Health Service Act (42 U.S.C.
 14 300jj).

15 **Subtitle A—Reducing Health** 16 **Disparities Through Health IT**

17 **SEC. 8101. HRSA ASSISTANCE TO HEALTH CENTERS FOR** 18 **PROMOTION OF HEALTH IT.**

19 (a) IN GENERAL.—The Secretary of Health and
 20 Human Services, acting through the Administrator of the
 21 Health Resources and Services Administration, shall ex-
 22 pand and intensify the programs and activities of the Ad-
 23 ministration (directly or through grants or contracts) to
 24 provide technical assistance and resources to health cen-
 25 ters (as defined in section 330(a) of the Public Health

1 Service Act (42 U.S.C. 254b(a))) to adopt and meaning-
2 fully use certified EHR technology for the management
3 of chronic diseases and health conditions and reduction
4 of health disparities.

5 (b) FUNDING INITIATIVES.—The activities under
6 subsection (a) may include funding initiatives, including
7 establishing basic connectivity such as 5G internet for
8 telemedicine capabilities, grant funding to implement the
9 next generation of EHR, and funding for technology hard-
10 ware.

11 **SEC. 8102. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**
12 **CIAL AND ETHNIC MINORITY COMMUNITIES;**
13 **OUTREACH AND ADOPTION OF HEALTH IT IN**
14 **SUCH COMMUNITIES.**

15 (a) NATIONAL COORDINATOR FOR HEALTH INFOR-
16 MATION TECHNOLOGY.—

17 (1) IN GENERAL.—Not later than 18 months
18 after the date of enactment of this Act, the National
19 Coordinator for Health Information Technology (re-
20 ferred to in this title as the “National Coordinator”)
21 shall—

22 (A) conduct an evaluation of the level of
23 interoperability, access, use, and accessibility of
24 EHRs in racial and ethnic minority commu-
25 nities, focusing on whether patients in such

1 communities have providers who use EHRs,
2 and the degree to which patients in such com-
3 munities can access, exchange, and use without
4 special effort their health information in those
5 EHRs;

6 (B) include in such evaluation an indica-
7 tion of whether such providers—

8 (i) are participating in the Medicare
9 program under title XVIII of the Social
10 Security Act (42 U.S.C. 1395 et seq.) or
11 a State plan under title XIX of such Act
12 (42 U.S.C. 1396 et seq.) (or a waiver of
13 such plan);

14 (ii) have received incentive payments
15 or incentive payment adjustments under
16 Medicare and Medicaid Electronic Health
17 Records Incentive Programs (as defined in
18 subsection (c)(2));

19 (iii) are MIPS eligible professionals,
20 as defined in paragraph (1)(C) of section
21 1848(q) of the Social Security Act (42
22 U.S.C. 1395w-4(q)), for purposes of the
23 Merit-Based Incentive Payment System
24 under such section; or

1 (iv) have been recruited by any of the
2 Health Information Technology Regional
3 Extension Centers established under sec-
4 tion 3012 of the Public Health Service Act
5 (42 U.S.C. 300jj–32); and

6 (C) publish the results of such evaluation,
7 including the indications under subparagraph
8 (B), the race and ethnicity of such providers,
9 and the populations served by such providers.

10 (2) EVALUATION OF INTEROPERABILITY.—The
11 evaluation of the level of interoperability described in
12 paragraph (1)(A) shall consider exchange of elec-
13 tronic health information, usability of exchanged
14 electronic health information, effective application
15 and use of the exchanged electronic health informa-
16 tion, and impact on outcomes of interoperability.

17 (3) CERTIFICATION CRITERION.—Not later
18 than 1 year after the date of enactment of this Act,
19 the National Coordinator shall—

20 (A) promulgate a certification criterion and
21 module of certified EHR technology that strati-
22 fies quality measures for purposes of the Merit-
23 Based Incentive Payment System by disparity
24 characteristics, including race, ethnicity, lan-
25 guage, gender, gender identity, sexual orienta-

tion, socio-economic status, and disability status, as such characteristics are defined for purposes of certified EHR technology; and

(B) report to the Centers for Medicare & Medicaid Services the quality measures stratified by race and at least 2 other disparity characteristics.

(b) NATIONAL CENTER FOR HEALTH STATISTICS.—

Not later than one year after the date of enactment of this Act, the Director of the National Center for Health Statistics shall provide to Congress a report that details the adoption of certified electronic health record systems and electronic information sharing in physicians' offices in communities of color and rural communities during fiscal years 2023 through 2026.

(c) CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—As part of the process of collecting information, with respect to a provider, at registration and attestation for purposes of Medicare and Medicaid Electronic Health Records Incentive Programs (as defined in paragraph (2)) or the Merit-Based Incentive Payment System under section 1848(q) of the Social Security Act (42 U.S.C. 1395w-4(q)), the Secretary of Health and Human

1 Services shall collect the race and ethnicity of such
 2 provider.

3 (2) MEDICARE AND MEDICAID ELECTRONIC
 4 HEALTH RECORDS INCENTIVE PROGRAMS DE-
 5 FINED.—For purposes of paragraph (1), the term
 6 “Medicare and Medicaid Electronic Health Records
 7 Incentive Programs” means the incentive programs
 8 under the following:

9 (A) Subsection (l)(3) of section 1814(l)(3)
 10 of the Social Security Act (42 U.S.C. 1395f).

11 (B) Subsections (a)(7) and (o) of section
 12 1848 of such Act (42 U.S.C. 1395w–4).

13 (C) Subsections (l) and (m) of section
 14 1853 of such Act (42 U.S.C. 1395w–23).

15 (D) Subsections (b)(3)(B)(ix)(I) and (n) of
 16 section 1886 of such Act (42 U.S.C. 1395ww).

17 (E) Subsections (a)(3)(F) and (t) of sec-
 18 tion 1903 such Act (42 U.S.C. 1396b).

19 (d) NATIONAL COORDINATOR’S ASSESSMENT OF IM-
 20 PACT OF HIT.—Section 3001(c)(6)(C) of the Public
 21 Health Service Act (42 U.S.C. 300jj–11(c)(6)(C)) is
 22 amended—

23 (1) in the heading by inserting “, RACIAL AND
 24 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
 25 DISPARITIES”;

1 (2) by inserting “, in communities with a high
2 proportion of individuals from racial and ethnic mi-
3 nority groups (as defined in section 1707(g)), in-
4 cluding people with disabilities in such groups,”
5 after “communities with health disparities”;

6 (3) by striking “The National Coordinator” and
7 inserting the following:

8 “(i) IN GENERAL.—The National Co-
9 ordinator”; and

10 (4) by adding at the end the following:

11 “(ii) CRITERIA.—In any publication
12 under clause (i), the National Coordinator
13 shall include best practices for encouraging
14 partnerships between the Federal Govern-
15 ment, States, private entities, national
16 nonprofit intermediaries, and community-
17 based organizations to expand outreach
18 and education for and the adoption of cer-
19 tified EHR technology in communities with
20 a high proportion of individuals from racial
21 and ethnic minority groups (as defined in
22 section 1707(g)), while also maintaining
23 the accessibility requirements of section
24 508 of the Rehabilitation Act of 1973 to
25 encourage patient involvement in patient

1 health care. The National Coordinator
2 shall—

3 “(I) not later than 6 months
4 after the submission of the report re-
5 quired under section 8302(b) of the
6 Health Equity and Accountability Act
7 of 2026, establish criteria for evalu-
8 ating the impact of health information
9 technology on communities with a
10 high proportion of individuals from
11 racial and ethnic minority groups (as
12 so defined) taking into account the
13 findings in such report; and

14 “(II) not later than 1 year after
15 the submission of such report, publish
16 the results of an evaluation of such
17 impact.”.

18 **SEC. 8103. NONDISCRIMINATION AND HEALTH EQUITY IN**
19 **HEALTH INFORMATION TECHNOLOGY.**

20 (a) IN GENERAL.—Covered entities shall ensure that
21 electronic and information technology in their health pro-
22 grams or activities does not exclude individuals from par-
23 ticipation in, deny individuals the benefits of, or subject
24 individuals to discrimination under any health program or

1 activity on the basis of race, color, national origin, sex,
2 age, or disability.

3 (b) COVERED ENTITIES.—In this section, the term
4 “covered entity” means—

5 (1) an entity that operates a health program or
6 activity, any part of which receives Federal financial
7 assistance;

8 (2) an entity established under title I of the Pa-
9 tient Protection and Affordable Care Act (Public
10 Law 114–148) that administers a health program or
11 activity; or

12 (3) the Department of Health and Human
13 Services.

14 **SEC. 8104. LANGUAGE ACCESS IN HEALTH INFORMATION**
15 **TECHNOLOGY.**

16 The National Coordinator shall—

17 (1) not later than 18 months after the date of
18 enactment of this Act, propose a rule for providing
19 access to patients, through certified EHR tech-
20 nology, to their personal health information in a
21 computable format, including using patient portals
22 or third-party applications (as described in section
23 3009(e) of the Public Health Service Act (42 U.S.C.
24 300jj–19(e))), in the 10 most common non-English
25 languages;

1 (2) hold a public hearing to identify best prac-
2 tices for carrying out paragraph (1); and

3 (3) not later than 6 months after the public
4 hearing under paragraph (2), promulgate a final
5 regulation with respect to paragraph (1).

6 **Subtitle B—Modifications To**
7 **Achieve Parity in Existing Pro-**
8 **grams**

9 **SEC. 8201. EXTENDING FUNDING TO STRENGTHEN THE**
10 **HEALTH IT INFRASTRUCTURE IN RACIAL**
11 **AND ETHNIC MINORITY COMMUNITIES.**

12 Section 3011 of the Public Health Service Act (42
13 U.S.C. 300jj–31) is amended—

14 (1) in subsection (a), in the matter preceding
15 paragraph (1), by inserting “, including with respect
16 to communities with a high proportion of individuals
17 from racial and ethnic minority groups (as defined
18 in section 1707(g))” before the colon at the end; and

19 (2) by adding at the end the following new sub-
20 section:

21 “(e) ANNUAL REPORT ON EXPENDITURES.—The
22 National Coordinator shall report annually to Congress on
23 activities and expenditures under this section.”.

1 **SEC. 8202. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
 2 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
 3 **TATE ADOPTION OF CERTIFIED EHR TECH-**
 4 **NOLOGY BY PROVIDERS SERVING RACIAL**
 5 **AND ETHNIC MINORITY GROUPS.**

6 Section 3014(e) of the Public Health Service Act (42
 7 U.S.C. 300jj–34(e)) is amended, in the matter preceding
 8 paragraph (1), by inserting “, including with respect to
 9 communities with a high proportion of individuals from
 10 racial and ethnic minority groups (as defined in section
 11 1707(g))” after “health care provider to”.

12 **SEC. 8203. AUTHORIZATION OF APPROPRIATIONS.**

13 Section 3018 of the Public Health Service Act (42
 14 U.S.C. 300jj–38) is amended by striking “fiscal years
 15 2009 through 2013” and inserting “fiscal years 2027
 16 through 2032”.

17 **Subtitle C—Additional Research**
 18 **and Studies**

19 **SEC. 8301. DATA COLLECTION AND ASSESSMENTS CON-**
 20 **DUCTED IN COORDINATION WITH MINORITY-**
 21 **SERVING INSTITUTIONS.**

22 Section 3001(c)(6) of the Public Health Service Act
 23 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
 24 end the following new subparagraph:

1 “(F) DATA COLLECTION AND ASSESS-
2 MENTS CONDUCTED IN COORDINATION WITH
3 MINORITY-SERVING INSTITUTIONS.—

4 “(i) IN GENERAL.—In carrying out
5 subparagraph (C) with respect to commu-
6 nities with a high proportion of individuals
7 from racial and ethnic minority groups (as
8 defined in section 1707(g)), the National
9 Coordinator shall, to the greatest extent
10 possible, coordinate with an entity de-
11 scribed in clause (ii).

12 “(ii) MINORITY-SERVING INSTITU-
13 TIONS.—For purposes of clause (i), an en-
14 tity described in this clause is a historically
15 Black college or university, a Hispanic-
16 serving institution, a Tribal College or
17 University, or an Asian-American-, Native
18 American-, or Pacific Islander-serving in-
19 stitution with an accredited public health,
20 health policy, or health services research
21 program.”.

1 **SEC. 8302. STUDY OF HEALTH INFORMATION TECHNOLOGY**
2 **IN MEDICALLY UNDERSERVED COMMU-**
3 **NITIES.**

4 (a) IN GENERAL.—Not later than 2 years after the
5 date of enactment of this Act, the Secretary of Health and
6 Human Services shall—

7 (1) enter into an agreement with the National
8 Academies of Sciences, Engineering, and Medicine to
9 conduct a study on the development, implementa-
10 tion, and effectiveness of health information tech-
11 nology within medically underserved areas; and

12 (2) submit a report to Congress describing the
13 results of such study, including any recommenda-
14 tions for legislative or administrative action.

15 (b) STUDY.—The study described in subsection
16 (a)(1) shall—

17 (1) identify barriers to successful implementa-
18 tion of health information technology in medically
19 underserved areas;

20 (2) survey a cross-section of individuals in
21 medically underserved areas and report their opin-
22 ions about the various topics of study;

23 (3) examine the degree of interoperability
24 among health information technology and users of
25 health information technology in medically under-
26 served areas, including patients, providers, and com-

1 community services, which such examination shall con-
2 sider the exchange of electronic health information,
3 usability of exchanged electronic health information,
4 effective application and use of the exchanged elec-
5 tronic health information, and impact on outcomes
6 of interoperability;

7 (4) examine the impact of health information
8 technology on providing quality care and reducing
9 the cost of care to individuals in such areas, includ-
10 ing the impact of such technology on improved
11 health outcomes for individuals, including which
12 technology worked for which population and how it
13 improved health outcomes for that population;

14 (5) examine the impact of health information
15 technology on improving health care-related deci-
16 sions by both patients and providers in such areas;

17 (6) identify specific best practices for using
18 health information technology to foster the con-
19 sistent provision of accessibility and reasonable pol-
20 icy accommodations in health care to individuals
21 with disabilities in such areas;

22 (7) assess the feasibility and costs associated
23 with the use of health information technology in
24 such areas;

1 (8) evaluate whether the adoption and use of
2 electronic health records is effective in reducing
3 health disparities, including analysis of clinical qual-
4 ity measures reported by providers who are partici-
5 pating in the Medicare program under title XVIII of
6 the Social Security Act (42 U.S.C. 1395 et seq.) or
7 a State plan under title XIX of such Act (42 U.S.C.
8 1396 et seq.) (or a waiver of such plan), pursuant
9 to programs to encourage the adoption and use of
10 certified EHR technology;

11 (9) identify providers in medically underserved
12 areas that are not electing to adopt and use EHRs
13 and determine what barriers are preventing those
14 providers from adopting and using such records; and

15 (10) examine urban and rural community
16 health systems and determine the impact that health
17 information technology may have on the capacity of
18 primary health providers in those systems.

19 (c) MEDICALLY UNDERSERVED AREA.—In this sec-
20 tion, the term “medically underserved area” means—

21 (1) a population that has been designated as a
22 medically underserved population under section
23 330(b)(3) of the Public Health Service Act (42
24 U.S.C. 254b(b)(3));

1 (2) an area that has been designated as a
 2 health professional shortage area under section 332
 3 of the Public Health Service Act (42 U.S.C. 254e);

4 (3) an area or population that has been des-
 5 ignated as a medically underserved community under
 6 section 799B of the Public Health Service Act (42
 7 U.S.C. 295p); or

8 (4) another area or population that—

9 (A) experiences significant barriers to ac-
 10 cessing quality health services; and

11 (B) has a high prevalence of diseases or
 12 conditions described in title VII, with such dis-
 13 eases or conditions having a disproportionate
 14 impact on racial and ethnic minority groups (as
 15 defined in section 1707(g) of the Public Health
 16 Service Act (42 U.S.C. 300u–6(g))) or a sub-
 17 group of people with disabilities who have spe-
 18 cific functional impairments.

19 **SEC. 8303. ASSESSMENT OF USE AND MISUSE OF DE-IDEN-**
 20 **TIFIED HEALTH DATA.**

21 (a) IN GENERAL.—Not later than 18 months after
 22 the date of enactment of this Act, the Secretary of Health
 23 and Human Services shall—

24 (1) enter into an agreement with the Office of
 25 the National Coordinator of Health Information

1 Technology to conduct a study, in consultation with
2 relevant stakeholders, on the impact of digital health
3 technology on medically underserved areas (as de-
4 fined in section 8302(c)); and

5 (2) submit a report to Congress describing the
6 results of such study, including any recommenda-
7 tions for legislative or administrative action.

8 (b) STUDY.—The study described in subsection
9 (a)(1) shall—

10 (1) examine the overall prevalence, and histor-
11 ical and existing practices and their respective preva-
12 lence, of use and misuse of de-identified protected
13 health information to discriminate against or benefit
14 medically underserved areas;

15 (2) identify best practices and tools to leverage
16 the benefits and prevent misuse of de-identified pro-
17 tected health information to discriminate against
18 medically underserved areas;

19 (3) examine the overall prevalence, and histor-
20 ical and existing practices and their respective preva-
21 lence, of use and misuse of de-identified personal
22 health information other than protected health infor-
23 mation to discriminate against or benefit medically
24 underserved areas; and

1 (4) identify best practices and tools to leverage
 2 the benefits and prevent misuse of de-identified per-
 3 sonal health information other than protected health
 4 information to discriminate against medically under-
 5 served areas.

6 (c) DEFINITION OF PROTECTED HEALTH INFORMA-
 7 TION.—In this section, the term “protected health infor-
 8 mation” has the meaning given such term in section
 9 160.103 of title 45, Code of Federal Regulations (or any
 10 successor regulations).

11 **Subtitle D—Closing Gaps in** 12 **Funding To Adopt Certified EHRs**

13 **SEC. 8401. EXTENDING MEDICAID EHR INCENTIVE PAY-** 14 **MENTS TO REHABILITATION FACILITIES,** 15 **LONG-TERM CARE FACILITIES, AND HOME** 16 **HEALTH AGENCIES.**

17 (a) IN GENERAL.—Section 1903(t)(2)(B) of the So-
 18 cial Security Act (42 U.S.C. 1396b(t)(2)(B)) is amend-
 19 ed—

20 (1) in clause (i), by striking “, or” and insert-
 21 ing a semicolon;

22 (2) in clause (ii), by striking the period at the
 23 end and inserting a semicolon; and

24 (3) by inserting after clause (ii) the following
 25 new clauses:

1 “(iii) a rehabilitation facility (as defined in sec-
 2 tion 1886(j)(1)) that furnishes acute or subacute re-
 3 habilitation services;

4 “(iv) a long-term care hospital described in sec-
 5 tion 1886(d)(1)(B)(iv); or

6 “(v) a home health agency (as defined in sec-
 7 tion 1861(o)).”.

8 (b) **EFFECTIVE DATE.**—The amendments made by
 9 subsection (a) shall apply with respect to amounts ex-
 10 pended under section 1903(a)(3)(F) of the Social Security
 11 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
 12 ginning on or after the date of the enactment of this Act.

13 **SEC. 8402. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**
 14 **FOR MEDICAID ELECTRONIC HEALTH**
 15 **RECORD INCENTIVE PAYMENTS.**

16 (a) **IN GENERAL.**—Section 1903(t)(3)(B)(v) of the
 17 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is
 18 amended to read as follows:

19 “(v) physician assistant.”.

20 (b) **EFFECTIVE DATE.**—The amendment made by
 21 subsection (a) shall apply with respect to amounts ex-
 22 pended under section 1903(a)(3)(F) of the Social Security
 23 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
 24 ginning on or after the date of the enactment of this Act.

1 **Subtitle E—Expanding Access to**
 2 **Telehealth Services**

3 **SEC. 8501. REMOVING GEOGRAPHIC REQUIREMENTS FOR**
 4 **TELEHEALTH SERVICES.**

5 Section 1834(m)(4)(C) of the Social Security Act (42
 6 U.S.C. 1395m(m)(4)(C)) is amended—

7 (1) in clause (i), in the matter preceding sub-
 8 clause (I), by striking “clause (iii)” and inserting
 9 “clauses (iii) and (iv)”; and

10 (2) by adding at the end the following new
 11 clause:

12 “(iv) REMOVAL OF GEOGRAPHIC RE-
 13 QUIREMENTS.—The geographic require-
 14 ments described in clause (i) shall not
 15 apply with respect to telehealth services
 16 furnished on or after the first day after the
 17 end of the period for which clause (iii) ap-
 18 plies.”.

19 **SEC. 8502. EXPANDING ORIGINATING SITES.**

20 (a) EXPANDING THE HOME AS AN ORIGINATING
 21 SITE.—Section 1834(m)(4)(C)(ii)(X) of the Social Secu-
 22 rity Act (42 U.S.C. 1395m(m)(4)(C)(ii)(X)) is amended
 23 to read as follows:

24 “(X)(aa) Prior to the date de-
 25 scribed in item (bb), the home of an

1 individual but only for purposes of
2 section 1881(b)(3)(B) or telehealth
3 services described in paragraph (7) or
4 clause (iii).

5 “(bb) On or after the first day
6 after the end of the period for which
7 clause (iii) applies, the home of an in-
8 dividual.”.

9 (b) ALLOWING ADDITIONAL ORIGINATING SITES.—
10 Section 1834(m)(4)(C)(ii) of the Social Security Act (42
11 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the
12 end the following new subclause:

13 “(XII) Any other site determined
14 appropriate by the Secretary at which
15 an eligible telehealth individual is lo-
16 cated at the time a telehealth service
17 is furnished via a telecommunications
18 system.”.

19 (c) PARAMETERS FOR NEW ORIGINATING SITES.—
20 Section 1834(m)(4)(C) of the Social Security Act (42
21 U.S.C. 1395m(m)(4)(C)), as amended by section 8501, is
22 amended by adding at the end the following new clause:

23 “(v) REQUIREMENTS FOR NEW
24 SITES.—

1 “(I) IN GENERAL.—The Sec-
 2 retary may establish requirements for
 3 the furnishing of telehealth services at
 4 sites described in clause (ii)(XII) to
 5 provide for beneficiary and program
 6 integrity protections.

7 “(II) CLARIFICATION.—Nothing
 8 in this clause shall be construed to
 9 preclude the Secretary from estab-
 10 lishing requirements for other origi-
 11 nating sites described in clause (ii).”.

12 (d) NO ORIGINATING SITE FACILITY FEE FOR NEW
 13 SITES.—Section 1834(m)(2)(B)(ii) of the Social Security
 14 Act (42 U.S.C. 1395m(m)(2)(B)(ii)) is amended—

15 (1) in the heading, by striking “IF ORIGINATING
 16 SITE IS THE HOME” and inserting “FOR CERTAIN
 17 SITES”; and

18 (2) by striking “paragraph (4)(C)(ii)(X)” and
 19 inserting “subclause (X) or (XII) of paragraph
 20 (4)(C)”.

TITLE IX—ACCOUNTABILITY AND EVALUATION

**SEC. 9001. PROHIBITION ON DISCRIMINATION IN FEDERAL
ASSISTED HEALTH CARE SERVICES AND RE-
SEARCH ON THE BASIS OF SEX (INCLUDING
SEXUAL ORIENTATION, GENDER IDENTITY,
AND PREGNANCY, INCLUDING TERMINATION
OF PREGNANCY), RACE, COLOR, NATIONAL
ORIGIN, MARITAL STATUS, FAMILIAL STATUS,
OR DISABILITY STATUS.**

(a) IN GENERAL.—No person in the United States shall, on the basis of sex (including sexual orientation, gender identity, and pregnancy, including termination of pregnancy), race, color, national origin, marital status, familial status, sexual orientation, gender identity, or disability status, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under—

(1) any health program or activity, including any health research program or activity, receiving Federal financial assistance, including credits, subsidies, or contracts of insurance; or

(2) any health program or activity that is administered by an executive agency.

(b) DEFINITION.—In this section, the term “familial status” means, with respect to one or more individuals—

- 1 (1) being domiciled with any individual related
2 by blood or affinity whose close association with the
3 individual is the equivalent of a family relationship;
4 (2) being in the process of securing legal cus-
5 tody of any individual; or
6 (3) being pregnant.

7 **SEC. 9002. TREATMENT OF MEDICARE PAYMENTS UNDER**
8 **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

9 For the purposes of title VI of the Civil Rights Act
10 of 1964 (42 U.S.C. 2000d et seq.), a payment made under
11 part A, B, C, or D of title XVIII of the Social Security
12 Act (42 U.S.C. 1395 et seq.) to a provider of services,
13 physician, or other supplier (including a payment made
14 to a subcontractor of the provider of services, physician,
15 or other supplier) shall be deemed a grant, not a contract
16 of insurance or guaranty.

17 **SEC. 9003. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
18 **THE DEPARTMENT OF HEALTH AND HUMAN**
19 **SERVICES.**

20 Title XXXIV of the Public Health Service Act, as
21 amended by titles I, II, III, and IV of this Act, is further
22 amended by inserting after subtitle D the following:

1 **“Subtitle E—Strengthening**
2 **Accountability**

3 **“SEC. 3451. ELEVATION OF THE OFFICE FOR CIVIL RIGHTS**
4 **AND HEALTH EQUITY.**

5 “(a) IN GENERAL.—

6 “(1) NAME OF OFFICE.—Beginning on the date
7 of enactment of this subtitle, the Office for Civil
8 Rights of the Department of Health and Human
9 Services shall be known as the ‘Office for Civil
10 Rights and Health Equity’ of the Department of
11 Health and Human Services. Any reference to the
12 Office for Civil Rights of the Department of Health
13 and Human Services in any law, regulation, map,
14 document, record, or other paper of the United
15 States shall be deemed to be a reference to the Of-
16 fice for Civil Rights and Health Equity.

17 “(2) HEAD OF OFFICE.—The head of the Office
18 for Civil Rights and Health Equity shall be the Di-
19 rector for Civil Rights and Health Equity, to be ap-
20 pointed by the President. Any reference to the Di-
21 rector of the Office for Civil Rights of the Depart-
22 ment of Health and Human Services in any law,
23 regulation, map, document, record, or other paper of
24 the United States shall be deemed to be a reference
25 to the Director for Civil Rights and Health Equity.

1 “(b) PURPOSE.—The Director for Civil Rights and
 2 Health Equity shall ensure that the health programs, ac-
 3 tivities, policies, projects, procedures, and operations of
 4 health entities that receive Federal financial assistance are
 5 in compliance with title VI of the Civil Rights Act of 1964,
 6 including through the following activities:

7 “(1) The development and implementation of
 8 an action plan to address racial and ethnic health
 9 care disparities. Such plan shall—

10 “(A) address concerns relating to the Of-
 11 fice for Civil Rights and Health Equity as re-
 12 leased by the United States Commission on
 13 Civil Rights in the report entitled ‘Health Care
 14 Challenge: Acknowledging Disparity, Con-
 15 fronting Discrimination, and Ensuring Equity’
 16 (September 1999), in conjunction with existing
 17 and future reports of the National Academy of
 18 Medicine (formerly known as the Institute of
 19 Medicine) including the reports titled ‘Unequal
 20 Treatment: Confronting Racial and Ethnic Dis-
 21 parities in Health Care’, ‘Crossing the Quality
 22 Chasm: A New Health System for the 21st
 23 Century’, ‘In the Nation’s Compelling Interest:
 24 Ensuring Diversity in the Health Care Work-
 25 force’, ‘The National Partnership for Action to

1 End Health Disparities’, and ‘The Health of
2 Lesbian, Gay, Bisexual, and Transgender Peo-
3 ple’, and other related reports of the National
4 Academies of Sciences, Engineering, and Medi-
5 cine;

6 “(B) be issued in proposed form for public
7 review and comment; and

8 “(C) be finalized taking into consideration
9 any comments or concerns that are received by
10 the Office.

11 “(2) Investigative and enforcement actions
12 against intentional or in effect discrimination and
13 policies and practices that have a disparate impact
14 on racial and ethnic minority groups and commu-
15 nities of color pursuant to section 9007 of the
16 Health Equity and Accountability Act of 2026.

17 “(3) The review of racial, ethnic, gender iden-
18 tity, sexual orientation, sex, disability status, socio-
19 economic status, and primary language health data
20 collected by Federal health agencies to assess health
21 care disparities related to intentional discrimination
22 and policies and practices that have a disparate im-
23 pact on minorities. Such review shall include an as-
24 sessment of health disparities in communities with a
25 combination of these classes.

1 “(4) Outreach and education activities relating
2 to compliance with title VI of the Civil Rights Act
3 of 1964, including the process of filing a complaint
4 in accordance with section 9007 of the Health Eq-
5 uity and Accountability Act of 2026.

6 “(5) The provision of technical assistance for
7 health entities to facilitate compliance with title VI
8 of the Civil Rights Act of 1964.

9 “(6) Coordination and oversight of activities of
10 the civil rights compliance offices established under
11 section 3452.

12 “(7) Ensuring—

13 “(A) at a minimum, compliance with the
14 most recent version of the Office of Manage-
15 ment and Budget statistical policy directive en-
16 titled ‘Standards for Maintaining, Collecting,
17 and Presenting Federal Data on Race and Eth-
18 nicity’; and

19 “(B) consideration of available data and
20 language standards such as—

21 “(i) the standards for collecting, mon-
22 itoring, and reporting data under section
23 3101; and

1 “(ii) the National Standards on Cul-
2 turally and Linguistically Appropriate
3 Services of the Office of Minority Health.

4 “(c) FUNDING AND STAFF.—The Secretary shall en-
5 sure the effectiveness of the Office for Civil Rights and
6 Health Equity by ensuring that the Office is provided
7 with—

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

10 “(2) staff with expertise in—

11 “(A) epidemiology;

12 “(B) statistics;

13 “(C) health quality assurance;

14 “(D) minority health and health dispari-
15 ties;

16 “(E) health equity;

17 “(F) cultural and linguistic competency;

18 “(G) civil rights; and

19 “(H) social, political, mental, behavioral,
20 economic, and related determinants of health,
21 including education access and quality, health
22 care access and quality, neighborhood and built
23 environment, and social and community context.

24 “(d) ADVISORY BOARD.—

1 “(1) ESTABLISHMENT.—The Secretary, in col-
2 laboration with the Director Civil Rights and Health
3 Equity and the Deputy Assistant Secretary for Mi-
4 nority Health, shall establish an advisory board (in
5 this subsection referred to as the ‘advisory board’)
6 to report in accordance with paragraph (2).

7 “(2) REPORTS TO CONGRESS.—Not later than
8 December 31, 2027, and annually thereafter, the ad-
9 visory board shall publish and submit to the Office,
10 other Federal agencies, and the Congress a report
11 that includes—

12 “(A) the number of complaints filed in ac-
13 cordance with section 9007 of the Health Eq-
14 uity and Accountability Act of 2026 during the
15 reporting period under title VI of the Civil
16 Rights Act of 1964, broken down by category;

17 “(B) the number of such complaints inves-
18 tigated and closed by the Office;

19 “(C) the outcomes of such complaints in-
20 vestigated;

21 “(D) the staffing levels of the Office, in-
22 cluding staff credentials;

23 “(E) the number of such complaints that
24 are pending (including backlogged complaints)
25 in which civil rights inequities can be dem-

1 onstrated and an explanation of why such com-
2 plaints remain pending; and

3 “(F) trends among filed complaints and
4 other systemic patterns or themes, including an
5 analysis from the Department of Justice about
6 litigation concerning such complaints.

7 “(3) COMPOSITION.—The members of the advi-
8 sory board shall include—

9 “(A) representatives of stakeholders; and

10 “(B) subject matter- and disciplinary-ap-
11 propriate experts.

12 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2027 through 2030.

16 **“SEC. 3452. ESTABLISHMENT OF HEALTH PROGRAM OF-**
17 **FICES FOR CIVIL RIGHTS WITHIN AGENCIES**
18 **OF DEPARTMENT OF HEALTH AND HUMAN**
19 **SERVICES.**

20 “(a) IN GENERAL.—The Secretary shall establish
21 civil rights compliance offices in each agency within the
22 Department of Health and Human Services that admin-
23 isters health programs.

24 “(b) PURPOSE OF OFFICES.—Each office established
25 under subsection (a) shall ensure that recipients of Fed-

1 eral financial assistance under Federal health programs
2 administer programs, and determine and implement poli-
3 cies, services, and activities, in a manner that—

4 “(1) does not discriminate, either intentionally
5 or in effect, on the basis of race, color, national ori-
6 gin, language, ethnicity, sex, age, disability status,
7 sexual orientation, or gender identity; and

8 “(2) promotes the reduction and elimination of
9 disparities in health and health care based on race,
10 color, national origin, language, ethnicity, sex, age,
11 disability status, sexual orientation, or gender iden-
12 tity.

13 “(c) POWERS AND DUTIES.—The offices established
14 in subsection (a) shall, with respect to the applicable agen-
15 cy, have the following powers and duties:

16 “(1) The establishment of compliance and pro-
17 gram participation standards for recipients of Fed-
18 eral financial assistance under each program admin-
19 istered by the agency, including the establishment of
20 disparity reduction standards to encompass dispari-
21 ties in health and health care related to race, color,
22 national origin, language, ethnicity, sex, age, dis-
23 ability, sexual orientation, or gender identity.

24 “(2) The development and implementation of
25 policies, procedures, and program-specific guidelines

1 that interpret and apply Department of Health and
2 Human Services guidance under title VI of the Civil
3 Rights Act of 1964 and section 1557 of the Patient
4 Protection and Affordable Care Act to each Federal
5 health program administered by the agency.

6 “(3) The development of a disparity-reduction
7 impact analysis methodology that shall—

8 “(A) be applied to every rule issued by the
9 agency and published as part of the formal
10 rulemaking process under sections 555, 556,
11 and 557 of title 5, United States Code; and

12 “(B) include an analysis of the intersecting
13 forms of discrimination.

14 “(4) Oversight of data collection, reporting,
15 analysis, and publication requirements for all recipi-
16 ents of Federal financial assistance under each Fed-
17 eral health program administered by the agency,
18 compliance with, at a minimum, the most recent
19 version of the Office of Management and Budget
20 statistical policy directive entitled ‘Standards for
21 Maintaining, Collecting, and Presenting Federal
22 Data on Race and Ethnicity’, and consideration of
23 available data and language standards such as—

24 “(A) the standards for collecting and re-
25 porting data under section 3101;

1 “(B) the National Standards on Culturally
2 and Linguistically Appropriate Services of the
3 Office of Minority Health; and

4 “(C) the disaggregation of all health and
5 health care data by racial and ethnic minority
6 group.

7 “(5) The conduct of publicly available studies
8 regarding discrimination within Federal health pro-
9 grams administered by the agency as well as dis-
10 parity reduction initiatives by recipients of Federal
11 financial assistance under Federal health programs.

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

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

22 “(1) DEPARTMENT OF HEALTH AND HUMAN
23 SERVICES.—The Office for Civil Rights of the De-
24 partment of Health and Human Services shall pro-
25 vide standard-setting and compliance review inves-

1 tigation support services to each civil rights compli-
 2 ance office established under subsection (a), subject
 3 to paragraph (2).

4 “(2) DEPARTMENT OF JUSTICE.—The Office
 5 for Civil Rights of the Department of Justice may,
 6 as appropriate, institute formal proceedings when a
 7 civil rights compliance office established under sub-
 8 section (a) determines that a recipient of Federal fi-
 9 nancial assistance is not in compliance with the dis-
 10 parity reduction standards of the applicable agency.

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

13 “(1) under the Social Security Act that pay for
 14 health care and services; and

15 “(2) under this Act that—

16 “(A) provide Federal financial assistance
 17 for health care, biomedical research, or health
 18 services research; or

19 “(B) are designed to improve the public’s
 20 health, including health service programs.”.

21 **SEC. 9004. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

22 (a) COORDINATION WITHIN DEPARTMENT OF JUS-
 23 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-
 24 TIES.—Section 3(a) of the Civil Rights Commission Act
 25 of 1983 (42 U.S.C. 1975a(a)) is amended—

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

3 (2) in paragraph (2), by striking the period at
4 the end and inserting “; and”; and

5 (3) by adding at the end the following:

6 “(3) shall, with respect to activities carried out
7 in health care and correctional facilities, toward the
8 goal of eliminating health disparities between the
9 general population and members of minority groups
10 based on race or color, promote coordination of such
11 activities of—

12 “(A) the Office of Justice Programs of the
13 Department of Justice, including the Office for
14 Civil Rights within that Office;

15 “(B) the Office for Civil Rights within the
16 Department of Health and Human Services;
17 and

18 “(C) the Office of Minority Health within
19 the Department of Health and Human Serv-
20 ices.”.

21 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
22 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
23 1975c) is amended by striking the first sentence and in-
24 serting the following: “For the purpose of carrying out
25 this Act, there are authorized to be appropriated

1 \$30,000,000 for fiscal year 2027, and such sums as may
2 be necessary for each of the fiscal years 2028 through
3 2032.”.

4 **SEC. 9005. SENSE OF CONGRESS CONCERNING FULL FUND-**
5 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
6 **AND ETHNIC HEALTH DISPARITIES.**

7 It is the sense of the Congress that—

8 (1) health disparities negatively impact out-
9 comes for health and human security of the Nation;

10 (2) reducing racial, ethnic, age, sexual, and
11 gender disparities in prevention and treatment are
12 unique civil and human rights challenges and, as
13 such, Federal agencies and health care entities and
14 systems receiving Federal funds should be account-
15 able for their role in causing disparities and in-
16 equity;

17 (3) funding for the National Institute on Mi-
18 nority Health and Health Disparities, the Office of
19 Civil Rights in the Department of Health and
20 Human Services, the National Institute of Nursing
21 Research, and the Office of Minority Health should
22 be doubled by fiscal year 2027, to effectively address
23 racial and ethnic disparities elimination in health
24 and health care as a matter of health and national
25 security;

1 (4) adequate funding by fiscal year 2027, and
2 subsequent funding increases, should be provided for
3 health and human service professions training pro-
4 grams, the Racial and Ethnic Approaches to Com-
5 munity Health Initiative at the Centers for Disease
6 Control and Prevention, the Minority HIV/AIDS
7 Initiative, the Excellence Centers to Eliminate Eth-
8 nic/Racial Disparities Program at the Agency for
9 Healthcare Research and Quality, and the National
10 Health Service Corps Scholarship Program initia-
11 tives, programs, policies, projects, and activities that
12 are the backbone of the Nation's agenda to eliminate
13 racial and ethnic health disparities and inequities;

14 (5) adequate funding for fiscal year 2027 and
15 increased funding for future years should be pro-
16 vided for the Racial and Ethnic Approaches to Com-
17 munity Health Initiative's United States Risk Fac-
18 tor Survey to ensure adequate data collection to
19 track health disparities, and there should be appro-
20 priate avenues provided to disseminate findings to
21 the general public;

22 (6) current and newly created health disparity
23 elimination incentives, programs, agencies, and de-
24 partments under this Act (and the amendments

1 made by this Act) should receive adequate staffing
2 and funding by fiscal year 2027; and

3 (7) stewardship and accountability should be
4 provided to the Congress and the President for
5 measurable and sustainable progress toward health
6 disparity elimination under programs under this Act,
7 including increased data collection and reporting, ca-
8 pacity building for impacted communities, technical
9 assistance, training programs, and avenues to dis-
10 seminate program details and successes to the public
11 and to policymakers.

12 **SEC. 9006. GAO AND NIH REPORTS.**

13 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-
14 NIC DIVERSITY.—

15 (1) IN GENERAL.—The Comptroller General of
16 the United States shall conduct a study on the racial
17 and ethnic diversity among the following groups:

18 (A) All applicants for grants, contracts,
19 and cooperative agreements awarded by the Na-
20 tional Institutes of Health during the period be-
21 ginning on January 1, 2027, and ending De-
22 cember 31, 2035.

23 (B) All recipients of such grants, con-
24 tracts, and cooperative agreements during such
25 period.

1 (C) All members of the peer review panels
2 of such applicants and recipients, respectively.

3 (2) REPORT.—Not later than 6 months after
4 the date of enactment of this Act, the Comptroller
5 General shall complete the study under paragraph
6 (1) and submit to Congress a report containing the
7 results of such study.

8 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
9 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
10 DISPARITIES.—Not later than 6 months after the date of
11 enactment of this Act, and biennially thereafter, the Direc-
12 tor of the National Institutes of Health, in collaboration
13 with the Director of the National Institute on Minority
14 Health and Health Disparities, shall submit to Congress
15 a report that details and evaluates—

16 (1) the steps taken during the applicable report
17 period by the Director of the National Institutes of
18 Health to plan, coordinate, review, and evaluate all
19 minority health and health disparity research that is
20 conducted or supported by the institutes and centers
21 at the National Institutes of Health; and

22 (2) the outcomes of such steps.

23 (c) GAO REPORT RELATED TO RECIPIENTS OF
24 PPACA FUNDING.—Not later than one year after the
25 date of enactment of this Act and biennially thereafter,

1 the Comptroller General of the United States shall submit
2 to Congress a report that identifies—

3 (1) the racial and ethnic diversity of commu-
4 nity-based organizations that applied for Federal en-
5 rollment funding provided pursuant to the Patient
6 Protection and Affordable Care Act (Public Law
7 111–148) (including the amendments made by such
8 Act);

9 (2) the percentage of such organizations that
10 were awarded such funding; and

11 (3) the impact of such community-based organi-
12 zations’ enrollment efforts on the insurance status of
13 their communities.

14 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
15 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
16 PARITIES.—The Director of the National Institute on Mi-
17 nority Health and Health Disparities shall prepare an an-
18 nual report on the activities carried out or to be carried
19 out by such institute, and shall submit each such report
20 to the Committee on Health, Education, Labor, and Pen-
21 sions of the Senate, the Committee on Energy and Com-
22 merce of the House of Representatives, the Secretary of
23 Health and Human Services, and the Director of the Na-
24 tional Institutes of Health. With respect to the fiscal year
25 involved, the report shall—

1 (1) describe and evaluate the progress made in
2 health disparities research conducted or supported
3 by institutes and centers of the National Institutes
4 of Health;

5 (2) summarize and analyze expenditures made
6 for activities with respect to health disparities re-
7 search conducted or supported by the National Insti-
8 tutes of Health;

9 (3) include a separate statement applying the
10 requirements of paragraphs (1) and (2) specifically
11 to minority health disparities research; and

12 (4) contain such recommendations as the Direc-
13 tor of the Institute considers appropriate.

14 **SEC. 9007. INVESTIGATIVE AND ENFORCEMENT ACTIONS.**

15 (a) IN GENERAL.—In carrying out the investigative
16 and enforcement actions of section 3451(b)(2) of the Pub-
17 lic Health Service Act, as added by section 9003 of this
18 Act, the Director for Civil Rights and Health Equity (re-
19 ferred to in this section as the “Director”) shall pursue
20 such investigative and enforcement actions pursuant to
21 this section.

22 (b) ADMINISTRATIVE COMPLAINT AND CONCILIATION
23 PROCESS.—

24 (1) COMPLAINTS AND ANSWERS.—

1 (A) IN GENERAL.—An aggrieved person
2 may, not later than 1 year after an alleged vio-
3 lation of subsection (a) has occurred or con-
4 cluded, file a complaint with the Director alleg-
5 ing inequitable provision of health care by a
6 provider described in subsection (a).

7 (B) COMPLAINT.—A complaint submitted
8 pursuant to subparagraph (A) shall be in writ-
9 ing and shall contain such information and be
10 in such form as the Director requires.

11 (C) OATH OR AFFIRMATION.—The com-
12 plaint and any answer made under this sub-
13 section shall be made under oath or affirmation,
14 and may be reasonably and fairly modified at
15 any time.

16 (2) RESPONSE TO COMPLAINTS.—

17 (A) IN GENERAL.—Upon the filing of a
18 complaint under this subsection, the following
19 procedures shall apply:

20 (i) COMPLAINANT NOTICE.—The Di-
21 rector shall serve notice upon the com-
22 plainant acknowledging receipt of such fil-
23 ing and advising the complainant of the
24 time limits and procedures provided under
25 this section.

1 (ii) RESPONDENT NOTICE.—The Di-
2 rector shall, not later than 30 days after
3 receipt of such filing—

4 (I) serve on the respondent a no-
5 tice of the complaint, together with a
6 copy of the original complaint; and

7 (II) advise the respondent of the
8 procedural rights and obligations of
9 respondents under this section.

10 (iii) ANSWER.—The respondent may
11 file, not later than 60 days after receipt of
12 the notice from the Director, an answer to
13 such complaint.

14 (iv) INVESTIGATIVE DUTIES.—The Di-
15 rector shall—

16 (I) make an investigation of the
17 alleged inequitable provision of health
18 care; and

19 (II) complete such investigation
20 within 180 days (unless it is impracti-
21 cable to complete such investigation
22 within 180 days) after the filing of
23 the complaint.

24 (B) INVESTIGATIONS.—

1 (i) PATTERN OR PRACTICE.—In the
2 course of investigating the complaint, the
3 Director may seek records of care provided
4 to patients other than the complainant if
5 necessary to demonstrate or disprove an
6 allegation of inequitable provision of health
7 care or to determine whether there is a
8 pattern or practice of such care.

9 (ii) ACCOUNTING FOR SOCIAL DETER-
10 MINANTS OF HEALTH.—In investigating
11 the complaint and reaching a determina-
12 tion on the validity of the complaint, the
13 Director shall account for social deter-
14 minants of health and the effect of such
15 social determinants on health care out-
16 comes.

17 (iii) INABILITY TO COMPLETE INVES-
18 TIGATION.—If the Director is unable to
19 complete (or finds it is impracticable to
20 complete) the investigation within 180
21 days after the filing of the complaint (or,
22 if the Secretary takes further action under
23 paragraph (6)(B) with respect to a com-
24 plaint, within 180 days after the com-
25 mencement of such further action), the Di-

1 rector shall notify the complainant and re-
2 spondent in writing of the reasons in-
3 volved.

4 (C) REPORT.—

5 (i) FINAL REPORT.—On completing
6 each investigation under this paragraph,
7 the Director shall prepare a final investiga-
8 tive report.

9 (ii) MODIFICATION OF REPORT.—A
10 final report under this subparagraph may
11 be modified if additional evidence is later
12 discovered.

13 (3) CONCILIATION.—

14 (A) IN GENERAL.—During the period be-
15 ginning on the date on which a complaint is
16 filed under this subsection and ending on the
17 date of final disposition of such complaint (in-
18 cluding during an investigation under para-
19 graph (2)(B)), the Director shall, to the extent
20 feasible, engage in conciliation with respect to
21 such complaint.

22 (B) CONCILIATION AGREEMENT.—A con-
23 ciliation agreement arising out of such concilia-
24 tion shall be an agreement between the re-

1 spondent and the complainant, and shall be
2 subject to approval by the Director.

3 (C) RIGHTS PROTECTED.—The Director
4 shall approve a conciliation agreement only if
5 the agreement protects the rights of the com-
6 plainant and other persons similarly situated.

7 (D) PUBLICLY AVAILABLE AGREEMENT.—

8 (i) IN GENERAL.—Subject to clause

9 (ii), the Secretary shall make available to
10 the public a copy of a conciliation agree-
11 ment entered into pursuant to this sub-
12 section unless the complainant and re-
13 spondent otherwise agree, and the Sec-
14 retary determines, that disclosure is not re-
15 quired to further the purposes of this sub-
16 section.

17 (ii) LIMITATION.—A conciliation
18 agreement that is made available to the
19 public pursuant to clause (i) may not dis-
20 close individually identifiable health infor-
21 mation.

22 (4) FAILURE TO COMPLY WITH CONCILIATION
23 AGREEMENT.—Whenever the Director has reason-
24 able cause to believe that a respondent has breached
25 a conciliation agreement, the Director shall refer the

1 matter to the Attorney General to consider filing a
2 civil action to enforce such agreement.

3 (5) WRITTEN CONSENT FOR DISCLOSURE OF
4 INFORMATION.—Nothing said or done in the course
5 of conciliation under this subsection may be made
6 public, or used as evidence in a subsequent pro-
7 ceeding under this subsection, without the written
8 consent of the parties to the conciliation.

9 (6) PROMPT JUDICIAL ACTION.—

10 (A) IN GENERAL.—If the Director deter-
11 mines at any time following the filing of a com-
12 plaint under this subsection that prompt judi-
13 cial action is necessary to carry out the pur-
14 poses of this subsection, the Director may rec-
15 ommend that the Attorney General promptly
16 commence a civil action under subsection (d).

17 (B) IMMEDIATE SUIT.—If the Director de-
18 termines at any time following the filing of a
19 complaint under this subsection that the public
20 interest would be served by allowing the com-
21 plainant to bring a civil action under subsection
22 (c) in a State or Federal court immediately, the
23 Director shall certify that the administrative
24 process has concluded and that the complainant
25 may file such a suit immediately.

1 (7) ANNUAL REPORT.—Not later than 1 year
2 after the date of enactment of this Act, and annually
3 thereafter, the Director shall make publicly available
4 a report detailing the activities of the Office for Civil
5 Rights and Health Equity under this subsection, in-
6 cluding—

7 (A) the number of complaints filed and the
8 basis on which the complaints were filed;

9 (B) the number of investigations under-
10 taken as a result of such complaints; and

11 (C) the disposition of all such investiga-
12 tions.

13 (c) ENFORCEMENT BY PRIVATE PERSONS.—

14 (1) IN GENERAL.—

15 (A) CIVIL ACTION.—

16 (i) IN SUIT.—A complainant under
17 subsection (b) may commence a civil action
18 to obtain appropriate relief with respect to
19 an alleged violation of subsection (a), or
20 for breach of a conciliation agreement
21 under subsection (b), in an appropriate
22 district court of the United States or State
23 court—

24 (I) not sooner than the earliest
25 of—

1 (aa) the date a conciliation
2 agreement is reached under sub-
3 section (b);

4 (bb) the date of a final dis-
5 position of a complaint under
6 subsection (b); or

7 (cc) 180 days after the first
8 day of the alleged violation; and

9 (II) not later than 2 years after
10 the final day of the alleged violation.

11 (ii) STATUTE OF LIMITATIONS.—The
12 computation of such 2-year period shall
13 not include any time during which an ad-
14 ministrative proceeding (including inves-
15 tigation or conciliation) under subsection
16 (b) was pending with respect to a com-
17 plaint under such subsection.

18 (B) BARRING SUIT.—If the Director has
19 obtained a conciliation agreement under sub-
20 section (b) regarding an alleged violation of
21 subsection (a), no action may be filed under
22 this paragraph by the complainant involved
23 with respect to the alleged violation except for
24 the purpose of enforcing the terms of such an
25 agreement.

1 (2) RELIEF WHICH MAY BE GRANTED.—

2 (A) IN GENERAL.—In a civil action under
3 paragraph (1), if the court finds that a viola-
4 tion of subsection (a) or breach of a conciliation
5 agreement has occurred, the court may award
6 to the plaintiff actual and punitive damages,
7 and may grant as relief, as the court deter-
8 mines to be appropriate, any permanent or tem-
9 porary injunction, temporary restraining order,
10 or other order (including an order enjoining the
11 defendant from engaging in a practice violating
12 subsection (a) or ordering such affirmative ac-
13 tion as may be appropriate).

14 (B) FEES AND COSTS.—In a civil action
15 under paragraph (1), the court, in its discre-
16 tion, may allow the prevailing party, other than
17 the United States, a reasonable attorney's fee
18 and costs. The United States shall be liable for
19 such fees and costs to the same extent as a pri-
20 vate person.

21 (3) INTERVENTION BY ATTORNEY GENERAL.—

22 Upon timely application, the Attorney General may
23 intervene in a civil action under paragraph (1), if
24 the Attorney General certifies that the case is of
25 general public importance.

1 (d) ENFORCEMENT BY THE ATTORNEY GENERAL.—

2 (1) COMMENCEMENT OF ACTIONS.—

3 (A) PATTERN OR PRACTICE CASES.—The
4 Attorney General may commence a civil action
5 in any appropriate district court of the United
6 States if the Attorney General has reasonable
7 cause to believe that any health care provider
8 covered by subsection (a)—

9 (i) is engaged in a pattern or practice
10 that violates such subsection; or

11 (ii) is engaged in a violation of such
12 subsection that raises an issue of signifi-
13 cant public importance.

14 (B) CASES BY REFERRAL.—The Director
15 may determine, based on a pattern of com-
16 plaints, a pattern of violations, a review of data
17 reported by a health care provider covered by
18 subsection (a), or any other means, that there
19 is reasonable cause to believe a health care pro-
20 vider is engaged in a pattern or practice that
21 violates subsection (a). If the Director makes
22 such a determination, the Director shall refer
23 the related findings to the Attorney General. If
24 the Attorney General finds that such reasonable
25 cause exists, the Attorney General may com-

1 mence a civil action in any appropriate district
2 court of the United States.

3 (2) ENFORCEMENT OF SUBPOENAS.—The At-
4 torney General, on behalf of the Director, or another
5 party at whose request a subpoena is issued under
6 this subsection, may enforce such subpoena in ap-
7 propriate proceedings in the district court of the
8 United States for the district in which the person to
9 whom the subpoena was addressed resides, was
10 served, or transacts business.

11 (3) RELIEF WHICH MAY BE GRANTED IN CIVIL
12 ACTIONS.—

13 (A) IN GENERAL.—In a civil action under
14 paragraph (1), the court—

15 (i) may award such preventive relief,
16 including a permanent or temporary in-
17 junction, temporary restraining order, or
18 other order against the person responsible
19 for a violation of subsection (a) as is nec-
20 essary to assure the full enjoyment of the
21 rights granted by this subsection;

22 (ii) may award such other relief as the
23 court determines to be appropriate, includ-
24 ing monetary damages, to aggrieved per-
25 sons; and

1 (iii) may, to vindicate the public inter-
2 est, assess punitive damages against the
3 respondent—

4 (I) in an amount not exceeding
5 \$500,000, for a first violation; and

6 (II) in an amount not exceeding
7 \$1,000,000, for any subsequent viola-
8 tion.

9 (B) FEES AND COSTS.—In a civil action
10 under this subsection, the court, in its discre-
11 tion, may allow the prevailing party, other than
12 the United States, a reasonable attorney's fee
13 and costs. The United States shall be liable for
14 such fees and costs to the extent provided by
15 section 2412 of title 28, United States Code.

16 (4) INTERVENTION IN CIVIL ACTIONS.—Upon
17 timely application, any person may intervene in a
18 civil action commenced by the Attorney General
19 under paragraphs (1) and (2) if the action involves
20 an alleged violation of subsection (a) with respect to
21 which such person is an aggrieved person (including
22 a person who is a complainant under subsection (b))
23 or a conciliation agreement to which such person is
24 a party.

1 **SEC. 9008. FEDERAL HEALTH EQUITY COMMISSION.**

2 (a) ESTABLISHMENT OF COMMISSION.—

3 (1) IN GENERAL.—There is established the
4 Federal Health Equity Commission (hereinafter in
5 this section referred to as the “Commission”).

6 (2) MEMBERSHIP.—

7 (A) IN GENERAL.—The Commission shall
8 be composed of—

9 (i) 8 voting members appointed under
10 subparagraph (B); and

11 (ii) the nonvoting, ex officio members
12 listed in subparagraph (C).

13 (B) VOTING MEMBERS.—Not more than 4
14 of the members described in subparagraph
15 (A)(i) shall at any one time be of the same po-
16 litical party. Such members shall have recog-
17 nized expertise in and personal experience with
18 racial and ethnic health inequities, health care
19 needs of vulnerable and marginalized popu-
20 lations, and health equity as a vehicle for im-
21 proving health status and health outcomes.
22 Such members shall be appointed to the Com-
23 mission as follows:

24 (i) Four members of the Commission
25 shall be appointed by the President.

1 (ii) Two members of the Commission
2 shall be appointed by the President pro
3 tempore of the Senate, upon the rec-
4 ommendations of the majority leader and
5 the minority leader of the Senate. Each
6 member appointed to the Commission
7 under this clause shall be appointed from
8 a different political party.

9 (iii) Two members of the Commission
10 shall be appointed by the Speaker of the
11 House of Representatives upon the rec-
12 ommendations of the majority leader and
13 the minority leader of the House of Rep-
14 resentatives. Each member appointed to
15 the Commission under this clause shall be
16 appointed from a different political party.

17 (C) EX OFFICIO MEMBER.—The Commis-
18 sion shall have the following nonvoting, ex offi-
19 cio members:

20 (i) The Director for Civil Rights and
21 Health Equity of the Department of
22 Health and Human Services.

23 (ii) The Deputy Assistant Secretary
24 for Minority Health of the Department of
25 Health and Human Services.

1 (iii) The Director of the National In-
 2 stitute on Minority Health and Health Dis-
 3 parities.

4 (iv) The Chairperson of the Advisory
 5 Committee on Minority Health established
 6 under section 1707(c) of the Public Health
 7 Service Act (42 U.S.C. 300u-6(c)).

8 (3) TERMS.—The term of office of each mem-
 9 ber appointed under paragraph (2)(B) of the Com-
 10 mission shall be 6 years.

11 (4) CHAIRPERSON; VICE CHAIRPERSON.—

12 (A) CHAIRPERSON.—The President shall,
 13 with the concurrence of a majority of the mem-
 14 bers of the Commission appointed under para-
 15 graph (2)(B), designate a Chairperson from
 16 among the members of the Commission ap-
 17 pointed under such paragraph.

18 (B) VICE CHAIRPERSON.—

19 (i) DESIGNATION.—The Speaker of
 20 the House of Representatives shall, in con-
 21 sultation with the majority leaders and the
 22 minority leaders of the Senate and the
 23 House of Representatives and with the
 24 concurrence of a majority of the members
 25 of the Commission appointed under para-

graph (2)(B), designate a Vice Chairperson from among the members of the Commission appointed under such paragraph. The Vice Chairperson may not be a member of the same political party as the Chairperson.

(ii) DUTY.—The Vice Chairperson shall act in place of the Chairperson in the absence of the Chairperson.

(5) REMOVAL OF MEMBERS.—The President may remove a member of the Commission only for neglect of duty or malfeasance in office.

(6) QUORUM.—A majority of members of the Commission appointed under paragraph (2)(B) shall constitute a quorum of the Commission, but a lesser number of members may hold hearings.

(b) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) monitor and report on the implementation of this Act; and

(B) investigate, monitor, and report on progress towards health equity and the elimination of health disparities.

(2) ANNUAL REPORT.—The Commission shall—

1 (A) submit to the President and Congress
2 at least one report annually on health equity
3 and health disparities; and

4 (B) include in such report—

- 5 (i) a description of actions taken by
6 the Department of Health and Human
7 Services and any other Federal agency re-
8 lated to health equity or health disparities;
9 and
10 (ii) recommendations on ensuring eq-
11 uitable health care and eliminating health
12 disparities.

13 (c) POWERS.—

14 (1) HEARINGS.—

15 (A) IN GENERAL.—The Commission or, at
16 the direction of the Commission, any sub-
17 committee or member of the Commission, may,
18 for the purpose of carrying out this section, as
19 the Commission or the subcommittee or mem-
20 ber considers advisable—

- 21 (i) hold such hearings, meet and act
22 at such times and places, take such testi-
23 mony, receive such evidence, and admin-
24 ister such oaths; and

1 (ii) require, by subpoena or otherwise,
 2 the attendance and testimony of such wit-
 3 nesses and the production of such books,
 4 records, correspondence, memoranda, pa-
 5 pers, documents, tapes, and materials.

6 (B) LIMITATION ON HEARINGS.—The
 7 Commission may hold a hearing under subpara-
 8 graph (A)(i) only if the hearing is approved—

9 (i) by a majority of the members of
 10 the Commission appointed under sub-
 11 section (a)(2)(B); or

12 (ii) by a majority of such members
 13 present at a meeting when a quorum is
 14 present.

15 (2) ISSUANCE AND ENFORCEMENT OF SUB-
 16 POENAS.—

17 (A) ISSUANCE.—A subpoena issued under
 18 paragraph (1) shall—

19 (i) bear the signature of the Chair-
 20 person of the Commission; and

21 (ii) be served by any person or class
 22 of persons designated by the Chairperson
 23 for that purpose.

24 (B) ENFORCEMENT.—In the case of contu-
 25 macy or failure to obey a subpoena issued

1 under paragraph (1), the United States district
2 court for the district in which the subpoenaed
3 person resides, is served, or may be found may
4 issue an order requiring the person to appear at
5 any designated place to testify or to produce
6 documentary or other evidence.

7 (C) NONCOMPLIANCE.—Any failure to
8 obey the order of the court may be punished by
9 the court as a contempt of court.

10 (3) WITNESS ALLOWANCES AND FEES.—

11 (A) IN GENERAL.—Section 1821 of title
12 28, United States Code, shall apply to a witness
13 requested or subpoenaed to appear at a hearing
14 of the Commission.

15 (B) EXPENSES.—The per diem and mile-
16 age allowances for a witness shall be paid from
17 funds available to pay the expenses of the Com-
18 mission.

19 (4) POSTAL SERVICES.—The Commission may
20 use the United States mails in the same manner and
21 under the same conditions as other agencies of the
22 Federal Government.

23 (5) GIFTS.—The Commission may accept, use,
24 and dispose of gifts or donations of services or prop-
25 erty.

1 (d) ADMINISTRATIVE PROVISIONS.—

2 (1) STAFF.—

3 (A) DIRECTOR.—There shall be a full-time
4 staff director for the Commission who shall—

5 (i) serve as the administrative head of
6 the Commission; and

7 (ii) be appointed by the Chairperson
8 with the concurrence of the Vice Chair-
9 person.

10 (B) OTHER PERSONNEL.—The Commis-
11 sion may—

12 (i) appoint such other personnel as it
13 considers advisable, subject to the provi-
14 sions of title 5, United States Code, gov-
15 erning appointments in the competitive
16 service, and the provisions of chapter 51
17 and subchapter III of chapter 53 of that
18 title relating to classification and General
19 Schedule pay rates; and

20 (ii) may procure temporary and inter-
21 mittent services under section 3109(b) of
22 title 5, United States Code, at rates for in-
23 dividuals not in excess of the daily equiva-
24 lent paid for positions at the maximum
25 rate for GS-15 of the General Schedule

1 under section 5332 of title 5, United
2 States Code.

3 (2) COMPENSATION OF MEMBERS.—

4 (A) NON-FEDERAL EMPLOYEES.—Each
5 member of the Commission who is not an offi-
6 cer or employee of the Federal Government
7 shall be compensated at a rate equal to the
8 daily equivalent of the annual rate of basic pay
9 prescribed for level IV of the Executive Sched-
10 ule under section 5315 of title 5, United States
11 Code, for each day (including travel time) dur-
12 ing which the member is engaged in the per-
13 formance of the duties of the Commission.

14 (B) FEDERAL EMPLOYEES.—Each member
15 of the Commission who is an officer or em-
16 ployee of the Federal Government shall serve
17 without compensation in addition to the com-
18 pensation received for the services of the mem-
19 ber as an officer or employee of the Federal
20 Government.

21 (C) TRAVEL EXPENSES.—A member of the
22 Commission shall be allowed travel expenses, in-
23 cluding per diem in lieu of subsistence, at rates
24 authorized for an employee of an agency under
25 subchapter I of chapter 57 of title 5, United

1 States Code, while away from the home or reg-
 2 ular place of business of the member in the per-
 3 formance of the duties of the Commission.

4 (3) COOPERATION.—The Commission may se-
 5 cure directly from any Federal department or agency
 6 such information as the Commission considers nec-
 7 essary to carry out this Act. Upon request of the
 8 Chairman of the Commission, the head of such de-
 9 partment or agency shall furnish such information to
 10 the Commission.

11 (e) PERMANENT COMMISSION.—Section 14 of the
 12 Federal Advisory Committee Act (5 U.S.C. App.) shall not
 13 apply to the Commission.

14 (f) AUTHORIZATION OF APPROPRIATIONS.—There
 15 are authorized to be appropriated for fiscal year 2027 and
 16 each fiscal year thereafter such sums as may be necessary
 17 to carry out the duties of the Commission.

18 **TITLE X—ADDRESSING SOCIAL**
 19 **DETERMINANTS AND IM-**
 20 **PROVING ENVIRONMENTAL**
 21 **JUSTICE**

22 **Subtitle A—In General**

23 **SEC. 10001. DEFINITIONS.**

24 In this title:

1 (1) ADMINISTRATOR.—The term “Adminis-
2 trator” means the Administrator of the Environ-
3 mental Protection Agency.

4 (2) AGENCY.—The term “Agency” means the
5 Environmental Protection Agency.

6 (3) BUILT ENVIRONMENT.—The term “built
7 environment” means the components of the environ-
8 ment, and the location of those components in a geo-
9 graphically defined space, that are created or modi-
10 fied by individuals to form the physical and social
11 characteristics of a community or enhance quality of
12 human life, including—

13 (A) homes, schools, and places of work and
14 worship;

15 (B) parks, recreation areas, and green-
16 ways;

17 (C) transportation systems;

18 (D) business, industry, and agriculture;

19 and

20 (E) land-use plans, projects, and policies
21 that impact the physical or social characteris-
22 tics of a community, including access to services
23 and amenities.

24 (4) DETERMINANTS OF HEALTH.—The term
25 “determinants of health”—

1 (A) means the range of nonclinical factors
 2 inclusive of personal, social, economic, and envi-
 3 ronmental factors that directly influence health
 4 status; and

5 (B) includes social determinants of health.

6 (5) ECONOMIC DETERMINANTS OF HEALTH.—
 7 The term “economic determinants of health” means
 8 income and social status.

9 (6) ENVIRONMENTAL DETERMINANTS OF
 10 HEALTH.—The term “environmental determinants
 11 of health” means the broad physical (including man-
 12 made and natural), psychological, social, spiritual,
 13 cultural, and aesthetic environment.

14 (7) PERSONAL DETERMINANTS OF HEALTH.—
 15 The term “personal determinants of health” means
 16 an individual’s behavior, biology, and genetics.

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

19 (9) SOCIAL DETERMINANTS OF HEALTH.—The
 20 term “social determinants of health”—

21 (A) means a subset of determinants of the
 22 health of individuals and environments (such as
 23 communities, neighborhoods, and societies) that
 24 describe an individual’s or group of people’s so-
 25 cial identity, describe the social and economic

1 resources to which such individual or group has
 2 access, and describe the conditions in which an
 3 individual or group of people works, lives, and
 4 plays; and

5 (B) are sometimes referred to as “social
 6 and economic determinants of health”, “socio-
 7 economic determinants of health”, “environ-
 8 mental determinants of health”, “social drivers
 9 of inequality”, or “personal determinants of
 10 health”.

11 **SEC. 10002. HEALTH IMPACT ASSESSMENTS.**

12 Part P of title III of the Public Health Service Act
 13 (42 U.S.C. 280g et seq.), as amended by section 7901C–
 14 1(a), is further amended by adding at the end the fol-
 15 lowing:

16 **“SEC. 399V–15. HEALTH IMPACT ASSESSMENTS.**

17 “(a) DEFINITIONS.—In this section:

18 “(1) ADMINISTRATOR.—The term ‘Adminis-
 19 trator’ means the Administrator of the Environ-
 20 mental Protection Agency.

21 “(2) DIRECTOR.—The term ‘Director’ means
 22 the Director of the Centers for Disease Control and
 23 Prevention.

24 “(3) HEALTH IMPACT ASSESSMENT.—The term
 25 ‘health impact assessment’ means a systematic proc-

1 ess that uses an array of data sources and analytic
 2 methods and considers input from stakeholders to
 3 determine the potential effects of a proposed policy,
 4 plan, program, or project on the health of a popu-
 5 lation and the distribution of those effects within the
 6 population. Such term includes identifying and rec-
 7 ommending appropriate actions on monitoring and
 8 maximizing potential benefits and minimizing poten-
 9 tial harms.

10 “(4) HEALTH INEQUITY.—The term ‘health in-
 11 equity’ means a particular type of health difference
 12 that is closely linked with social, economic, or envi-
 13 ronmental disadvantage and that adversely affects
 14 groups of people who have systematically experi-
 15 enced greater obstacles to health based on their—

16 “(A) racial or ethnic group;

17 “(B) religion;

18 “(C) socioeconomic status;

19 “(D) gender;

20 “(E) age;

21 “(F) mental health;

22 “(G) cognitive, sensory, or physical dis-
 23 ability;

24 “(H) sexual orientation or gender identity;

25 “(I) geographic location;

1 “(J) citizenship status; or

2 “(K) other characteristics historically
3 linked to discrimination or exclusion.

4 “(b) ESTABLISHMENT.—The Secretary, acting
5 through the Director and in collaboration with the Admin-
6 istrator, shall—

7 “(1) in consultation with the Director of the
8 National Center for Chronic Disease Prevention and
9 Health Promotion and the heads of relevant offices
10 within the Department of Housing and Urban De-
11 velopment, the Department of Transportation, and
12 the Department of Agriculture, establish a program
13 at the National Center for Environmental Health of
14 the Centers for Disease Control and Prevention fo-
15 cused on advancing the field of health impact assess-
16 ment that includes—

17 “(A) collecting and disseminating best
18 practices;

19 “(B) administering capacity building
20 grants to States, Indian Tribes, and Tribal or-
21 ganizations to support subgrantees in initiating
22 health impact assessments, in accordance with
23 subsection (d);

24 “(C) providing technical assistance;

1 “(D) developing training tools and pro-
2 viding training on conducting a health impact
3 assessment and the implementation of built en-
4 vironment and health indicators;

5 “(E) making information available, as ap-
6 propriate, regarding the existence of other com-
7 munity healthy living tools, checklists, and indi-
8 ces that help connect public health to other sec-
9 tors, and tools to help examine the effect of the
10 indoor built environment and building codes on
11 population health;

12 “(F) conducting research and evaluations
13 of health impact assessments; and

14 “(G) awarding competitive extramural re-
15 search grants;

16 “(2) develop guidance and guidelines to conduct
17 health impact assessments in accordance with sub-
18 section (c); and

19 “(3) establish a grant program to allow States,
20 Indian Tribes, and Tribal organizations to award
21 subgrants to eligible entities to conduct health im-
22 pact assessments.

23 “(c) GUIDANCE.—

24 “(1) IN GENERAL.—Not later than 1 year after
25 the date of enactment of the Health Equity and Ac-

1 countability Act of 2026, the Secretary, acting
2 through the Director, shall issue final guidance for
3 conducting health impact assessments. In developing
4 such guidance, the Secretary shall—

5 “(A) consult with the Director of the Na-
6 tional Center for Environmental Health, the Di-
7 rector of the National Center for Chronic Dis-
8 ease Prevention and Health Promotion, and the
9 heads of relevant offices within the Department
10 of Housing and Urban Development, the De-
11 partment of Transportation, and the Depart-
12 ment of Agriculture; and

13 “(B) consider available international health
14 impact assessment guidance, North American
15 health impact assessment practice standards,
16 and recommendations from the National Acad-
17 emy of Sciences.

18 “(2) CONTENT.—The guidance under this sub-
19 section shall include—

20 “(A) background on national and inter-
21 national efforts to bridge urban planning, cli-
22 mate forecasting, and public health institutions
23 and disciplines, including a review of health im-
24 pact assessment best practices internationally;

1 “(B) evidence-based direct and indirect
2 pathways that link land-use planning, transpor-
3 tation, and housing policy and objectives to
4 human health outcomes;

5 “(C) data resources and quantitative and
6 qualitative forecasting methods to evaluate both
7 the status of health determinants and health ef-
8 fects, including identification of existing pro-
9 grams that can disseminate these resources;

10 “(D) best practices for inclusive public in-
11 volvement in conducting health impact assess-
12 ments; and

13 “(E) technical assistance for other agen-
14 cies seeking to develop their own guidelines and
15 procedures for health impact assessment.

16 “(d) GRANT PROGRAM.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Director and in collaboration with the
19 Administrator, shall—

20 “(A) award grants to States, Indian
21 Tribes, and Tribal organizations to award sub-
22 grants to eligible entities for capacity building
23 or to prepare health impact assessments; and

24 “(B) ensure that States, Indian Tribes,
25 and Tribal organizations receiving a grant

1 under this subsection further support training
2 and technical assistance for subgrantees under
3 subparagraph (A) by funding and overseeing
4 appropriate experts on health impact assess-
5 ments from local, State, and Tribal govern-
6 ments, the Federal Government, institutions of
7 higher education, and nonprofit organizations
8 to provide such training and technical assist-
9 ance.

10 “(2) APPLICATIONS FOR SUBGRANTS.—

11 “(A) IN GENERAL.—To be eligible to re-
12 ceive a subgrant under this subsection, an eligi-
13 ble entity shall—

14 “(i) be a community-based organiza-
15 tion serving individuals or populations, the
16 health of which are, or will be, affected by
17 an activity or a proposed activity; and

18 “(ii) submit to the grantee an applica-
19 tion in accordance with this subsection, at
20 such time, in such manner, and containing
21 such additional information as the Sec-
22 retary (acting through the Director and in
23 collaboration with the Administrator) and
24 the grantee may require.

1 “(B) INCLUSION.—An application for a
2 subgrant under this subsection shall include—

3 “(i) a list of proposed activities that
4 require or would benefit from conducting a
5 health impact assessment by not later than
6 180 days after receiving the subgrant;

7 “(ii) supporting documentation, in-
8 cluding letters of support, from potential
9 conductors of health impact assessments
10 for the listed proposed activities;

11 “(iii) an assessment by the applicant
12 of the health of the population to be served
13 through the subgrant; and

14 “(iv) a description of potential adverse
15 or positive effects on health that the pro-
16 posed activities may create.

17 “(C) PREFERENCE.—In awarding sub-
18 grants under this subsection, a State may give
19 preference to eligible entities that demonstrate
20 the potential to significantly improve population
21 health or lower health care costs as a result of
22 potential health impact assessment work.

23 “(3) USE OF FUNDS.—

24 “(A) IN GENERAL.—A State, Indian Tribe,
25 or Tribal organization receiving a grant under

1 this subsection shall use such grant to conduct
2 health impact assessment capacity building in
3 support of a subgrantee conducting a health im-
4 pact assessment for a proposed activity in ac-
5 cordance with this subsection.

6 “(B) PURPOSES.—The purposes of a
7 health impact assessment under this subsection
8 are—

9 “(i) to facilitate the involvement of
10 Tribal, State, and local public health offi-
11 cials in community planning, transpor-
12 tation, housing, and land use decisions and
13 other decisions affecting the built environ-
14 ment to identify any potential health con-
15 cern or health benefit relating to an activ-
16 ity or proposed activity;

17 “(ii) to provide for an investigation of
18 any health-related issue of concern raised
19 in a planning process, an environmental
20 impact assessment process, or policy ap-
21 praisal relating to a proposed activity;

22 “(iii) to describe and compare alter-
23 natives (including no-action alternatives) to
24 a proposed activity to provide clarification
25 with respect to the potential health out-

comes associated with the proposed activity and, where appropriate, to the related benefit-cost or cost-effectiveness of the proposed activity and alternatives;

“(iv) to contribute, when applicable, to the findings of a planning process, policy appraisal, or an environmental impact statement with respect to the terms and conditions of implementing a proposed activity or related mitigation recommendations, as necessary;

“(v) to ensure that the disproportionate distribution of negative impacts among vulnerable populations is minimized as much as possible;

“(vi) to engage affected community members and ensure adequate opportunity for public comment on all stages of the health impact assessment;

“(vii) where appropriate, to consult with local and county health departments and appropriate organizations, including planning, transportation, and housing organizations, and provide them information and tools regarding how to conduct and in-

1 tegrate health impact assessment into their
2 work; and

3 “(viii) to inspect homes, water sys-
4 tems, and other elements that pose risks to
5 lead exposure, with an emphasis on areas
6 that pose a higher risk to children.

7 “(4) ASSESSMENTS.—Health impact assess-
8 ments carried out using funds under this section
9 shall—

10 “(A) take appropriate health factors into
11 consideration as early as practicable during the
12 planning, review, or decision-making processes;

13 “(B) assess the effect on the health of in-
14 dividuals and populations of proposed policies,
15 projects, or plans that result in modifications to
16 the built environment; and

17 “(C) assess the distribution of health ef-
18 fects across various factors, such as race, in-
19 come, ethnicity, age, disability status, gender,
20 and geography.

21 “(5) ELIGIBLE ACTIVITIES.—

22 “(A) IN GENERAL.—A State, Indian Tribe,
23 or Tribal organization receiving a grant under
24 this section shall conduct an evaluation of any
25 activity proposed to be funded through the

1 grant, including through a subgrant, to deter-
 2 mine whether such activity will have a signifi-
 3 cant adverse or positive effect on the health of
 4 the affected population to be served, based on
 5 the criteria described in subparagraph (B).

6 “(B) CRITERIA.—The criteria described in
 7 this subparagraph include, as applicable to the
 8 proposed activity, the following:

9 “(i) Any substantial adverse effect or
 10 significant health benefit on health out-
 11 comes or factors known to influence health,
 12 including the following:

13 “(I) Physical activity.

14 “(II) Injury.

15 “(III) Mental health.

16 “(IV) Accessibility to health-pro-
 17 moting goods and services.

18 “(V) Respiratory health.

19 “(VI) Chronic disease.

20 “(VII) Nutrition.

21 “(VIII) Land use changes that
 22 promote local, sustainable food
 23 sources.

24 “(IX) Infectious disease.

25 “(X) Health inequities.

1 “(XI) Existing air quality,
2 ground or surface water quality or
3 quantity, or noise levels.

4 “(XII) Lead exposure.

5 “(XIII) Drinking water quality
6 and accessibility.

7 “(ii) Other factors that may be con-
8 sidered, including—

9 “(I) the potential for a proposed
10 activity to result in systems failure
11 that leads to a public health emer-
12 gency;

13 “(II) the probability that the pro-
14 posed activity will result in a signifi-
15 cant increase in tourism, economic de-
16 velopment, or employment in the pop-
17 ulation to be served;

18 “(III) any other significant po-
19 tential hazard or enhancement to
20 human health, as determined by the
21 grantee; or

22 “(IV) whether the evaluation of a
23 proposed activity would duplicate an-
24 other analysis or study being under-

1 taken in conjunction with the pro-
2 posed activity.

3 “(C) FACTORS FOR CONSIDERATION.—In
4 evaluating a proposed activity under subpara-
5 graph (A), a grantee may take into consider-
6 ation any reasonable, direct, indirect, or cumu-
7 lative effect that can be clearly related to poten-
8 tial health effects and that is related to the pro-
9 posed activity, including the effect of any action
10 that is—

11 “(i) included in the long-range plan
12 relating to the proposed activity;

13 “(ii) likely to be carried out in coordi-
14 nation with the proposed activity;

15 “(iii) dependent on the occurrence of
16 the proposed activity; or

17 “(iv) likely to have a disproportionate
18 impact on high-risk or vulnerable popu-
19 lations.

20 “(6) REQUIREMENTS.—A health impact assess-
21 ment prepared with funds awarded under this sub-
22 section shall incorporate the following, after con-
23 ducting the screening phase (identifying projects or
24 policies for which a health impact assessment would

1 be valuable and feasible) through the application
2 process:

3 “(A) SCOPING.—Identifying which health
4 effects to consider and the research methods to
5 be utilized.

6 “(B) ASSESSING RISKS AND BENEFITS.—
7 Assessing the baseline health status and factors
8 known to influence the health status in the af-
9 fected community, which may include aggre-
10 gating and synthesizing existing health assess-
11 ment evidence and data from the community.

12 “(C) DEVELOPING RECOMMENDATIONS.—
13 Suggesting changes to proposals to promote
14 positive or mitigate adverse health effects.

15 “(D) REPORTING.—Synthesizing the as-
16 sessment and recommendations and commu-
17 nicating the results to decision makers.

18 “(E) MONITORING AND EVALUATING.—
19 Tracking the decision and implementation effect
20 on health determinants and health status.

21 “(7) PLAN.—A subgrantee under this sub-
22 section shall develop and implement a plan, to be ap-
23 proved by the Secretary (acting through the Director
24 and in collaboration with the Administrator) and the
25 grantee, for meaningful and inclusive stakeholder in-

1 involvement in all phases of the health impact assess-
2 ment. Stakeholders may include community leaders,
3 community-based organizations, youth-serving orga-
4 nizations, planners, public health experts, State and
5 local public health departments and officials, health
6 care experts or officials, housing experts or officials,
7 and transportation experts or officials.

8 “(8) SUBMISSION OF FINDINGS.—A grantee
9 under this subsection shall submit the findings of
10 any funded health impact assessment activities to
11 the Secretary and make these findings publicly avail-
12 able.

13 “(9) ASSESSMENT OF IMPACTS.—A subgrantee
14 under this subsection shall ensure the assessment of
15 the distribution of health impacts (related to the
16 proposed activity) across race, ethnicity, income,
17 age, gender, disability status, and geography.

18 “(10) CONDUCT OF ASSESSMENT.—To the
19 greatest extent feasible, a health impact assessment
20 shall be conducted under this section in a manner
21 that respects the needs and timing of the decision-
22 making process such assessment evaluates.

23 “(11) METHODOLOGY.—In preparing a health
24 impact assessment funded under this subsection, a

1 subgrantee under this subsection shall follow the
2 guidance published under subsection (c).

3 “(e) HEALTH IMPACT ASSESSMENT DATABASE.—

4 The Secretary, acting through the Director and in collabo-
5 ration with the Administrator, shall establish, maintain,
6 and make publicly available a health impact assessment
7 database, including—

8 “(1) a catalog of health impact assessments re-
9 ceived under this section;

10 “(2) an inventory of tools used by subgrantees
11 to conduct health impact assessments; and

12 “(3) guidance for subgrantees with respect to
13 the selection of appropriate tools described in para-
14 graph (2).

15 “(f) EVALUATION OF GRANTEE ACTIVITIES.—The
16 Secretary shall award competitive grants to Prevention
17 Research Centers, or nonprofit organizations or academic
18 institutions with expertise in health impact assessments,
19 to—

20 “(1) assist grantees and subgrantees with the
21 provision of training and technical assistance in the
22 conducting of health impact assessments;

23 “(2) evaluate the activities carried out with
24 grants and subgrants under subsection (d); and

1 “(3) assist the Secretary in disseminating evi-
2 dence, best practices, and lessons learned from
3 grantees and subgrantees.

4 “(g) REPORT TO CONGRESS.—Not later than 1 year
5 after the date of enactment of the Health Equity and Ac-
6 countability Act of 2026, the Secretary shall submit to
7 Congress a report concerning the evaluation of the pro-
8 grams under this section, including recommendations as
9 to how lessons learned from such programs can be incor-
10 porated into future guidance documents developed and
11 provided by the Secretary and other Federal agencies, as
12 appropriate.

13 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to carry out this section
15 such sums as may be necessary.

16 **“SEC. 399V-16. IMPLEMENTATION OF RESEARCH FINDINGS**
17 **TO IMPROVE HEALTH OUTCOMES THROUGH**
18 **THE BUILT ENVIRONMENT.**

19 “(a) RESEARCH GRANT PROGRAM.—The Secretary,
20 in collaboration with the Administrator of the Environ-
21 mental Protection Agency (referred to in this section as
22 the ‘Administrator’), shall award grants to public agencies
23 or private nonprofit institutions to implement evidence-
24 based programming to improve human health through im-

1 improvements to the built environment and subsequently
2 human health, by addressing—

3 “(1) levels of physical activity;

4 “(2) consumption of nutritional foods;

5 “(3) rates of crime;

6 “(4) air, water, and soil quality;

7 “(5) risk or rate of injury;

8 “(6) accessibility to health-promoting goods and
9 services;

10 “(7) chronic disease rates;

11 “(8) community design;

12 “(9) housing;

13 “(10) transportation options; and

14 “(11) other factors as the Secretary determines
15 appropriate.

16 “(b) APPLICATIONS.—A public agency or private
17 nonprofit institution desiring a grant under this section
18 shall submit to the Secretary an application at such time,
19 in such manner, and containing such agreements, assur-
20 ances, and information as the Secretary, in consultation
21 with the Administrator, may require.

22 “(c) RESEARCH.—The Secretary, in consultation
23 with the Administrator, shall support, through grants
24 awarded under this section, research that—

1 “(1) uses evidence-based research to improve
2 the built environment and human health;

3 “(2) examines—

4 “(A) the scope and intensity of the impacts
5 that the built environment (including the var-
6 ious characteristics of the built environment)
7 has on human health; or

8 “(B) the distribution of such impacts by—

9 “(i) location; and

10 “(ii) population subgroup;

11 “(3) is used to develop—

12 “(A) measures and indicators to address
13 health impacts and the connection of health to
14 the built environment;

15 “(B) efforts to link the measures to trans-
16 portation, land use, and health databases; and

17 “(C) efforts to enhance the collection of
18 built environment surveillance data;

19 “(4) distinguishes carefully between personal
20 attitudes and choices and external influences on be-
21 havior to determine how much the association be-
22 tween the built environment and the health of resi-
23 dents, versus the lifestyle preferences of the people
24 that choose to live in the neighborhood, reflects the
25 physical characteristics of the neighborhood; and

1 “(5)(A) identifies or develops effective interven-
2 tion strategies focusing on enhancements to the built
3 environment that promote increased use, physical ac-
4 tivity, access to nutritious foods, or other health-pro-
5 moting activities by residents; and

6 “(B) in developing the intervention strategies
7 under subparagraph (A), ensures that the interven-
8 tion strategies will reach out to high-risk or vulner-
9 able populations, including low-income urban and
10 rural communities and aging populations, in addi-
11 tion to the general population.

12 “(d) SURVEYS.—The Secretary may allow recipients
13 of grants under this section to use such grant funds to
14 support the expansion of national surveys and data track-
15 ing systems to provide more detailed information about
16 the connection between the built environment and health.

17 “(e) PRIORITY.—In awarding grants under this sec-
18 tion, the Secretary and the Administrator shall give pri-
19 ority to entities with programming that incorporates—

20 “(1) interdisciplinary approaches; or

21 “(2) the expertise of the public health, physical
22 activity, urban planning, land use, and transpor-
23 tation research communities in the United States
24 and abroad.

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated such sums as may be
 3 necessary to carry out this section. The Secretary may al-
 4 locate not more than 20 percent of the amount so appro-
 5 priated for a fiscal year for purposes of conducting re-
 6 search under subsection (c).”.

7 **SEC. 10003. GRANT PROGRAM TO CONDUCT ENVIRON-**
 8 **MENTAL HEALTH IMPROVEMENT ACTIVITIES**
 9 **AND TO IMPROVE SOCIAL DETERMINANTS OF**
 10 **HEALTH.**

11 (a) DEFINITIONS.—In this section:

12 (1) DIRECTOR.—The term “Director” means
 13 the Director of the Centers for Disease Control and
 14 Prevention, acting in collaboration with the Adminis-
 15 trator and the Director of the National Institute of
 16 Environmental Health Sciences.

17 (2) ELIGIBLE ENTITY.—The term “eligible enti-
 18 ty” means a State, Indian Tribe, Tribal organiza-
 19 tion, or local community that—

20 (A) bears a disproportionate burden of ex-
 21 posure to environmental health hazards;

22 (B) bears a disproportionate burden of ex-
 23 posure to unhealthy living conditions, low
 24 standard housing conditions, low socioeconomic
 25 status, poor nutrition, less opportunity for edu-

1 cational attainment, disproportionately high un-
2 employment rates, or lower literacy levels and
3 access to information;

4 (C) has established a coalition—

5 (i) with not less than 1 community-
6 based organization or demonstration pro-
7 gram; and

8 (ii) with not less than 1—

9 (I) public health entity;

10 (II) health care provider organi-
11 zation;

12 (III) academic institution, includ-
13 ing any minority-serving institution
14 described in section 371(a) of the
15 Higher Education Act of 1965 (20
16 U.S.C. 1067q(a));

17 (IV) child-serving institution; or

18 (V) landlord or housing provider
19 working on lead remediation;

20 (D) ensures planned activities and funding
21 streams are coordinated to improve community
22 health; and

23 (E) submits an application in accordance
24 with subsection (c).

1 (b) ESTABLISHMENT.—The Director shall establish a
2 grant program under which eligible entities shall receive
3 grants to conduct environmental health improvement ac-
4 tivities and to improve social determinants of health.

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

9 (d) USE OF GRANT FUNDS.—An eligible entity may
10 use a grant under this section—

11 (1) to promote environmental health;

12 (2) to address environmental health inequities
13 among all populations, including children; and

14 (3) to address racial and ethnic inequities in so-
15 cial determinants of health.

16 (e) AMOUNT OF GRANTS.—The Director shall award
17 grants to eligible entities at the following 3 funding levels:

18 (1) LEVEL 1 GRANTS.—

19 (A) IN GENERAL.—An eligible entity
20 awarded a grant under this paragraph shall use
21 the funds to identify environmental health prob-
22 lems and solutions by—

23 (i) establishing a planning and
24 prioritizing council in accordance with sub-
25 paragraph (B); and

1 (ii) conducting an environmental
2 health assessment in accordance with sub-
3 paragraph (C).

4 (B) PLANNING AND PRIORITIZING COUN-
5 CIL.—

6 (i) IN GENERAL.—A planning and
7 prioritizing council established under sub-
8 paragraph (A)(i) (referred to in this para-
9 graph as a “PPC”) shall assist the envi-
10 ronmental health assessment process and
11 environmental health promotion activities
12 of the eligible entity.

13 (ii) MEMBERSHIP.—Membership of a
14 PPC shall consist of representatives from
15 various organizations within public health,
16 planning, development, and environmental
17 services and shall include stakeholders
18 from vulnerable groups such as children,
19 the elderly, disabled, and minority ethnic
20 groups that are often not actively involved
21 in democratic or decision-making proc-
22 esses.

23 (iii) DUTIES.—A PPC shall—

1 (I) identify key stakeholders and
 2 engage and coordinate potential part-
 3 ners in the planning process;

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

7 (III) conduct an in-depth review
 8 of the nature and extent of the need
 9 for an environmental health assess-
 10 ment, including a local epidemiological
 11 profile, an evaluation of the service
 12 provider capacity of the community,
 13 and a profile of any target popu-
 14 lations; and

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

19 (C) ENVIRONMENTAL HEALTH ASSESS-
 20 MENT.—

21 (i) IN GENERAL.—A PPC shall carry
 22 out an environmental health assessment to
 23 identify environmental health concerns.

24 (ii) ASSESSMENT PROCESS.—The
 25 PPC shall—

- 1 (I) define the goals of the assess-
2 ment;
- 3 (II) generate the environmental
4 health issue list;
- 5 (III) analyze issues with a sys-
6 tems framework;
- 7 (IV) develop appropriate commu-
8 nity environmental health indicators;
- 9 (V) rank the environmental
10 health issues;
- 11 (VI) set priorities for action;
- 12 (VII) develop an action plan;
- 13 (VIII) implement the plan; and
- 14 (IX) evaluate progress and plan-
15 ning for the future.

16 (D) EVALUATION.—Each eligible entity
17 that receives a grant under this paragraph shall
18 evaluate, report, and disseminate program find-
19 ings and outcomes.

20 (E) TECHNICAL ASSISTANCE.—The Direc-
21 tor may provide such technical and other non-
22 financial assistance to eligible entities as the
23 Director determines to be necessary.

24 (2) LEVEL 2 GRANTS.—

25 (A) ELIGIBILITY.—

1 (i) IN GENERAL.—The Director shall
2 award grants under this paragraph to eli-
3 gible entities that have already—

4 (I) established broad-based col-
5 laborative partnerships; and

6 (II) completed environmental as-
7 sessments.

8 (ii) NO LEVEL 1 REQUIREMENT.—To
9 be eligible to receive a grant under this
10 paragraph, an eligible entity is not re-
11 quired to have successfully completed a
12 Level 1 grant (as described in paragraph
13 (1)).

14 (B) USE OF GRANT FUNDS.—An eligible
15 entity awarded a grant under this paragraph
16 shall use the funds to further activities to carry
17 out environmental health improvement activi-
18 ties, including—

19 (i) addressing community environ-
20 mental health priorities in accordance with
21 paragraph (1)(C)(ii), including—

22 (I) geography;

23 (II) the built environment;

24 (III) air quality;

25 (IV) water quality;

- 1 (V) land use;
- 2 (VI) solid waste;
- 3 (VII) housing;
- 4 (VIII) violence;
- 5 (IX) socioeconomic status;
- 6 (X) ethnicity, social construct,
- 7 and language preference;
- 8 (XI) educational attainment;
- 9 (XII) employment;
- 10 (XIII) food safety, accessibility,
- 11 and affordability;
- 12 (XIV) nutrition;
- 13 (XV) health care services; and
- 14 (XVI) injuries;
- 15 (ii) building partnerships between
- 16 planning, public health, and other sectors,
- 17 including child-serving institutions, to ad-
- 18 dress how the built environment impacts
- 19 food availability and access and physical
- 20 activity to promote healthy behaviors and
- 21 lifestyles and reduce overweight and obe-
- 22 sity, musculoskeletal diseases, respiratory
- 23 conditions, infectious diseases, dental, oral,
- 24 and mental health conditions, poverty, and
- 25 related co-morbidities;

1 (iii) establishing programs to ad-
2 dress—

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

7 (II) how the conditions described
8 in subclause (I) influence the concerns
9 and needs of people who have im-
10 paired mobility and use assistance de-
11 vices, including wheelchairs, lower
12 limb prostheses, and hip, knee, and
13 other joint replacements; and

14 (iv) convening intervention and dem-
15 onstration programs that examine the role
16 of the social environment in connection
17 with the physical and chemical environ-
18 ment in—

19 (I) determining access to nutri-
20 tional food;

21 (II) improving physical activity to
22 reduce overweight, obesity, and co-
23 morbidities and increase quality of
24 life; and

1 (III) location and access to med-
2 ical facilities.

3 (3) LEVEL 3 GRANTS.—

4 (A) IN GENERAL.—An eligible entity
5 awarded a grant under this paragraph shall use
6 the funds to identify and address racial and
7 ethnic inequities in social determinants of
8 health by creating demonstration programs that
9 assess the feasibility of establishing a federally
10 funded comprehensive program and describe
11 key outcomes that address racial and ethnic in-
12 equities in social determinants of health.

13 (B) PROGRAM DESIGN.—

14 (i) EVALUATION.—Not later than 1
15 year after the date of enactment of this
16 Act, the Director shall evaluate the best
17 practices of existing programs from the
18 private, public, community-based, and aca-
19 demically supported initiatives focused on
20 reducing inequities in the social deter-
21 minants of health for racial and ethnic
22 populations.

23 (ii) DEMONSTRATION PROJECTS.—
24 Not later than 2 years after the date of en-
25 actment of this Act, the Director shall im-

plement at least 12 demonstration projects, including at least one project for each major racial and ethnic minority group, each of which is unique to the cultural and linguistic needs of each of the following groups:

(I) Native Americans and Alaska Natives.

(II) Asian Americans.

(III) African Americans/Blacks.

(IV) Hispanic/Latino-Americans.

(V) Native Hawaiians and Pacific Islanders.

(VI) Middle Eastern and Northern African communities.

(iii) REPORT TO CONGRESS.—No later than 2 years after the implementation of the initial demonstration projects under this paragraph, the Director shall submit to Congress a report that includes—

(I) a description of each demonstration project and design;

(II) an evaluation of the cost-effectiveness of each project's prevention and treatment efforts;

1 (III) an evaluation of the cultural
2 and linguistic appropriateness of each
3 project by racial and ethnic group;
4 and

5 (IV) an evaluation of the bene-
6 ficiary's health status improvement
7 under the demonstration project.

8 (iv) ANY OTHER INFORMATION DE-
9 TERMINED APPROPRIATE BY THE DIREC-
10 TOR.—The Director shall require eligible
11 entities awarded a grant under this para-
12 graph to report any other information the
13 Director determines appropriate to be
14 shared by or developed by such entity, in-
15 cluding the following:

16 (I) Developing models and evalu-
17 ating methods that improve the cul-
18 tural and linguistically appropriate
19 services provided through the Centers
20 for Disease Control and Prevention to
21 target individuals impacted by health
22 inequities based on their race, eth-
23 nicity, gender, or sexual orientation.

24 (II) Promoting the collaboration
25 between primary and specialty care

1 health care providers and patients, to
2 ensure patients impacted by health in-
3 equities based on race, ethnicity, gen-
4 der, or sexual orientation are receiving
5 comprehensive and organized treat-
6 ment and care.

7 (III) Educating health care pro-
8 fessionals on the causes and effects of
9 inequities in the social determinants
10 of health in relation to minority and
11 racial and ethnic communities and the
12 need for culturally and linguistically
13 appropriate care in the prevention and
14 treatment of high-impact diseases.

15 (IV) Encouraging collaboration
16 among community- and patient-based
17 organizations that work to address in-
18 equities in the social determinants of
19 health in relation to high-impact dis-
20 eases in minority and racial and eth-
21 nic populations.

22 (f) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this sec-
24 tion—

25 (1) \$25,000,000 for fiscal year 2027; and

1 (2) such sums as may be necessary for fiscal
2 years 2028 through 2030.

3 **SEC. 10004. ADDITIONAL RESEARCH ON THE RELATION-**
4 **SHIP BETWEEN THE BUILT ENVIRONMENT**
5 **AND THE HEALTH OF COMMUNITY RESI-**
6 **DENTS.**

7 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
8 section, the term “eligible institution” means a public or
9 private nonprofit institution that submits to the Secretary
10 and the Administrator an application for a grant under
11 the grant program authorized under subsection (b)(2) at
12 such time, in such manner, and containing such agree-
13 ments, assurances, and information as the Secretary and
14 Administrator may require.

15 (b) RESEARCH GRANT PROGRAM.—

16 (1) DEFINITION OF HEALTH.—In this section,
17 the term “health” includes—

18 (A) levels of physical activity;

19 (B) degree of mobility due to factors such
20 as musculoskeletal diseases, arthritis, and obe-
21 sity;

22 (C) consumption of nutritional foods;

23 (D) rates of crime;

24 (E) air, water, and soil quality;

25 (F) risk of injury;

- 1 (G) accessibility to health care services;
- 2 (H) levels of educational attainment; and
- 3 (I) other indicators as determined appro-
- 4 priate by the Secretary.

5 (2) GRANTS.—The Secretary, in collaboration
6 with the Administrator, shall provide grants to eligi-
7 ble institutions to conduct and coordinate research
8 on the built environment and its influence on indi-
9 vidual and population-based health.

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

12 (A) investigates and defines the causal
13 links between all aspects of the built environ-
14 ment and the health of residents;

15 (B) examines—

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

20 (ii) the variation in the health of resi-
21 dents by—

22 (I) location (such as inner cities,
23 inner suburbs, outer suburbs, reserva-
24 tions, and rural areas); and

1 (II) population subgroup (includ-
2 ing children, young adults, the elderly,
3 the disadvantaged); or

4 (iii) the importance of the built envi-
5 ronment to the total health of residents,
6 which is the primary variable of interest
7 from a public health perspective;

8 (C) is used to develop—

9 (i) measures to address health and the
10 connection of health to the built environ-
11 ment; and

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

14 (D) distinguishes carefully between per-
15 sonal attitudes and choices and external influ-
16 ences on observed behavior to determine how
17 much an observed association between the built
18 environment and the health of residents, versus
19 the lifestyle preferences of the people that
20 choose to live in the neighborhood, reflects the
21 physical characteristics of the neighborhood;
22 and

23 (E)(i) identifies or develops effective inter-
24 vention strategies to promote better health
25 among residents with a focus on behavioral

1 interventions and enhancements of the built en-
 2 vironment that promote increased use by resi-
 3 dents; and

4 (ii) in developing the intervention strate-
 5 gies under clause (i), ensures that the interven-
 6 tion strategies will reach out to high-risk popu-
 7 lations, including racial and ethnic minorities,
 8 low-income urban and rural communities, and
 9 children.

10 (4) PRIORITY.—In providing assistance under
 11 the grant program authorized under paragraph (2),
 12 the Secretary and the Administrator shall give pri-
 13 ority to research that incorporates—

14 (A) minority-serving institutions as grant-
 15 ees;

16 (B) interdisciplinary approaches; or

17 (C) the expertise of the public health,
 18 physical activity, nutrition and health care (in-
 19 cluding child health), urban planning, and
 20 transportation research communities in the
 21 United States and abroad.

22 **SEC. 10005. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**
 23 **TION.**

24 (a) STATEMENT OF POLICY.—It is the policy of the
 25 Federal Government to work in conjunction with States,

1 territories, Tribal governments, international organiza-
 2 tions, and foreign governments as a steward of the envi-
 3 ronment for the benefit of public health, to maintain air
 4 quality and water quality, to sustain the diversity of plant
 5 and animal species, to combat global climate change, and
 6 to protect the environment for future generations.

7 (b) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
 8 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
 9 TIONS, LAWS, OR OTHER AGENCY DECISIONS.—

10 (1) STUDY.—Not later than 30 days after the
 11 date of enactment of this Act, the President shall
 12 seek to enter into an arrangement under which the
 13 National Academy of Sciences shall conduct a study
 14 to determine the effects on public health, air quality,
 15 water quality, wildlife, and the environment of the
 16 following regulations, laws, and other agency deci-
 17 sions:

18 (A) CLEAN WATER.—

19 (i) The final rule of the Environ-
 20 mental Protection Agency and the Corps of
 21 Engineers entitled “Final Revisions to the
 22 Clean Water Act Regulatory Definitions of
 23 ‘Fill Material’ and ‘Discharge of Fill Mate-
 24 rial’” and published in the Federal Reg-

1 ister on May 9, 2002 (67 Fed. Reg.
2 31129).

3 (ii) The final rule of the Environ-
4 mental Protection Agency entitled “Na-
5 tional Pollutant Discharge Elimination
6 System Permit Regulation for Con-
7 centrated Animal Feeding Operations: Re-
8 moval of Vacated Elements in Response to
9 2011 Court Decision” and published in the
10 Federal Register on July 30, 2012 (77
11 Fed. Reg. 44494).

12 (iii) The final rule of the Environ-
13 mental Protection Agency entitled “With-
14 drawal of Revisions to the Water Quality
15 Planning and Management Regulation and
16 Revisions to the National Pollutant Dis-
17 charge Elimination System Program in
18 Support of Revisions to the Water Quality
19 Planning and Management Regulation”
20 and published in the Federal Register on
21 March 19, 2003 (68 Fed. Reg. 13608).

22 (iv) The final rule of the Environ-
23 mental Protection Agency entitled “Con-
24 solidated Permit Regulations: RCRA Haz-
25 ardous Waste; SDWA Underground Injec-

tion Control; CWA National Pollutant Discharge Elimination System; CWA Section 404 Dredge or Fill Programs; and CAA Prevention of Significant Deterioration” and published in the Federal Register on May 19, 1980 (45 Fed. Reg. 33290), with respect to the definition of the “waters of the United States”.

(v) The final rule of the Corps of Engineers and the Environmental Protection Agency entitled “Definition of ‘Waters of the United States’—Recodification of Pre-Existing Rules” and published in the Federal Register on October 22, 2019 (84 Fed. Reg. 56626).

(vi) The final rule of the Corps of Engineers and the Environmental Protection Agency entitled “The Navigable Waters Protection Rule: Definition of ‘Waters of the United States’” and published in the Federal Register on April 21, 2020 (85 Fed. Reg. 22250).

(B) FORESTS AND LAND MANAGEMENT.—

(i) The Healthy Forests Restoration Act of 2003 (16 U.S.C. 6501 et seq.).

1 (ii) The application of section 553(e)
2 of title 5, United States Code, such that a
3 State may petition for a special rule for
4 the inventoried roadless areas within Na-
5 tional Forest System land within the State.

6 (iii) The final rules of the Forest
7 Service entitled “National Forest System
8 Land Management Planning” (77 Fed.
9 Reg. 21162), “National Forest System
10 Land Management Planning; Correction”
11 (78 Fed. Reg. 23491), and “National For-
12 est System Land Management Planning”
13 (81 Fed. Reg. 90723), published on April
14 9, 2012, April 19, 2013, and December 15,
15 2016, respectively.

16 (iv) The final rule of the Bureau of
17 Land Management entitled “Oil Shale
18 Management—General” and published on
19 November 18, 2008 (73 Fed. Reg. 69414).

20 (v) The record of decision described in
21 the notice of availability of the Bureau of
22 Land Management entitled “Notice of
23 Availability of Approved Land Use Plan
24 Amendments/Record of Decision for Allo-
25 cation of Oil Shale and Tar Sands Re-

1 sources on Lands Administered by the Bu-
2 reau of Land Management in Colorado,
3 Utah, and Wyoming and Final Pro-
4 grammatic Environmental Impact State-
5 ment” and published on April 1, 2013 (78
6 Fed. Reg. 19518).

7 (C) SCIENTIFIC REVIEW.—The final rule
8 of the United States Fish and Wildlife Service
9 and the National Oceanic and Atmospheric Ad-
10 ministration entitled “Interagency Cooperation
11 Under the Endangered Species Act” and pub-
12 lished on December 16, 2008 (73 Fed. Reg.
13 76272), as amended by the final rule of the
14 United States Fish and Wildlife Service and the
15 National Oceanic and Atmospheric Administra-
16 tion entitled “Endangered and Threatened
17 Wildlife and Plants; Regulations for Inter-
18 agency Cooperation” and published on August
19 27, 2019 (84 Fed. Reg. 44976).

20 (2) METHOD.—In conducting the study under
21 paragraph (1), the National Academy of Sciences
22 may use and compare existing scientific studies re-
23 garding the regulations, laws, and other agency deci-
24 sions described in paragraph (1).

1 (3) REPORT.—Not later than 270 days after
2 the date on which the President enters into the ar-
3 rangement under paragraph (1), the National Acad-
4 emy of Sciences shall make publicly available and
5 shall submit to Congress and to the head of each de-
6 partment and agency of the Federal Government
7 that issued, implements, or would implement a regu-
8 lation, law, or other agency decision described in
9 paragraph (1), a report that includes—

10 (A) a description of the effects of each reg-
11 ulation, law, or other agency decision described
12 in paragraph (1) on public health, air quality,
13 water quality, wildlife, and the environment,
14 compared to the impact of preexisting regula-
15 tions, laws, or other agency decisions in effect,
16 as applicable, including—

17 (i) any negative impacts to air quality
18 or water quality;

19 (ii) any negative impacts to wildlife;

20 (iii) any delays in hazardous waste
21 cleanup that are projected to be hazardous
22 to public health; and

23 (iv) any other negative impact on pub-
24 lic health or the environment; and

1 (B) any recommendations that the Na-
2 tional Academy of Sciences considers appro-
3 priate to maintain, restore, or improve in whole
4 or in part protections for public health, air
5 quality, water quality, wildlife, and the environ-
6 ment for each of the regulations, laws, and
7 other agency decisions described in paragraph
8 (1), which may include recommendations for
9 the adoption of any regulation or law in place
10 or proposed prior to January 1, 2001.

11 (c) DEPARTMENT AND AGENCY REVISION OF EXIST-
12 ING RULES, REGULATIONS, OR LAWS.—Not later than
13 180 days after the date on which the report is submitted
14 pursuant to subsection (b)(3), the head of each depart-
15 ment or agency that has issued or implemented a regula-
16 tion, law, or other agency decision described in subsection
17 (b)(1) shall submit to Congress a plan describing the steps
18 the department or agency will take, or has taken, to re-
19 store or improve protections for public health and the envi-
20 ronment in whole or in part that were in existence prior
21 to the issuance of the applicable regulation, law, or other
22 agency decision.

1 **SEC. 10006. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
2 **WATER HORIZON OIL RIG EXPLOSION IN THE**
3 **GULF COAST.**

4 (a) STUDY.—The Comptroller General of the United
5 States shall conduct a study on the type and scope of
6 health care services administered through the Department
7 of Health and Human Services addressing the provision
8 of health care to racial and ethnic minorities, including
9 residents, cleanup workers, and volunteers, affected by the
10 blowout and explosion of the mobile offshore drilling unit
11 Deepwater Horizon that occurred on April 20, 2010, and
12 resulting hydrocarbon releases into the environment.

13 (b) SPECIFIC COMPONENTS.—In carrying out sub-
14 section (a), the Comptroller General of the United States
15 shall—

16 (1) assess the type, size, and scope of programs
17 administered by the Secretary that focus on the pro-
18 vision of health care to communities on the Gulf
19 Coast;

20 (2) identify the merits and disadvantages asso-
21 ciated with each of the programs;

22 (3) perform an analysis of the costs and bene-
23 fits of the programs; and

24 (4) determine whether there is any duplication
25 of programs.

1 (c) REPORT.—Not later than 180 days after the date
 2 of enactment of this Act, the Comptroller General of the
 3 United States shall submit to Congress a report that in-
 4 cludes—

5 (1) the findings of the study conducted under
 6 subsection (a); and

7 (2) recommendations for improving access to
 8 health care for racial and ethnic minorities.

9 **SEC. 10007. ESTABLISH AN INTERAGENCY COUNCIL AND**
 10 **GRANT PROGRAMS ON SOCIAL DETER-**
 11 **MINANTS OF HEALTH.**

12 (a) PURPOSES.—The purposes of this section are as
 13 follows:

14 (1) To establish effective, coordinated Federal
 15 technical assistance to help State and local govern-
 16 ments to improve outcomes and cost-effectiveness of,
 17 and return on investment from, health and social
 18 services programs.

19 (2) To build a pipeline of State and locally de-
 20 signed, cross-sector interventions and strategies that
 21 generate rigorous evidence about how to improve
 22 health and social outcomes, and increase the cost-ef-
 23 fectiveness of, and return on investment from, Fed-
 24 eral, State, local, and Tribal health and social serv-
 25 ices programs.

1 (3) To enlist State and local governments and
 2 the service providers of such governments as part-
 3 ners in identifying Federal statutory, regulatory, and
 4 administrative challenges in improving the health
 5 and social outcomes of, cost-effectiveness of, and re-
 6 turn on investment from, Federal spending on indi-
 7 viduals enrolled in Medicaid.

8 (4) To develop strategies to improve health and
 9 social outcomes without denying services to, or re-
 10 stricting the eligibility of, vulnerable populations.

11 (b) SOCIAL DETERMINANTS ACCELERATOR COUN-
 12 CIL.—

13 (1) ESTABLISHMENT.—The Secretary, in co-
 14 ordination with the Administrator of the Centers for
 15 Medicare & Medicaid Services (referred to in this
 16 section as the “Administrator”), shall establish an
 17 interagency council, to be known as the Social De-
 18 terminants Accelerator Interagency Council (referred
 19 to in this section as the “Council”) to achieve the
 20 purposes listed in subsection (a).

21 (2) MEMBERSHIP.—

22 (A) FEDERAL COMPOSITION.—The Council
 23 shall be composed of at least one designee from
 24 each of the following Federal agencies:

1 (i) The Office of Management and
2 Budget.

3 (ii) The Department of Agriculture.

4 (iii) The Department of Education.

5 (iv) The Indian Health Service.

6 (v) The Department of Housing and
7 Urban Development.

8 (vi) The Department of Labor.

9 (vii) The Department of Transpor-
10 tation.

11 (viii) Any other Federal agency the
12 Chair of the Council determines necessary.

13 (B) DESIGNATION.—

14 (i) IN GENERAL.—The head of each
15 agency specified in subparagraph (A) shall
16 designate at least one employee described
17 in clause (ii) to serve as a member of the
18 Council.

19 (ii) RESPONSIBILITIES.—An employee
20 described in this clause shall be a senior
21 employee of the agency—

22 (I) whose responsibilities relate
23 to authorities, policies, and procedures
24 with respect to the health and well-
25 being of individuals receiving medical

1 assistance under a State plan (or a
2 waiver of such plan) under title XIX
3 of the Social Security Act (42 U.S.C.
4 1396 et seq.); or

5 (II) who has authority to imple-
6 ment and evaluate transformative ini-
7 tiatives that harness data or conduct
8 rigorous evaluation to improve the im-
9 pact and cost-effectiveness of federally
10 funded services and benefits.

11 (C) HHS REPRESENTATION.—In addition
12 to the designees under subparagraph (A), the
13 Council shall include designees from at least 3
14 agencies within the Department of Health and
15 Human Services, including the Centers for
16 Medicare & Medicaid Services, at least one of
17 whom shall meet the criteria under subpara-
18 graph (B)(ii).

19 (D) OMB ROLE.—The Director of the Of-
20 fice of Management and Budget shall facilitate
21 the timely resolution of Federal Government-
22 wide and multiagency issues to help the Council
23 achieve consensus recommendations described
24 under this section.

1 (E) NON-FEDERAL COMPOSITION.—The
 2 Comptroller General of the United States may
 3 designate up to 6 Council designees—

4 (i) who have relevant subject matter
 5 expertise, including expertise implementing
 6 and evaluating transformative initiatives
 7 that harness data and conduct evaluations
 8 to improve the impact and cost-effective-
 9 ness of Federal Government services; and

10 (ii) that each represent—

11 (I) State, local, and Tribal health
 12 and human services agencies;

13 (II) public housing authorities or
 14 State housing finance agencies;

15 (III) State and local government
 16 budget offices;

17 (IV) State Medicaid agencies; or

18 (V) national consumer advocacy
 19 organizations.

20 (F) CHAIR.—

21 (i) IN GENERAL.—The Secretary shall
 22 select the Chair of the Council from among
 23 the members of the Council.

24 (ii) INITIATING GUIDANCE.—The
 25 Chair, on behalf of the Council, shall iden-

1 tify and invite individuals from diverse en-
 2 tities to provide the Council with advice
 3 and information pertaining to addressing
 4 social determinants of health, including—

5 (I) individuals from State and
 6 local government health and human
 7 services agencies;

8 (II) individuals from State Med-
 9 icaid agencies;

10 (III) individuals from State and
 11 local government budget offices;

12 (IV) individuals from public
 13 housing authorities or State housing
 14 finance agencies;

15 (V) individuals from nonprofit or-
 16 ganizations, small businesses, and
 17 philanthropic organizations;

18 (VI) advocates;

19 (VII) researchers; and

20 (VIII) any other individuals the
 21 Chair determines to be appropriate.

22 (3) DUTIES.—The duties of the Council are—

23 (A) to make recommendations to the Sec-
 24 retary and the Administrator regarding the cri-
 25 teria for making awards under this section;

1 (B) to identify Federal authorities and op-
2 portunities for use by States or local govern-
3 ments to improve coordination of funding and
4 administration of Federal programs, the bene-
5 ficiaries of whom include individuals, and which
6 may be unknown or underutilized, and to make
7 information on such authorities and opportuni-
8 ties publicly available;

9 (C) to provide targeted technical assistance
10 to States developing a social determinants ac-
11 celerator plan under this section, including
12 identifying potential statutory or regulatory
13 pathways for implementation of the plan and
14 assisting in identifying potential sources of
15 funding to implement the plan;

16 (D) to report to Congress annually on the
17 subjects set forth in this section;

18 (E) to develop and disseminate evaluation
19 guidelines and standards that can be used to
20 reliably assess the impact of an intervention or
21 approach that may be implemented pursuant to
22 this section on outcomes and cost-effectiveness
23 of, and return on investment from, Federal,
24 State, local, and Tribal governments, and to fa-
25 cilitate technical assistance, where needed, to

1 help to improve State and local evaluation de-
2 signs and implementation;

3 (F) to seek feedback from State, local, and
4 Tribal governments, including through an an-
5 nual survey by an independent third party, on
6 how to improve the technical assistance the
7 Council provides to better equip State, local,
8 and Tribal governments to coordinate health
9 and social service programs;

10 (G) to solicit applications for grants under
11 subsection (c); and

12 (H) to coordinate with other cross-agency
13 initiatives focused on improving the health and
14 well-being of low-income and at-risk populations
15 in order to prevent unnecessary duplication be-
16 tween agency initiatives.

17 (4) SCHEDULE.—Not later than 60 days after
18 the date of enactment of this Act, the Council shall
19 convene to develop a schedule and plan for carrying
20 out the duties described in this section, including so-
21 licitation of applications for the grants under this
22 section.

23 (5) REPORT TO CONGRESS.—The Council shall
24 submit an annual report to Congress, which shall in-
25 clude—

1 (A) a list of the Council members;

2 (B) activities and expenditures of the
3 Council;

4 (C) summaries of the interventions and ap-
5 proaches that will be supported by State, local,
6 and Tribal governments that received a grant
7 under this section, including—

8 (i) the best practices and evidence-
9 based approaches such governments plan
10 to employ to achieve the purposes listed in
11 this section; and

12 (ii) a description of how the practices
13 and approaches will impact the outcomes
14 and cost-effectiveness of, and return on in-
15 vestment from, Federal, State, local, and
16 Tribal governments with respect to such
17 purposes;

18 (D) the feedback received from State and
19 local governments on ways to improve the tech-
20 nical assistance of the Council, including find-
21 ings from a third-party survey and actions the
22 Council plans to take in response to such feed-
23 back; and

24 (E) the major statutory, regulatory, and
25 administrative challenges identified by State,

1 local, and Tribal governments that received a
2 grant under subsection (c), and the actions that
3 Federal agencies are taking to address such
4 challenges.

5 (6) FACA INAPPLICABILITY.—Chapter 10 of
6 title 5, United States Code, shall not apply to the
7 Council.

8 (7) COUNCIL PROCEDURES.—The Secretary, in
9 consultation with the Comptroller General of the
10 United States and the Director of the Office of Man-
11 agement and Budget, shall establish procedures for
12 the Council to—

13 (A) ensure that adequate resources are
14 available to effectively execute the responsibil-
15 ities of the Council;

16 (B) effectively coordinate with other rel-
17 evant advisory bodies and working groups to
18 avoid unnecessary duplication;

19 (C) create transparency to the public and
20 Congress with regard to Council membership,
21 costs, and activities, including through use of
22 modern technology and social media to dissemi-
23 nate information; and

1 (D) avoid conflicts of interest that would
 2 jeopardize the ability of the Council to make de-
 3 cisions and provide recommendations.

4 (c) SOCIAL DETERMINANTS ACCELERATOR GRANTS
 5 TO STATES OR LOCAL GOVERNMENTS.—

6 (1) GRANTS TO STATES, LOCAL GOVERNMENTS,
 7 AND TRIBES.—Not later than 180 days after the
 8 date of enactment of this Act, the Administrator, in
 9 consultation with the Secretary and the Council,
 10 shall award on a competitive basis not more than 25
 11 grants to eligible applicants described in this sub-
 12 section, for the development of social determinants
 13 accelerator plans, as described in this subsection.

14 (2) ELIGIBLE APPLICANT.—An eligible appli-
 15 cant described in this subsection is a State, local, or
 16 Tribal health or human services agency that—

17 (A) demonstrates the support of relevant
 18 parties across relevant State, local, or Tribal ju-
 19 risdictions; and

20 (B) in the case of an applicant that is a
 21 local government agency, provides to the Sec-
 22 retary a letter of support from the lead State
 23 health or human services agency for the State
 24 in which the local government is located.

1 (3) AMOUNT OF GRANT.—The Administrator,
2 in coordination with the Council, shall determine the
3 total amount that the Administrator will make avail-
4 able to each grantee under this subsection.

5 (4) APPLICATION.—An eligible applicant seek-
6 ing a grant under this subsection shall include in the
7 application the following information:

8 (A) The target population (or populations)
9 that would benefit from implementation of the
10 social determinants accelerator plan proposed to
11 be developed by the applicant.

12 (B) A description of the objective or objec-
13 tives and outcome goals of such proposed plan,
14 which shall include at least one health outcome
15 and at least one other important social out-
16 come.

17 (C) The sources and scope of inefficiencies
18 that, if addressed by the plan, could result in
19 improved cost-effectiveness of or return on in-
20 vestment from Federal, State, local, and Tribal
21 governments.

22 (D) A description of potential interventions
23 that could be designed or enabled using such
24 proposed plan.

1 (E) The State, local, and Tribal govern-
2 ments, academic institutions, nonprofit organi-
3 zations, community-based organizations, and
4 other public and private sector partners that
5 would participate in the development of the pro-
6 posed plan and subsequent implementation of
7 programs or initiatives included in such pro-
8 posed plan.

9 (F) Such other information as the Admin-
10 istrator, in consultation with the Secretary and
11 the Council, determines necessary to achieve the
12 purposes of this section.

13 (5) USE OF FUNDS.—A recipient of a grant
14 under this subsection may use funds received
15 through the grant for the following purposes:

16 (A) To convene and coordinate with rel-
17 evant government entities and other stake-
18 holders across sectors to assist in the develop-
19 ment of a social determinant accelerator plan.

20 (B) To identify populations of individuals
21 receiving medical assistance under a State plan
22 (or a waiver of such plan) under title XIX of
23 the Social Security Act (42 U.S.C. 1396 et
24 seq.) who may benefit from the proposed ap-
25 proaches to improving the health and well-being

1 of such individuals through the implementation
2 of the proposed social determinants accelerator
3 plan.

4 (C) To engage qualified research experts to
5 advise on relevant research and to design a pro-
6 posed evaluation plan, in accordance with the
7 standards and guidelines issued by the Admin-
8 istrator.

9 (D) To collaborate with the Council to sup-
10 port the development of social determinants ac-
11 celerator plans.

12 (E) To prepare and submit a final social
13 determinants accelerator plan to the Council.

14 (6) CONTENTS OF PLANS.—A social deter-
15 minant accelerator plan developed under this sub-
16 section shall include the following:

17 (A) A description of the target population
18 (or populations) that would benefit from imple-
19 mentation of the social determinants accelerator
20 plan, including an analysis describing the pro-
21 jected impact on the well-being of individuals
22 described in paragraph (5)(B).

23 (B) A description of the interventions or
24 approaches designed under the social deter-

1 minants accelerator plan and the evidence for
2 selecting such interventions or approaches.

3 (C) The objectives and outcome goals of
4 such interventions or approaches, including at
5 least one health outcome and at least one other
6 important social outcome.

7 (D) A plan for accessing and linking rel-
8 evant data to enable coordinated benefits and
9 services for the jurisdictions described in this
10 section and an evaluation of the proposed inter-
11 ventions and approaches.

12 (E) A description of the State, local, and
13 Tribal governments, academic institutions, non-
14 profit organizations, or any other public or pri-
15 vate sector organizations that would participate
16 in implementing the proposed interventions or
17 approaches, and the role each would play to
18 contribute to the success of the proposed inter-
19 ventions or approaches.

20 (F) The identification of the funding
21 sources that would be used to finance the pro-
22 posed interventions or approaches.

23 (G) A description of any financial incen-
24 tives that may be provided, including outcome-
25 focused contracting approaches to encourage

1 service providers and other partners to improve
2 outcomes of, cost-effectiveness of, and return on
3 investment from, Federal, State, local, or Tribal
4 government spending.

5 (H) The identification of the applicable
6 Federal, State, local, or Tribal statutory and
7 regulatory authorities, including waiver authori-
8 ties, to be leveraged to implement the proposed
9 interventions or approaches.

10 (I) A description of potential consider-
11 ations that would enhance the impact,
12 scalability, or sustainability of the proposed
13 interventions or approaches and the actions the
14 grant awardee would take to address such con-
15 siderations.

16 (J) A proposed evaluation plan, to be car-
17 ried out by an independent evaluator, to meas-
18 ure the impact of the proposed interventions or
19 approaches on the outcomes of, cost-effective-
20 ness of, and return on investment from, Fed-
21 eral, State, local, and Tribal governments.

22 (K) Precautions for ensuring that vulner-
23 able populations will not be denied access to
24 Medicaid or other essential services as a result
25 of implementing the proposed plan.

1 (d) FUNDING.—

2 (1) IN GENERAL.—Out of any money in the
3 Treasury not otherwise appropriated, there is appro-
4 priated to carry out this section \$25,000,000, to re-
5 main available for obligation until the date that is
6 5 years after the date of enactment of this section.

7 (2) RESERVATION OF FUNDS.—

8 (A) IN GENERAL.—Of the funds made
9 available under paragraph (1), the Secretary
10 shall reserve not less than 20 percent to award
11 grants to eligible applicants for the development
12 of social determinants accelerator plans under
13 this section intended to serve rural populations.

14 (B) EXCEPTION.—In the case of a fiscal
15 year for which the Secretary determines that
16 there are not sufficient eligible applicants to
17 award up to 25 grants under subsection (c)
18 that are intended to serve rural populations and
19 the Secretary cannot satisfy the 20-percent re-
20 quirement, the Secretary may reserve an
21 amount that is less than 20 percent of amounts
22 made available under paragraph (1) to award
23 grants for such purpose.

24 (3) RULE OF CONSTRUCTION.—Nothing in this
25 section shall prevent Federal agencies represented

1 on the Council from contributing additional funding
 2 from other sources to support activities to improve
 3 the effectiveness of the Council.

4 **SEC. 10008. CORRECTING HURTFUL AND ALIENATING**
 5 **NAMES IN GOVERNMENT EXPRESSION**
 6 **(CHANGE).**

7 (a) **SHORT TITLE.**—This section may be cited as the
 8 “Correcting Hurtful and Alienating Names in Government
 9 Expression Act” or the “CHANGE Act”.

10 (b) **DEFINITIONS.**—In this section:

11 (1) **EMPLOYEE.**—The term “employee” has the
 12 meaning given the term in section 2105 of title 5,
 13 United States Code.

14 (2) **EXECUTIVE AGENCY.**—The term “Executive
 15 agency” has the meaning given the term in section
 16 105 of title 5, United States Code.

17 (3) **OFFICER.**—The term “officer” has the
 18 meaning given the term in section 2104 of title 5,
 19 United States Code.

20 (4) **PROHIBITED TERM.**—The term “prohibited
 21 term” means—

22 (A) the term “alien”, when used to refer to
 23 an individual who is not a citizen or national of
 24 the United States; and

1 (B) the term “illegal alien”, when used to
 2 refer to an individual who—

3 (i) is unlawfully present in the United
 4 States; or

5 (ii) lacks a lawful immigration status
 6 in the United States.

7 (c) MODERNIZATION OF LANGUAGE REFERRING TO
 8 INDIVIDUALS WHO ARE NOT CITIZENS OR NATIONALS OF
 9 THE UNITED STATES.—

10 (1) IN GENERAL.—Except as provided in para-
 11 graph (2), on and after the date of enactment of this
 12 Act, an Executive agency may not use a prohibited
 13 term in any proposed or final rule, regulation, inter-
 14 pretation, publication, other document, display, or
 15 sign issued by the Executive agency.

16 (2) EXCEPTION.—An Executive agency may use
 17 a prohibited term under paragraph (1) if the Execu-
 18 tive agency uses the prohibited term while quoting
 19 or reproducing text written by a source that is not
 20 an officer or employee of the Executive agency.

21 (d) UNIFORM DEFINITION.—

22 (1) IN GENERAL.—Chapter 1 of title 1, United
 23 States Code, is amended by adding at the end the
 24 following:

1 **“§ 9. Definition of ‘foreign national’**

2 “In determining the meaning of any Act of Congress
3 or any ruling, regulation, or interpretation of an adminis-
4 trative bureau or agency of the United States, the term
5 ‘foreign national’ means any individual who is not an indi-
6 vidual who—

7 “(1) is a citizen of the United States; or

8 “(2) though not a citizen of the United States,
9 owes permanent allegiance to the United States.”.

10 (2) TECHNICAL AMENDMENT.—The table of
11 sections for chapter 1 of title 1, United States Code,
12 is amended by adding at the end the following:

“9. Definition of ‘foreign national’.”.

13 (e) REFERENCES.—Any reference in any Federal
14 statute, rule, regulation, Executive order, publication, or
15 other document of the United States—

16 (1) to the term “alien”, when used to refer to
17 an individual who is not a citizen or national of the
18 United States, is deemed to refer to the term “for-
19 eign national”; and

20 (2) to the term “illegal alien” is deemed to
21 refer to the term “undocumented foreign national”,
22 when used to refer to an individual who—

23 (A) is unlawfully present in the United
24 States; or

1 (B) lacks a lawful immigration status in
2 the United States.

3 **SEC. 10009. ANDREW KEARSE ACCOUNTABILITY FOR DE-**
4 **NIAL OF MEDICAL CARE.**

5 (a) IN GENERAL.—Chapter 13 of title 18, United
6 States Code, is amended by adding at the end the fol-
7 lowing:

8 **“§ 251. Medical attention for individuals in Federal**
9 **custody displaying medical distress**

10 “(a) DEFINITIONS.—In this section—

11 “(1) the term ‘appropriate Inspector General’,
12 with respect to a covered official, means—

13 “(A) the Inspector General of the Federal
14 agency that employs the covered official; or

15 “(B) in the case of a covered official em-
16 ployed by a Federal agency that does not have
17 an Inspector General, the Inspector General of
18 the Department of Justice;

19 “(2) the term ‘covered official’ means—

20 “(A) a Federal law enforcement officer (as
21 defined in section 115);

22 “(B) an officer or employee of the Bureau
23 of Prisons; or

24 “(C) an officer or employee of the United
25 States Marshals Service; and

1 “(3) the term ‘medical distress’ includes breath-
2 ing difficulties.

3 “(b) REQUIREMENT.—

4 “(1) OFFENSE.—It shall be unlawful for a cov-
5 ered official to negligently fail to obtain or provide
6 immediate medical attention to an individual in Fed-
7 eral custody who displays medical distress in the
8 presence of the covered official if the individual suf-
9 fers unnecessary pain, injury, or death as a result of
10 that failure.

11 “(2) PENALTY.—A covered official who violates
12 paragraph (1) shall be fined under this title, impris-
13 oned for not more than 1 year, or both.

14 “(3) STATE CIVIL ENFORCEMENT.—Whenever
15 an attorney general of a State has reasonable cause
16 to believe that a resident of the State has been ag-
17 grieved by a violation of paragraph (1) by a covered
18 official, the attorney general, or another official,
19 agency, or entity designated by the State, may bring
20 a civil action in any appropriate district court of the
21 United States to obtain appropriate equitable and
22 declaratory relief.

23 “(c) INSPECTOR GENERAL INVESTIGATION.—

24 “(1) IN GENERAL.—The appropriate Inspector
25 General shall investigate any instance in which—

1 “(A) a covered official fails to obtain or
2 provide immediate medical attention to an indi-
3 vidual in Federal custody who displays medical
4 distress in the presence of the covered official;
5 and

6 “(B) the individual suffers unnecessary
7 pain, injury, or death as a result of the failure
8 to obtain or provide immediate medical atten-
9 tion.

10 “(2) REFERRAL FOR PROSECUTION.—If an ap-
11 propriate Inspector General, in conducting an inves-
12 tigation under paragraph (1), concludes that the
13 covered official acted negligently in failing to obtain
14 or provide immediate medical attention to the indi-
15 vidual in Federal custody, the appropriate Inspector
16 General shall refer the case to the Attorney General
17 for prosecution under this section.

18 “(3) CONFIDENTIAL COMPLAINT PROCESS.—
19 The Inspector General of a Federal agency that em-
20 ploys covered officials shall establish a process under
21 which an individual may confidentially submit a
22 complaint to the Inspector General regarding an in-
23 cident described in paragraph (1) involving a covered
24 official employed by the Federal agency (or, in the
25 case of the Inspector General of the Department of

1 Justice, involving a covered official employed by a
 2 Federal agency that does not have an Inspector Gen-
 3 eral).

4 “(d) TRAINING.—The head of an agency that em-
 5 ploys covered officials shall provide training to each such
 6 covered official on obtaining or providing medical assist-
 7 ance to individuals in medical distress.”.

8 (b) TECHNICAL AND CONFORMING AMENDMENT.—
 9 The table of sections for chapter 13 of title 18, United
 10 States Code, is amended by adding at the end the fol-
 11 lowing:

“251. Medical attention for individuals in Federal custody displaying medical
 distress.”.

12 **SEC. 10010. INVESTING IN COMMUNITY HEALING.**

13 (a) SENSE OF CONGRESS.—It is the sense of Con-
 14 gress that it is imperative that a comprehensive public
 15 health approach to addressing trauma and mental health
 16 care be focused on care delivery that is culturally sensitive
 17 and competent.

18 (b) RESEARCH ON ADVERSE HEALTH EFFECTS AS-
 19 SOCIATED WITH INTERACTIONS WITH LAW ENFORCE-
 20 MENT.—

21 (1) IN GENERAL.—The Secretary, acting
 22 through the Director of the Office of Minority
 23 Health of the Centers for Disease Control and Pre-
 24 vention (established pursuant to section 1707A of

1 the Public Health Service Act (42 U.S.C. 300u–
2 6a)), shall conduct research on the adverse health
3 effects associated with interactions with law enforce-
4 ment.

5 (2) EFFECTS AMONG RACIAL AND ETHNIC MI-
6 NORITIES.—The research under paragraph (1) shall
7 include research on—

8 (A) the health consequences, both indi-
9 vidual and community-wide, of trauma related
10 to violence committed by law enforcement
11 among racial and ethnic minorities; and

12 (B) the disproportionate burden of mor-
13 bidity and mortality associated with such trau-
14 ma.

15 (3) REPORT.—Not later than 1 year after the
16 date of enactment of this Act, the Secretary shall—

17 (A) complete the research under this sub-
18 section; and

19 (B) submit to Congress a report on the
20 findings, conclusions, and recommendations re-
21 sulting from such research.

22 (c) GRANTS FOR INCREASING RACIAL AND ETHNIC
23 MINORITY ACCESS TO HIGH-QUALITY TRAUMA SUPPORT
24 SERVICES AND MENTAL HEALTH CARE.—

1 (1) IN GENERAL.—The Secretary, acting
2 through the Assistant Secretary for Mental Health
3 and Substance Use, shall award grants to eligible
4 entities to establish or expand programs for the pur-
5 pose of increasing racial and ethnic minority access
6 to high-quality trauma support services and mental
7 health care.

8 (2) ELIGIBLE ENTITIES.—To seek a grant
9 under this subsection, an entity shall be a commu-
10 nity-based program or organization that—

11 (A) provides culturally competent pro-
12 grams and resources that are aligned with evi-
13 dence-based practices for trauma-informed care;
14 and

15 (B) has demonstrated expertise in serving
16 communities of color or can partner with a pro-
17 gram that has such demonstrated expertise.

18 (3) USE OF FUNDS.—As a condition on receipt
19 of a grant under this subsection, a grantee shall
20 agree to use the grant to increase racial and ethnic
21 minority access to high-quality trauma support serv-
22 ices and mental health care, such as by—

23 (A) establishing and maintaining commu-
24 nity-based programs providing evidence-based

1 services in trauma-informed care and culturally
2 specific services and other resources;

3 (B) developing innovative culturally spe-
4 cific strategies and projects to enhance access
5 to trauma-informed care and resources for ra-
6 cial and ethnic minorities who face obstacles to
7 using more traditional services and resources
8 (such as obstacles in geographic access to pro-
9 viders, insurance coverage, and access to audio
10 and video technologies);

11 (C) working with State and local govern-
12 ments and social service agencies to develop and
13 enhance effective strategies to provide culturally
14 specific services to racial and ethnic minorities;

15 (D) increasing communities' capacity to
16 provide culturally specific resources and support
17 for communities of color;

18 (E) working in cooperation with the com-
19 munity to develop education and prevention
20 strategies highlighting culturally specific issues
21 and resources regarding racial and ethnic mi-
22 norities;

23 (F) providing culturally specific programs
24 for racial and ethnic minorities exposed to law
25 enforcement violence; and

1 (G) examining the dynamics of culture and
2 its impact on victimization and healing.

3 (4) PRIORITY.—In awarding grants under this
4 subsection, the Secretary shall give priority to eligi-
5 ble entities proposing to serve communities that have
6 faced high rates of community trauma, including
7 from exposure to law enforcement violence, intergen-
8 erational poverty, civil unrest, discrimination, or op-
9 pression.

10 (5) GRANT PERIOD.—The period of a grant
11 under this subsection shall be 4 years.

12 (6) EVALUATION.—Not later than 6 months
13 after the end of the period of all grants under this
14 subsection, the Secretary shall—

15 (A) conduct an evaluation of the programs
16 funded by a grant under this subsection;

17 (B) include in such evaluation an assess-
18 ment of the outcomes of each such program;
19 and

20 (C) submit a report on the results of such
21 evaluation to Congress.

22 (7) AUTHORIZATION OF APPROPRIATIONS.—To
23 carry out this subsection, there is authorized to be
24 appropriated \$20,000,000 for each of fiscal years
25 2027 through 2031.

1 (d) BEHAVIORAL AND MENTAL HEALTH OUTREACH
2 EDUCATION STRATEGY.—

3 (1) IN GENERAL.—The Secretary, in coordina-
4 tion with advocacy and behavioral and mental health
5 organizations serving racial and ethnic minority
6 groups, shall develop and implement an outreach
7 and education strategy to promote behavioral and
8 mental health, and reduce stigma associated with
9 mental health conditions, among racial and ethnic
10 minorities.

11 (2) DESIGN.—The strategy under this sub-
12 section shall be designed to—

13 (A) meet the diverse cultural and language
14 needs of racial and ethnic minority groups;

15 (B) provide information on evidence-based,
16 culturally and linguistically appropriate and
17 adapted interventions and treatments;

18 (C) increase awareness of symptoms of
19 mental illness among racial and ethnic minority
20 groups; and

21 (D) ensure full participation of, and en-
22 gage, both consumers and community members
23 in the development and implementation of ma-
24 terials.

1 (3) REPORT.—Not later than 1 year after the
2 date of enactment of this Act, the Secretary shall
3 submit to Congress, and make publicly available, a
4 report detailing the outreach and education strategy
5 that is developed and implemented under this sub-
6 section and the results of such implementation.

7 **SEC. 10011. ENVIRONMENTAL JUSTICE MAPPING AND DATA**
8 **COLLECTION.**

9 (a) DEFINITIONS.—In this section:

10 (1) ADVISORY COUNCIL.—The term “advisory
11 council” means the advisory council established
12 under subsection (b)(4)(B)(i).

13 (2) COMMITTEE.—The term “Committee”
14 means the Environmental Justice Mapping Com-
15 mittee established by subsection (b)(1).

16 (3) ENVIRONMENTAL JUSTICE.—The term “en-
17 vironmental justice” means the fair treatment and
18 meaningful involvement of all people regardless of
19 race, color, culture, national origin, or income, with
20 respect to the development, implementation, and en-
21 forcement of environmental laws, regulations, and
22 policies to ensure that each person enjoys—

23 (A) the same degree of protection from en-
24 vironmental and health hazards; and

1 (B) equal access to any Federal agency ac-
2 tion relating to the development, implementa-
3 tion, and enforcement of environmental laws,
4 regulations, and policies for the purpose of hav-
5 ing a healthy environment in which to live,
6 learn, work, and recreate.

7 (4) ENVIRONMENTAL JUSTICE COMMUNITY.—
8 The term “environmental justice community” means
9 a community with significant representation of com-
10 munities of color, low-income communities, or Tribal
11 and indigenous communities, that experiences, or is
12 at risk of experiencing, higher or more adverse
13 human health or environmental effects, as compared
14 to other communities.

15 (5) GROUND-TRUTHING.—The term “ground-
16 truthing” means a community fact-finding process
17 by which residents of a community supplement tech-
18 nical information with local knowledge for the pur-
19 pose of better informing policy and project decisions.

20 (6) RELEVANT STAKEHOLDER.—The term “rel-
21 evant stakeholder” means—

22 (A) a representative of a regional, State,
23 Tribal, or local government agency;

24 (B) a representative of a nongovernmental
25 organization with experience in areas that may

1 include Tribal relations, environmental con-
2 servation, city and regional planning, and public
3 health;

4 (C) a representative of a labor union;

5 (D) a representative or member of—

6 (i) an environmental justice commu-
7 nity; or

8 (ii) a community-based organization
9 for an environmental justice community;

10 (E) an individual with expertise in cumu-
11 lative impacts, geospatial data, and environ-
12 mental justice, particularly such an individual
13 from an academic or research institution; and

14 (F) an advocate with experience in envi-
15 ronmental justice who represents an environ-
16 mental justice community.

17 (b) ESTABLISHMENT OF COMMITTEE.—

18 (1) IN GENERAL.—There is established a com-
19 mittee, to be known as the “Environmental Justice
20 Mapping Committee”.

21 (2) MEMBERSHIP.—

22 (A) IN GENERAL.—The Committee shall be
23 composed of not fewer than 1 representative of
24 each of the following:

1 (i) Of the Environmental Protection
2 Agency—

3 (I) the Office of Air and Radi-
4 ation;

5 (II) the Office of Chemical Safety
6 and Pollution Prevention;

7 (III) the Office of International
8 and Tribal Affairs;

9 (IV) the Office of Land and
10 Emergency Management;

11 (V) the Office of Water;

12 (VI) the Office of Environmental
13 Justice and External Civil Rights;

14 (VII) the Office of Research and
15 Development; and

16 (VIII) the Office of Public En-
17 gagement and Environmental Edu-
18 cation.

19 (ii) The Council on Environmental
20 Quality.

21 (iii) Of the Department of Com-
22 merce—

23 (I) the Office of Oceanic and At-
24 mospheric Research of the National
25 Oceanic and Atmospheric Administra-

1 tion, including not fewer than 1 rep-
2 resentative of the Climate Program
3 Office;

4 (II) the Bureau of Economic
5 Analysis; and

6 (III) the National Institute of
7 Standards and Technology.

8 (iv) Of the Department of Health and
9 Human Services—

10 (I) the Centers for Disease Con-
11 trol and Prevention, not including the
12 Agency for Toxic Substances and Dis-
13 ease Registry;

14 (II) the Agency for Toxic Sub-
15 stances and Disease Registry;

16 (III) the Administration for Chil-
17 dren and Families;

18 (IV) of the National Institutes of
19 Health—

20 (aa) the National Institute
21 of Environmental Health
22 Sciences;

23 (bb) the National Institute
24 of Mental Health; and

1 (cc) the National Institute
2 on Minority Health and Health
3 Disparities; and

4 (V) the Office for Civil Rights.

5 (v) Of the Department of the Inte-
6 rior—

7 (I) the Bureau of Indian Affairs;

8 (II) the Office of Diversity, In-
9 clusion, and Civil Rights; and

10 (III) the United States Geologi-
11 cal Survey.

12 (vi) The Forest Service.

13 (vii) The Department of Housing and
14 Urban Development.

15 (viii) The Department of Energy.

16 (ix) The Department of Transpor-
17 tation.

18 (x) The Department of Justice.

19 (xi) The Federal Energy Regulatory
20 Commission.

21 (xii) The Department of the Treasury.

22 (xiii) Such other Federal departments,
23 agencies, and offices as the Administrator
24 determines to be appropriate, particularly
25 offices relating to public engagement.

(B) SELECTION OF REPRESENTATIVES.—

The head of a department or agency described in subparagraph (A) shall, in appointing to the Committee a representative of the department or agency, select a representative—

(i) of a component of the department or agency that is among the components that are the most relevant to the responsibilities of the Committee; or

(ii) who has expertise in areas relevant to those responsibilities, such as demographic indicators relating to socioeconomic hardship, environmental justice, public engagement, public health, exposure to pollution, future climate and extreme weather mapping, affordable energy, sustainable transportation, and access to water, food, and green space.

(C) CO-CHAIRS.—

(i) IN GENERAL.—The members of the Committee shall select 3 members to serve as co-chairs of the Committee—

(I) 1 of whom shall be a representative of the Environmental Protection Agency;

1 (II) 1 of whom shall be a rep-
 2 resentative of the Council on Environ-
 3 mental Quality; and

4 (III) 1 of whom shall have sub-
 5 stantial experience in public engage-
 6 ment.

7 (ii) TERMS.—Each co-chair shall
 8 serve for a term of not more than 3 years.

9 (iii) RESPONSIBILITIES OF CO-
 10 CHAIRS.—The co-chairs of the Committee
 11 shall—

12 (I) determine the agenda of the
 13 Committee, in consultation with other
 14 members of the Committee;

15 (II) direct the work of the Com-
 16 mittee, including the oversight of a
 17 meaningful public engagement proc-
 18 ess; and

19 (III) convene meetings of the
 20 Committee not less frequently than
 21 once each fiscal quarter.

22 (3) ADMINISTRATIVE SUPPORT.—

23 (A) IN GENERAL.—The Administrator
 24 shall provide technical and administrative sup-
 25 port to the Committee.

1 (B) FUNDING.—The Administrator may
2 carry out subparagraph (A) using, in addition
3 to any amounts made available under sub-
4 section (e), amounts authorized to be appro-
5 priated to the Administrator before the date of
6 enactment of this Act and available for obliga-
7 tion as of that date of enactment.

8 (4) CONSULTATION.—

9 (A) IN GENERAL.—In carrying out the du-
10 ties of the Committee, the Committee shall con-
11 sult with relevant stakeholders.

12 (B) ADVISORY COUNCIL.—

13 (i) IN GENERAL.—The Committee
14 shall establish an advisory council com-
15 posed of a balanced proportion of relevant
16 stakeholders, at least $\frac{1}{2}$ of whom shall
17 represent environmental justice commu-
18 nities.

19 (ii) CHAIR.—The advisory council
20 shall be chaired by an environmental jus-
21 tice advocate or other relevant stakeholder
22 with substantial experience in environ-
23 mental justice.

1 (iii) REQUIREMENTS.—Consultation
2 described in subparagraph (A) shall in-
3 clude—

4 (I) early and regular engagement
5 with the advisory council, including in
6 carrying out public engagement under
7 subparagraph (C); and

8 (II) consideration of the rec-
9 ommendations of the advisory council.

10 (iv) RECOMMENDATIONS NOT USED.—
11 If the Committee does not use a rec-
12 ommendation of the advisory council, not
13 later than 60 days after the date on which
14 the Committee receives notice of the rec-
15 ommendation, the Committee shall—

16 (I) make available to the public
17 on an internet website of the Environ-
18 mental Protection Agency a written
19 report describing the rationale of the
20 Committee for not using the rec-
21 ommendation; and

22 (II) submit the report described
23 in subclause (I) to the Committee on
24 Environment and Public Works of the
25 Senate and the Committee on Energy

1 and Commerce of the House of Rep-
2 resentatives.

3 (v) OUTREACH.—The advisory council
4 may carry out public outreach activities
5 using amounts made available under sub-
6 section (e) to supplement public engage-
7 ment carried out by the Committee under
8 subparagraph (C).

9 (C) PUBLIC ENGAGEMENT.—

10 (i) IN GENERAL.—The Committee
11 shall, throughout the process of carrying
12 out the duties of the Committee described
13 in subsection (c)—

14 (I) meaningfully engage with rel-
15 evant stakeholders, particularly—

16 (aa) members and represent-
17 atives of environmental justice
18 communities;

19 (bb) environmental justice
20 advocates; and

21 (cc) individuals with exper-
22 tise in cumulative impacts and
23 geospatial data; and

24 (II) ensure that the input of the
25 stakeholders described in subclause (I)

1 is central to the activities of the Com-
2 mittee.

3 (ii) PLAN.—

4 (I) IN GENERAL.—In carrying
5 out clause (i), the Committee shall de-
6 velop a plan, in consultation with the
7 advisory council, for comprehensive
8 public engagement with, and incorpo-
9 ration of feedback from, environ-
10 mental justice advocates and members
11 of environmental justice communities.

12 (II) STRATEGIES TO OVERCOME
13 BARRIERS TO PUBLIC ENGAGE-
14 MENT.—The plan developed under
15 subclause (I) shall include strategies
16 to overcome barriers to public engage-
17 ment, including—

18 (aa) language barriers;

19 (bb) transportation barriers;

20 (cc) economic barriers; and

21 (dd) lack of internet access.

22 (III) CONSIDERATION.—In devel-
23 oping the plan under subclause (I),
24 the Committee shall consider the di-
25 verse and varied experiences of envi-

ronmental justice communities relating to the scope and types of environmental hazards and socioeconomic injustices.

(iii) CONSULTATION AND SOLICITATION OF PUBLIC COMMENT.—

(I) IN GENERAL.—In carrying out clause (i), not less frequently than once each fiscal quarter, the Committee shall consult with the advisory council and solicit meaningful public comment, particularly from relevant stakeholders, on the activities of the Committee.

(II) REQUIREMENTS.—The Committee shall carry out subclause (I) through means including—

(aa) public notice of a meeting of the Committee occurring during the applicable fiscal quarter, which shall include—

(AA) notice in publications relevant to environmental justice communities;

1 (BB) notification to en-
2 vironmental justice commu-
3 nities through direct means,
4 such as community centers
5 and schools; and

6 (CC) direct outreach to
7 known environmental justice
8 groups;

9 (bb) public broadcast of that
10 meeting, including soliciting and
11 receiving comments by virtual
12 means; and

13 (cc) public availability of a
14 transcript of that meeting
15 through publication on an acces-
16 sible website.

17 (III) LANGUAGES.—The Com-
18 mittee shall provide each notice, noti-
19 fication, direct outreach, broadcast,
20 and transcript described in subclause
21 (II) in each language commonly used
22 in the applicable environmental justice
23 community, including through oral in-
24 terpretation, if applicable.

1 (iv) FUNDING.—Of amounts made
 2 available under subsection (e), the Admin-
 3 istrator shall make available to the Com-
 4 mittee such sums as are necessary for par-
 5 ticipation by relevant stakeholders in pub-
 6 lic engagement under this paragraph, as
 7 determined by the Administrator, in con-
 8 sultation with the advisory council.

9 (c) DUTIES OF COMMITTEE.—

10 (1) IN GENERAL.—The Committee shall—

11 (A) establish a tool described in paragraph

12 (2) to identify environmental justice commu-
 13 nities, including the identification of—

14 (i) criteria to be used in the tool; and

15 (ii) a methodology to determine the
 16 cumulative impacts of those criteria;

17 (B) assess and address data gaps in ac-
 18 cordance with paragraph (4); and

19 (C) collect data for the environmental jus-
 20 tice data repository established under sub-
 21 section (d).

22 (2) ESTABLISHMENT OF TOOL.—

23 (A) IN GENERAL.—The Committee, in con-
 24 sultation with relevant stakeholders and the ad-
 25 visory council, shall establish an interactive,

1 transparent, integrated, and Federal Govern-
2 ment-wide tool for assessing and mapping envi-
3 ronmental justice communities based on the cu-
4 mulative impacts of all indicators selected by
5 the Committee to be integrated into the tool.

6 (B) REQUIREMENTS.—In establishing the
7 tool under subparagraph (A), the Committee
8 shall—

9 (i) integrate into the tool multiple
10 data layers of indicators that fall into cat-
11 egories including—

12 (I) demographics, particularly re-
13 lating to socioeconomic hardship and
14 social stressors, such as—

15 (aa) race and ethnicity;

16 (bb) low income;

17 (cc) high unemployment;

18 (dd) low levels of home own-

19 ership;

20 (ee) high rent burden;

21 (ff) high transportation bur-

22 den;

23 (gg) low levels of educational

24 attainment;

25 (hh) linguistic isolation;

- 1 (ii) energy insecurity or high
- 2 utility rate burden;
- 3 (jj) food insecurity;
- 4 (kk) health insurance status
- 5 and access to health care; and
- 6 (ll) membership in an Indian
- 7 Tribe;
- 8 (II) public health, particularly
- 9 data that are indicative of sensitive
- 10 populations, such as—
- 11 (aa) rates of asthma;
- 12 (bb) rates of cardiovascular
- 13 disease;
- 14 (cc) childhood leukemia or
- 15 other cancers that correlate with
- 16 environmental hazards;
- 17 (dd) low birth weight;
- 18 (ee) maternal mortality;
- 19 (ff) rates of lead poisoning;
- 20 and
- 21 (gg) rates of diabetes;
- 22 (III) pollution burdens, such as
- 23 pollution burdens created by—
- 24 (aa) toxic chemicals;
- 25 (bb) air pollutants;

1 (cc) water pollutants;
2 (dd) soil contaminants; and
3 (ee) perfluoroalkyl and
4 polyfluoroalkyl substances; and
5 (IV) environmental effects, such
6 as effects created by proximity to—

7 (aa) risk management plan
8 sites;

9 (bb) hazardous waste facili-
10 ties;

11 (cc) sites on the National
12 Priorities List developed by the
13 President in accordance with sec-
14 tion 105(a)(8)(B) of the Com-
15 prehensive Environmental Re-
16 sponse, Compensation, and Li-
17 ability Act of 1980 (42 U.S.C.
18 9605(a)(8)(B)); and

19 (dd) fossil fuel infrastruc-
20 ture;

21 (ii) investigate how further indicators
22 of vulnerability to the impacts of climate
23 change (including proximity and exposure
24 to sea level rise, wildfire smoke, flooding,
25 drought, rising average temperatures, ex-

1 treme storms, and extreme heat, and fi-
2 nancial burdens from flood and fire insur-
3 ance) should be incorporated into the tool
4 as an additional set of layers;

5 (iii) identify and consider the effects
6 of other indicators relating to environ-
7 mental justice for integration into the tool
8 as layers, including—

9 (I) safe, sufficient, and affordable
10 drinking water, sanitation, and
11 stormwater services;

12 (II) access to and the quality
13 of—

14 (aa) green space and tree
15 canopy cover;

16 (bb) healthy food;

17 (cc) affordable energy and
18 water;

19 (dd) transportation;

20 (ee) reliable communication
21 systems, such as broadband
22 internet;

23 (ff) child care;

1 (gg) high-quality public
 2 schools, early childhood edu-
 3 cation, and child care; and

4 (hh) health care facilities;

5 (III) length of commute;

6 (IV) indoor air quality in multi-
 7 unit dwellings;

8 (V) mental health;

9 (VI) labor market categories,
 10 particularly relating to essential work-
 11 ers; and

12 (VII) each type of utility expense;

13 (iv) consider the implementation of
 14 specific regional indicators, with the poten-
 15 tial—

16 (I) to create regionally and lo-
 17 cally downscaled maps in addition to a
 18 national map;

19 (II) to provide incentives for
 20 States to collect data and conduct ad-
 21 ditional analyses to capture conditions
 22 specific to their localities;

23 (III) to provide resources for and
 24 engage in ground-truthing to identify

1 and verify important data with com-
2 munity members; and

3 (IV) to develop companion re-
4 sources for, and provide technical sup-
5 port to, regional, State, local, or Trib-
6 al governments to create their own
7 maps and environmental justice scores
8 with relevant regional, State, local,
9 and Tribal data;

10 (v) identify a methodology to account
11 for the cumulative impacts of all indicators
12 selected by the Committee under clause (i),
13 in addition to other indicators as the Com-
14 mittee determines to be necessary, to pro-
15 vide relative environmental justice scores
16 for regions that are—

17 (I) as small as practicable to
18 identify communities; and

19 (II) not larger than a census
20 tract;

21 (vi) ensure that the tool is capable of
22 providing maps of environmental justice
23 communities based on environmental jus-
24 tice scores described in clause (v);

1 (vii) ensure that users of the tool are
2 able to map available layers together or
3 independently as desired;

4 (viii) implement a method for users of
5 the tool to generate a map and environ-
6 mental justice score based on a subset of
7 indicators, particularly for the purpose of
8 using the tool in addressing various policy
9 needs, permitting processes, and invest-
10 ment goals;

11 (ix) make the tool customizable to ad-
12 dress specific policy needs, permitting
13 processes, and investment goals;

14 (x) account for conditions that are not
15 captured by the quantitative data used to
16 develop the 1 or more maps and environ-
17 mental justice scores comprising the tool,
18 by—

19 (I) developing and executing a
20 plan to perform outreach to relevant
21 communities; and

22 (II) establishing a mechanism by
23 which communities can self-identify as
24 environmental justice communities to
25 be included in the tool, which may in-

1 include citing qualitative data on condi-
2 tions for which quantitative data are
3 lacking, such as cultural loss in Tribal
4 communities;

5 (xi) consider that the tool—

6 (I) will be used across the Fed-
7 eral Government in screening Federal
8 policies, permitting processes, and in-
9 vestments for environmental and cli-
10 mate justice impacts; and

11 (II) may be used to assess com-
12 munities for pollution reduction pro-
13 grams; and

14 (xii) carry out such other activities as
15 the Committee determines to be appro-
16 priate.

17 (3) TRANSPARENCY AND UPDATES.—

18 (A) IN GENERAL.—

19 (i) NOTICE AND COMMENT.—The
20 Committee shall establish the tool de-
21 scribed in paragraph (2) after providing
22 notice and an opportunity for public com-
23 ment.

24 (ii) HEARINGS.—In carrying out
25 clause (i), the Committee shall hold hear-

1 ings, which shall be time and language ap-
2 propriate, in communities affected by envi-
3 ronmental justice issues in geographically
4 disparate States and Tribal areas.

5 (B) UPDATES.—

6 (i) ANNUAL UPDATES.—The Com-
7 mittee shall update the tool described in
8 paragraph (2) not less frequently than an-
9 nually to account for data sets that are up-
10 dated annually.

11 (ii) OTHER UPDATES.—Not less fre-
12 quently than once every 3 years, the Com-
13 mittee shall—

14 (I) update the indicators, meth-
15 odology, or both for the tool described
16 in paragraph (2); and

17 (II) reevaluate data submitted by
18 Federal departments and agencies
19 that is used for the tool.

20 (iii) REPORTS.—After the initial es-
21 tablishment of the tool described in para-
22 graph (2) and each update under clause (i)
23 or (ii), the Committee shall publish a re-
24 port describing—

1 (I) the process for identifying in-
2 dicators relating to environmental jus-
3 tice in the development of the tool;

4 (II) the methodology described in
5 paragraph (2)(B)(v); and

6 (III) the use of public input and
7 community engagement in that proc-
8 ess.

9 (C) TRAINING TUTORIALS AND SES-
10 SIONS.—

11 (i) IN GENERAL.—The Committee
12 shall—

13 (I) develop virtual training tuto-
14 rials and sessions for environmental
15 justice communities for the use of the
16 tool described in paragraph (2); and

17 (II) where practicable, provide in-
18 person training sessions for environ-
19 mental justice communities for the
20 use of that tool.

21 (ii) LANGUAGES.—The tutorials and
22 sessions under clause (i) shall be made
23 available in each language commonly used
24 in the applicable environmental justice
25 community.

(D) PUBLIC AVAILABILITY.—

(i) IN GENERAL.—The Committee shall make available to the public on an internet website of the Environmental Protection Agency—

(I) the tool described in paragraph (2);

(II) each update under clauses (i) and (ii) of subparagraph (B);

(III) each report under subparagraph (B)(iii); and

(IV) the training tutorials and sessions developed under subparagraph (C)(i)(I).

(ii) ACCESSIBILITY.—The Committee shall make the tool, updates, and reports described in clause (i) accessible to the public by publication in relevant languages and with accessibility functions, as appropriate.

(iii) REQUIREMENT.—In carrying out clause (i)(I), the Committee shall take measures to prevent the tool from being misused to discriminate against environmental justice communities, such as by

1 providing safeguards against the use of
2 downscaled data that may enable the iden-
3 tification of individuals.

4 (4) DATA GAP AUDIT.—

5 (A) IN GENERAL.—In establishing the tool
6 described in paragraph (2), the Committee shall
7 direct relevant Federal departments and agen-
8 cies to conduct an audit of data collected by the
9 department or agency to identify any data that
10 are relevant to environmental justice concerns,
11 including data relating to—

12 (i) public health metrics;

13 (ii) toxic chemicals;

14 (iii) socioeconomic demographics;

15 (iv) air quality;

16 (v) water quality; and

17 (vi) killings of individuals by law en-
18 forcement officers.

19 (B) REQUIREMENTS.—An audit described
20 in subparagraph (A) shall—

21 (i) examine the granularity and acces-
22 sibility of the data;

23 (ii) address the need for improved air
24 quality monitoring; and

1 (iii) include recommendations to other
2 Federal departments and agencies on
3 means to improve the quality, granularity,
4 and transparency of, and public involve-
5 ment in, data collection and dissemination.

6 (C) IMPROVEMENTS.—The Committee
7 shall direct a Federal department or agency, in
8 conducting an audit under subparagraph (A), to
9 address gaps in existing data collection that will
10 assist the Committee in establishing and oper-
11 ating the tool described in paragraph (2), in-
12 cluding by providing to the department or agen-
13 cy—

14 (i) benchmarks to meet in addressing
15 the gaps;

16 (ii) instructions for consistency in
17 data formatting that will allow for inclu-
18 sion of data in the environmental justice
19 data repository described in subsection (d);
20 and

21 (iii) best practices for collecting data
22 in collaboration with local organizations
23 and partners, such as engaging in ground-
24 truthing.

1 (D) REPORTS.—Not later than 180 days
2 after a Federal department or agency has con-
3 ducted an audit under subparagraph (A), the
4 Committee shall—

5 (i) make available to the public on an
6 internet website of the Environmental Pro-
7 tection Agency a report describing the
8 findings and conclusions of the audit, in-
9 cluding the progress made by the Federal
10 department or agency in addressing envi-
11 ronmental justice data gaps; and

12 (ii) submit the report described in
13 clause (i) to—

14 (I) the Committee on Environ-
15 ment and Public Works of the Senate;

16 (II) the Committee on Health,
17 Education, Labor, and Pensions of
18 the Senate;

19 (III) the Committee on Energy
20 and Commerce of the House of Rep-
21 resentatives; and

22 (IV) the Committee on Education
23 and Workforce of the House of Rep-
24 resentatives.

25 (d) ENVIRONMENTAL JUSTICE DATA REPOSITORY.—

1 (1) IN GENERAL.—The Administrator shall es-
2 tablish an environmental justice data repository to
3 maintain—

4 (A) the data collected by the Committee
5 through the establishment of the tool described
6 in subsection (c)(2) and the audits conducted
7 under subsection (c)(4)(A); and

8 (B) any subnational data collected under
9 paragraph (3)(B).

10 (2) UPDATES.—The Administrator shall update
11 the data in the data repository described in para-
12 graph (1) as frequently as practicable, including
13 every year if practicable, but not less frequently than
14 once every 3 years.

15 (3) AVAILABILITY; INCLUSION OF SUBNATIONAL
16 DATA.—The Administrator—

17 (A) shall make the data repository de-
18 scribed in paragraph (1) available to regional,
19 State, local, and Tribal governments; and

20 (B) may collaborate with the governments
21 described in subparagraph (A) to include within
22 that data repository subnational data in exist-
23 ence before the establishment of the tool de-
24 scribed in subsection (c)(2) and the completion
25 of the audits under subsection (c)(4)(A).

1 (4) REQUIREMENT.—The Administrator shall
 2 take measures to prevent the data in the data repos-
 3 itory described in paragraph (1) from being misused
 4 to discriminate against environmental justice com-
 5 munities, such as by providing safeguards against
 6 the use of downscaled data that may enable the
 7 identification of individuals.

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There
 9 are authorized to be appropriated to the Administrator to
 10 carry out this section, including any necessary administra-
 11 tive costs of the Committee—

12 (1) \$20,000,000 for each of fiscal years 2027
 13 and 2028; and

14 (2) \$18,000,000 for each of fiscal years 2029
 15 through 2031.

16 (f) EFFECT.—Nothing in any provision of this section
 17 relating to the tool described in subsection (c)(2) prohibits
 18 a State from developing a map relating to environmental
 19 justice or pollution burden that relies on different data,
 20 or analyzes data differently, than that tool.

21 **SEC. 10012. ANTIRACISM IN PUBLIC HEALTH.**

22 (a) PUBLIC HEALTH RESEARCH AND INVESTMENT
 23 IN DISMANTLING STRUCTURAL RACISM.—Part B of title
 24 III of the Public Health Service Act (42 U.S.C. 243 et

1 seq.), as amended by section 5201(d), is further amended
 2 by adding at the end the following:

3 **“SEC. 320D. NATIONAL CENTER ON ANTIRACISM AND**
 4 **HEALTH.**

5 “(a) IN GENERAL.—

6 “(1) NATIONAL CENTER.—There is established
 7 within the Centers for Disease Control and Preven-
 8 tion a center to be known as the ‘National Center
 9 on Antiracism and Health’ (referred to in this sec-
 10 tion as the ‘Center’). The Director of the Centers for
 11 Disease Control and Prevention shall appoint a di-
 12 rector to head the Center who has experience living
 13 in and working with racial and ethnic minority com-
 14 munities. The Center shall promote public health
 15 by—

16 “(A) declaring racism a public health crisis
 17 and naming racism as an historical and present
 18 threat to the physical and mental health and
 19 well-being of the United States and world;

20 “(B) aiming to develop new knowledge in
 21 the science and practice of antiracism, including
 22 by identifying the mechanisms by which racism
 23 operates in the provision of health care and in
 24 systems that impact health and well-being;

1 “(C) transferring that knowledge into
2 practice, including by developing interventions
3 that dismantle the mechanisms of racism and
4 replace such mechanisms with equitable struc-
5 tures, policies, practices, norms, and values so
6 that a healthy society can be realized; and

7 “(D) contributing to a national and global
8 conversation regarding the impacts of racism on
9 the health and well-being of the United States
10 and world.

11 “(2) GENERAL DUTIES.—The Secretary, acting
12 through the Center, shall undertake activities to
13 carry out the mission of the Center as described in
14 paragraph (1), such as the following:

15 “(A) Conduct research into, collect, ana-
16 lyze and make publicly available data on, and
17 provide leadership and coordination for the
18 science and practice of antiracism, the public
19 health impacts of structural racism, and the ef-
20 fectiveness of intervention strategies to address
21 these impacts. Topics of research and data col-
22 lection under this subparagraph may include
23 identifying and understanding—

1 “(i) policies and practices that have a
 2 disparate impact on the health and well-
 3 being of communities of color;

4 “(ii) the public health impacts of im-
 5 plicit racial bias, White supremacy, weath-
 6 ering, xenophobia, discrimination, and
 7 prejudice;

8 “(iii) the social determinants of health
 9 resulting from structural racism, including
 10 poverty, housing, employment, political
 11 participation, and environmental factors;
 12 and

13 “(iv) the intersection of racism and
 14 other systems of oppression, including as
 15 related to age, sexual orientation, gender
 16 identity, and disability status.

17 “(B) Award noncompetitive grants and co-
 18 operative agreements to eligible public and non-
 19 profit private entities, including State, local,
 20 territorial, and Tribal health agencies and orga-
 21 nizations, for the research and collection, anal-
 22 ysis, and reporting of data on the topics de-
 23 scribed in subparagraph (A).

24 “(C) Establish, through grants or coopera-
 25 tive agreements, at least 3 regional centers of

1 excellence, located in racial and ethnic minority
2 communities, in antiracism for the purpose of
3 developing new knowledge in the science and
4 practice of antiracism in health by researching,
5 understanding, and identifying the mechanisms
6 by which racism operates in the health space,
7 racial and ethnic inequities in health care ac-
8 cess and outcomes, the history of successful
9 antiracist movements in health, and other
10 antiracist public health work.

11 “(D) Establish a clearinghouse within the
12 Centers for Disease Control and Prevention for
13 the collection and storage of data generated
14 under the programs implemented under this
15 section for which there is not an otherwise ex-
16 isting surveillance system at the Centers for
17 Disease Control and Prevention. Such data
18 shall—

19 “(i) be comprehensive and
20 disaggregated, to the extent practicable, by
21 including racial, ethnic, primary language,
22 sex, gender identity, sexual orientation,
23 age, socioeconomic status, and disability
24 disparities;

25 “(ii) be made publicly available;

1 “(iii) protect the privacy of individuals
 2 whose information is included in such data;
 3 and

4 “(iv) comply with privacy protections
 5 under the regulations promulgated under
 6 section 264(c) of the Health Insurance
 7 Portability and Accountability Act of 1996.

8 “(E) Provide information and education to
 9 the public on the public health impacts of struc-
 10 tural racism and on antiracist public health
 11 interventions.

12 “(F) Consult with other Centers and Na-
 13 tional Institutes within the Centers for Disease
 14 Control and Prevention, including the Office of
 15 Health Equity, the Office of Tribal Affairs and
 16 Strategic Alliances, the Office of Rural Health,
 17 and the Office of Island Affairs, to ensure that
 18 scientific and programmatic activities initiated
 19 by the agency consider structural racism in
 20 their designs, conceptualizations, and execu-
 21 tions, which shall include—

22 “(i) putting measures of racism in
 23 population-based surveys;

24 “(ii) establishing a Federal Advisory
 25 Committee on racism and health for the

1 Centers for Disease Control and Preven-
2 tion;

3 “(iii) developing training programs,
4 curricula, and seminars for the purposes of
5 training public health professionals and re-
6 searchers around issues of race, racism,
7 and antiracism;

8 “(iv) providing standards and best
9 practices for programming and grant re-
10 cipient compliance with Federal data col-
11 lection standards, including section 3101
12 of the Public Health Service Act; and

13 “(v) establishing leadership and stake-
14 holder councils with experts and leaders in
15 racism and public health disparities.

16 “(G) Coordinate with the Indian Health
17 Service and with the Tribal Advisory Committee
18 of the Centers for Disease Control and Preven-
19 tion to ensure meaningful Tribal consultation,
20 the gathering of information from Tribal au-
21 thorities, and respect for Tribal data sov-
22 ereignty.

23 “(H) Engage in government to government
24 consultation with Indian Tribes and Tribal or-
25 ganizations.

1 “(I) At least every 2 years, produce and
 2 publicly post on the Centers for Disease Control
 3 and Prevention’s website a report on antiracist
 4 activities completed by the Center, which may
 5 include newly identified antiracist public health
 6 practices.

7 “(b) DEFINITIONS.—In this section:

8 “(1) ANTIRACISM.—The term ‘antiracism’ is a
 9 collection of antiracist policies that lead to racial eq-
 10 uity, and are substantiated by antiracist ideas.

11 “(2) ANTIRACIST.—The term ‘antiracist’ is any
 12 measure that produces or sustains racial equity be-
 13 tween racial groups.

14 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
 15 is authorized to be appropriated such sums as may be nec-
 16 essary to carry out this section.”.

17 (b) PUBLIC HEALTH RESEARCH AND INVESTMENT
 18 IN POLICE VIOLENCE.—

19 (1) IN GENERAL.—The Secretary shall establish
 20 within the National Center for Injury Prevention
 21 and Control of the Centers for Disease Control and
 22 Prevention (referred to in this subsection as the
 23 “Center”) a law enforcement violence prevention
 24 program.

1 (2) GENERAL DUTIES.—In implementing the
2 program under paragraph (1), the Center shall con-
3 duct research into, and provide leadership and co-
4 ordination for—

5 (A) the understanding and promotion of
6 knowledge about the public health impacts of
7 uses of force by law enforcement, including po-
8 lice brutality and violence;

9 (B) developing public health interventions
10 and perspectives for eliminating deaths, injury,
11 trauma, and negative mental health effects
12 from police presence and interactions, including
13 police brutality and violence; and

14 (C) ensuring comprehensive data collection,
15 analysis, and reporting regarding police violence
16 and misconduct, in consultation with the De-
17 partment of Justice and independent research-
18 ers.

19 (3) FUNCTIONS.—Under the program under
20 paragraph (1), the Center shall—

21 (A) summarize and enhance the knowledge
22 of the distribution, status, and characteristics
23 of law enforcement-related death, trauma, and
24 injury;

1 (B) conduct research and prepare, with the
2 assistance of State public health departments—

3 (i) statistics on law enforcement-re-
4 lated death, injury, and brutality;

5 (ii) studies of the factors, including
6 legal, socioeconomic, discrimination, and
7 other factors that correlate with or influ-
8 ence police brutality;

9 (iii) public information about uses of
10 force by law enforcement, including police
11 brutality and violence, for the practical use
12 of the public health community, including
13 publications that synthesize information
14 relevant to the national goal of under-
15 standing police violence and methods for
16 its control;

17 (iv) information to identify socio-
18 economic groups, communities, and geo-
19 graphic areas in need of study, and a stra-
20 tegic plan for research necessary to com-
21 prehend the extent and nature of police
22 uses of force by law enforcement, including
23 police brutality and violence, and deter-
24 mine what options exist to reduce or eradi-
25 cate death and injury that result; and

1 (v) best practices in police violence
2 prevention in other countries;

3 (C) award grants, contracts, and coopera-
4 tive agreements to provide for the conduct of
5 epidemiologic research on uses of force by law
6 enforcement, including police brutality and vio-
7 lence, by Federal, State, local, and private
8 agencies, institutions, organizations, and indi-
9 viduals;

10 (D) award grants, contracts, and coopera-
11 tive agreements to community groups, inde-
12 pendent research organizations, academic insti-
13 tutions, and other entities to support, execute,
14 or conduct research on interventions to reduce
15 or eliminate uses of force by law enforcement,
16 including police brutality and violence;

17 (E) coordinate with the Department of
18 Justice and other Federal, State, and local
19 agencies on the standardization of data collec-
20 tion, storage, and retrieval necessary to collect,
21 evaluate, analyze, and disseminate information
22 about the extent and nature of uses of force by
23 law enforcement, including police brutality and
24 violence, as well as options for the eradication
25 of such practices;

1 (F) submit an annual report to Congress
2 on research findings with recommendations to
3 improve data collection and standardization and
4 to disrupt processes in policing that preserve
5 and reinforce racism and racial disparities in
6 public health;

7 (G) conduct primary research and explore
8 uses of force by law enforcement, including po-
9 lice brutality and violence, and options for its
10 control; and

11 (H) study alternatives to law enforcement
12 response as a method of reducing police vio-
13 lence.

14 (4) AUTHORIZATION OF APPROPRIATIONS.—

15 There is authorized to be appropriated such sums as
16 may be necessary to carry out this subsection.

17 **SEC. 10013. LGBTQ ESSENTIAL DATA.**

18 (a) IMPROVING DATA COLLECTION ON THE SEXUAL
19 ORIENTATION AND GENDER IDENTITY OF DECEASED IN-
20 DIVIDUALS THROUGH THE NATIONAL VIOLENT DEATH
21 REPORTING SYSTEM.—

22 (1) COLLECTION OF SEXUAL ORIENTATION AND
23 GENDER IDENTITY DATA.—

24 (A) IN GENERAL.—Not later than 120
25 days after the date of enactment of this Act,

1 the Director of the Centers for Disease Control
2 and Prevention shall take measures to improve
3 the incidence of the collection of information on
4 the sexual orientation and gender identity of de-
5 ceased individuals through the National Violent
6 Death Reporting System or any successor pro-
7 grams.

8 (B) CONFIDENTIALITY.—Any information
9 collected relating to the sexual orientation or
10 gender identity of a decedent shall be main-
11 tained in accordance with the confidentiality
12 and privacy standards and policies for the pro-
13 tection of individuals applicable to all other
14 data collected for purposes of the National Vio-
15 lent Death Reporting System.

16 (2) DEFINITIONS.—In this subsection:

17 (A) GENDER IDENTITY.—The term “gen-
18 der identity” means an individual’s sense of
19 being male, female, transgender, or another
20 gender, as distinct from the individual’s sex as-
21 signed at birth.

22 (B) SEXUAL ORIENTATION.—The term
23 “sexual orientation” means how a person iden-
24 tifies in terms of their emotional, romantic, or
25 sexual attractions, and includes identification as

1 straight, heterosexual, gay, lesbian, or bisexual,
2 among other terms.

3 (3) AUTHORIZATION.—There is authorized to
4 be appropriated \$25,000,000 for fiscal year 2027 to
5 carry out this subsection.

6 (b) SENSE OF CONGRESS.—It is the sense of Con-
7 gress that—

8 (1) the Centers for Disease Control and Preven-
9 tion has made significant efforts to encourage States
10 and other jurisdictions to collect data on sexual ori-
11 entation and gender identity through the National
12 Violent Death Reporting System; and

13 (2) jurisdictions that participate in the collec-
14 tion of such data through the National Violent
15 Death Reporting System should be commended for
16 their participation.

17 **SEC. 10014. SOCIAL DETERMINANTS ACCELERATOR.**

18 (a) PURPOSES.—The purposes of this section are as
19 follows:

20 (1) To establish effective, coordinated Federal
21 technical assistance to help State and local govern-
22 ments to improve outcomes and cost-effectiveness of,
23 and return on investment from, health and social
24 services programs.

1 (2) To build a pipeline of State and locally de-
2 signed, cross-sector interventions and strategies that
3 generate rigorous evidence about how to improve
4 health and social outcomes, and increase the cost-ef-
5 fectiveness of, and return on investment from, Fed-
6 eral, State, local, and Tribal health and social serv-
7 ices programs.

8 (3) To enlist State and local governments and
9 the service providers of such governments as part-
10 ners in identifying Federal statutory, regulatory, and
11 administrative challenges in improving the health
12 and social outcomes of, cost-effectiveness of, and re-
13 turn on investment from, Federal spending on indi-
14 viduals enrolled in the Medicaid program under title
15 XIX of the Social Security Act (42 U.S.C. 1396 et
16 seq.).

17 (4) To develop strategies to improve health and
18 social outcomes without denying services to, or re-
19 stricting the eligibility of, vulnerable populations.

20 (b) SOCIAL DETERMINANTS ACCELERATOR COUN-
21 CIL.—

22 (1) ESTABLISHMENT.—The Secretary, in co-
23 ordination with the Administrator of the Centers for
24 Medicare & Medicaid Services (referred to in this
25 section as the “Administrator”), shall establish an

1 interagency council, to be known as the Social De-
2 terminants Accelerator Interagency Council (referred
3 to in this section as the “Council”), to achieve the
4 purposes listed in subsection (a).

5 (2) MEMBERSHIP.—

6 (A) FEDERAL COMPOSITION.—The Council
7 shall be composed of at least one designee from
8 each of the following Federal agencies:

9 (i) The Office of Management and
10 Budget.

11 (ii) The Department of Agriculture.

12 (iii) The Department of Education.

13 (iv) The Indian Health Service.

14 (v) The Department of Housing and
15 Urban Development.

16 (vi) The Department of Labor.

17 (vii) The Department of Transpor-
18 tation.

19 (viii) Any other Federal agency the
20 Chair of the Council determines necessary.

21 (B) DESIGNATION.—

22 (i) IN GENERAL.—The head of each
23 agency specified in subparagraph (A) shall
24 designate at least one employee described

1 in clause (ii) to serve as a member of the
2 Council.

3 (ii) RESPONSIBILITIES.—An employee
4 described in this clause shall be a senior
5 employee of the agency—

6 (I) whose responsibilities relate
7 to authorities, policies, and procedures
8 with respect to the health and well-
9 being of individuals receiving medical
10 assistance under a State plan (or a
11 waiver of such plan) under title XIX
12 of the Social Security Act (42 U.S.C.
13 1396 et seq.); or

14 (II) who has authority to imple-
15 ment and evaluate transformative ini-
16 tiatives that harness data or conducts
17 rigorous evaluation to improve the im-
18 pact and cost-effectiveness of federally
19 funded services and benefits.

20 (C) HHS REPRESENTATION.—In addition
21 to the designees under subparagraph (A), the
22 Council shall include designees from at least
23 three agencies within the Department of Health
24 and Human Services, including the Centers for
25 Medicare & Medicaid Services, at least one of

whom shall meet the criteria under subparagraph (B)(ii).

(D) OMB ROLE.—The Director of the Office of Management and Budget shall facilitate the timely resolution of Government-wide and multiagency issues to help the Council achieve consensus recommendations described under paragraph (3)(A).

(E) NON-FEDERAL COMPOSITION.—The Comptroller General of the United States may designate up to 6 Council designees—

(i) who have relevant subject matter expertise, including expertise implementing and evaluating transformative initiatives that harness data and conduct evaluations to improve the impact and cost-effectiveness of Federal Government services; and

(ii) that each represent—

(I) State, local, and Tribal health and human services agencies;

(II) public housing authorities or State housing finance agencies;

(III) State and local government budget offices;

(IV) State Medicaid agencies; or

1 (V) national consumer advocacy
2 organizations.

3 (F) CHAIR.—

4 (i) IN GENERAL.—The Secretary shall
5 select the Chair of the Council from among
6 the members of the Council.

7 (ii) INITIATING GUIDANCE.—The
8 Chair, on behalf of the Council, shall iden-
9 tify and invite individuals from diverse en-
10 tities to provide the Council with advice
11 and information pertaining to addressing
12 social determinants of health, including—

13 (I) individuals from State and
14 local government health and human
15 services agencies;

16 (II) individuals from State Med-
17 icaid agencies;

18 (III) individuals from State and
19 local government budget offices;

20 (IV) individuals from public
21 housing authorities or State housing
22 finance agencies;

23 (V) individuals from nonprofit or-
24 ganizations, small businesses, and
25 philanthropic organizations;

- 1 (VI) advocates;
- 2 (VII) researchers; and
- 3 (VIII) any other individuals the
- 4 Chair determines to be appropriate.

5 (3) DUTIES.—The duties of the Council are—

6 (A) to make recommendations to the Sec-
7 retary and the Administrator regarding the cri-
8 teria for making awards under subsection (b);

9 (B) to identify Federal authorities and op-
10 portunities for use by States or local govern-
11 ments to improve coordination of funding and
12 administration of Federal programs, the bene-
13 ficiaries of whom include individuals described
14 in subsection (a), and which may be unknown
15 or underutilized and to make information on
16 such authorities and opportunities publicly
17 available;

18 (C) to provide targeted technical assistance
19 to States developing a social determinants ac-
20 celerator plan under subsection (c), including
21 identifying potential statutory or regulatory
22 pathways for implementation of the plan and
23 assisting in identifying potential sources of
24 funding to implement the plan;

1 (D) to report to Congress annually on the
2 subjects set forth in paragraph (5);

3 (E) to develop and disseminate evaluation
4 guidelines and standards that can be used to
5 reliably assess the impact of an intervention or
6 approach that may be implemented pursuant to
7 this section on outcomes, cost-effectiveness of,
8 and return on investment from Federal, State,
9 local, and Tribal governments, and to facilitate
10 technical assistance, where needed, to help to
11 improve State and local evaluation designs and
12 implementation;

13 (F) to seek feedback from State, local, and
14 Tribal governments, including through an an-
15 nual survey by an independent third party, on
16 how to improve the technical assistance the
17 Council provides to better equip State, local,
18 and Tribal governments to coordinate health
19 and social service programs;

20 (G) to solicit applications for grants under
21 subsection (c); and

22 (H) to coordinate with other cross-agency
23 initiatives focused on improving the health and
24 well-being of low-income and at-risk populations

1 in order to prevent unnecessary duplication be-
2 tween agency initiatives.

3 (4) SCHEDULE.—Not later than 60 days after
4 the date of enactment of this Act, the Council shall
5 convene to develop a schedule and plan for carrying
6 out the duties described in paragraph (3), including
7 solicitation of applications for the grants under sub-
8 section (c).

9 (5) REPORT TO CONGRESS.—The Council shall
10 submit an annual report to Congress, which shall in-
11 clude—

12 (A) a list of the Council members;

13 (B) a description of the activities and ex-
14 penditures of the Council;

15 (C) summaries of the interventions and ap-
16 proaches that will be supported by State, local,
17 and Tribal governments that received a grant
18 under subsection (c), including—

19 (i) the best practices and evidence-
20 based approaches such governments plan
21 to employ to achieve the purposes listed in
22 subsection (a); and

23 (ii) a description of how the practices
24 and approaches will impact the outcomes,
25 cost-effectiveness of, and return on invest-

1 ment from, Federal, State, local, and Trib-
2 al governments with respect to such pur-
3 poses;

4 (D) the feedback received from State and
5 local governments on ways to improve the tech-
6 nical assistance of the Council, including find-
7 ings from a third-party survey and actions the
8 Council plans to take in response to such feed-
9 back; and

10 (E) the major statutory, regulatory, and
11 administrative challenges identified by State,
12 local, and Tribal governments that received a
13 grant under subsection (c), and the actions that
14 Federal agencies are taking to address such
15 challenges.

16 (6) FACA APPLICABILITY.—Chapter 10 of title
17 5, United States Code, shall not apply to the Coun-
18 cil.

19 (7) COUNCIL PROCEDURES.—The Secretary, in
20 consultation with the Comptroller General of the
21 United States and the Director of the Office of Man-
22 agement and Budget, shall establish procedures for
23 the Council to—

1 (A) ensure that adequate resources are
2 available to effectively execute the responsibil-
3 ities of the Council;

4 (B) effectively coordinate with other rel-
5 evant advisory bodies and working groups to
6 avoid unnecessary duplication;

7 (C) create transparency to the public and
8 Congress with regard to Council membership,
9 costs, and activities, including through use of
10 modern technology and social media to dissemi-
11 nate information; and

12 (D) avoid conflicts of interest that would
13 jeopardize the ability of the Council to make de-
14 cisions and provide recommendations.

15 (c) SOCIAL DETERMINANTS ACCELERATOR GRANTS
16 TO STATES OR LOCAL GOVERNMENTS.—

17 (1) GRANTS TO STATES, LOCAL GOVERNMENTS,
18 AND TRIBES.—Not later than 180 days after the
19 date of enactment of this Act, the Administrator, in
20 consultation with the Secretary and the Council,
21 shall award on a competitive basis not more than 25
22 grants to eligible applicants described in paragraph
23 (2), for the development of social determinants ac-
24 celerator plans, as described in paragraph (6).

1 (2) ELIGIBLE APPLICANT.—An eligible appli-
2 cant described in this subsection is a State, local, or
3 Tribal health or human services agency that—

4 (A) demonstrates the support of relevant
5 parties across relevant State, local, or Tribal ju-
6 risdictions; and

7 (B) in the case of an applicant that is a
8 local government agency, provides to the Sec-
9 retary a letter of support from the lead State
10 health or human services agency for the State
11 in which the local government is located.

12 (3) AMOUNT OF GRANT.—The Administrator,
13 in coordination with the Council, shall determine the
14 total amount that the Administrator will make avail-
15 able to each grantee under this subsection.

16 (4) APPLICATION.—An eligible applicant seek-
17 ing a grant under this subsection shall include in the
18 application the following information:

19 (A) The target population (or populations)
20 that would benefit from implementation of the
21 social determinants accelerator plan proposed to
22 be developed by the applicant.

23 (B) A description of the objective or objec-
24 tives and outcome goals of such proposed plan,
25 which shall include at least one health outcome

1 and at least one other important social out-
2 come.

3 (C) The sources and scope of inefficiencies
4 that, if addressed by the plan, could result in
5 improved cost-effectiveness of or return on in-
6 vestment from Federal, State, local, and Tribal
7 governments.

8 (D) A description of potential interventions
9 that could be designed or enabled using such
10 proposed plan.

11 (E) The State, local, Tribal, academic,
12 nonprofit, community-based organizations, and
13 other private sector partners that would partici-
14 pate in the development of the proposed plan
15 and subsequent implementation of programs or
16 initiatives included in such proposed plan.

17 (F) Such other information as the Admin-
18 istrator, in consultation with the Secretary and
19 the Council, determines necessary to achieve the
20 purposes of this section.

21 (5) USE OF FUNDS.—A recipient of a grant
22 under this subsection may use funds received
23 through the grant for the following purposes:

24 (A) To convene and coordinate with rel-
25 evant government entities and other stake-

1 holders across sectors to assist in the develop-
2 ment of a social determinants accelerator plan.

3 (B) To identify populations of individuals
4 receiving medical assistance under a State plan
5 (or a waiver of such plan) under title XIX of
6 the Social Security Act (42 U.S.C. 1396 et
7 seq.) who may benefit from the proposed ap-
8 proaches to improving the health and well-being
9 of such individuals through the implementation
10 of the proposed social determinants accelerator
11 plan.

12 (C) To engage qualified research experts to
13 advise on relevant research and to design a pro-
14 posed evaluation plan, in accordance with the
15 standards and guidelines issued by the Admin-
16 istrator.

17 (D) To collaborate with the Council to sup-
18 port the development of social determinants ac-
19 celerator plans.

20 (E) To prepare and submit a final social
21 determinants accelerator plan to the Council.

22 (6) CONTENTS OF PLANS.—A social deter-
23 minants accelerator plan developed under this sub-
24 section shall include the following:

1 (A) A description of the target population
2 (or populations) that would benefit from imple-
3 mentation of the social determinants accelerator
4 plan, including an analysis describing the pro-
5 jected impact on the well-being of individuals
6 described in paragraph (5)(B).

7 (B) A description of the interventions or
8 approaches designed under the social deter-
9 minants accelerator plan and the evidence for
10 selecting such interventions or approaches.

11 (C) The objectives and outcome goals of
12 such interventions or approaches, including at
13 least one health outcome and at least one other
14 important social outcome.

15 (D) A plan for accessing and linking rel-
16 evant data to enable coordinated benefits and
17 services for the jurisdictions described in para-
18 graph (2)(A) and an evaluation of the proposed
19 interventions and approaches.

20 (E) A description of the State, local, Trib-
21 al, academic, nonprofit, or community-based or-
22 ganizations, or any other private sector organi-
23 zations that would participate in implementing
24 the proposed interventions or approaches, and
25 the role each would play to contribute to the

1 success of the proposed interventions or ap-
2 proaches.

3 (F) The identification of the funding
4 sources that would be used to finance the pro-
5 posed interventions or approaches.

6 (G) A description of any financial incen-
7 tives that may be provided, including outcome-
8 focused contracting approaches to encourage
9 service providers and other partners to improve
10 outcomes of, cost-effectiveness of, and return on
11 investment from, Federal, State, local, or Tribal
12 government spending.

13 (H) The identification of the applicable
14 Federal, State, local, or Tribal statutory and
15 regulatory authorities, including waiver authori-
16 ties, to be leveraged to implement the proposed
17 interventions or approaches.

18 (I) A description of potential consider-
19 ations that would enhance the impact,
20 scalability, or sustainability of the proposed
21 interventions or approaches and the actions the
22 grant awardee would take to address such con-
23 siderations.

24 (J) A proposed evaluation plan, to be car-
25 ried out by an independent evaluator, to meas-

1 ure the impact of the proposed interventions or
2 approaches on the outcomes of, cost-effective-
3 ness of, and return on investment from, Fed-
4 eral, State, local, and Tribal governments.

5 (K) Precautions for ensuring that vulner-
6 able populations will not be denied access to
7 Medicaid or other essential services as a result
8 of implementing the proposed plan.

9 (d) FUNDING.—

10 (1) IN GENERAL.—Out of any money in the
11 Treasury not otherwise appropriated, there is appro-
12 priated to carry out this section \$25,000,000 for the
13 period of fiscal years 2027 through 2031, of which
14 up to \$5,000,000 may be used to carry out this sec-
15 tion, to remain available for obligation until the date
16 that is 5 years after the date of enactment of this
17 Act.

18 (2) RESERVATION OF FUNDS.—

19 (A) IN GENERAL.—Of the funds made
20 available under paragraph (1), the Secretary
21 shall reserve not less than 20 percent to award
22 grants to eligible applicants for the development
23 of social determinants accelerator plans under
24 subsection (c) intended to serve rural popu-
25 lations.

1 (B) EXCEPTION.—In the case of a fiscal
2 year for which the Secretary determines that
3 there are not sufficient eligible applicants for
4 grants under subsection (c) that are intended to
5 serve rural populations and the Secretary can-
6 not satisfy the 20-percent requirement, the Sec-
7 retary may reserve an amount that is less than
8 20 percent of amounts made available under
9 paragraph (1) to award grants for such pur-
10 pose.

11 (3) RULE OF CONSTRUCTION.—Nothing in this
12 section shall prevent Federal agencies represented
13 on the Council from contributing additional funding
14 from other sources to support activities to improve
15 the effectiveness of the Council.

16 **SEC. 10015. IMPROVING SOCIAL DETERMINANTS OF**
17 **HEALTH.**

18 (a) SOCIAL DETERMINANTS OF HEALTH PRO-
19 GRAM.—

20 (1) PROGRAM.—To the extent and in the
21 amounts made available in advance in appropriations
22 Acts, the Director of the Centers for Disease Control
23 and Prevention (in this section referred to as the
24 “Director”) shall carry out a program, to be known
25 as the Social Determinants of Health Program (in

1 this section referred to as the “Program”), to
2 achieve the following goals:

3 (A) Improve health outcomes and reduce
4 health inequities by coordinating social deter-
5 minants of health activities across the Centers
6 for Disease Control and Prevention.

7 (B) Improve the capacity of public health
8 agencies and community organizations to ad-
9 dress social determinants of health in commu-
10 nities.

11 (2) ACTIVITIES.—To achieve the goals listed in
12 paragraph (1), the Director shall carry out activities
13 including the following:

14 (A) Coordinating across the Centers for
15 Disease Control and Prevention to ensure that
16 relevant programs consider and incorporate so-
17 cial determinants of health in grant awards and
18 other activities.

19 (B) Awarding grants under subsection (b)
20 to State, local, territorial, and Tribal health
21 agencies and organizations, and to other eligible
22 entities, to address social determinants of
23 health in target communities.

1 (C) Awarding grants under subsection (c)
 2 to nonprofit organizations and public or other
 3 nonprofit institutions of higher education—

4 (i) to conduct research on best prac-
 5 tices to improve social determinants of
 6 health;

7 (ii) to provide technical assistance,
 8 training, and evaluation assistance to
 9 grantees under subsection (b); and

10 (iii) to disseminate best practices to
 11 grantees under subsection (b).

12 (D) Coordinating, supporting, and aligning
 13 activities of the Centers for Disease Control and
 14 Prevention related to social determinants of
 15 health with activities of other Federal agencies
 16 related to social determinants of health, includ-
 17 ing such activities of agencies in the Depart-
 18 ment of Health and Human Services such as
 19 the Centers for Medicare & Medicaid Services.

20 (E) Collecting and analyzing data related
 21 to the social determinants of health.

22 (b) GRANTS TO ADDRESS SOCIAL DETERMINANTS
 23 OF HEALTH.—

24 (1) IN GENERAL.—The Director, as part of the
 25 Program, shall award grants to eligible entities to

1 address social determinants of health in their com-
2 munities.

3 (2) ELIGIBILITY.—To be eligible to apply for a
4 grant under this subsection, an entity shall be—

5 (A) a State, local, territorial, or Tribal
6 health agency or organization;

7 (B) a qualified nongovernmental entity, as
8 defined by the Director; or

9 (C) a consortium of entities that includes
10 a State, local, territorial, or Tribal health agen-
11 cy or organization.

12 (3) USE OF FUNDS.—

13 (A) IN GENERAL.—A grant under this sub-
14 section shall be used to address social deter-
15 minants of health in a target community by de-
16 signing and implementing innovative, evidence-
17 based, cross-sector strategies.

18 (B) TARGET COMMUNITY.—For purposes
19 of this subsection, a target community shall be
20 a State, county, city, or other municipality.

21 (4) PRIORITY.—In awarding grants under this
22 subsection, the Director shall prioritize applicants
23 proposing to serve target communities with signifi-
24 cant unmet health and social needs, as defined by
25 the Director.

1 (5) APPLICATION.—To seek a grant under this
2 subsection, an eligible entity shall—

3 (A) submit an application at such time, in
4 such manner, and containing such information
5 as the Director may require;

6 (B) propose a set of activities to address
7 social determinants of health through evidence-
8 based, cross-sector strategies, which activities
9 may include—

10 (i) collecting quantifiable data from
11 health care, social services, and other enti-
12 ties regarding the most significant gaps in
13 health-promoting social, economic, and en-
14 vironmental needs;

15 (ii) identifying evidence-based ap-
16 proaches to meeting the nonmedical, social
17 needs of populations identified by data col-
18 lection described in clause (i), such as un-
19 stable housing or food insecurity;

20 (iii) developing scalable methods to
21 meet patients' social needs identified in
22 clinical settings or other sites;

23 (iv) convening entities such as local
24 and State governmental and nongovern-
25 mental organizations, health systems,

1 payors, and community-based organiza-
 2 tions to review, plan, and implement com-
 3 munity-wide interventions and strategies to
 4 advance health-promoting social conditions;

5 (v) monitoring and evaluating the im-
 6 pact of activities funded through the grant
 7 on the health and well-being of the resi-
 8 dents of the target community and on the
 9 cost of health care; and

10 (vi) such other activities as may be
 11 specified by the Director;

12 (C) demonstrate how the eligible entity will
 13 collaborate with—

14 (i) health systems;

15 (ii) payors, including, as appropriate,
 16 Medicaid managed care organizations (as
 17 defined in section 1903(m)(1)(A) of the
 18 Social Security Act (42 U.S.C.
 19 1396b(m)(1)(A))), Medicare Advantage
 20 plans under part C of title XVIII of such
 21 Act (42 U.S.C. 1395w-21 et seq.), and
 22 health insurance issuers and group health
 23 plans (as such terms are defined in section
 24 2791 of the Public Health Service Act (42
 25 U.S.C. 300gg-91));

(iii) other relevant stakeholders and initiatives in areas of need, such as the Accountable Health Communities Model of the Centers for Medicare & Medicaid Services, health homes under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), community-based organizations, and human services organizations;

(iv) other non-health care sector organizations, including organizations focusing on transportation, housing, or food access; and

(v) local employers; and

(D) identify key health inequities in the target community and demonstrate how the proposed efforts of the eligible entity would address such inequities.

(6) MONITORING AND EVALUATION.—As a condition of receipt of a grant under this subsection, a grantee shall agree to submit an annual report to the Director describing the activities carried out through the grant and the outcomes of such activities.

(7) INDEPENDENT NATIONAL EVALUATION.—

1 (A) IN GENERAL.—Not later than 5 years
2 after the first grants are awarded under this
3 subsection, the Director shall provide for the
4 commencement of an independent national eval-
5 uation of the program under this subsection.

6 (B) REPORT TO CONGRESS.—Not later
7 than 60 days after receiving the results of such
8 independent national evaluation, the Director
9 shall report such results to Congress.

10 (c) RESEARCH AND TRAINING.—The Director, as
11 part of the Program—

12 (1) shall award grants to nonprofit organiza-
13 tions and public or other nonprofit institutions of
14 higher education—

15 (A) to conduct research on best practices
16 to improve social determinants of health;

17 (B) to provide technical assistance, train-
18 ing, and evaluation assistance to grantees under
19 subsection (b); and

20 (C) to disseminate best practices to grant-
21 ees under subsection (b); and

22 (2) may require a grantee under paragraph (1)
23 to provide technical assistance and capacity building
24 to entities that are eligible entities under subsection
25 (b) but not receiving funds through such subsection.

1 (d) FUNDING.—

2 (1) IN GENERAL.—There is authorized to be
3 appropriated to carry out this section, \$50,000,000
4 for each of fiscal years 2027 through 2032.

5 (2) ALLOCATION.—Of the amount made avail-
6 able to carry out this section for a fiscal year, not
7 less than 75 percent shall be used for grants under
8 subsections (b) and (c).

9 **SEC. 10016. NOTIFICATION REGARDING SNAP FOR STU-**
10 **DENTS RECEIVING FEDERAL WORK-STUDY**
11 **ASSISTANCE.**

12 Section 443 of the Higher Education Act of 1965 (20
13 U.S.C. 1087–53) is amended by adding at the end the fol-
14 lowing:

15 “(f) NOTIFICATION REGARDING SNAP.—

16 “(1) IN GENERAL.—An institution receiving a
17 grant under this part shall send a notification (by
18 email or other electronic means) to each eligible stu-
19 dent informing the student of their potential eligi-
20 bility for participation in SNAP and the process for
21 obtaining more information, confirming eligibility,
22 and accessing benefits under that program. The no-
23 tification shall be developed by the Secretary of Edu-
24 cation in consultation with the Secretary of Agri-
25 culture, and shall include details on eligibility re-

1 quirements for participation in SNAP that a student
2 must satisfy. The notification shall be, to the extent
3 practicable, specific to the student's State of resi-
4 dence and shall provide contact information for the
5 local office where an application for SNAP may be
6 made.

7 “(2) EVIDENCE OF PARTICIPATION IN FEDER-
8 ALLY FINANCED WORK-STUDY PROGRAM.—The noti-
9 fication under paragraph (1) shall include an official
10 document confirming that the recipient is an eligible
11 student sufficient for purposes of demonstrating that
12 the exclusion from ineligibility for participation in
13 SNAP under section 6(e)(4) of the Food and Nutri-
14 tion Act of 2008 (7 U.S.C. 2015(e)(4)) applies to
15 the student.

16 “(3) GUIDANCE.—The Secretary of Education,
17 in consultation with the Secretary of Agriculture,
18 shall provide guidance to States and institutions of
19 higher education on how to identify and commu-
20 nicate with students who are likely to be eligible for
21 SNAP, including those eligible for a State or feder-
22 ally financed work-study program.

23 “(4) DEFINITIONS.—For purposes of this sub-
24 section:

1 “(A) The term ‘eligible student’ means a
2 student receiving work-study assistance under
3 this part.

4 “(B) The term ‘SNAP’ means the supple-
5 mental nutrition assistance program (as defined
6 in section 3(t) of the Food and Nutrition Act
7 of 2008 (7 U.S.C. 2012(t))).”.

8 **Subtitle B—Gun Violence**

9 **SEC. 10101. REAFFIRMING RESEARCH AUTHORITY OF THE** 10 **CENTERS FOR DISEASE CONTROL AND PRE-** 11 **VENTION.**

12 (a) IN GENERAL.—Section 391 of the Public Health
13 Service Act (42 U.S.C. 280b) is amended—

14 (1) in subsection (a)(1), by striking “research
15 relating to the causes, mechanisms, prevention, diag-
16 nosis, treatment of injuries, and rehabilitation from
17 injuries;” and inserting the following: “research, in-
18 cluding data collection, relating to—

19 “(A) the causes, mechanisms, prevention,
20 diagnosis, and treatment of injuries, including
21 with respect to gun violence; and

22 “(B) rehabilitation from such injuries;”;
23 and

24 (2) by adding at the end the following:

1 “(c) NO ADVOCACY OR PROMOTION OF GUN CON-
2 TROL.—Nothing in this section shall be construed to—

3 “(1) authorize the Secretary to give assistance,
4 make grants, or enter into cooperative agreements or
5 contracts for the purpose of advocating or promoting
6 gun control; or

7 “(2) permit a recipient of any assistance, grant,
8 cooperative agreement, or contract under this section
9 to use such assistance, grant, agreement, or contract
10 for the purpose of advocating or promoting gun con-
11 trol.”.

12 **SEC. 10102. NATIONAL VIOLENT DEATH REPORTING SYS-**
13 **TEM.**

14 The Secretary, acting through the Director of the
15 Centers for Disease Control and Prevention, shall improve
16 the National Violent Death Reporting System (as author-
17 ized by sections 301(a) and 391(a) of the Public Service
18 Health Act (42 U.S.C. 241(a), 280b(a))), particularly
19 through the inclusion of additional States and activities
20 to increase the quality, type, and timeliness of reported
21 data. Participation in the System by the States shall be
22 voluntary.

1 **SEC. 10103. REPORT ON EFFECTS OF GUN VIOLENCE ON**
2 **PUBLIC HEALTH.**

3 Not later than one year after the date of enactment
4 of this Act, and annually thereafter, the Surgeon General
5 shall submit to Congress a report on the effects on public
6 health, including mental health, of gun violence in the
7 United States during the preceding year, and the status
8 of actions taken to address such effects.

9 **SEC. 10104. REPORT ON EFFECTS OF GUN VIOLENCE ON**
10 **MENTAL HEALTH IN MINORITY COMMU-**
11 **NITIES.**

12 Not later than one year after the date of enactment
13 of this Act, the Deputy Assistant Secretary for Minority
14 Health shall submit to Congress a report on the effects
15 of gun violence on public health, including mental health,
16 in minority communities in the United States, and the sta-
17 tus of actions taken to address such effects.

18 **Subtitle C—Nutrition for Women,**
19 **Children, Families**

20 **CHAPTER 1—SENIOR HUNGER**
21 **PREVENTION**

22 **SEC. 10201. SHORT TITLE.**

23 This chapter may be cited as the “Senior Hunger
24 Prevention Act”.

1 **SEC. 10202. IMPROVING SNAP EFFICACY.**

2 (a) CERTIFICATION PERIOD.—Section 3(f) of the
3 Food and Nutrition Act of 2008 (7 U.S.C. 2012(f)) is
4 amended, in the second sentence, by striking “24” and
5 inserting “36”.

6 (b) STANDARD MEDICAL EXPENSE DEDUCTION.—
7 Section 5(e)(5) of the Food and Nutrition Act of 2008
8 (7 U.S.C. 2014(e)(5)) is amended—

9 (1) in the paragraph heading, by striking “EX-
10 CESS MEDICAL” and inserting “MEDICAL”;

11 (2) in subparagraph (A), by striking “an excess
12 medical” and all that follows through the period at
13 the end and inserting “a standard medical deduction
14 or a medical expense deduction of actual costs for
15 the allowable medical expenses incurred by the elder-
16 ly or disabled member, exclusive of special diets.”;

17 (3) in subparagraph (B)(i), by striking “ex-
18 cess”; and

19 (4) by adding at the end the following:

20 “(D) STANDARD MEDICAL EXPENSE DE-
21 Duction AMOUNT.—

22 “(i) IN GENERAL.—Except as pro-
23 vided in clause (ii), the standard medical
24 expense deduction shall be equal to—

25 “(I) for fiscal year 2027, \$155;

26 and

1 “(II) for each subsequent fiscal
2 year, the applicable amount for the
3 immediately preceding fiscal year, as
4 adjusted to reflect changes for the 12-
5 month period ending the preceding
6 June 30 in the Consumer Price Index
7 for All Urban Consumers: Medical
8 Care published by the Bureau of
9 Labor Statistics of the Department of
10 Labor.

11 “(ii) EXCEPTION.—For any fiscal
12 year, a State agency may establish a great-
13 er standard medical expense deduction
14 than the deduction described in clause (i)
15 if the greater deduction satisfies the appli-
16 cable cost-neutrality standards established
17 by the Secretary for that fiscal year.”.

18 (c) VALUE OF ALLOTMENT.—Section 8(a) of the
19 Food and Nutrition Act of 2008 (7 U.S.C. 2017(a)) is
20 amended, in the proviso, by striking “8 percent” and in-
21 serting “ $\frac{1}{3}$ ”.

1 **SEC. 10203. STREAMLINING NUTRITION ACCESS FOR**
 2 **OLDER ADULTS AND ADULTS WITH DISABIL-**
 3 **ITIES.**

4 (a) DEFINITION OF ELDERLY AND DISABLED.—Sec-
 5 tion 3(j) of the Food and Nutrition Act of 2008 (7 U.S.C.
 6 2012(j)) is amended—

7 (1) in the matter preceding paragraph (1), by
 8 striking the subsection designation and all that fol-
 9 lows through “who” and inserting the following:

10 “(j) ELDERLY OR DISABLED.—The term ‘elderly or
 11 disabled’, with respect to an individual or member of a
 12 household, means that the individual or member of the
 13 household”; and

14 (2) in paragraph (2)(B), by inserting “(which
 15 includes medical assistance provided to an individual
 16 described in section 1902(e)(14)(D)(i)(III) of that
 17 Act (42 U.S.C. 1396a(e)(14)(D)(i)(III)))” after
 18 “(42 U.S.C. 1396 et seq.)”.

19 (b) ELDERLY SIMPLIFIED APPLICATION PRO-
 20 GRAM.—The Food and Nutrition Act of 2008 (7 U.S.C.
 21 2011 et seq.) is amended by adding at the end the fol-
 22 lowing:

23 **“SEC. 31. ELDERLY SIMPLIFIED APPLICATION PROGRAM.**

24 “(a) IN GENERAL.—Not later than 180 days after
 25 the date of enactment of this section, the Secretary shall
 26 establish a program, to be known as the ‘elderly simplified

1 application program' (referred to in this section as
 2 'ESAP'), under which a State, in carrying out the supple-
 3 mental nutrition assistance program, may elect to imple-
 4 ment a streamlined application and certification process
 5 for households in which all adult members—

6 “(1) are elderly or disabled members; and

7 “(2) have no earned income.

8 “(b) CERTIFICATION PERIOD.—The certification pe-
 9 riod for participants in ESAP shall be 36 months.

10 “(c) INCOME AND OTHER DATA VERIFICATION.—

11 “(1) IN GENERAL.—A State agency deter-
 12 mining the eligibility for an applicant household
 13 under ESAP shall, notwithstanding section
 14 11(e)(3)—

15 “(A) to the maximum extent practicable,
 16 use data matching for income verification and
 17 household size; and

18 “(B)(i) allow self-declaration by the appli-
 19 cant of the information required under section
 20 273.2(f) of title 7, Code of Federal Regulations
 21 (or a successor regulation); but

22 “(ii) verify, prior to certification of the
 23 household, factors of eligibility provided by the
 24 applicant that the State agency determines are
 25 questionable.

1 “(2) ACCOUNTABILITY AND FRAUD PREVEN-
2 TION.—In carrying out paragraph (1), a State agen-
3 cy shall establish accountability and fraud protection
4 measures to deter fraud and ensure the integrity of
5 ESAP and the supplemental nutrition assistance
6 program.

7 “(d) INTERVIEWS.—

8 “(1) IN GENERAL.—Notwithstanding section
9 11(e)(6)(A), for recertification of a household under
10 ESAP, a State agency shall not require an interview
11 unless requested by the household.

12 “(2) VIRTUAL INTERVIEWS.—An interview
13 under paragraph (1) may be conducted virtually.

14 “(e) GUIDANCE.—Prior to the establishment of
15 ESAP under subsection (a), the Administrator of the
16 Food and Nutrition Service shall develop guidance for
17 States, including by consulting with States, to carry out
18 ESAP, which shall include—

19 “(1) general implementation guidelines;

20 “(2) reporting requirements;

21 “(3) quality control requirements; and

22 “(4) best practices.”.

23 (c) COMBINED APPLICATION PROGRAM.—The Food
24 and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.) (as

1 amended by subsection (b)) is amended by adding at the
2 end the following:

3 **“SEC. 32. COMBINED APPLICATION PROGRAM.**

4 “(a) IN GENERAL.—Not later than 180 days after
5 the date of enactment of this section, the Secretary, in
6 coordination with the Commissioner of Social Security,
7 shall establish a program, to be known as the ‘combined
8 application program’ (referred to in this section as ‘CAP’),
9 under which a State, in carrying out the supplemental nu-
10 trition assistance program, may elect to implement a
11 streamlined application process for households in which all
12 adult members are applicants for or recipients of benefits
13 under title II of the Social Security Act (42 U.S.C. 401
14 et seq.) on the basis of a disability or supplemental secu-
15 rity income under title XVI of that Act (42 U.S.C. 1381
16 et seq.).

17 “(b) PURPOSES.—The purposes of CAP are—

18 “(1) to reduce the need for households de-
19 scribed in subsection (a) to have in-person interviews
20 with State offices administering the supplemental
21 nutrition assistance program; and

22 “(2) to increase participation in the supple-
23 mental nutrition assistance program by simplifying
24 the application process for the supplemental nutri-

1 tion assistance program through increased automa-
2 tion and simplified calculation of benefits.

3 “(c) CAP MODELS.—The Secretary, in coordination
4 with the Commissioner of the Social Security Administra-
5 tion, shall offer, at a minimum, each of the following mod-
6 els for States to implement CAP:

7 “(1) STANDARD MODEL.—

8 “(A) IN GENERAL.—Under the standard
9 model, the Commissioner of the Social Security
10 Administration and the State agency admin-
11 istering the supplemental nutrition assistance
12 program shall coordinate—

13 “(i) to develop a simplified joint appli-
14 cation process for the supplemental nutri-
15 tion assistance program that uses stand-
16 ardized benefit amounts or standardized
17 shelter expenses, in accordance with this
18 paragraph; and

19 “(ii) to conduct outreach to adult
20 members receiving supplemental security
21 income under title XVI of the Social Secu-
22 rity Act (42 U.S.C. 1381 et seq.) that are
23 not receiving benefits under the supple-
24 mental nutrition assistance program.

1 “(B) STANDARDIZED BENEFIT
2 AMOUNTS.—

3 “(i) IN GENERAL.—Under the stand-
4 ardized model described in subparagraph
5 (A), applicants shall receive a standardized
6 or automated benefit level under the sup-
7 plemental nutrition assistance program
8 based on the shelter expenses and other in-
9 come of the applicants.

10 “(ii) MINIMUM STANDARDIZED BEN-
11 EFIT LEVELS.—At a minimum, there shall
12 be in effect 2 standardized benefit levels
13 under clause (i), including, as determined
14 by the State—

15 “(I) a level for participants with
16 low shelter expenses; and

17 “(II) a level for participants with
18 high shelter expenses.

19 “(iii) COMPARABLE AMOUNT.—A
20 State shall ensure that the amount pro-
21 vided under a standardized benefit level
22 under clause (i) is comparable to an
23 amount that a participant would otherwise
24 receive under the supplemental nutrition
25 assistance program.

1 “(iv) REFERRAL.—A State shall refer
2 a household described in subsection (a) to
3 the supplemental nutrition assistance pro-
4 gram instead of enrolling that household in
5 CAP if the standardized amount that the
6 household would receive under CAP would
7 be significantly less than the amount of
8 benefits that the household would receive
9 under the supplemental nutrition assist-
10 ance program.

11 “(C) STANDARDIZED SHELTER EX-
12 PENSES.—In computing an excess shelter ex-
13 pense deduction under section 5(e)(6), a State
14 agency may use a standard utility allowance in
15 accordance with regulations promulgated by the
16 Secretary.

17 “(2) MODIFIED MODEL.—Under the modified
18 model, a State agency administering the supple-
19 mental nutrition assistance program shall—

20 “(A) conduct outreach to prospective par-
21 ticipants in the supplemental nutrition assist-
22 ance program using information from the Social
23 Security Administration to identify households
24 described in subsection (a) that are not partici-

1 pants in the supplemental nutrition assistance
 2 program; and

3 “(B) send to those households simplified
 4 application forms for the supplemental nutrition
 5 assistance program.”.

6 **SEC. 10204. ENROLLMENT AND OUTREACH PILOT PRO-**
 7 **GRAM FOR OLDER ADULTS, KINSHIP FAMI-**
 8 **LIES, AND ADULTS WITH DISABILITIES.**

9 The Food and Nutrition Act of 2008 (7 U.S.C. 2011
 10 et seq.) (as amended by section 10203(c)) is amended by
 11 adding at the end the following:

12 **“SEC. 33. ENROLLMENT AND OUTREACH PILOT PROGRAM**
 13 **FOR OLDER ADULTS, KINSHIP FAMILIES, AND**
 14 **ADULTS WITH DISABILITIES.**

15 “(a) DEFINITIONS.—In this section:

16 “(1) DISABILITY.—The term ‘disability’ has the
 17 meaning given the term in section 3 of the Ameri-
 18 cans with Disabilities Act of 1990 (42 U.S.C.
 19 12102).

20 “(2) ELIGIBLE ENTITY.—The term ‘eligible en-
 21 tity’ means—

22 “(A) a State or local government agency;

23 “(B) an Indian tribe or Tribal organiza-
 24 tion;

1 “(C) a nonprofit organization, including a
2 public or nonprofit provider of services;

3 “(D) a community-based organization; and

4 “(E) an educational provider.

5 “(3) KINSHIP FAMILY.—The term ‘kinship fam-
6 ily’ means a family in which a child resides with,
7 and is being raised by, a grandparent, another ex-
8 tended family member, or an adult with whom the
9 child has a close family-like relationship, such as a
10 godparent or a close family friend.

11 “(4) OLDER ADULT.—The term ‘older adult’
12 has the meaning given the term ‘older individual’ in
13 section 102 of the Older Americans Act of 1965 (42
14 U.S.C. 3002).

15 “(5) PILOT PROGRAM.—The term ‘pilot pro-
16 gram’ means the Enrollment and Outreach Pilot
17 Program for Older Adults, Kinship Families, and
18 Adults with Disabilities established under subsection
19 (b).

20 “(b) ESTABLISHMENT.—Not later than 180 days
21 after the date of enactment of this section, the Secretary
22 shall establish a pilot program, to be known as the ‘Enroll-
23 ment and Outreach Pilot Program for Older Adults, Kin-
24 ship Families, and Adults with Disabilities’, under which
25 the Secretary shall award grants to eligible entities—

1 “(1) to raise awareness among older adults,
2 kinship families, and adults with disabilities of the
3 availability, eligibility requirements, application pro-
4 cedures, and benefits of the supplemental nutrition
5 assistance program; and

6 “(2) to support older adults, kinship families,
7 and adults with disabilities in enrolling in the sup-
8 plemental nutrition assistance program.

9 “(c) PRIORITY.—In awarding grants under the pilot
10 program, the Secretary shall give priority to—

11 “(1) eligible entities that—

12 “(A) provide services to older adults or
13 adults with disabilities;

14 “(B) provide services to kinship families,
15 including kinship navigator programs;

16 “(C) have experience implementing pro-
17 grams that receive funding under the Older
18 Americans Act of 1965 (42 U.S.C. 3001 et
19 seq.);

20 “(D) have experience implementing pro-
21 grams administered by the Food and Nutrition
22 Service; or

23 “(E) receive, plan to receive, or dem-
24 onstrate an ability to partner with a program
25 that receives, funding under—

1 “(i) the Older Americans Act of 1965
2 (42 U.S.C. 3001 et seq.);
3 “(ii) the Americans with Disabilities
4 Act of 1990 (42 U.S.C. 12101 et seq.); or
5 “(iii) 1 or more nutrition programs
6 administered by the Secretary; and
7 “(2) projects that will—
8 “(A) serve communities with—
9 “(i) high rates of food insecurity or
10 malnutrition; or
11 “(ii) low food access;
12 “(B) serve rural communities, indigenous
13 communities, or communities of color;
14 “(C) serve members of the lesbian, gay, bi-
15 sexual, transgender, and queer community;
16 “(D) serve adults with limited English pro-
17 ficiency;
18 “(E) serve veterans;
19 “(F) serve residents in federally subsidized
20 housing, including federally subsidized housing
21 units for older adults and adults with disabil-
22 ities;
23 “(G) serve residents living in housing serv-
24 ing kinship families; and

1 “(H) incorporate nutrition education ac-
2 tivities that promote healthy eating and active
3 lifestyles.

4 “(d) ELIGIBLE ACTIVITIES.—An eligible entity re-
5 ceiving a grant under the pilot program shall use the grant
6 to carry out 1 or more of the following activities:

7 “(1) Application assistance, including—

8 “(A) eligibility prescreening;

9 “(B) assistance in completing an applica-
10 tion for the supplemental nutrition assistance
11 program;

12 “(C) assistance in obtaining application
13 verification documents;

14 “(D) medical expense deduction coun-
15 seling; and

16 “(E) translation of materials and bilingual
17 accommodation.

18 “(2) Tailored dissemination of information re-
19 lating to the supplemental nutrition assistance pro-
20 gram, including through—

21 “(A) community-based outreach workshops
22 and events;

23 “(B) a toll-free hotline to provide informa-
24 tion relating to Federal, State, and local food
25 resources;

1 “(C) informational websites and other so-
2 cial media sites; and

3 “(D) printed or digital informational con-
4 tent.

5 “(3) Transportation, including—

6 “(A) transportation to or from a local of-
7 fice of the supplemental nutrition assistance
8 program; and

9 “(B) administration of vouchers or similar
10 items for the transportation described in sub-
11 paragraph (A).

12 “(4) Identification, implementation, analysis,
13 and dissemination of replicable and scalable models
14 for increasing enrollment in the supplemental nutri-
15 tion assistance program among older adults, kinship
16 families, and adults with disabilities.

17 “(e) GRANTS.—

18 “(1) MAXIMUM AMOUNT.—A grant awarded
19 under the pilot program to an eligible entity for a
20 fiscal year shall be—

21 “(A) not less than \$50,000; and

22 “(B) not more than \$250,000.

23 “(2) DURATION.—An eligible entity may be
24 awarded a grant under the pilot program for not
25 more than 5 years.

1 “(f) EVALUATION.—Not later than 2 years after the
 2 date of establishment of the pilot program, the Secretary
 3 shall conduct an evaluation of the pilot program.

4 “(g) FUNDING.—

5 “(1) IN GENERAL.—In addition to amounts
 6 otherwise available, there is appropriated, out of any
 7 funds in the Treasury not otherwise appropriated,
 8 \$12,250,000, to remain available until expended, to
 9 carry out the pilot program, of which not more than
 10 \$250,000 shall be used to carry out the evaluation
 11 under subsection (f).

12 “(2) ADMINISTRATIVE COSTS.—Of the amounts
 13 made available under paragraph (1) (excluding the
 14 amount made available to carry out subsection (f)),
 15 not more than 3 percent may be used by the Sec-
 16 retary for administrative costs.”.

17 **SEC. 10205. FOOD DELIVERY UNDER SUPPLEMENTAL NU-**
 18 **TRITION ASSISTANCE PROGRAM.**

19 The Food and Nutrition Act of 2008 (7 U.S.C. 2011
 20 et seq.) (as amended by section 10204) is amended by
 21 adding at the end the following:

22 **“SEC. 34. FOOD DELIVERY.**

23 “(a) DEFINITIONS.—In this section:

24 “(1) COVERED RETAIL FOOD STORE.—The
 25 term ‘covered retail food store’ means a retail food

1 store, a public or private nonprofit meal delivery
 2 service, or a public or nonprofit meal delivery pro-
 3 vider participating in the supplemental nutrition as-
 4 sistance program that is unable to cover the cost of
 5 food delivery for participants of the supplemental
 6 nutrition assistance program.

7 “(2) EMPLOYEE.—The term ‘employee’ has the
 8 meaning given the term in section 3 of the Fair
 9 Labor Standards Act of 1938 (29 U.S.C. 203).

10 “(b) PROGRAM MODIFICATIONS.—

11 “(1) IN GENERAL.—In carrying out the supple-
 12 mental nutrition assistance program, the Secretary
 13 shall—

14 “(A) notify retail food stores participating
 15 in the supplemental nutrition assistance pro-
 16 gram of existing opportunities through which
 17 the retail food stores can deliver food to pro-
 18 gram participants, including by—

19 “(i) allowing an EBT card to be
 20 swiped with a mobile device on delivery of
 21 food to the home; and

22 “(ii) preparing food for pickup;

23 “(B) authorize public-private partnerships
 24 between the Department of Agriculture, retail
 25 food stores participating in the supplemental

1 nutrition assistance program, and community-
2 based organizations to provide free or low-cost
3 food delivery, including through the use of pri-
4 vate funds;

5 “(C) in the case of a covered retail food
6 store, use funds made available under subpara-
7 graph (E) of paragraph (3) to provide, in ac-
8 cordance with that paragraph, free grocery de-
9 livery for participants in the supplemental nu-
10 trition assistance program who are older adults
11 or adults with disabilities (as those terms are
12 defined in section 33(a)) who are unable to
13 shop for food or lack safe and accessible trans-
14 portation options to the covered retail food
15 store; and

16 “(D) require each State to submit to the
17 Secretary a plan that describes the methods by
18 which the State will—

19 “(i) work with retail food stores par-
20 ticipating in the supplemental nutrition as-
21 sistance program and other community-
22 based partners to establish a process for
23 food delivery for program participants;

24 “(ii) administer the reimbursements
25 described in paragraph (3), including tim-

ing, eligibility, and distribution processes;
and

“(iii) ensure that retail food stores
participating in the supplemental nutrition
assistance program that are reimbursed for
delivery costs under paragraph (3) adhere
to the requirements described in subpara-
graph (B) of that paragraph.

“(2) STATE PLANS.—Not later than 10 days
after the date on which the Secretary receives a
State plan under paragraph (1)(D), the Secretary
shall—

“(A) determine whether to approve or dis-
approve the State plan; and

“(B) make publicly available on the
website of the Department of Agriculture—

“(i) the State plan;

“(ii) the determination made under
subparagraph (A) with respect to that
plan; and

“(iii) any guidance issued to the State
with respect to that plan.

“(3) REIMBURSEMENT OF COVERED RETAIL
FOOD STORES.—

1 “(A) IN GENERAL.—Notwithstanding any
 2 other provision of law (including sections
 3 274.7(f) and 278.2(b) of title 7, Code of Fed-
 4 eral Regulations (or successor regulations), and
 5 any other regulations), subject to the avail-
 6 ability of funds, a State agency shall reimburse
 7 a covered retail food store for the cost of food
 8 delivery to participants described in paragraph
 9 (1)(C) if—

10 “(i) the covered retail food store
 11 meets the requirements under subpara-
 12 graph (B); and

13 “(ii) the majority of the number of
 14 food items delivered by the covered retail
 15 food store are eligible for redemption using
 16 benefits under the supplemental nutrition
 17 assistance program, regardless of whether
 18 the delivery includes nonfood items, subject
 19 to the condition that those nonfood items
 20 shall be of de minimis value.

21 “(B) REQUIREMENTS.—A covered retail
 22 food store may receive reimbursement for the
 23 cost of food delivery to participants described in
 24 paragraph (1)(C) if the following requirements
 25 are met:

1 “(i) Food delivery is performed by
2 employees of the covered retail food store
3 or employees of an entity contracted by the
4 covered retail food store to perform deliveries.
5

6 “(ii) Before any employee described in
7 clause (i) begins making food deliveries,
8 that employee receives employer-provided
9 health and safety training that reflects the
10 most recent guidelines of the Centers for
11 Disease Control and Prevention.

12 “(iii) All employees described in
13 clause (i) performing deliveries are paid at
14 a rate that is not less than the greater
15 of—

16 “(I) the minimum wage rate es-
17 tablished under section 6(a)(1) of the
18 Fair Labor Standards Act of 1938
19 (29 U.S.C. 206(a)(1)); and

20 “(II) the minimum wage rate es-
21 tablished by the applicable State or lo-
22 cality in which the employee works.

23 “(iv) The covered retail food store
24 meets the size standard determined by the
25 Small Business Administration for a super-

1 market or other grocery retailer or a con-
 2 venience retailer under section 121.201 of
 3 title 13, Code of Federal Regulations (or a
 4 successor regulation).

5 “(v) The covered retail food store does
 6 not—

7 “(I) charge the supplemental nu-
 8 trition assistance program participant
 9 for delivery costs for which the cov-
 10 ered retail food store will be reim-
 11 bursed;

12 “(II) require minimum purchase
 13 thresholds in order to provide free de-
 14 livery;

15 “(III) restrict delivery times to
 16 least-favorable windows for those par-
 17 ticipants; or

18 “(IV) charge surge pricing.

19 “(C) REIMBURSABLE COSTS.—Reimburs-
 20 able costs under subparagraph (A) include costs
 21 associated with purchasing point-of-sale devices
 22 or receiving technical assistance relating to
 23 point-of-sale devices.

24 “(D) MAXIMUM REIMBURSEMENT PER DE-
 25 LIVERY.—The maximum amount of reimburse-

1 ment under subparagraph (A) for a food deliv-
2 ery fee shall be \$10 per delivery, which may be
3 adjusted by the Secretary for inflation.

4 “(E) AUTHORIZATION OF APPROPRIA-
5 TIONS.—There is authorized to be appropriated
6 to the Secretary \$500,000,000 for fiscal year
7 2027, and each fiscal year thereafter, to remain
8 available until expended, to cover the cost of
9 food delivery described in paragraph (1)(C), to
10 be distributed among States to fund reimburse-
11 ments by States under subparagraph (A).

12 “(4) REPORT.—Not later than April 30, 2027,
13 and April 30 of each year thereafter, the Secretary
14 shall submit to the Committee on Agriculture, Nutri-
15 tion, and Forestry of the Senate and the Committee
16 on Agriculture of the House of Representatives a re-
17 port that describes, for the period covered by the re-
18 port, as applicable—

19 “(A) the number of supplemental nutrition
20 assistance program participants using food de-
21 livery services, including the percentage of those
22 participants that are older adults and adults
23 with disabilities (as those terms are defined in
24 section 33(a));

1 “(B) the covered retail food stores that
2 were reimbursed under paragraph (3), including
3 the amount of each reimbursement;

4 “(C) any complications or difficulties expe-
5 rienced by States in administering reimburse-
6 ments under paragraph (3); and

7 “(D) recommendations or best practices to
8 assist States in implementing food delivery pro-
9 grams similar to the program under this sec-
10 tion.”.

11 **SEC. 10206. COMMODITY SUPPLEMENTAL FOOD PROGRAM.**

12 (a) FUNDS.—Section 4 of the Agriculture and Con-
13 sumer Protection Act of 1973 (7 U.S.C. 612c note; Public
14 Law 93–86) is amended—

15 (1) in subsection (a), in the first sentence, by
16 striking “2023” and inserting “2031”; and

17 (2) by adding at the end the following:

18 “(d) FUNDS.—In addition to amounts otherwise
19 available, there is appropriated, out of any funds in the
20 Treasury not otherwise appropriated, to carry out the pro-
21 gram under this section \$10,000,000 for each of fiscal
22 years 2027 through 2031.”.

23 (b) ADULTS WITH DISABILITIES.—Section 5 of the
24 Agriculture and Consumer Protection Act of 1973 (7
25 U.S.C. 612c note; Public Law 93–86) is amended—

1 (1) by striking “2023” each place it appears
2 and inserting “2031”;

3 (2) in subsection (g)—

4 (A) in paragraph (1), by striking “to low-
5 income persons aged 60 and older.” and insert-
6 ing the following: “to—

7 “(A) low-income persons aged 60 and
8 older; and

9 “(B) low-income adults with disabilities (as
10 defined in section 3 of the Americans with Dis-
11 abilities Act of 1990 (42 U.S.C. 12102)).”;

12 (B) by redesignating paragraph (2) as
13 paragraph (3);

14 (C) by inserting after paragraph (1) the
15 following:

16 “(2) INCOME ELIGIBILITY.—For purposes of
17 paragraph (1), a low-income individual described in
18 subparagraph (A) or (B) of that paragraph shall
19 have a gross income level that is less than 185 per-
20 cent of the Federal poverty line.”; and

21 (D) in subparagraph (B) of paragraph (3)
22 (as so redesignated), in the matter preceding
23 clause (i), by striking “of—” and all that fol-
24 lows through the period at the end of clause (ii)
25 and inserting “of 36 months.”; and

1 (3) in subsection (i), in the matter preceding
2 paragraph (1)—

3 (A) by inserting “or low-income adults
4 with disabilities described in subsection
5 (g)(1)(B)” after “elderly persons”; and

6 (B) by striking “to each elderly participant
7 in, or applicant for, the commodity supple-
8 mental food program for the elderly” and in-
9 serting “to each participant in, or applicant for,
10 such a program”.

11 **SEC. 10207. SENIORS FARMERS’ MARKET NUTRITION PRO-**
12 **GRAM.**

13 (a) IN GENERAL.—Section 4402 of the Farm Secu-
14 rity and Rural Investment Act of 2002 (7 U.S.C. 3007)
15 is amended—

16 (1) in subsection (a)—

17 (A) by striking “Of the funds” and insert-
18 ing the following:

19 “(1) MANDATORY FUNDING.—Of the funds”;

20 (B) in paragraph (1) (as so designated), by
21 inserting “(referred to in this section as the
22 ‘Secretary’)” after “Agriculture”; and

23 (C) by adding at the end the following:

24 “(2) AUTHORIZATION OF APPROPRIATIONS.—

25 There are authorized to be appropriated to the Sec-

1 retary to carry out and expand the seniors farmers’
2 market nutrition program—

3 “(A) not less than \$60,000,000 for fiscal
4 year 2027;

5 “(B) not less than \$70,000,000 for fiscal
6 year 2028; and

7 “(C) not less than \$100,000,000 for each
8 of fiscal years 2029 through 2031.”;

9 (2) in subsection (b)(1), by inserting “and
10 adults with disabilities (as defined in section 3 of the
11 Americans with Disabilities Act of 1990 (42 U.S.C.
12 12102))” before the semicolon at the end;

13 (3) by redesignating subsections (c) through (f)
14 as subsections (f) through (i), respectively; and

15 (4) by inserting after subsection (b) the fol-
16 lowing:

17 “(c) BENEFIT AMOUNTS.—Under the seniors farm-
18 ers’ market nutrition program—

19 “(1) the minimum individual benefit shall be
20 \$35; and

21 “(2) the maximum individual benefit shall be
22 \$80.

23 “(d) CERTIFICATION PERIOD.—The certification pe-
24 riod for participants in the seniors farmers’ market nutri-
25 tion program shall be 36 months.

1 “(e) MODERNIZATION GRANTS.—

2 “(1) IN GENERAL.—Not later than 180 days
3 after the date of enactment of the Senior Hunger
4 Prevention Act, the Secretary shall establish a grant
5 program under which the Secretary shall award
6 grants to State agencies, including Tribal organiza-
7 tions (as defined in section 3 of the Food and Nutri-
8 tion Act of 2008 (7 U.S.C. 2012)) and territories,
9 that administer the senior farmers’ market nutrition
10 program to modernize program operations, includ-
11 ing—

12 “(A) by transitioning from paper-based
13 coupons to an electronic transaction technology,
14 such as a web-based service or installable soft-
15 ware; and

16 “(B) by increasing benefit use at farmers’
17 markets.

18 “(2) GRANT AMOUNT.—

19 “(A) IN GENERAL.—The amount of a
20 grant awarded under paragraph (1) shall not
21 exceed \$350,000.

22 “(B) SUPPLIES.—Not more than \$25,000
23 may be used to carry out subparagraph (F) of
24 paragraph (3).

1 “(3) ELIGIBLE EXPENSES.—An entity receiving
2 a grant under paragraph (1) may use the grant
3 for—

4 “(A) costs associated with the procurement
5 of electronic transaction technology;

6 “(B) planning costs, including personnel
7 costs, relating to electronic transaction tech-
8 nology procurement and implementation;

9 “(C) costs associated with evaluating the
10 impact of transitioning from coupon-based oper-
11 ations to an electronic transaction technology;

12 “(D) training, outreach, and promotional
13 material costs, including the costs associated
14 with translating materials;

15 “(E) maintenance and operation of elec-
16 tronic transaction technology procured using
17 the grant during the period of performance of
18 the grant;

19 “(F) subject to paragraph (2)(B), the pur-
20 chase of supplies needed to perform electronic
21 transactions onsite; and

22 “(G) additional costs associated with mod-
23 ernizing program operations, as determined ap-
24 propriate by the Secretary.

1 “(4) REPORTS.—Each entity that receives a
2 grant under paragraph (1) shall submit to the Sec-
3 retary and the Administrator of the Food and Nutri-
4 tion Service quarterly performance progress reports
5 on the use of the grant.

6 “(5) AUTHORIZATION OF APPROPRIATIONS.—
7 There is authorized to be appropriated to the Sec-
8 retary to carry out this subsection \$15,000,000 for
9 fiscal year 2027 and each fiscal year thereafter.”.

10 (b) INCOME GUIDELINES.—The Secretary of Agri-
11 culture shall revise section 249.6(a)(3) of title 7, Code of
12 Federal Regulations, to ensure that income eligibility
13 under that section is at or below 200 percent of the pov-
14 erty income guidelines.

15 **SEC. 10208. INFRASTRUCTURE FUNDING FOR FARMERS’**
16 **MARKETS; LOCAL PROCUREMENT PILOT**
17 **PROGRAM.**

18 The Farm Security and Rural Investment Act of
19 2002 is amended by inserting after section 4402 (7 U.S.C.
20 3007) the following:

21 **“SEC. 4403. INFRASTRUCTURE FUNDING FOR FARMERS’**
22 **MARKETS; LOCAL PROCUREMENT PILOT**
23 **PROGRAM.**

24 “(a) DEFINITIONS.—In this section:

1 “(1) DISABILITY.—The term ‘disability’ has the
2 meaning given the term in section 3 of the Ameri-
3 cans with Disabilities Act of 1990 (42 U.S.C.
4 12102).

5 “(2) OLDER ADULT.—The term ‘older adult’
6 has the meaning given the term ‘older individual’ in
7 section 102 of the Older Americans Act of 1965 (42
8 U.S.C. 3002).

9 “(3) SECRETARY.—The term ‘Secretary’ means
10 the Secretary of Agriculture.

11 “(b) INFRASTRUCTURE FUNDING FOR FARMERS’
12 MARKETS.—

13 “(1) DEFINITION OF ELIGIBLE ENTITY.—In
14 this subsection, the term ‘eligible entity’ means an
15 entity that—

16 “(A) is—

17 “(i) an agricultural cooperative or
18 other agricultural business entity or a pro-
19 ducer network or association, including a
20 community-supported agriculture network
21 or association;

22 “(ii) a local or Tribal government;

23 “(iii) a nonprofit corporation;

24 “(iv) a public benefit corporation;

1 “(v) an economic development cor-
2 poration;

3 “(vi) a regional farmers’ market au-
4 thority;

5 “(vii) a food council; or

6 “(viii) any other entity as determined
7 by the Secretary; and

8 “(B) can demonstrate financial need, as
9 determined by the Secretary.

10 “(2) ESTABLISHMENT.—Not later than 180
11 days after the date of enactment of the Senior Hun-
12 ger Prevention Act, the Secretary shall establish a
13 program under which the Secretary shall provide fi-
14 nancial assistance, in the form of loans, loan guar-
15 antees, and grants, to eligible entities for—

16 “(A) the establishment of new farmers’
17 markets;

18 “(B) the improvement or rehabilitation of
19 existing farmers’ markets, including by adding
20 or improving payment technologies used in
21 those farmers’ markets; and

22 “(C) the expansion of community sup-
23 ported agriculture to serve older adults and
24 adults with disabilities.

1 “(3) REQUIREMENTS.—An eligible entity that
2 receives financial assistance under paragraph (2)
3 shall be required—

4 “(A) to host farmers’ markets or related
5 activities at locations accessible—

6 “(i) by public transportation;

7 “(ii) by paratransit; or

8 “(iii) through transportation services
9 provided under the Older Americans Act of
10 1965 (42 U.S.C. 3001 et seq.); and

11 “(B) to reserve not less than 50 percent of
12 the floor area of an applicable farmers’ market
13 for the sale of products that are produced lo-
14 cally, as determined by the Secretary, by—

15 “(i) farmers, ranchers, or aquaculture,
16 mariculture, or fisheries operators; or

17 “(ii) associations of farmers, ranchers,
18 or aquaculture, mariculture, or fisheries
19 operators.

20 “(4) COST SHARING.—The non-Federal share
21 of a grant provided under this subsection shall be 20
22 percent of the amount of the grant, which may com-
23 prise transportation costs, volunteer contributions,
24 and in-kind staffing.

1 “(5) FUNDING.—Of the funds of the Com-
 2 modity Credit Corporation, the Secretary shall use
 3 to carry out this subsection \$50,000,000 for each of
 4 fiscal years 2027 through 2031.

5 “(c) LOCAL PROCUREMENT PILOT PROGRAM.—

6 “(1) DEFINITIONS.—In this subsection:

7 “(A) AGRICULTURAL PRODUCER.—The
 8 term ‘agricultural producer’ includes—

9 “(i) an agricultural cooperative;

10 “(ii) a person engaged in farming,
 11 ranching, or aquaculture;

12 “(iii) a person engaged in the packing
 13 of a food product; and

14 “(iv) a person engaged in the minimal
 15 processing of a food product, as deter-
 16 mined by the Secretary.

17 “(B) ELIGIBLE ENTITY.—The term ‘eligi-
 18 ble entity’ means an entity that—

19 “(i)(I) coordinates enrollment in, and
 20 distribution of, benefits under the seniors
 21 farmers’ market nutrition program; or

22 “(II) demonstrates an ability to part-
 23 ner with an entity that coordinates enroll-
 24 ment in and distribution of benefits under

1930

1 the seniors farmers' market nutrition pro-
2 gram; and

3 “(ii) is—

4 “(I) a public or nonprofit pro-
5 vider of nutrition services or support
6 to older adults or adults with disabil-
7 ities, including—

8 “(aa) an Aging and Dis-
9 ability Resource Center (as de-
10 fined in section 102 of the Older
11 Americans Act of 1965 (42
12 U.S.C. 3002));

13 “(bb) an area agency on
14 aging (as defined in that section);

15 “(cc) a State health insur-
16 ance program;

17 “(dd) a State unit on aging;

18 “(ee) a center for inde-
19 pendent living;

20 “(ff) a community health
21 center;

22 “(gg) a multipurpose senior
23 center; and

24 “(hh) federally subsidized
25 housing, including federally sub-

1 sidized housing units for older
2 adults and adults with disabil-
3 ities; or

4 “(II) a local, State, or national
5 parks and recreation department.

6 “(2) ESTABLISHMENT.—Not later than 180
7 days after the date of enactment of the Senior Hun-
8 ger Prevention Act, the Secretary shall establish a
9 pilot program under which the Secretary shall award
10 grants to eligible entities to contract with agricul-
11 tural producers that will grow produce to support
12 the local procurement and contracting of produce for
13 eligible entities.

14 “(3) PRIORITY.—In awarding grants under
15 paragraph (2), the Secretary shall give priority to an
16 eligible entity that will use grant funds to benefit
17 underserved communities, including communities
18 that are located in areas of concentrated poverty
19 with limited access to fresh locally or regionally
20 grown food.

21 “(4) METHODS.—Under a contract described in
22 paragraph (2), an agricultural producer may grow
23 produce through traditional or controlled environ-
24 mental agriculture.

1 “(5) EVALUATION.—Not later than 2 years
 2 after the date of establishment of the pilot program
 3 under paragraph (2), the Secretary shall conduct an
 4 evaluation of the pilot program.

5 “(6) FUNDING.—

6 “(A) IN GENERAL.—Of the funds of the
 7 Commodity Credit Corporation, the Secretary
 8 shall use to carry out this subsection \$350,000
 9 for each of fiscal years 2027 through 2031.

10 “(B) ADMINISTRATIVE COSTS.—Of the
 11 amounts made available under subparagraph
 12 (A) for a fiscal year, not more than 5 percent
 13 may be used for administrative costs.

14 “(C) EVALUATION.—In addition to
 15 amounts made available under subparagraph
 16 (A), there is appropriated to the Secretary, out
 17 of any funds in the Treasury not otherwise ap-
 18 propriated, \$25,000 to carry out paragraph
 19 (5).”.

20 **CHAPTER 2—CLOSING THE MEAL GAP**

21 **SEC. 10211. ELIMINATION OF TIME LIMIT.**

22 (a) IN GENERAL.—Section 6 of the Food and Nutri-
 23 tion Act of 2008 (7 U.S.C. 2015) is amended—

24 (1) by striking subsection (o); and

1 (2) by redesignating subsections (p) through (s)
2 as subsections (o) through (r), respectively.

3 (b) CONFORMING AMENDMENTS.—

4 (1) Section 5(a) of the Food and Nutrition Act
5 of 2008 (7 U.S.C. 2014(a)) is amended, in the sec-
6 ond sentence, by striking “(r)” and inserting “(q)”.

7 (2) Section 6(d)(4) of the Food and Nutrition
8 Act of 2008 (7 U.S.C. 2015(d)(4)) is amended—

9 (A) in subparagraph (B)(ii)(I)(bb)(DD),
10 by striking “or subsection (o)”;

11 (B) in subparagraph (N), by striking “or
12 subsection (o)” each place it appears.

13 (3) Section 7(i)(1) of the Food and Nutrition
14 Act of 2008 (7 U.S.C. 2016(i)(1)) is amended by
15 striking “section 6(o)(2) of this Act or”.

16 (4) Section 16(h) of the Food and Nutrition
17 Act of 2008 (7 U.S.C. 2025(h)) is amended—

18 (A) in paragraph (1)—

19 (i) in subparagraph (B), in the matter
20 preceding clause (i), by striking “that—”
21 and all that follows through the period at
22 the end of clause (ii) and inserting “that
23 is determined and adjusted by the Sec-
24 retary.”;

25 (ii) by striking subparagraph (E);

1 (iii) by redesignating subparagraph
2 (F) as subparagraph (E); and

3 (iv) in clause (ii)(III)(ee)(AA) of sub-
4 paragraph (E) (as so redesignated), by
5 striking “, individuals subject to the re-
6 quirements under section 6(o),”; and
7 (B) in paragraph (5)(C)—

8 (i) in clause (ii), by adding “and” at
9 the end;

10 (ii) in clause (iii), by striking “; and”
11 and inserting a period; and

12 (iii) by striking clause (iv).

13 (5) Section 51(d)(8)(A)(ii) of the Internal Rev-
14 enue Code of 1986 is amended—

15 (A) in subclause (I), by striking “, or” at
16 the end and inserting a period;

17 (B) in the matter preceding subclause (I),
18 by striking “family—” and all that follows
19 through “receiving” in subclause (I) and insert-
20 ing “family receiving”; and

21 (C) by striking subclause (II).

22 (6) Section 103(a)(2) of the Workforce Innova-
23 tion and Opportunity Act (29 U.S.C. 3113) is
24 amended—

25 (A) by striking subparagraph (D); and

1 (B) by redesignating subparagraphs (E)
 2 through (K) as subparagraphs (D) through (J),
 3 respectively.

4 (7) Section 121(b)(2)(B) of the Workforce In-
 5 novation and Opportunity Act (29 U.S.C. 3151) is
 6 amended—

7 (A) by striking clause (iv); and

8 (B) by redesignating clauses (v) through
 9 (vii) as clauses (iv) through (vi), respectively.

10 **SEC. 10212. INCLUSION OF PUERTO RICO IN SUPPLE-**
 11 **MENTAL NUTRITIONAL ASSISTANCE PRO-**
 12 **GRAM.**

13 (a) DEFINITIONS.—Section 3 of the Food and Nutri-
 14 tion Act of 2008 (7 U.S.C. 2012) is amended—

15 (1) in subsection (r), by inserting “the Com-
 16 monwealth of Puerto Rico,” after “Guam,”; and

17 (2) in subsection (u)(3)(B), by striking “Guam
 18 and” and inserting “Guam, the Commonwealth of
 19 Puerto Rico, and” after “Guam,”.

20 (b) ELIGIBLE HOUSEHOLDS.—Section 5 of the Food
 21 and Nutrition Act of 2008 (7 U.S.C. 2014) is amended—

22 (1) in subsection (b), in the first sentence, by
 23 inserting “the Commonwealth of Puerto Rico,” after
 24 “Guam,”;

25 (2) in subsection (c)—

1 (A) in paragraph (1), by striking “and
2 Guam,” and inserting “Guam, and the Com-
3 monwealth of Puerto Rico,”; and

4 (B) in the undesignated matter at the end,
5 by striking “States or Guam” and inserting
6 “States, Guam, or the Commonwealth of Puer-
7 to Rico”; and

8 (3) in subsection (e)—

9 (A) in paragraph (1)(A), by inserting “the
10 Commonwealth of Puerto Rico,” after “Ha-
11 waii,” each place it appears; and

12 (B) in paragraph (6)(B), in the matter
13 preceding clause (i), by inserting “the Common-
14 wealth of Puerto Rico,” after “Guam,”.

15 (c) EFFECTIVE DATE.—

16 (1) IN GENERAL.—The amendments made by
17 subsections (a) and (b) shall be effective with re-
18 spect to the Commonwealth of Puerto Rico on the
19 date described in paragraph (2) if the Secretary of
20 Agriculture submits to Congress a certification
21 under subsection (f)(2)(C) of section 19 of the Food
22 and Nutrition Act of 2008 (7 U.S.C. 2028) (as
23 added by subsection (d)).

24 (2) DATE DESCRIBED.—The date referred to in
25 paragraph (1) is the date established by the Com-

1 monwealth of Puerto Rico in the applicable plan of
 2 operation submitted to the Secretary of Agriculture
 3 under subsection (f)(1) of section 19 of the Food
 4 and Nutrition Act of 2008 (7 U.S.C. 2028) (as
 5 added by subsection (d)).

6 (d) TRANSITION OF PUERTO RICO TO SUPPLE-
 7 MENTAL NUTRITION ASSISTANCE PROGRAM.—Section 19
 8 of the Food and Nutrition Act of 2008 (7 U.S.C. 2028)
 9 is amended by adding at the end the following:

10 “(f) TRANSITION OF PUERTO RICO TO SUPPLE-
 11 MENTAL NUTRITION ASSISTANCE PROGRAM.—

12 “(1) REQUEST FOR PARTICIPATION.—The Com-
 13 monwealth of Puerto Rico may submit to the Sec-
 14 retary a request to participate in the supplemental
 15 nutrition assistance program, which shall include a
 16 plan of operation described in section 11(d), includ-
 17 ing a description of the date on which the Common-
 18 wealth of Puerto Rico intends to begin participation
 19 in the supplemental nutrition assistance program.

20 “(2) CERTIFICATION BY SECRETARY.—

21 “(A) IN GENERAL.—On submission of a
 22 request by the Commonwealth of Puerto Rico
 23 under paragraph (1), the Secretary shall certify
 24 the Commonwealth of Puerto Rico as qualified

1 to participate in the supplemental nutrition as-
 2 sistance program if the Secretary—

3 “(i) approves the plan of operation
 4 submitted with the request, in accordance
 5 with this subsection; and

6 “(ii) approves the applications de-
 7 scribed in paragraph (4) in accordance
 8 with that paragraph.

9 “(B) DEADLINE.—The Secretary shall cer-
 10 tify or deny the request of the Commonwealth
 11 of Puerto Rico under paragraph (1) not later
 12 than 90 days after the date on which the Sec-
 13 retary receives the request.

14 “(C) SUBMISSION TO CONGRESS.—The
 15 Secretary shall submit a certification under
 16 subparagraph (A) to Congress.

17 “(3) DETERMINATION OF PLAN OF OPER-
 18 ATION.—

19 “(A) APPROVAL.—The Secretary shall ap-
 20 prove a plan of operation submitted with a re-
 21 quest under paragraph (1) if the plan satisfies
 22 the requirements under this Act.

23 “(B) DISAPPROVAL.—If the Secretary does
 24 not approve a plan of operation submitted with
 25 a request under paragraph (1), the Secretary

1 shall provide a statement that describes each
2 requirement under this Act that is not satisfied
3 by the plan.

4 “(4) APPROVAL OF RETAIL FOOD STORES.—If
5 the Secretary approves a plan of operation under
6 paragraph (3)(A) for the Commonwealth of Puerto
7 Rico, the Secretary shall accept applications from re-
8 tail food stores located in the Commonwealth of
9 Puerto Rico to be authorized under section 9 to par-
10 ticipate in the supplemental nutrition assistance pro-
11 gram.

12 “(5) FAMILY MARKET PROGRAM.—Notwith-
13 standing subsection (g), the Secretary shall allow the
14 Commonwealth of Puerto Rico to continue to carry
15 out under the supplemental nutrition assistance pro-
16 gram the Family Market Program established pur-
17 suant to this section.

18 “(6) TEMPORARY FUNDING.—If the Common-
19 wealth of Puerto Rico has a request under para-
20 graph (1) pending before the Secretary (including a
21 plan of operation pending under paragraph (3)), the
22 Commonwealth of Puerto Rico shall receive block
23 grants under this section, in amounts determined by
24 the Secretary, until the date on which the Secretary

1 certifies the Commonwealth of Puerto Rico under
2 paragraph (2)(B).

3 “(7) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated to the Sec-
5 retary such sums as are necessary to carry out this
6 subsection for fiscal year 2027, to remain available
7 until expended.

8 “(g) TECHNICAL INFRASTRUCTURE IMPLEMENTA-
9 TION.—

10 “(1) IN GENERAL.—The Commonwealth of
11 Puerto Rico may request from the Secretary a 1-
12 time grant to pay for the cost of the technology in-
13 frastructure necessary to implement the supple-
14 mental nutrition assistance program, including the
15 cost of information technology, information tech-
16 nology personnel, and training relating to program
17 implementation.

18 “(2) APPLICATION.—In making a request under
19 paragraph (1), the Commonwealth of Puerto Rico
20 shall submit to the Secretary an application at such
21 time, in such manner, and containing such informa-
22 tion as the Secretary may require, including—

23 “(A) a description of the costs to be paid
24 for by the grant; and

1 “(B) a plan for implementing the tech-
2 nology infrastructure described in paragraph
3 (1)—

4 “(i) within 1 year of receiving the
5 grant; and

6 “(ii) that is reasonably cost efficient,
7 as determined by the Secretary.

8 “(3) DETERMINATION.—

9 “(A) TIME LIMIT.—The Secretary shall
10 approve or deny an application submitted under
11 paragraph (2) not later than 90 days after the
12 date on which the application is submitted.

13 “(B) DENIAL.—If the Secretary denies an
14 application submitted under paragraph (2), the
15 Commonwealth of Puerto Rico may amend the
16 plan described in subparagraph (B) of that
17 paragraph, in coordination with the Secretary,
18 to resubmit to the Secretary for approval.

19 “(4) FUNDING.—

20 “(A) IN GENERAL.—There is appropriated
21 to the Secretary, out of funds in the Treasury
22 not otherwise appropriated, \$112,500,000 to
23 carry out this subsection, to remain available
24 until 3 years after the date of enactment of this
25 subsection.

1 “(B) REVERSION OF FUNDS.—Any funds
 2 appropriated to the Secretary under subpara-
 3 graph (A) that remain available by the date de-
 4 scribed in that subparagraph shall revert to the
 5 Treasury.

6 “(h) TERMINATION OF EFFECTIVENESS.—

7 “(1) IN GENERAL.—Subsections (a) through (e)
 8 shall cease to be effective with respect to the Com-
 9 monwealth of Puerto Rico on the date described in
 10 paragraph (2) if the Secretary submits to Congress
 11 a certification under subsection (f)(2)(C) for the
 12 Commonwealth of Puerto Rico.

13 “(2) DATE DESCRIBED.—The date referred to
 14 in paragraph (1) is the date established by the Com-
 15 monwealth of Puerto Rico in the applicable plan of
 16 operation submitted to the Secretary under sub-
 17 section (f)(1).”.

18 **Subtitle D—Universal School Meals**

19 **SEC. 10301. SHORT TITLE.**

20 This subtitle may be cited as the “Universal School
 21 Meals Program Act of 2026”.

22 **SEC. 10302. EFFECTIVE DATE.**

23 Except as otherwise provided, this subtitle, and the
 24 amendments made by this subtitle, shall take effect on the

1 date that is 1 year after the date of enactment of this
2 Act.

3 **CHAPTER 1—SCHOOL BREAKFAST** 4 **PROGRAM**

5 **SEC. 10311. FREE SCHOOL BREAKFAST PROGRAM.**

6 (a) IN GENERAL.—Section 4(a) of the Child Nutri-
7 tion Act of 1966 (42 U.S.C. 1773(a)) is amended, in the
8 first sentence—

9 (1) by striking “is hereby” and inserting “are”;
10 and

11 (2) by inserting “to provide free breakfast to all
12 children enrolled at those schools” before “in accord-
13 ance”.

14 (b) APPORTIONMENT TO STATES.—Section 4(b) of
15 the Child Nutrition Act of 1966 (42 U.S.C. 1773(b)) is
16 amended—

17 (1) in paragraph (1)—

18 (A) in subparagraph (A)(i), by striking
19 subclause (II) and inserting the following:

20 “(II) the national average pay-
21 ment for free breakfasts, as specified
22 in subparagraph (B).”;

23 (B) by striking subparagraph (B) and in-
24 serting the following:

25 “(B) PAYMENT AMOUNTS.—

1 “(i) IN GENERAL.—The national aver-
2 age payment for each free breakfast shall
3 be \$2.80, adjusted annually for inflation in
4 accordance with clause (ii) and rounded in
5 accordance with clause (iii).

6 “(ii) INFLATION ADJUSTMENT.—

7 “(I) IN GENERAL.—The annual
8 inflation adjustment under clause (i)
9 shall reflect changes in the cost of op-
10 erating the free breakfast program
11 under this section, as indicated by the
12 change in the Consumer Price Index
13 for food away from home for all urban
14 consumers.

15 “(II) BASIS.—Each inflation an-
16 nual adjustment under clause (i) shall
17 reflect the changes in the Consumer
18 Price Index for food away from home
19 for the most recent 12-month period
20 for which those data are available.

21 “(iii) ROUNDING.—On July 1, 2027,
22 and annually thereafter, the national aver-
23 age payment rate for free breakfast shall
24 be—

1 “(I) adjusted to the nearest
2 lower-cent increment; and

3 “(II) based on the unrounded
4 amounts for the preceding 12-month
5 period.”;

6 (C) by striking subparagraphs (C) and
7 (E); and

8 (D) by redesignating subparagraph (D) as
9 subparagraph (C);

10 (2) by striking paragraphs (2) and (3);

11 (3) by redesignating paragraphs (4) and (5) as
12 paragraphs (2) and (3), respectively; and

13 (4) in paragraph (3) (as so redesignated), by
14 striking “paragraph (3) or (4)” and inserting “para-
15 graph (2)”.

16 (c) STATE DISBURSEMENT TO SCHOOLS.—Section 4
17 of the Child Nutrition Act of 1966 (42 U.S.C. 1773) is
18 amended by striking subsection (c) and inserting the fol-
19 lowing:

20 “(c) STATE DISBURSEMENT TO SCHOOLS.—Funds
21 apportioned and paid to any State for the purpose of this
22 section shall be disbursed by the State educational agency
23 to schools selected by the State educational agency to as-
24 sist those schools in operating a breakfast program.”.

25 (d) NO COLLECTION OF DEBT.—

1 (1) IN GENERAL.—Notwithstanding any other
2 provision of the Child Nutrition Act of 1966 (42
3 U.S.C. 1771 et seq.) or any other provision of law,
4 effective beginning on the date of enactment of this
5 Act, as a condition of participation in the breakfast
6 program under section 4 of that Act (42 U.S.C.
7 1773), a school—

8 (A) shall not collect any debt owed to the
9 school for unpaid meal charges; and

10 (B) shall continue to accrue debt for un-
11 paid meal charges—

12 (i) for the purpose of receiving reim-
13 bursement under section 10332; and

14 (ii) until the effective date specified in
15 section 10302.

16 (2) CHILD NUTRITION ACT OF 1966.—

17 (A) IN GENERAL.—Section 4 of the Child
18 Nutrition Act of 1966 (42 U.S.C. 1773) is
19 amended by striking subsection (d) and insert-
20 ing the following:

21 “(d) NO COLLECTION OF DEBT.—A school partici-
22 pating in the free breakfast program under this section
23 shall not collect any debt owed to the school for unpaid
24 meal charges.”.

1 (B) CONFORMING AMENDMENT.—Section
 2 23(a) of the Child Nutrition Act of 1966 (42
 3 U.S.C. 1793(a)) is amended by striking “a
 4 school in severe need, as described in section
 5 4(d)(1)” and inserting the following: “a
 6 school—

7 “(1) participating in the free breakfast program
 8 under section 4, or seeking to initiate a free break-
 9 fast program under that section; and

10 “(2) not less than 40 percent of the students of
 11 which are economically disadvantaged students (as
 12 identified under a measure described in section
 13 1113(a)(5) of the Elementary and Secondary Edu-
 14 cation Act of 1965 (20 U.S.C. 6313(a)(5)))”.

15 (e) NUTRITIONAL AND OTHER PROGRAM REQUIRE-
 16 MENTS.—Section 4(e) of the Child Nutrition Act of 1966
 17 (42 U.S.C. 1773(e)) is amended—

18 (1) in paragraph (1)(A), in the second sentence,
 19 by striking “free or” and all that follows through
 20 the period at the end and inserting “free to all chil-
 21 dren enrolled at a school participating in the school
 22 breakfast program.”; and

23 (2) in paragraph (2), in the second sentence, by
 24 striking “the full charge to the student for a break-
 25 fast meeting the requirements of this section or”.

1 (f) PROHIBITION ON BREAKFAST SHAMING, MEAL
2 DENIAL.—

3 (1) IN GENERAL.—Effective beginning on the
4 date of enactment of this Act, a school or school
5 food authority—

6 (A) shall not—

7 (i) physically segregate for the pur-
8 pose of debt shaming or otherwise dis-
9 criminate against any child participating in
10 the breakfast program under section 4 of
11 the Child Nutrition Act of 1966 (42
12 U.S.C. 1773); or

13 (ii) overtly identify a child described
14 in clause (i) by a special token or ticket,
15 an announced or published list of names,
16 or any other means; and

17 (B) shall provide the program meal to each
18 child eligible under the program described in
19 subparagraph (A)(i).

20 (2) CHILD NUTRITION ACT OF 1966.—Section 4
21 of the Child Nutrition Act of 1966 (42 U.S.C. 1773)
22 is amended by adding at the end the following:

23 “(f) PROHIBITION ON BREAKFAST SHAMING.—A
24 school or school food authority shall not—

1 “(1) physically segregate for the purpose of
2 debt shaming or otherwise discriminate against any
3 child participating in the free breakfast program
4 under this section; or

5 “(2) overtly identify a child described in para-
6 graph (1) by a special token or ticket, an announced
7 or published list of names, or any other means.”.

8 (g) DEPARTMENT OF DEFENSE OVERSEAS DEPEND-
9 ENTS’ SCHOOLS.—Section 20(b) of the Child Nutrition
10 Act of 1966 (42 U.S.C. 1789(b)) is amended by striking
11 “by this section” and all that follows through the period
12 at the end and inserting “by this section.”.

13 (h) CONFORMING AMENDMENTS.—The Child Nutri-
14 tion Act of 1966 (42 U.S.C. 1771 et seq.) is amended—

15 (1) by striking “or reduced price” each place it
16 appears;

17 (2) by striking “and reduced price” each place
18 it appears; and

19 (3) by striking “a reduced price” each place it
20 appears.

21 **CHAPTER 2—SCHOOL LUNCH PROGRAM**

22 **SEC. 10321. APPORTIONMENT TO STATES.**

23 Section 4(b) of the Richard B. Russell National
24 School Lunch Act (42 U.S.C. 1753(b)) is amended—

25 (1) in paragraph (1)—

1 (A) in subparagraph (A), by striking “of
2 this Act”; and

3 (B) in subparagraph (B), by striking “of
4 this subsection”; and

5 (2) by striking paragraphs (2) and (3) and in-
6 serting the following:

7 “(2) PAYMENT AMOUNTS.—

8 “(A) IN GENERAL.—The national average
9 payment for each free lunch shall be \$4.63, ad-
10 justed annually for inflation in accordance with
11 subparagraph (C) and rounded in accordance
12 with subparagraph (D).

13 “(B) ADDITIONAL PAYMENT FOR LOCAL
14 FOOD.—

15 “(i) IN GENERAL.—During a school
16 year, a school food authority shall receive
17 an additional payment described in clause
18 (ii) if the State certifies that the school
19 food authority served meals (including
20 breakfasts, lunches, suppers, and supple-
21 ments) during the preceding school year
22 not less than 25 percent of which were
23 made with farm products that were—

24 “(I) produced and distributed—

1 “(aa) in the State in which
2 the school food authority is lo-
3 cated; or

4 “(bb) not more than 250
5 miles from the location of the
6 school food authority; and

7 “(II) marketed to consumers—

8 “(aa) directly; or

9 “(bb) through an intermedi-
10 ated channel (such as a food hub
11 or cooperative).

12 “(ii) PAYMENT AMOUNT.—

13 “(I) IN GENERAL.—The addi-
14 tional payment amount under this
15 subparagraph shall be—

16 “(aa) \$0.30 for each free
17 lunch and supper;

18 “(bb) \$0.21 for each free
19 breakfast; and

20 “(cc) \$0.08 for each free
21 supplement.

22 “(II) ADJUSTMENTS.—Each ad-
23 ditional payment amount under sub-
24 clause (I) shall be adjusted annually
25 in accordance with subparagraph (C)

1 and rounded in accordance with sub-
2 paragraph (D).

3 “(iii) DISBURSEMENT.—The State
4 agency shall disburse funds made available
5 under this subparagraph to school food au-
6 thorities eligible to receive additional reim-
7 bursement.

8 “(C) INFLATION ADJUSTMENT.—

9 “(i) IN GENERAL.—The annual infla-
10 tion adjustment under subparagraphs (A)
11 and (B)(ii) shall reflect changes in the cost
12 of operating the free lunch program under
13 this Act, as indicated by the change in the
14 Consumer Price Index for food away from
15 home for all urban consumers.

16 “(ii) BASIS.—Each annual inflation
17 adjustment under subparagraphs (A) and
18 (B)(ii) shall reflect the changes in the Con-
19 sumer Price Index for food away from
20 home for the most recent 12-month period
21 for which those data are available.

22 “(D) ROUNDING.—On July 1, 2027, and
23 annually thereafter, the national average pay-
24 ment rate for free lunch and the additional pay-
25 ment amount for free breakfast, lunch, supper,

1 and supplement under subparagraph (B) shall
2 be—

3 “(i) adjusted to the nearest lower-cent
4 increment; and

5 “(ii) based on the unrounded amounts
6 for the preceding 12-month period.”.

7 **SEC. 10322. NUTRITIONAL AND OTHER PROGRAM REQUIRE-**
8 **MENTS.**

9 (a) **ELIMINATION OF FREE LUNCH ELIGIBILITY RE-**
10 **QUIREMENTS.—**

11 (1) **IN GENERAL.**—Section 9 of the Richard B.
12 Russell National School Lunch Act (42 U.S.C.
13 1758) is amended by striking subsection (b) and in-
14 serting the following:

15 “(b) **ELIGIBILITY.**—All children enrolled in a school
16 that participates in the school lunch program under this
17 Act shall be eligible to receive free lunch under this Act.”.

18 (2) **CONFORMING AMENDMENTS.—**

19 (A) Section 9 of the Richard B. Russell
20 National School Lunch Act (42 U.S.C. 1758) is
21 amended—

22 (i) in subsection (c), in the third sen-
23 tence, by striking “or at a reduced cost”;
24 and

1 (ii) in subsection (e), by striking “, re-
2 duced price,”.

3 (B) Section 18 of the Richard B. Russell
4 National School Lunch Act (42 U.S.C. 1769) is
5 amended—

6 (i) in subsection (b), by striking
7 “(b)(1) Upon” and inserting the following:

8 “(a) EXTENSION OF ELIGIBILITY OF CERTAIN
9 SCHOOL DISTRICTS TO RECEIVE CASH OR COMMODITY
10 LETTERS OF CREDIT ASSISTANCE FOR SCHOOL LUNCH
11 PROGRAMS.—

12 “(1) IN GENERAL.—On”;

13 (ii) in subsection (c), by striking
14 “(c)(1) The” and inserting the following:

15 “(b) ALTERNATIVE COUNTING AND CLAIMING PRO-
16 CEDURES.—

17 “(1) IN GENERAL.—The”;

18 (iii) in subsection (g), by striking the
19 subsection designation and heading and in-
20 serting the following:

21 “(c) ACCESS TO LOCAL FOODS: PATRICK LEAHY
22 FARM TO SCHOOL PROGRAM.—”;

23 (iv) by striking subsection (j); and

1 (v) by redesignating subsections (h),
2 (i), and (k) as subsections (d), (e), and (f),
3 respectively.

4 (C) Section 17(r)(5) of the Richard B.
5 Russell National School Lunch Act (42 U.S.C.
6 1766(r)(5)) is amended by striking “18(h)” and
7 inserting “18(d)”.

8 (D) Section 19(i)(2) of the Richard B.
9 Russell National School Lunch Act (42 U.S.C.
10 1769a(i)(2)) is amended by striking “State that
11 received funding under section 18(f) on the day
12 before the date of enactment of the Food, Con-
13 servation, and Energy Act of 2008” and insert-
14 ing “State that, on the day before the date of
15 enactment of the Food, Conservation, and En-
16 ergy Act of 2008 (Public Law 110–246; 122
17 Stat. 1651), received funding under section
18 18(f) (as in effect on the day before that date
19 of enactment)”.

20 (E) Section 413(b)(2) of the Agricultural
21 Research, Extension, and Education Reform
22 Act of 1998 (7 U.S.C. 7633(b)(2)) is amended
23 by striking “section 18(g) of the Richard B.
24 Russell National School Lunch Act (42 U.S.C.
25 1769(g))” and inserting “subsection (c) of sec-

1 tion 18 of the Richard B. Russell National
2 School Lunch Act (42 U.S.C. 1769)”.

3 (F) Section 28 of the Richard B. Russell
4 National School Lunch Act (42 U.S.C. 1769i)
5 is amended—

6 (i) by striking subsection (b); and

7 (ii) by redesignating subsection (c) as
8 subsection (b).

9 (G) Section 1154(a)(2)(A)(i) of title 10,
10 United States Code, is amended by striking “in
11 accordance with section 9(b)(1) of the Richard
12 B. Russell National School Lunch Act (42
13 U.S.C. 1758(b)(1))”.

14 (H) Section 1902(a) of the Social Security
15 Act (42 U.S.C. 1396a(a)) is amended by strik-
16 ing paragraph (7) and inserting the following:
17 “(7) provide safeguards that restrict the use or
18 disclosure of information concerning applicants and
19 recipients to purposes directly connected with the
20 administration of the plan;”.

21 (I) Section 4301 of the Food, Conserva-
22 tion, and Energy Act of 2008 (42 U.S.C.
23 1758a) is repealed.

24 (J) Section 17 of the Child Nutrition Act
25 of 1966 (42 U.S.C. 1786) is amended—

1 (i) in subsection (d)—

2 (I) in paragraph (2)(A)—

3 (aa) by striking clause (i);

4 and

5 (bb) by redesignating

6 clauses (ii) and (iii) as clauses (i)

7 and (ii), respectively; and

8 (II) in paragraph (3)—

9 (aa) by striking subpara-
10 graph (D);

11 (bb) by redesignating sub-
12 paragraphs (E) and (F) as sub-
13 paragraphs (D) and (E), respec-
14 tively; and

15 (cc) in subparagraph (D) (as
16 so redesignated), by striking
17 “clause (ii) or (iii)” and inserting
18 “clause (i) or (ii)”; and

19 (ii) in subsection (f)(17), by striking
20 “Notwithstanding subsection (d)(2)(A)(i),
21 not later” and inserting “Not later”.

22 (b) NO COLLECTION OF DEBT.—

23 (1) IN GENERAL.—Notwithstanding any other
24 provision of the Richard B. Russell National School
25 Lunch Act (42 U.S.C. 1751 et seq.) or any other

1 provision of law, effective beginning on the date of
 2 enactment of this Act, as a condition of participation
 3 in the school lunch program under that Act, a
 4 school—

5 (A) shall not collect any debt owed to the
 6 school for unpaid meal charges; and

7 (B) shall continue to accrue debt for un-
 8 paid meal charges—

9 (i) for the purpose of receiving reim-
 10 bursement under section 10332; and

11 (ii) until the effective date specified in
 12 section 10302.

13 (2) NATIONAL SCHOOL LUNCH ACT.—Section 9
 14 of the Richard B. Russell National School Lunch
 15 Act (42 U.S.C. 1758) is amended by striking sub-
 16 section (d) and inserting the following:

17 “(d) NO COLLECTION OF DEBT.—A school partici-
 18 pating in the school lunch program under this Act shall
 19 not collect any debt owed to the school for unpaid meal
 20 charges.”.

21 **SEC. 10323. SPECIAL ASSISTANCE PROGRAM.**

22 (a) IN GENERAL.—Section 11 of the Richard B. Rus-
 23 sell National School Lunch Act (42 U.S.C. 1759a) is re-
 24 pealed.

25 (b) CONFORMING AMENDMENTS.—

1 (1) Section 6 of the Richard B. Russell Na-
2 tional School Lunch Act (42 U.S.C. 1755) is amend-
3 ed—

4 (A) in subsection (a)(2), by striking “sec-
5 tions 11 and 13” and inserting “section 13”;
6 and

7 (B) in subsection (e)(1), in the matter pre-
8 ceding subparagraph (A), by striking “section
9 4, this section, and section 11” and inserting
10 “this section and section 4”.

11 (2) Section 7(d) of the Richard B. Russell Na-
12 tional School Lunch Act (42 U.S.C. 1756(d)) is
13 amended by striking “or 11”.

14 (3) Section 8(g) of the Richard B. Russell Na-
15 tional School Lunch Act (42 U.S.C. 1757(g)) is
16 amended by striking “and under section 11 of this
17 Act”.

18 (4) Section 12(f) of the Richard B. Russell Na-
19 tional School Lunch Act (42 U.S.C. 1760(f)) is
20 amended by striking “11,”.

21 (5) Section 7(a) of the Child Nutrition Act of
22 1966 (42 U.S.C. 1766(a)) is amended—

23 (A) in paragraph (1)(A), by striking “4,
24 11, and 17” and inserting “4 and 17”; and

1 (B) in paragraph (2)(A), by striking “sec-
 2 tions 4 and 11” and inserting “section 4”.

3 (6) Section 1101(j)(3) of the Families First
 4 Coronavirus Response Act (7 U.S.C. 2011 note;
 5 Public Law 116–127) is amended—

6 (A) by striking “or served under section
 7 11(a)(1) of the Richard B. Russell National
 8 School Lunch Act (42 U.S.C. 1760(d),
 9 1759(a)(1))” and inserting “of the Richard B.
 10 Russell National School Lunch Act (42 U.S.C.
 11 1760(d))”; and

12 (B) by striking “or reduced price”.

13 **SEC. 10324. PRICE FOR PAID LUNCH.**

14 Section 12 of the Richard B. Russell National School
 15 Lunch Act (42 U.S.C. 1760) is amended—

16 (1) in subsection (l)(4)—

17 (A) by striking subparagraph (D); and

18 (B) by redesignating subparagraphs (E)
 19 through (M) as subparagraphs (D) through
 20 (L), respectively;

21 (2) by striking subsection (p); and

22 (3) by redesignating subsections (q) and (r) as
 23 subsections (p) and (q), respectively.

1 **SEC. 10325. SUMMER FOOD SERVICE PROGRAM FOR CHIL-**
2 **DREN.**

3 Section 13 of the Richard B. Russell National School
4 Lunch Act (42 U.S.C. 1761) is amended—

5 (1) in subsection (a)—

6 (A) in paragraph (1)(A)(i)—

7 (i) in subclause (I), by striking “have
8 been determined eligible for free or re-
9 duced price school meals under this Act
10 and the Child Nutrition Act of 1966 (42
11 U.S.C. 1771 et seq.)” and inserting “are
12 economically disadvantaged students (as
13 identified under a measure described in
14 section 1113(a)(5) of the Elementary and
15 Secondary Education Act of 1965 (20
16 U.S.C. 6313(a)(5)))”;

17 (ii) in subclause (II), by striking “are
18 eligible for free or reduced price school
19 meals under this Act and the Child Nutri-
20 tion Act of 1966 (42 U.S.C. 1771 et seq.)”
21 and inserting “are economically disadvan-
22 tagged students (as identified under a meas-
23 ure described in section 1113(a)(5) of the
24 Elementary and Secondary Education Act
25 of 1965 (20 U.S.C. 6313(a)(5)))”;

1 (iii) in subclause (III)(bb), by striking
2 “meet the income standards for free or re-
3 duced price school meals under this Act
4 and the Child Nutrition Act of 1966 (42
5 U.S.C. 1771 et seq.)” and inserting “are
6 economically disadvantaged students (as
7 identified under a measure described in
8 section 1113(a)(5) of the Elementary and
9 Secondary Education Act of 1965 (20
10 U.S.C. 6313(a)(5)))”;

11 (iv) in subclause (IV), by striking
12 “are eligible for free or reduced price
13 school meals under this Act and the Child
14 Nutrition Act of 1966 (42 U.S.C. 1771 et
15 seq.)” and inserting “are economically dis-
16 advantaged students (as identified under a
17 measure described in section 1113(a)(5) of
18 the Elementary and Secondary Education
19 Act of 1965 (20 U.S.C. 6313(a)(5)))”; and

20 (v) in subclause (V), by striking “are
21 eligible for free or reduced price school
22 meals under this Act and the Child Nutri-
23 tion Act of 1966 (42 U.S.C. 1771 et seq.)”
24 and inserting “are economically disadvan-
25 tagged students (as identified under a meas-

1 ure described in section 1113(a)(5) of the
 2 Elementary and Secondary Education Act
 3 of 1965 (20 U.S.C. 6313(a)(5)))”;

4 (B) in paragraph (2), by adding at the end
 5 the following:

6 “(C) WAIVER.—If the Secretary deter-
 7 mines that a program requirement under this
 8 section limits the access of children to meals
 9 served under this section, the Secretary may
 10 waive that program requirement.

11 “(D) ELIGIBILITY.—All children shall be
 12 eligible to participate in the program under this
 13 section.”;

14 (C) in paragraph (5), by striking “only
 15 for” and all that follows through the period at
 16 the end and inserting “for meals served to all
 17 children.”; and

18 (D) in paragraph (13)—

19 (i) in subparagraph (C)(ii), by strik-
 20 ing “eligible for a free or reduced price
 21 lunch under this Act or a free or reduced
 22 price breakfast under section 4 of the
 23 Child Nutrition Act of 1966 (42 U.S.C.
 24 1773)” and inserting “an economically dis-
 25 advantaged student (as identified under a

1 measure described in section 1113(a)(5) of
 2 the Elementary and Secondary Education
 3 Act of 1965 (20 U.S.C. 6313(a)(5)))”;

4 (ii) in subparagraph (D)(ii), by strik-
 5 ing “eligible for free or reduced price lunch
 6 under this Act or free or reduced price
 7 breakfast under section 4 of the Child Nu-
 8 trition Act of 1966 (42 U.S.C. 1773)” and
 9 inserting “economically disadvantaged stu-
 10 dents (as identified under a measure de-
 11 scribed in section 1113(a)(5) of the Ele-
 12 mentary and Secondary Education Act of
 13 1965 (20 U.S.C. 6313(a)(5)))”;

14 (2) in subsection (b)(2), by striking “may only
 15 serve” and all that follows through “migrant chil-
 16 dren”;

17 (3) by striking subsection (c) and inserting the
 18 following:

19 “(c) PAYMENTS.—

20 “(1) IN GENERAL.—Payments shall be made to
 21 service institutions for meals served—

22 “(A) during the months of May through
 23 September;

24 “(B) during school vacation at any time
 25 during an academic school year;

1 “(C) during a teacher in-service day; and

2 “(D) on days that school is closed due to
3 a natural disaster, building repair, court order,
4 or similar cause, as determined by the Sec-
5 retary.

6 “(2) LIMITATION ON PAYMENTS.—A service in-
7 stitution shall receive payments under this section
8 for not more than 3 meals and 1 supplement per
9 child per day.”; and

10 (4) in subsection (f)(3), by striking “, except
11 that” and all that follows through “of this section”.

12 **SEC. 10326. SUMMER ELECTRONIC BENEFIT TRANSFER FOR**
13 **CHILDREN PROGRAM.**

14 Section 13A of the Richard B. Russell National
15 School Lunch Act (42 U.S.C. 1762) is amended—

16 (1) in subsection (b)(2)(A)(i), by striking
17 “\$40” and inserting “\$60”;

18 (2) in subsection (c)(1)—

19 (A) in subparagraph (A), by striking “di-
20 rectly certified” and all that follows through
21 “this section” and inserting “an economically
22 disadvantaged student (as identified under a
23 measure described in section 1113(a)(5) of the
24 Elementary and Secondary Education Act of
25 1965 (20 U.S.C. 6313(a)(5)))”;

1 (B) by striking subparagraph (B); and
 2 (C) by redesignating subparagraphs (C)
 3 through (E) as subparagraphs (B) through (D),
 4 respectively;
 5 (3) in subsection (f)—

6 (A) in paragraph (3), in the matter pre-
 7 ceding subparagraph (A), by striking “proc-
 8 esses—” and all that follows through “to reli-
 9 ably” in subparagraph (B) and inserting “proc-
 10 esses to reliably”; and

11 (B) in paragraph (4), in the matter pre-
 12 ceding subparagraph (A), by striking “by—”
 13 and all that follows through “establishing” in
 14 subparagraph (B) and inserting “by estab-
 15 lishing”; and

16 (4) in subsection (h), by striking paragraph (2)
 17 and inserting the following:

18 “(2) ELIGIBLE CHILD.—The term ‘eligible
 19 child’ means any child residing in a State or on land
 20 under the jurisdiction of a covered Indian Tribal or-
 21 ganization that participates in the program estab-
 22 lished under this section.”.

23 **SEC. 10327. CHILD AND ADULT CARE FOOD PROGRAM.**

24 Section 17 of the Richard B. Russell National School
 25 Lunch Act (42 U.S.C. 1766) is amended—

1 (1) in subsection (a)(2), by striking subpara-
2 graph (B) and inserting the following:

3 “(B) any other private organization pro-
4 viding nonresidential child care or day care out-
5 side school hours for school children;”;

6 (2) by striking subsection (c) and inserting the
7 following:

8 “(c) FREE MEALS.—Notwithstanding any other pro-
9 vision of law—

10 “(1) all meals and supplements served under
11 the program authorized under this section shall be
12 provided for free to participants of the program; and

13 “(2) an institution that serves those meals and
14 supplements shall be reimbursed—

15 “(A) in the case of breakfast, at the rate
16 established for free breakfast under section
17 4(b)(1)(B)(i) of the Child Nutrition Act of
18 1966 (42 U.S.C. 1773(b)(1)(B)(i));

19 “(B) in the case of lunch, at the rate es-
20 tablished for free lunch under section
21 4(b)(2)(A); and

22 “(C) in the case of a supplemental meal,
23 \$1.20, adjusted for inflation in accordance with
24 section 4(b)(2)(C).”;

25 (3) in subsection (f)—

1 (A) in paragraph (2), by striking subpara-
 2 graph (B) and inserting the following:

3 “(B) LIMITATION TO REIMBURSEMENTS.—
 4 An institution may claim reimbursement under
 5 this paragraph for not more than 3 meals and
 6 1 supplement per day per child.”;

7 (B) by striking paragraph (3); and

8 (C) by redesignating paragraph (4) as
 9 paragraph (3);
 10 (4) in subsection (o)—

11 (A) by striking paragraph (4); and

12 (B) by redesignating paragraphs (5) and
 13 (6) as paragraphs (4) and (5), respectively; and
 14 (5) in subsection (r)—

15 (A) in the subsection heading, by striking
 16 “PROGRAM FOR AT-RISK SCHOOL CHILDREN”
 17 and inserting “AFTERSCHOOL MEAL AND
 18 SNACK PROGRAM”;

19 (B) by striking “at-risk school” each place
 20 it appears and inserting “eligible”;

21 (C) in paragraph (1)—

22 (i) in the paragraph heading, by strik-
 23 ing “AT-RISK SCHOOL” and inserting “ELI-
 24 GIBLE”; and

1 (ii) in subparagraph (B), by striking
 2 “operated” and all that follows through
 3 the period at the end and inserting a pe-
 4 riod; and

5 (D) in paragraph (4)(A), by striking “only
 6 for” and all that follows through the period at
 7 the end and inserting the following: “for—

8 “(i) not more than 1 meal and 1 sup-
 9 plement per child per day served on a reg-
 10 ular school day; and

11 “(ii) not more than 3 meals and 1
 12 supplement per child per day served on
 13 any day other than a regular school day.”.

14 **SEC. 10328. MEALS AND SUPPLEMENTS FOR CHILDREN IN**
 15 **AFTERSCHOOL CARE.**

16 Section 17A of the Richard B. Russell National
 17 School Lunch Act (42 U.S.C. 1766a) is amended—

18 (1) in the section heading, by striking “**MEAL**
 19 **SUPPLEMENTS**” and inserting “**MEALS AND SUP-**
 20 **PLEMENTS**”;

21 (2) in subsection (a)(1), by striking “meal sup-
 22 plements” and inserting “free meals and supple-
 23 ments”;

24 (3) in subsection (b), by inserting “meals and”
 25 before “supplements”; and

1 (4) by striking subsection (c) and inserting the
2 following:

3 “(c) REIMBURSEMENT.—

4 “(1) IN GENERAL.—

5 “(A) MEALS.—A free meal provided under
6 this section to a child shall be reimbursed at a
7 rate of \$4.63, adjusted annually for inflation in
8 accordance with paragraph (3)(A) and rounded
9 in accordance with paragraph (3)(B).

10 “(B) SUPPLEMENTS.—A free supplement
11 provided under this section to a child shall be
12 reimbursed at the rate at which free supple-
13 ments are reimbursed under section
14 17(c)(2)(C).

15 “(2) LIMITATION TO REIMBURSEMENTS.—An
16 institution may claim reimbursement under this sec-
17 tion for not more than 1 meal and 1 supplement per
18 day per child served on a regular school day.

19 “(3) INFLATION; ROUNDING.—

20 “(A) INFLATION ADJUSTMENT.—

21 “(i) IN GENERAL.—The annual infla-
22 tion adjustment under paragraph (1)(A)
23 shall reflect changes in the cost of oper-
24 ating the program under this section, as
25 indicated by the change in the Consumer

1 Price Index for food away from home for
2 all urban consumers.

3 “(ii) BASIS.—Each inflation annual
4 adjustment under paragraph (1)(A) shall
5 reflect the changes in the Consumer Price
6 Index for food away from home for the
7 most recent 12-month period for which
8 those data are available.

9 “(B) ROUNDING.—On July 1, 2027, and
10 annually thereafter, the reimbursement rate for
11 a free meal under this section shall be—

12 “(i) adjusted to the nearest lower-cent
13 increment; and

14 “(ii) based on the unrounded amounts
15 for the preceding 12-month period.”.

16 **SEC. 10329. PILOT PROJECTS.**

17 Section 18 of the Richard B. Russell National School
18 Lunch Act (42 U.S.C. 1769) is amended—

19 (1) in paragraph (5) of subsection (c) (as redes-
20 igned by section 10322(a)(2)(B)(i)(III)), by strik-
21 ing subparagraph (B) and inserting the following:

22 “(B) serve a high proportion of economi-
23 cally disadvantaged students (as identified
24 under a measure described in section
25 1113(a)(5) of the Elementary and Secondary

1 Education Act of 1965 (20 U.S.C.
 2 6313(a)(5)))”; and
 3 (2) in paragraph (1)(A)(ii) of subsection (d) (as
 4 redesignated by section 10322(a)(2)(B)(i)(V)), by
 5 striking “eligible for free or reduced price meals
 6 under this Act” and inserting “economically dis-
 7 advantaged students (as identified under a measure
 8 described in section 1113(a)(5) of the Elementary
 9 and Secondary Education Act of 1965 (20 U.S.C.
 10 6313(a)(5)))”.

11 **SEC. 10330. FRESH FRUIT AND VEGETABLE PROGRAM.**

12 Section 19(d) of the Richard B. Russell National
 13 School Lunch Act (42 U.S.C. 1769a(d)) is amended—

14 (1) in paragraph (1)—

15 (A) in the matter preceding subparagraph
 16 (A), by striking “paragraph (2) of this sub-
 17 section and”;

18 (B) in subparagraph (A), in the matter
 19 preceding clause (i), by striking “school—” and
 20 all that follows through “submits” in clause (ii)
 21 and inserting “school that submits”;

22 (C) in subparagraph (B), by striking
 23 “schools” and all that follows through “Act”
 24 and inserting “high-need schools (as defined in
 25 section 2211(b) of the Elementary and Sec-

1 ondary Education Act of 1965 (20 U.S.C.
2 6631(b)))”; and

3 (D) in subparagraph (D)—

4 (i) by striking clause (i); and

5 (ii) by redesignating clauses (ii)
6 through (iv) as clauses (i) through (iii), re-
7 spectively; and

8 (2) by striking paragraphs (2) and (3) and in-
9 serting the following:

10 “(2) OUTREACH TO HIGH-NEED SCHOOLS.—

11 Prior to making decisions regarding school participa-
12 tion in the program, a State agency shall inform
13 high-need schools (as defined in section 2211(b) of
14 the Elementary and Secondary Education Act of
15 1965 (20 U.S.C. 6631(b))), including Tribal schools,
16 of the eligibility of the schools for the program.”.

17 **SEC. 10331. TRAINING, TECHNICAL ASSISTANCE, AND FOOD**
18 **SERVICE MANAGEMENT INSTITUTE.**

19 Section 21(a)(1)(B) of the Richard B. Russell Na-
20 tional School Lunch Act (42 U.S.C. 1769b–1(a)(1)(B)) is
21 amended, in the matter preceding clause (i), by striking
22 “certified to receive free or reduced price meals” and in-
23 serting “who are economically disadvantaged students (as
24 identified under a measure described in section 1113(a)(5)

1 of the Elementary and Secondary Education Act of 1965
2 (20 U.S.C. 6313(a)(5)))”.

3 **SEC. 10332. REIMBURSEMENT OF SCHOOL MEAL DELIN-**
4 **QUENT DEBT PROGRAM.**

5 (a) DEFINITIONS.—In this section:

6 (1) DELINQUENT DEBT.—The term “delinquent
7 debt” means the debt owed by a parent or guardian
8 of a child to a school—

9 (A) as of the effective date specified in sec-
10 tion 10302; and

11 (B) for meals served by the school under—

12 (i) the school breakfast program
13 under section 4 of the Child Nutrition Act
14 of 1966 (42 U.S.C. 1773);

15 (ii) the school lunch program estab-
16 lished under the Richard B. Russell Na-
17 tional School Lunch Act (42 U.S.C. 1751
18 et seq.); or

19 (iii) both of the programs described in
20 clauses (i) and (ii).

21 (2) PROGRAM.—The term “program” means
22 the program established under subsection (b)(1).

23 (3) SECRETARY.—The term “Secretary” means
24 the Secretary of Agriculture.

25 (b) REIMBURSEMENT PROGRAM.—

1 (1) ESTABLISHMENT.—Not later than 60 days
2 after the effective date specified in section 10302,
3 the Secretary shall establish a program under which
4 the Secretary shall reimburse each school partici-
5 pating in a program described in clause (i) or (ii) of
6 subsection (a)(1)(B) for all delinquent debt.

7 (2) FORM FOR REIMBURSEMENT.—To carry out
8 the program, the Secretary shall design and dis-
9 tribute to State agencies a form to collect data relat-
10 ing to all delinquent debt in applicable schools in the
11 State, organized by school food authority.

12 (3) COMPLETION DATE.—The Secretary shall
13 provide all reimbursements under the program not
14 later than 180 days after the effective date specified
15 in section 10302.

16 (c) REPORT.—Not later than 2 years after the effec-
17 tive date specified in section 10302, the Comptroller Gen-
18 eral of the United States shall submit to Congress and
19 make publicly available a report that describes the suc-
20 cesses and challenges of the program.

21 **SEC. 10333. CONFORMING AMENDMENTS.**

22 The Richard B. Russell National School Lunch Act
23 (42 U.S.C. 1751 et seq.) is amended—

24 (1) by striking “or reduced price” each place it
25 appears;

1 (2) by striking “or a reduced price” each place
2 it appears;

3 (3) by striking “and reduced price” each place
4 it appears; and

5 (4) by striking “a reduced price” each place it
6 appears.

7 **CHAPTER 3—ELEMENTARY AND**
8 **SECONDARY EDUCATION DATA**

9 **SEC. 10341. MEASURE OF POVERTY.**

10 Section 1113(a)(5) of the Elementary and Secondary
11 Education Act of 1965 (20 U.S.C. 6313(a)(5)) is amend-
12 ed—

13 (1) in subparagraph (A), by striking “the num-
14 ber of children eligible for a free or reduced price
15 lunch under the Richard B. Russell National School
16 Lunch Act (42 U.S.C. 1751 et seq.)” and inserting
17 “the number of children from low-income back-
18 grounds, identified under subparagraph (D)”;

19 (2) by adding at the end the following:

20 “(D) IDENTIFICATION OF CHILDREN FROM
21 LOW-INCOME BACKGROUNDS.—

22 “(i) IN GENERAL.—A local edu-
23 cational agency or State agency, for the
24 purpose of identifying children from low-in-
25 come backgrounds enrolled in a school

1 served by a local educational agency,
2 may—

3 “(I) maintain a record, with re-
4 spect to each student for whom the
5 local educational agency provides a
6 free public education that contains the
7 information collected from the survey
8 described in clause (iii);

9 “(II) distribute and collect a stu-
10 dent survey based on the template de-
11 veloped under clause (iii) to identify
12 children from low-income back-
13 grounds; and

14 “(III) utilize direct certification
15 data described in clause (iv)(I) to
16 identify children from low-income
17 backgrounds.

18 “(ii) PRIVACY.—

19 “(I) IN GENERAL.—All individual
20 data collected under this subpara-
21 graph shall be protected by the local
22 educational agency or State agency in
23 a manner consistent with all applica-
24 ble local, State, and Federal privacy
25 laws.

1 “(II) REPORTING DATA.—Only
2 aggregated data, which may include
3 data disaggregated at the school, local
4 educational agency, or State level,
5 shall be reported to the Secretary at
6 such time and in such manner as the
7 Secretary may reasonably require.

8 “(iii) SURVEY.—Not later than 180
9 days after the date of enactment of the
10 Universal School Meals Program Act of
11 2026, the Secretary, in consultation with
12 the Secretary of Agriculture, shall develop
13 a template survey—

14 “(I) to identify children from
15 low-income backgrounds that contains
16 only the information necessary to
17 identify a child as a child from a low-
18 income background by using the cri-
19 teria of eligibility for a free or reduced
20 priced lunch under the Richard B.
21 Russell National School Lunch Act, as
22 such criteria were in effect on Sep-
23 tember 30, 2022; and

1 “(II) that shall be designed to be
2 easily accessible and in a user-friendly
3 manner.

4 “(iv) TRANSITION AUTHORITY FROM
5 FRPL TO ESEA MEASURES.—The Sec-
6 retary, in coordination with the Secretary
7 of Agriculture, shall have the authority to
8 take such steps as are necessary to provide
9 for the orderly transition to, and imple-
10 mentation of—

11 “(I) activities that are necessary
12 for the continuity of direct certifi-
13 cation carried out by local educational
14 agencies and State agencies specified
15 in paragraphs (4), (5), and (15) sec-
16 tion 9(b) of the Richard B. Russell
17 National School Lunch Act, as in ef-
18 fect on September 30, 2022, for the
19 purposes of identifying any child eligi-
20 ble for free or reduced priced lunch
21 under such Act, as in effect on such
22 date, as a child from a low-income
23 background;

24 “(II) procedures for verification
25 of information collected under this

1 subparagraph, which may include pro-
2 cedures modeled on the requirement
3 specified in section 9(b)(3) of the
4 Richard B. Russell National School
5 Lunch Act, as in effect on September
6 30, 2022; and

7 “(III) data privacy provisions for
8 information collected under this sub-
9 paragraph, in accordance with the re-
10 quirements specified in section 9(b)(6)
11 of the Richard B. Russell National
12 School Lunch Act, as in effect on Sep-
13 tember 30, 2022.

14 “(v) SPECIAL RULE.—For the pur-
15 poses of subparagraph (A), a local edu-
16 cational agency may determine the number
17 of children from low-income backgrounds
18 enrolled in a school served by such agency
19 using one or more of the following meth-
20 ods:

21 “(I) Results from surveys speci-
22 fied in clause (i)(II).

23 “(II) Direct certification data
24 specified in clause (i)(III).

1 “(III) Utilization of both meth-
 2 ods described in subclauses (I) and
 3 (II).”.

4 **CHAPTER 4—AMENDMENTS TO OTHER**
 5 **PROGRAMS AND LAWS**

6 **SEC. 10351. SUPPLEMENTAL NUTRITION ASSISTANCE PRO-**
 7 **GRAM.**

8 (a) AGREEMENT FOR DIRECT CERTIFICATION.—

9 (1) IN GENERAL.—Section 11 of the Food and
 10 Nutrition Act of 2008 (7 U.S.C. 2020) is amend-
 11 ed—

12 (A) by striking subsection (u); and

13 (B) by redesignating subsections (v)
 14 through (x) as subsections (u) through (w), re-
 15 spectively.

16 (2) CONFORMING AMENDMENTS.—Section 11(e)
 17 of the Food and Nutrition Act of 2008 (7 U.S.C.
 18 2020(e)) is amended—

19 (A) in paragraph (8)(F), by striking “or
 20 subsection (u)”;

21 (B) in paragraph (26)(B), by striking
 22 “(x)” and inserting “(w)”.

23 (b) NUTRITION EDUCATION AND OBESITY PREVEN-
 24 TION GRANT PROGRAM.—Section 28(a) of the Food and

1 Nutrition Act of 2008 (7 U.S.C. 2036a(a)) is amended
2 by striking paragraph (1) and inserting the following:

3 “(1) an individual eligible for benefits under
4 this Act;”.

5 **SEC. 10352. HIGHER EDUCATION ACT OF 1965.**

6 (a) **TEACHER QUALITY ENHANCEMENT.**—Section
7 200(11) of the Higher Education Act of 1965 (20 U.S.C.
8 1021(11)) is amended by striking subparagraph (A) and
9 inserting the following:

10 “(A) **IN GENERAL.**—The term ‘high-need
11 school’ means a school that is in the highest
12 quartile of schools in a ranking of all schools
13 served by a local educational agency, ranked in
14 descending order by percentage of students
15 from low-income families enrolled in such
16 schools, as determined by the local educational
17 agency based on one of the following measures
18 of poverty:

19 “(i) The percentage of students aged
20 5 through 17 in poverty counted in the
21 most recent census data approved by the
22 Secretary.

23 “(ii) The percentage of students in
24 families receiving assistance under the
25 State program funded under the program

1 of block grants to States for temporary as-
 2 sistance for needy families established
 3 under part A of title IV of the Social Secu-
 4 rity Act (42 U.S.C. 601 et seq.).

5 “(iii) The percentage of students eligi-
 6 ble to receive medical assistance under the
 7 program of medical assistance established
 8 under title XIX of the Social Security Act
 9 (42 U.S.C. 1396 et seq.).

10 “(iv) A composite of 2 or more of the
 11 measures described in clauses (i) through
 12 (iii).”.

13 (b) GEAR UP.—Section 404B(d)(1) of the Higher
 14 Education Act of 1965 (20 U.S.C. 1070a–22(d)(1)) is
 15 amended by striking subparagraph (A) and inserting the
 16 following:

17 “(A) provide services under this chapter to
 18 at least one grade level of students, beginning
 19 not later than 7th grade, in a participating
 20 school—

21 “(i) that has a 7th grade; and

22 “(ii) in which—

23 “(I) at least 50 percent of the
 24 students enrolled are economically dis-
 25 advantaged students (as identified

1 under a measure described in section
 2 1113(a)(5) of the Elementary and
 3 Secondary Education Act of 1965); or
 4 “(II) if an eligible entity deter-
 5 mines that it would promote the effec-
 6 tiveness of a program, an entire grade
 7 level of students, beginning not later
 8 than the 7th grade, reside in public
 9 housing, as defined in section 3(b)(1)
 10 of the United States Housing Act of
 11 1937 (42 U.S.C. 1437a(b)(1)).”.

12 (c) SIMPLIFIED APPLICATION FOR FEDERAL STU-
 13 DENT FINANCIAL AID.—

14 (1) IN GENERAL.—Section
 15 483(a)(2)(B)(ii)(XVII) of the Higher Education Act
 16 of 1965 (20 U.S.C. 1090(a)(2)(B)(ii)(XVII)) is
 17 amended—

18 (A) by striking item (cc); and

19 (B) by redesignating items (dd) through
 20 (jj) as items (cc) through (ii), respectively.

21 (2) EFFECTIVE DATE.—The amendments made
 22 by this section shall take effect as if included in sec-
 23 tion 702 of division FF of the Consolidated Appro-
 24 priations Act, 2021 (Public Law 116–260) and sub-
 25 ject to the effective date of section 701(b) of such

1 FAFSA Simplification Act, as amended by section
2 102(a) of the FAFSA Simplification Act Technical
3 Corrections Act (division R of Public Law 117–103)
4 (including the authorization provided under section
5 102(c)(1)(A) of such Act).

6 (d) EARLY FEDERAL PELL GRANT COMMITMENT
7 DEMONSTRATION PROGRAM.—Section 894(b) of the
8 Higher Education Act of 1965 (20 U.S.C. 1161y(b)) is
9 amended—

10 (1) in paragraph (1)(B), by striking “qualify
11 for a free or reduced price school lunch under the
12 Richard B. Russell National School Lunch Act (42
13 U.S.C. 1751 et seq.) or the Child Nutrition Act of
14 1966 (42 U.S.C. 1771 et seq.)” and inserting “are
15 economically disadvantaged students (as identified
16 under a measure described in section 1113(a)(5) of
17 the Elementary and Secondary Education Act of
18 1965)”; and

19 (2) in paragraph (5), by striking “eligible for a
20 free or reduced price school lunch under the Richard
21 B. Russell National School Lunch Act (42 U.S.C.
22 1751 et seq.) or the Child Nutrition Act of 1966 (42
23 U.S.C. 1771 et seq.)” and inserting “economically
24 disadvantaged students (as identified under a meas-

1 ure described in section 1113(a)(5) of the Elemen-
2 tary and Secondary Education Act of 1965)”.
3

3 **SEC. 10353. ELEMENTARY AND SECONDARY EDUCATION**

4 **ACT OF 1965.**

5 (a) LITERACY EDUCATION FOR ALL.—Section
6 2221(b)(3)(B) of the Elementary and Secondary Edu-
7 cation Act of 1965 (20 U.S.C. 6641(b)(3)(B)) is amend-
8 ed—

9 (1) by striking clause (i); and

10 (2) by redesignating clauses (ii) and (iii) as
11 clauses (i) and (ii), respectively.

12 (b) GRANTS FOR EDUCATION INNOVATION AND RE-
13 SEARCH.—Section 4611(d)(2) of the Elementary and Sec-
14 ondary Education Act of 1965 (20 U.S.C. 7261(d)(2)) is
15 amended—

16 (1) by striking subparagraph (B); and

17 (2) by redesignating subparagraphs (C) and
18 (D) as subparagraphs (B) and (C), respectively.

19 **SEC. 10354. AMERICA COMPETES ACT.**

20 Section 6122(3) of the America COMPETES Act (20
21 U.S.C. 9832(3)) is amended by striking “data on children
22 eligible for free or reduced-price lunches under the Rich-
23 ard B. Russell National School Lunch Act,”.

1 **SEC. 10355. WORKFORCE INNOVATION AND OPPORTUNITY**
2 **ACT.**

3 Section 3(36)(A) of the Workforce Innovation and
4 Opportunity Act (29 U.S.C. 3102(36)(A)) is amended—

5 (1) by striking clause (iv); and

6 (2) by redesignating clauses (v) and (vi) as
7 clauses (iv) and (v), respectively.

8 **SEC. 10356. NATIONAL SCIENCE FOUNDATION AUTHORIZA-**
9 **TION ACT OF 2002.**

10 Section 4(8) of the National Science Foundation Au-
11 thorization Act of 2002 (42 U.S.C. 1862n note; Public
12 Law 107–368) is amended—

13 (1) by striking subparagraph (A); and

14 (2) by redesignating subparagraphs (B) and
15 (C) as subparagraphs (A) and (B), respectively.

16 **SEC. 10357. CHILD CARE AND DEVELOPMENT BLOCK**
17 **GRANT.**

18 Section 658O(b) of the Child Care and Development
19 Block Grant Act of 1990 (42 U.S.C. 9858m(b)) is amend-
20 ed—

21 (1) in paragraph (1)(B), by striking “school
22 lunch factor” and inserting “economically disadvan-
23 tagged students factor”; and

24 (2) by striking paragraph (3) and inserting the
25 following:

1 “(3) ECONOMICALLY DISADVANTAGED STU-
 2 DENTS FACTOR.—In this subsection, the term ‘eco-
 3 nomically disadvantaged students factor’ means the
 4 ratio of the number of children in the State who are
 5 economically disadvantaged students (as identified
 6 under a measure described in section 1113(a)(5) of
 7 the Elementary and Secondary Education Act of
 8 1965 (20 U.S.C. 6313(a)(5))) to the number of such
 9 children in all the States as determined annually by
 10 the Secretary of Education.”.

11 **SEC. 10358. CHILDREN’S HEALTH ACT OF 2000.**

12 Section 1404(b) of the Children’s Health Act of 2000
 13 (42 U.S.C. 9859c(b)) is amended—

14 (1) in paragraph (1)(B), by striking “school
 15 lunch factor” and inserting “economically disadvan-
 16 taged students factor”; and

17 (2) by striking paragraph (3) and inserting the
 18 following:

19 “(3) ECONOMICALLY DISADVANTAGED STU-
 20 DENTS FACTOR.—In this subsection, the term ‘eco-
 21 nomically disadvantaged students factor’ means the
 22 ratio of the number of children in the State who are
 23 economically disadvantaged students (as identified
 24 under a measure described in section 1113(a)(5) of
 25 the Elementary and Secondary Education Act of

1 1965 (20 U.S.C. 6313(a)(5))) to the number of such
 2 children in all the States as determined annually by
 3 the Secretary of Education.”.

4 **SEC. 10359. JUVENILE JUSTICE AND DELINQUENCY PRE-**
 5 **VENTION.**

6 Section 252 of the Juvenile Justice and Delinquency
 7 Prevention Act of 1974 (34 U.S.C. 11162) is amended
 8 by striking subsection (i) and inserting the following:

9 “(i) FREE SCHOOL LUNCHES FOR INCARCERATED
 10 JUVENILES.—

11 “(1) DEFINITION OF ELIGIBLE JUVENILE DE-
 12 TENTION CENTER.—In this subsection, the term ‘eli-
 13 gible juvenile detention center’ does not include any
 14 private, for-profit detention center.

15 “(2) FREE LUNCH.—A juvenile who is incarcer-
 16 ated in an eligible juvenile detention center is eligible
 17 to receive free lunch under the Richard B. Russell
 18 National School Lunch Act (42 U.S.C. 1751 et
 19 seq.).

20 “(3) GUIDANCE.—Not later than 1 year after
 21 the date of enactment of the Universal School Meals
 22 Program Act of 2026, the Attorney General, in con-
 23 sultation with the Secretary of Agriculture, shall
 24 provide guidance to States relating to the options for
 25 school food authorities in the States to apply for re-

1 imbursement for free lunches under the Richard B.
 2 Russell National School Lunch Act (42 U.S.C. 1751
 3 et seq.) for juveniles who are incarcerated.”.

4 **TITLE XI—PROTECTIONS TO**
 5 **COMBAT REGULATORY HARM**
 6 **TO HEALTH EQUITY**

7 **SEC. 11001. REPEAL OF EXECUTIVE ORDERS.**

8 (a) IN GENERAL.—The Executive orders described in
 9 subsection (b) shall have no force or effect, and no Federal
 10 funds may be used to implement, administer, enforce, or
 11 carry out any of those Executive orders.

12 (b) EXECUTIVE ORDERS DESCRIBED.—The Execu-
 13 tive orders described in this subsection are the following:

14 (1) Executive Order 14148 (90 Fed. Reg. 8237;
 15 relating to initial rescissions of harmful executive or-
 16 ders and actions).

17 (2) Executive Order 14158 (90 Fed. Reg. 8441;
 18 relating to establishing and implementing the Presi-
 19 dent’s “Department of Government Efficiency”).

20 (3) Executive Order 14151 (90 Fed. Reg. 8339;
 21 relating to ending radical and wasteful Government
 22 DEI programs and preferencing).

23 (4) Executive Order 14168 (90 Fed. Reg. 8615;
 24 relating to defending women from gender ideology

1 extremism and restoring biological truth to the Fed-
2 eral Government).

3 (5) Executive Order 14173 (90 Fed. Reg. 8633;
4 relating to ending illegal discrimination and restor-
5 ing merit-based opportunity).

6 (6) Executive Order 14183 (90 Fed. Reg. 8757;
7 relating to prioritizing military excellence and readi-
8 ness).

9 (7) Executive Order 14185 (90 Fed. Reg. 8763;
10 relating to restoring America's fighting force).

11 (8) Executive Order 14201 (90 Fed. Reg. 9279;
12 relating to keeping men out of women's sports).

13 (9) Executive Order 14212 (90 Fed. Reg. 9833;
14 relating to establishing the President's Make Amer-
15 ica Healthy Again Commission).

16 (10) Executive Order 14321 (90 Fed. Reg.
17 35817; relating to ending crime and disorder on
18 America's streets).

19 (c) REINSTATEMENT.—To the extent that any Exec-
20 utive order described in subsection (b) revoked or re-
21 scinded another Executive order or other Executive action,
22 such revoked or rescinded Executive order or Executive
23 action is hereby reinstated and restored to full legal force
24 and effect.

1 **SEC. 11002. STATUTORY RESTORATION AND REESTABLISH-**
2 **MENT OF FEDERAL OFFICES AND PROGRAMS.**

3 (a) OFFICES OF MINORITY HEALTH AND HEALTH
4 EQUITY.—

5 (1) IN GENERAL.—Not later than 30 days after
6 the date of enactment of this Act, each office de-
7 scribed in paragraph (2) shall—

8 (A) employ not less than the number of
9 staff as such office employed as of January 19,
10 2025; and

11 (B) carry out all functions as such office
12 carried out as of such date.

13 (2) OFFICES.—The offices described in this
14 paragraph are each of the following:

15 (A) The Office of Minority Health of the
16 Department of Health and Human Services, es-
17 tablished by section 1707 of the Public Health
18 Service Act (42 U.S.C. 300u–6).

19 (B) The Office of Minority Health of the
20 Centers for Medicare & Medicaid Services, es-
21 tablished pursuant to section 1707A of such
22 Act (42 U.S.C. 300u–6a).

23 (C) The Office of Minority Health and
24 Health Equity of the Food and Drug Adminis-
25 tration, established pursuant to such section
26 1707A.

1 (3) RESOURCES.—Not later than 30 days after
2 the date of enactment of this Act, all websites, data
3 portals, and public-facing resources of the offices de-
4 scribed in paragraph (2), removed pursuant to any
5 Executive order described in section 11001(b), shall
6 be fully restored to their forms as in existence on
7 January 19, 2025.

8 (4) FUNDING.—The Secretary of Health and
9 Human Services shall ensure that any amounts ap-
10 propriated or otherwise made available for an office
11 described in paragraph (2) as of January 19, 2025,
12 that were retracted or otherwise withheld from such
13 office during the period beginning on January 19,
14 2025, and ending on the date of enactment of this
15 Act are transferred to, or otherwise reinstated for,
16 such office. Any such amounts shall be used by the
17 office to carry out paragraph (1) with respect to
18 such office.

19 (b) NATIONAL INSTITUTE ON MINORITY HEALTH
20 AND HEALTH DISPARITIES.—

21 (1) IN GENERAL.—Not later than 30 days after
22 the date of enactment of this Act, the National In-
23 stitute on Minority Health and Health Disparities,
24 established by section 401(b)(24) of the Public
25 Health Service Act (42 U.S.C. 281(b)(24)), shall—

1 (A) employ not less than the number of
2 staff as such Institute employed as of January
3 19, 2025; and

4 (B) carry out all functions as such Insti-
5 tute carried out as of such date.

6 (2) DIRECTOR.—The Director of the National
7 Institute on Minority Health and Health Disparities,
8 or any Acting Director of such Institute, placed on
9 administrative leave or terminated pursuant to any
10 Executive order described in section 11001(b), or a
11 related Executive action, is reinstated, subject to the
12 consent of such Director, for a term of 5 years be-
13 ginning on the date of enactment of this Act. Noth-
14 ing in this paragraph shall limit the authority of the
15 Secretary or the Director of the National Institutes
16 of Health described in section 405(a)(2)(E) of the
17 Public Health Service Act (42 U.S.C. 284(a)(2)(E)).

18 (3) FUNCTIONS.—No provision of Federal stat-
19 utory law may eliminate the National Institute on
20 Minority Health and Health Disparities without
21 specifying how the statutory functions of the Insti-
22 tute will be carried out.

23 (4) FUNDING.—The Secretary of Health and
24 Human Services shall ensure that any amounts ap-
25 propriated or otherwise made available for the Na-

1 tional Institute on Minority Health and Health Dis-
2 parities as of January 19, 2025, that were retracted
3 or otherwise withheld from such Institute during the
4 period beginning on January 19, 2025, and ending
5 on the date of enactment of this Act are transferred
6 to, or otherwise reinstated for, such Institute. Any
7 such amounts shall be used by the Institute to carry
8 out paragraph (1).

9 (c) OFFICES OF HEALTH EQUITY; HEALTH EQUITY
10 ADVISORY COMMITTEE.—Title XVII of the Public Health
11 Service Act (42 U.S.C. 300u et seq.) is amended by insert-
12 ing after section 1707A (42 U.S.C. 300ua–6a) the fol-
13 lowing:

14 **“SEC. 1707B. INDIVIDUAL OFFICES OF HEALTH EQUITY**
15 **WITHIN THE DEPARTMENT.**

16 “(a) IN GENERAL.—The head of each agency speci-
17 fied in subsection (b) shall establish within the agency an
18 office to be known as the Office of Health Equity. The
19 head of each such Office shall be a Director appointed by
20 the head of the agency within which the Office is estab-
21 lished, and such Director shall report directly to the head
22 of the agency. The head of such agency shall carry out
23 all functions (as this section relates to the agency) acting
24 through such Director.

1 “(b) AGENCIES.—The agencies described in this sub-
2 section are each of the following:

3 “(1) The Centers for Disease Control and Pre-
4 vention.

5 “(2) The Health Resources and Services Ad-
6 ministration.

7 “(c) FUNCTIONS AND STAFF.—

8 “(1) CDC.—The Office of Health Equity of the
9 Centers for Disease Control and Prevention estab-
10 lished by this section shall—

11 “(A) employ not less than the number of
12 staff the Office of Health Equity of the Centers
13 for Disease Control and Prevention operating
14 on January 19, 2025, employed as of such date;
15 and

16 “(B) carry out all functions that the Office
17 of Health Equity of the Centers for Disease
18 Control and Prevention operating on January
19 19, 2025, carried out as of such date.

20 “(2) HRSA.—The Office of Health Equity of
21 the Health Resources and Services Administration
22 established by this section shall—

23 “(A) employ not less than the number of
24 staff the Office of Health Equity of the Health
25 Resources and Services Administration oper-

1 ating on January 19, 2025, employed as of
2 such date; and

3 “(B) carry out all functions that the Office
4 of Health Equity of the Health Resources and
5 Services Administration operating on January
6 19, 2025, carried out as of such date.

7 “(d) FUNDING.—

8 “(1) CDC.—The Secretary shall ensure that
9 any amounts appropriated or otherwise made avail-
10 able for the Office of Health Equity of the Centers
11 for Disease Control and Prevention operating on
12 January 19, 2025, that were retracted or otherwise
13 withheld from such office during the period begin-
14 ning on January 19, 2025, and ending on the date
15 of enactment of the Health Equity and Account-
16 ability Act of 2026 are transferred to, or otherwise
17 reinstated for, the Office of Health Equity of the
18 Centers for Disease Control and Prevention estab-
19 lished under this section. Any such amounts shall be
20 used by such Office to carry out subsection (c)(1).

21 “(2) HRSA.—The Secretary shall ensure that
22 any amounts appropriated or otherwise made avail-
23 able for the Office of Health Equity of the Health
24 Resources and Services Administration operating on
25 January 19, 2025, that were retracted or otherwise

1 withheld from such office during the period begin-
2 ning on January 19, 2025, and ending on the date
3 of enactment of the Health Equity and Account-
4 ability Act of 2026 are transferred to, or otherwise
5 reinstated for, the Office of Health Equity of the
6 Health Resources and Services Administration es-
7 tablished under this section. Any such amounts shall
8 be used by such Office to carry out subsection
9 (c)(2).

10 **“SEC. 1707C. HEALTH EQUITY ADVISORY COMMITTEE.**

11 “(a) ESTABLISHMENT.—There is established in the
12 Department of Health and Human Services an advisory
13 committee to be known as the ‘Health Equity Advisory
14 Committee’ (referred to in this section as the ‘Advisory
15 Committee’).

16 “(b) MEMBERS.—The Advisory Committee shall be
17 composed of 20 members, all of whom shall be appointed
18 by the Secretary not later than 90 days after the date
19 of enactment of the Health Equity and Accountability Act
20 of 2026.

21 “(c) DUTIES.—The Advisory Committee shall—

22 “(1) advise the Secretary on the priorities and
23 concerns of populations experiencing health dispari-
24 ties;

1 “(2) recommend actions, standards, and meth-
2 odologies that are data-driven, evidence-based, and
3 culturally and linguistically appropriate for the iden-
4 tification, measurement, and elimination of health
5 disparities;

6 “(3) advise the Secretary on the design, collec-
7 tion, analysis, disaggregation, and public reporting
8 of data necessary to identify and monitor health dis-
9 parities, including data on race, ethnicity, primary
10 language, sexual orientation, gender identity, dis-
11 ability status, and socioeconomic status;

12 “(4) review, and recommend revisions to, de-
13 partmental policies, standards, regulations, and pro-
14 cedures that may create, perpetuate, or fail to miti-
15 gate health inequities;

16 “(5) assist the Secretary in developing, imple-
17 menting, and monitoring performance measures re-
18 lated to the advancement of health equity across the
19 programs of the Department;

20 “(6) increase public awareness of the existence,
21 causes, and consequences of health disparities;

22 “(7) carry out such other duties as the Sec-
23 retary may assign to advance the purposes of the
24 Health Equity and Accountability Act of 2026; and

1 “(8) carry out any other duty that the Health
2 Equity Advisory Committee of the Department of
3 Health and Human Services, operating on January
4 19, 2025, carried out as of such date.”.

5 (d) SAMHSA AND OTHER HEALTH AGENCIES.—

6 (1) IN GENERAL.—Not later than 30 days after
7 the date of enactment of this Act, each of the agen-
8 cies of the Department of Health and Human Serv-
9 ices described in paragraph (2) shall—

10 (A) employ not less than the number of
11 staff as such agency employed as of January
12 19, 2025; and

13 (B) carry out all functions (including by
14 carrying out all grants and programs) that such
15 agency carried out as of such date.

16 (2) AGENCIES.—The agencies described in this
17 paragraph are each of the following:

18 (A) The Substance Use and Mental Health
19 Services Administration established by title V of
20 the Public Health Service Act (42 U.S.C. 290aa
21 et seq.) and renamed pursuant to the amend-
22 ments made by section 6707.

23 (B) The Office of Infectious Diseases and
24 HIV/AIDS Policy.

1 (C) The National Institute of Nursing Re-
2 search, established by section 401(b)(17) of the
3 Public Health Service Act (42 U.S.C.
4 281(b)(17)).

5 (D) The John E. Fogarty International
6 Center for Advanced Study in the Health
7 Sciences, established by section 401(b)(22) of
8 such Act.

9 (E) The National Center for Complemen-
10 tary and Integrative Health, established by sec-
11 tion 401(b)(23) of such Act.

12 (3) FUNDING.—The Secretary of Health and
13 Human Services shall ensure that any amounts ap-
14 propriated or otherwise made available for an agency
15 described in paragraph (2) as of January 19, 2025,
16 that were retracted or otherwise withheld from such
17 agency during the period beginning on January 19,
18 2025, and ending on the date of enactment of this
19 Act are transferred to, or otherwise reinstated for,
20 such agency. Any such amounts shall be used by the
21 agency to carry out paragraph (1) with respect to
22 such agency.

23 (e) OFFICE OF FEDERAL CONTRACT COMPLIANCE
24 PROGRAMS.—

1 (1) IN GENERAL.—Not later than 30 days after
2 the date of enactment of this Act, the Office of Fed-
3 eral Contract Compliance Programs of the Depart-
4 ment of Labor shall—

5 (A) employ not less than the number of
6 staff as such Office employed as of January 19,
7 2025; and

8 (B) carry out all functions that such Office
9 carried out as of such date.

10 (2) FUNDING.—The Secretary of Labor shall
11 ensure that any amounts appropriated or otherwise
12 made available for the Office of Federal Contract
13 Compliance Programs of the Department of Labor
14 as of January 19, 2025, that were retracted or oth-
15 erwise withheld from such Office during the period
16 beginning on January 19, 2025, and ending on the
17 date of enactment of this Act are transferred to, or
18 otherwise reinstated for, such Office. Any such
19 amounts shall be used by the Office to carry out
20 paragraph (1).

21 (f) UNITED STATES AGENCY FOR INTERNATIONAL
22 DEVELOPMENT HEALTH PROGRAMS.—

23 (1) IN GENERAL.—Not later than 30 days after
24 the date of the enactment of this Act, the Secretary
25 of State shall—

1 (A) reestablish the Bureau for Global
2 Health of the United States Agency for Inter-
3 national Development as an independent agency
4 of the Federal Government;

5 (B) initiate the hiring or rehiring of staff
6 in the Bureau for Global Health so that the
7 number of such staff and the positions occupied
8 by such staff are roughly equivalent to the
9 number and positions of such staff that were
10 employed by the Bureau as of January 19,
11 2025; and

12 (C) establish a detailed strategy for ensur-
13 ing the Bureau for Global Health resumes the
14 responsibility of carrying out all of the func-
15 tions that were assigned to the Bureau as of
16 such date.

17 (2) FUNDING.—The Secretary of State shall
18 ensure that any amounts appropriated or otherwise
19 made available for the Bureau for Global Health as
20 of January 19, 2025, which were subsequently with-
21 held from the Bureau, are made available to the Bu-
22 reau to carry out the actions required under para-
23 graph (1), including implementing the strategy re-
24 ferred to in paragraph (1)(C).

1 **SEC. 11003. REINSTATEMENT OF FEDERAL DATA COLLEC-**
2 **TION STANDARDS.**

3 (a) REINSTATEMENT.—Not later than 60 days after
4 the date of enactment of this Act, each Federal agency
5 shall restore all Federal sociodemographic data collection
6 systems (including survey instruments), datasets, and re-
7 porting mechanisms relating to race, ethnicity, sex, sexual
8 orientation, gender identity, disability status, income, and
9 other characteristics protected by Federal law, to the sys-
10 tems, datasets, and mechanisms of the Federal agency as
11 in existence on January 19, 2025.

12 (b) DATA RESTORATION.—Not later than 30 days
13 after the date of enactment of this Act, all datasets, publi-
14 cations, and web resources removed from public access,
15 modified, or restricted by any Federal agency pursuant to
16 any Executive order described in section 11001(b) shall
17 be fully restored as in existence on January 19, 2025, with
18 no data permanently deleted.

19 (c) REPORTING.—Not later than 90 days after the
20 date of enactment of this Act, the Director of the Office
21 of Management and Budget shall submit to Congress a
22 comprehensive report—

23 (1) identifying every Federal dataset, publica-
24 tion, and web resource that was removed, modified,
25 or restricted pursuant to an Executive order de-
26 scribed in section 11001(b); and

1 (2) certifying that each such dataset, publica-
2 tion, or resource has been restored as in existence on
3 January 19, 2025.

4 **SEC. 11004. REINSTATEMENT OF ANTI-DISCRIMINATION RE-**
5 **QUIREMENTS FOR FEDERAL CONTRACTORS.**

6 (a) **AFFIRMATIVE ACTION REQUIREMENTS.**—With-
7 out an express provision of Federal statutory law, no Ex-
8 ecutive action, including any Executive order, guidance or
9 directive of the Office of Management and Budget, or
10 other Federal agency guidance or directive, may relieve
11 any Federal contractor of equal employment opportunity
12 and affirmative action obligations under Executive Order
13 11246 (42 U.S.C. 2000e note; relating to equal employ-
14 ment opportunity), as reinstated pursuant to section
15 11001(c) or under other applicable law.

16 (b) **CERTIFICATION REQUIREMENTS.**—Any certifi-
17 cation requirement imposed by Executive Order 14173 (90
18 Fed. Reg. 8633; relating to ending illegal discrimination
19 and restoring merit-based opportunity) requiring Federal
20 contractors, including subcontractors, to certify that such
21 contractors do not maintain any diversity, equity, and in-
22 clusion programs that violate any applicable Federal anti-
23 discrimination laws shall have no force or effect. No such
24 certification, or any similar certification, may be required
25 as a condition of any Federal contract.

1 (c) ENFORCEMENT.—The Office of Federal Contract
2 Compliance Programs of the Department of Labor shall
3 resume full enforcement of equal employment opportunity
4 and affirmative action requirements for Federal contrac-
5 tors under Executive Order 11246 (42 U.S.C. 2000e note;
6 relating to equal employment opportunity), and any other
7 applicable law, consistent with the law as in effect on Jan-
8 uary 19, 2025.

9 **SEC. 11005. REAFFIRMATION AND CODIFICATION OF DIS-**
10 **PARATE IMPACT LIABILITY.**

11 (a) ENFORCEMENT.—All Federal agencies shall ac-
12 tively enforce disparate impact discrimination prohibitions
13 under Federal statutory law to the full extent of applicable
14 law, consistent with the regulations, guidance, and en-
15 forcement policies of the Federal Government in effect on
16 January 19, 2025.

17 (b) STATUTORY CODIFICATION.—No Executive ac-
18 tion, including any Executive order, presidential memo-
19 randum, or Federal agency guidance or directive, may di-
20 rect any Federal agency to deprioritize, suspend, or cease
21 enforcement of disparate impact discrimination liability
22 under any Federal statutory law. Any such direction in
23 such an Executive action to deprioritize, suspend, or cease
24 enforcement is contrary to law and shall have no force or
25 effect.

1 **SEC. 11006. LIMITATIONS ON FUTURE EXECUTIVE ACTION.**

2 (a) PROHIBITION.—Notwithstanding any other provi-
3 sion of law, without an express provision of Federal statu-
4 tory law, no Executive action, including any Executive
5 order, presidential memorandum, or directive of the Office
6 of Management and Budget, may—

7 (1) abolish, eliminate, defund (or otherwise re-
8 duce funding for), or reduce below legally mandated
9 minimum staffing levels (including as provided in
10 this title) any Federal office, agency, or program es-
11 tablished by a provision of Federal statutory law, or
12 otherwise described in section 11002;

13 (2) direct a Federal agency to remove
14 sociodemographic data from any Federal survey,
15 dataset, or public health surveillance system relating
16 to characteristics protected under Federal law; or

17 (3) direct any Federal agency to terminate, sus-
18 pend, or cease enforcement of any provision of the
19 Civil Rights Act of 1964 (42 U.S.C. 2000a et seq.),
20 the Fair Housing Act (42 U.S.C. 3601 et seq.), the
21 Americans with Disabilities Act of 1990 (42 U.S.C.
22 12101 et seq.), the Age Discrimination in Employ-
23 ment Act of 1967 (29 U.S.C. 621 et seq.), the Vot-
24 ing Rights Act of 1965 (52 U.S.C. 10301 et seq.),
25 or any other Federal civil rights statute.

1 (b) CONGRESSIONAL NOTIFICATION REQUIRE-
2 MENT.—Not later than 5 days after the issuance of any
3 Executive order that the President contends affects Fed-
4 eral offices or programs relating to health equity, civil
5 rights, anti-discrimination, or sociodemographic data col-
6 lection, the Director of the Office of Management and
7 Budget shall submit a written notification to the relevant
8 congressional oversight committees describing the actions
9 directed by such order and their projected effects on the
10 affected offices and programs.

11 (c) PRIVATE RIGHT OF ACTION.—Any person ag-
12 grieved by a violation of subsection (a) may bring a civil
13 action in an appropriate Federal district court for declara-
14 tory and injunctive relief. A court in such an action may
15 award reasonable attorneys' fees to prevailing plaintiffs.

16 **SEC. 11007. SEVERABILITY.**

17 If any provision of this title, or the application of any
18 provision of this title to any person or circumstance, is
19 held to be invalid, the remainder of this title and the appli-
20 cation of its provisions to other persons or circumstances
21 shall not be affected thereby.

22 **SEC. 11008. AUTHORIZATION OF APPROPRIATIONS.**

23 (a) IN GENERAL.—There are authorized to be appro-
24 priated such sums as may be necessary to carry out this
25 title, including to restore all offices, programs, staffing lev-

1 els, and data systems described in this title to the status
2 as of January 19, 2025, and to make whole all persons
3 harmed by unlawful impoundment or agency actions pur-
4 suant to any Executive order described in section
5 11001(b).

6 (b) RETROACTIVE PAYMENTS.—There are authorized
7 to be appropriated such sum as may be necessary to pro-
8 vide retroactive payment of all grants, contracts, awards,
9 and employee compensation withheld or cancelled pursu-
10 ant to any Executive order described in section 11001(b).

11 (c) PROHIBITION ON IMPOUNDMENT.—No funds ap-
12 propriated pursuant to this Act may be withheld, deferred,
13 or rescinded by the Executive branch without compliance
14 with the procedures set forth in the Impoundment Control
15 Act of 1974 (2 U.S.C. 681 et seq.).

